

**Zuiderent-Jerak Teun (2015) *Situated Intervention: Sociological Experiments in Health Care*. Cambridge & London: The MIT Press. 248 pages.**

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Good afternoon. I'm Gary Downey, senior manager at a large outpatient clinic and day care treatment center focused on hematology and oncology. Along with my colleagues, all highly-trained medical professionals and health care managers, I have to tell you that I'm truly going crazy.

Our health care workers are here to cure patients, but it's just not working. There's simply too much variation in our care.

It's so confusing. We have long been committed to proper standardization. You'll find here a foundational commitment to EBM, evidence-based medicine (pp. 61–68). Our practitioners rightly trust evidence from randomized controlled clinical trials. Indeed, we're participating in several trials right now, and we have to guarantee researchers that we're properly following their test protocols. Furthermore, drawing on EBM, we have developed solid sets of CPG's – clinical practice guidelines – to implement proven diagnostic and therapeutic knowledge (pp. 63–70). Finally, we have even developed and implement detailed ICP's – integrated care pathways – indicating precisely what actions our professionals are to take at each and every moment of treatment. We are even cutting edge in our understanding of the diversity of patients. We have distinct ICPs for different categories of patient based on sex, gender, race, ethnicity, and age.

But look at our schedule and the waiting room out there!! Waiting times for diagnostic proce-

dures have gone through the roof. Patients don't comply with our schedules. And care—we're so crowded sometimes that some patients receiving chemotherapy have to sit on a stool rather than reclining properly in an adjustable chair. That is flat-out unsafe!

Again, I have to tell you: variations in delivery are preventing us from providing to our patients what we know is quality care.

***Encountering the sociologist***

A friend of mine over in the hemophilia care center in Chapter 1 tells me that this sociologist might be helpful. His name is Teun Zuiderent-Jerak. Since I'm not a Dutchman, I can't say (or sometimes spell) his name properly, so let me just call him Z-J.

My friend said that Z-J might be helpful, but not "useful" (p. 38). I didn't understand. She said he's not a sociologist who comes with solutions. He doesn't just identify factors that are supporting or hampering the implementation of existing policy agendas.

She said he'd hang out for a while, and I should be patient. She gushed about him suggesting an "experiment" that involved installing a multidisciplinary hemophilia clinic, including one site led by nurses and another for the physiotherapist (p. 55). "It worked!" she said.

So I gave him three months, here in Chapter 2.

### **Later – Situated standardization**

After spending many hours watching, talking, and counting things, Z-J came back and somewhat brazenly told me that the bandwidth of our collective focus had narrowed. He said that we're focusing almost entirely on curative aspect of care rather than on other aspects that our professionals may not see as directly relevant to the continuation of treatment.

The main reason, he said, is that over the past three years, we've doubled the number patients that come through our doors. He says that he "learned" in the process of watching and counting that our definition of "good work" had shifted substantially. It's now about keeping up with the fast pace by whatever means necessary. (pp. 74–75). He showed me tables indicating that our hematologists are working far more surgery hours than we planned for them. Interestingly, though, our oncologists are not — but there's a huge variation among them.

Z-J then presented a proposal to undertake what he called "experimental" changes. These experiments were a bit weird. They threw out my understanding of organizational structure – outpatient clinic, laboratories, radiology department, clinical departments, and so on. They focused instead on processual pathways – flows of patients through the clinic.

We let him go ahead.

He kept redefining the place.

He showed us that doctors' assistants are not assisting if we define their work as either "front-office" or "back-office" (pp. 79–80). Instead of the easily understandable categories of sex, gender, race, ethnicity, and age, Z-J said we should focus on someone called the "emergency relapse patient." Another one is the "come-back-later patient," whose blood levels prohibit chemotherapy (p. 80). Z-J then aggregated practices based on these new categories of people, coming up with some new processual pathways.

In meetings with our staff, Z-J explained it all with simple one-page flow charts. Everyone found these far easier to understand than those 20-page integrated care pathways that, actually, we all hate. They really are hard to implement.

Just as my friend in the hemophilia center had predicted, Z-J told me he was not implementing

a method. We pressed him a bit on this. All we could get out of him was "situated standardization" – standardization related to specific issues (p. 181). He explained how our incessant search for "standardized methods" are precisely what was generating the problems of variability and non-compliance in the first place.

We are now standardizing in a way that is situated in this clinic — it's not supposed to be universal. My friends at other clinics don't understand. I tell them that we've got a sociologist who "reconfigure[s our] problem spaces," whatever that means (p. 161). They're curious. They should be. Have a look at our waiting room.

### **Multiple ontologies**

I've got an acquaintance in the Ministry of Health, over in Chapter 3, who's terribly worried about people seeing hospitals as unsafe place. I recommended ZJ and his colleagues (ok, not really).

They went over there with an assignment to "evaluate" an improvement collaborative designed to "improve safety" in health care. The Ministry's "Care for Better" initiative brought together multi-disciplinary teams from many institutions. They were searching for best practices to spread across the country.

Evidently, Z-J was interested to see if his situated intervention stuff could work in a setting in which he couldn't just redefine the whole problem space, the way he did here. Project leaders wanted the team of sociologists to just "evaluate" the implementation of best practices.

But of course Z-J didn't behave.

Instead of proper evaluation, he and his colleagues started to document what they called "multiple ontologies" – a notion they borrowed from some other Dutch sociologist. I can't remember her name.

Rather than "acceptance of" or "resistance to" innovative practices, the sociologists saw distinct ways of "doing medication safety" that had specific consequences for the actions they afforded. One group did safety, they said, as controlling medication behavior by care workers and clients. Another did safety by reflecting on which errors were actually problematic, which were permissible, and when clients should delegate responsibilities back to care workers.

My acquaintance was evidently impressed, even if a bit uncertain. They persuaded him that improving safety might not be about visionary leadership successfully diffusing best practices across an organization, or a country. They said it could be about everyone recognizing that medication safety is done different ways. So, directly at odds with what all the evaluation experts tell us, repeatedly, they suggested that different teams might try formulating team-specific indicators for particular targets rather than assuming that everyone always does safety the same way.

Curious, I listened in on some conversations Z-J had with his buddies. Rather than importing a “theory of care,” or a “normative approach” to medicine, Z-J says he’s situating himself in the “surfeit of normativities” (pp. 189–190) that live on our wards.

He says he’s conducting experiments by intervening. He says it doesn’t matter if we develop some kind of shared commitments or not. He wants to help but says his value as a sociologist is not defined wholly, or even primarily, by whether or not his proposed solutions work. Since he claims not to be an organizational consultant, all the work is worth it to him if only if he is producing new knowledge about the conceptualization and delivery of medical care.

Z-J says that situated intervention doesn’t work all the time or everywhere. It struggles especially when participants in a given problem space are absolutely resistant to rethinking their definitions, or recognizing other ontologies. I’m familiar with many such places.

He then went kind of theoretical on me, so I’m not sure if I got it right. Borrowing from Ian Hacking, Z-J has written a book that brings to sociology a back-to-Bacon movement that sees experiments as “fingerposts that are set up where roads part, to indicate the several directions” (p. 20). Z-J brings this notion to sociology because he wants to let go of what he describes as scholarly objectivism and scholarly engagement. Z-J questions both detached scholarly positions and pre-set normative agendas. His book makes the case that fingerpost experiments can produce new sociological knowledge.

Z-J argues that efforts at engagement tend to get stuck in a dualism. They risk either adopting

the problem definitions pre-set by the actors they engage with, or becoming organizational consultants with their own problem definitions who are caught up in what Z-J calls the problem of implementation. That argument struck me as a bit familiar.

Z-J then went on to say that his experiments are about generating knowledge by reconfiguring problem spaces. They are about investigating what it means to situate one’s work amidst previously unpacked normative complexities. They are about how unpacking normative complexities can be part of knowledge production and vice-versa, how intelligible theoretical positions must lie within the fields of practical action, and how intervention need not be tied to a pre-defined diagnosis of what the normative problem is, followed by implementation of a solution.

Along the way, Z-J evidently highlights the importance of material re-figurings of medical practices, claiming that these reveal more, or at least different, knowledge than discursive ways of intervening. He labels this situated work “artful contamination” (pp. 185–186), pointing out that sociologists must accept the contamination of both their epistemologies and their normativities when doing experimental work. Finally, Z-J explains how “ecologies of intervention” (pp. 185–192) are both analyzable and matter greatly.

Some say it’s a great book to think with. To me it sounds like a great book to “act with” (p. 9).

I think I’m going to buy a copy because I have a few questions.

1. I’m a little confused by this concept of fingerpost experiments in the back to Bacon movement. Do the fingerpost experiments that Z-J and his colleagues undertook in my outpatient clinic differ in any significant ways from fingerpost experiments in the natural sciences? Might the normative complexities differ in any way, e.g., in their levels of complexity?
2. What about those normative attachments to which Z-J devotes so much ink. Z-J acknowledges that fingerpost experiments have consequences for “scholars’ resultant normative attachments” (p. 18).

Well, that made me think about the flow of chapters in this book. The chapters have a kind of narrative arc traveling through them. Z-J offers an account of developing, expanding access, as he moves from a hemophilia clinic to national evaluation standards. Somehow successes at various points led to opportunities at later point.

I did not notice in the book, however, an account of how all these fingerpost experiments has “resultant normative attachments” for Z-J and his colleagues. Does Z-J have such an account? Z-J is up-front about characterizing his interventions as helpful (e.g., pp. 34, 184) or as seeming worthwhile (p. 162). What happened to make these situated interventions helpful or worthwhile? And whom did Z-J become, or what commitments might he have added to himself, along the way?

3. Indeed, might this work raise important questions about the relationship between the person and the scholar in experimental work [and other scholarly work]? Might Z-J’s account actually reframe the distinction between the person and the scholar by pointing out

that the scholar [especially the scholar doing experimental work] is immersed in normativities as much as is the person? If the scholar is immersed in normativities to the same extent as the person, might it also be the case that the person is immersed in epistemics to the same extent as the scholar? Might accounts of scholarly learning, especially one focused so self-consciously on specific positioning of the scholar within the field of study, benefit from addressing more explicitly evolving relationships between the scholar and person? I myself have been playing with the image of multiple identities – added, subtracted, and with interacting agencies – to wrestle with this question. In Z-J’s book, how is the scholar related to the person?

4. Ok, one last one. A small one. Z-J can surely answer it quickly: What’s the difference between sociology and STS? Or put another way: How would the book’s attachments differ if the subtitle read: *STS Experiments in Health Care*?