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Chapter 7

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Introduction

This chapter focuses on the tension between complexity of caring practices and the normative dimension of providing good care. The question we raise in this chapter is whether practice theory provides conceptual space for the good of the patient, being a vulnerable person, longing for cure and support in dire times, receiving care under conditions of complexity? Our answer is that this is possible, by considering the epistemological and moral position of a patient as someone dealing with illness and social vulnerability as well ('precarity'). The very character of being a patient is that he or she is suffering. Suffering, however, is not specific to patients. As the French philosopher Paul Ricoeur puts it, suffering and more broadly being the subject of forces displays what is common to all humans. People are 'passible': they constantly undergo processes, they are subject to time and material circumstances, such as heat, light and air pressure (Ricoeur, 1986: 125). People also constantly undergo acts of other people (pep talk, admonishments, putting a needle in one's back for diagnostic reasons, caressing fingers). And people undergo diseases. Of course some diseases are self-inflicted. But even then, when the disease is raging or slumbering in the body, people undergo it: they feel the contractions, the throbbing pain, the itching. People are also actors but with the constant reality of being 'passible'. Thus Ricoeur balances his idea of human agency with his observation that people are sentient beings undergoing situations, time and space; they are both subjects and objects and often at the same time. The neologism *passibilité* points at something different than passivity. When passivity means remaining without action, *passibility* does indicate movements: inner movements, even if people are not always consciously aware of them. Undergoing evokes inner movements: repulsion, attraction, contraction etcetera. In ethics this interplay of action and undergoing realities is a major shift: what if human acts are not just reigned by intention, decision, will, by principles, by duty, by rational accounts of consequences but by mere passibility as well? We thus propose that it is not evident that a patient is an actor in care practices similar to the acting roles of nurses, physicians, care managers; patients should not be seen as co-players in this field.

In this chapter, we will take up the issue of whether the passibility and vulnerability of patients can be weaved in a practices oriented conceptualization of complex care.

While our aim is to offer a conceptual contribution to practice theory, our considerations are based on five years of qualitative empirical research (2009–2014) of the first two authors in a general hospital in the Netherlands. As care ethicists, we were (and are) interested in how good care can come about and how it can turn, in an instant, into bad care (see Tronto 1993 and Held 2006 on the philosophical ethics of care and caring).

We have shadowed patients waiting for hours in the emergency room; we have witnessed astonishingly good care and unnecessary incriminating acting by one and the same physician on the very same day; we observed the use of high tech and physicians at particular moments relying on more classical experience based diagnostics; we shadowed and interviewed nurses on their rounds distributing medicine while using a computerized safety system, pointing to just one example of the prominent role of materiality in care practices. Complexity became a more and more predominant issue during our observations. Standing explanations from organization theory, interesting as they are, were not satisfying, as suffering of patients or even 'harm added by care' (Van Heijst, 2011) were absent in them. If an organization is an arrangement of things, people, ideas or activities (Hatch, 2011) the lack of any telos, and the absence of any conceptualization of the substance of the work, and the experiences that it brings about, render that definition problematic. Such a formal definition of an organization is theoretically weak: that what is done and what is experienced seems irrelevant (cf. Pellegrino, 2001). As Lyotard has analysed there is no such thing as a 'nil institution', an organization defined as devoid from content. Thus, the presence of patients *constitute* the carework in a hospital, they are not just add-ons to an already existing, morally neutral organization.

As we were sceptical of theories concentrating on complexity that leave out the substance of care and the normative, we were looking for a theory that could serve us better as a heuristic tool for our research. We needed a theory that could help to dig up matters of concern to those working and being ill in the hospital organization and which is also capable of capturing issues of complexity and normativity. How could caring, suffering and the high complexity of the late modern hospital be adequately theorized? We side with Annemarie Mol (2003) as she emphasizes 'that what is enacted' in an organization. However, we do not concentrate, as she does, on the enactment of the body multiple or perhaps disease multiple in various care practices in which health care is leading. Rather, we wanted to understand the very nature of being a patient: the one who is suffering, undergoing both the disease and the care practice. We are interested in the complaints and concerns of patients as they come for assistance and help to doctors, nurses, physiotherapists, nutrition experts, and we are interested in the actions of the care professionals as they take place in the highly complex setting of the hospital too. Any theory that is of heuristic value to our research would

have to contain these interests. We adopted a practice approach to understand what the complexity of the organization and the work processes are about, while staying loyal to the fact that people enter a hospital because they are ill, suffer, recover, are in pain or die as well as to the fact that health care workers have professional concerns of their own. The understanding of complex care practices cannot come about if these realities are neglected.

In what follows, we first will discuss what complexity in hospital settings is about. Second, we ask how the moral good of the patient can be understood under conditions of such complexity. After that, we discuss how and to what extent practice theory allows taking the nature of being a patient seriously in complex care practices.

Complexity in the hospital

Complexity in an organization appears when 'things relate but don't add up' as Annemarie Mol and John Law put it (Mol and Law, 2002: 1). With regard to hospitals there is ever increasing complexity but also a constant effort to reduce complexity: the activity of complexity reduction, mostly not grounded on an idea of how the hospital should be, but as relentless labour to keep basic work processes going. And there is good reason to that. Complexity is enhanced by trends that are helpful (e.g. the introduction of new technologies that offer better chances for less harmful intervention) but burdensome as well: it burdens the work of care givers and often it draws attention away from the patients and their suffering. As we are interested in hospital care practice in its present form, permeated by complexity and the question of how good care is conceivable under such conditions, we will have to get a more detailed picture of that complexity.

There is a range of factors that bring about complexity in hospital care. Ongoing specialization is one. In his critical approach of three review studies on upcoming themes in medicine, Cooke (2013), a physician himself, calls these factors 'megatrends'. 'Across medicine, specialties are becoming subspecialized, and subspecialties are developing sub-subspecialties'. One of the leading theorists on complexity, philosopher Edgar Morin (2011), argues that what he calls the hyperspecialization in the medical and nursing professions, is one of the hardest form of complexity to cope with: communication between the representatives of the subdisciplines is becoming increasingly difficult the more the medical domains are splitting up (Morin, 2011). Specificity wins from generality.

The upswing of technology in care is a second factor of increasing complexity. Even if the official goals of medicine are about quality of care enhancement, this pursuit is in fact accompanied by enhancing technology. Technology here points at the broad range of technology usage, ranging from computerized communication, registration, and management systems used in the hospital as well as to high tech medicine, like in neurosurgical robots, nano-technological diagnostic and therapeutic devices but also telemedicine for patients with cardiac vascular conditions. The technological development within domains of medicine

and nursing has been considerable and is a driver in complexity: systems have to work together, they take time and tend to absorb the attention of caregivers. This technology is not just about handy devices, it also affects patients. To cite Cooke on this: 'Critical moments of human experience – from conception to death – are now technologically mediated or forestalled.' He points at the difficulty but also the urgency to 'understand the effect on patients and their loved ones of the "technologizing" of these fundamental elements of human existence'. In that sense the practice of medicine in hospital becomes more complex as physicians have to take control over the effects of technology, also in their relationship with patients.

There is another source of complexity growth next to the internal factors of specialization and technology: societal pressure. As there is high pressure on hospital governance to ensure patient safety, control systems have been brought into place, like for instance drug delivery systems. The same goes for demands to increase transparency of hospital outcomes, resulting in reports to be delivered to society and the intervention of controlling and monitoring organizations (governmental agencies and insurance companies). It also goes for the constant political tendency towards austerity measures. The systems installed in hospitals aim at producing desired effects (e.g. no mistakes with drug deliveries, immediate clarity about how any hospital deals with her outcomes, clarity about costs), which involves time consuming labour of physicians, nurses, managers and staff. Even if figures may vary slightly, both physicians and nurses in a hospital setting tend to spend about 30 per cent of their working hours on documentation and registration, mostly via computerized systems (Füchtbauer *et al.*, 2013). While these systems were intended to reduce complexity, they unintendedly increase complexity as well. Complexity here means: while tackling issues of uncertainty, uncertainty grows; while trying to deal with the concatenation of processes the entanglement of them grows (see De Haan and Rotmans, 2011, on Dutch health care systems).

It appears that the problems and misunderstandings that are brought about by complexity, notably in the form of hyper-specialization, are often seen as communication problems. Jeffs *et al.* (2013) have shown that the urge for more communication is reflex like, for example, when doctors notice that serious problems and misunderstandings arise at the moment when patients are taken from intensive care to the ward. Jeffs *et al.* notice in their qualitative study that physicians act as if they are 'working in silos'. Zwarenstein *et al.* (2013) note that the appeal 'Let's communicate and work in teams' seems to be rhetorical and seems to represent a hope for the future, rather than an attainable goal. We have encountered similar, mantra-like talk during our fieldwork. The talk about 'more communication' as a solution for complexity occurred at many instances without ever raising the question why this talk, going on for many years, did not lead to any satisfying results. The talk seems reductionist, as if more communication can match the forces that create an ever increasing number of specialized practices that make up social life in the hospital. Similarly, Ament *et al.* (2014)

provide a set of measures to increase communication and collaboration (administrative reminders, involving a coordinator, booster meetings, working agreements), but they curiously leave aside the very substance of hospital care: the treatment of very sick patients. This brings us back to our original concern: the provision of good care in complex care practices.

Good care under conditions of complexity

Drawing on his extensive ethnographic research on nursing in hospitals, Chambliss (1996) points at ethical problems that are created by the organization. He explicitly wants to refrain from so called 'classical' ethical issues, often phrased as dilemmas, which revolve around the work of nurses and physicians. Instead, Chambliss focuses the attention on ethical issues that are created by the way work is structured in the hospital. More specifically, Chambliss argues that they result from the struggle of the hospital with complexity. These new ethical issues are hard to understand when using classical ethical distinctions like intention or choice. They are not simply or predominantly a matter of choices by actors, nor are they a matter of attaching a moral value to an act. Rather, they are about the moral substance of the interacting itself. As actors participate in complexity ridden bundles of caring practices where buildings, technology and administrative monitoring are pervasive, it is necessary to find out how this complexity affects the moral dimension of care. The moral dimension is not restricted to the realm of purposive action by the participants, like physicians, nurses and managers. Indeed, the moral dimension is in the practice itself. This implies a recasting of what moral care is about. We do stick to the idea that the good concerns the well-being of the patient, which is dependent on the health care work and the healing process. However, under conditions of complexity we have to take into account how the different elements of practices bring about morally good care. Thus, for instance, when technology shapes the work of care givers and takes a hold on the existential experiences of patients, we cannot reduce morality to what the physician did or did not do. Before we elaborate further on how the goodness of care can be brought about in complex care practices, we will first outline how the hospital can be conceptualized from a practice oriented approach.

A practice theoretical view on hospital complexity

Practice theory is about how people act in arrangements of people and things. We can identify an organization as such an arrangement 'as they happen' (Schatzki, 2006). Theories of practices are in the plural, drawing on sources as different as Heidegger, Wittgenstein, Marx and Bourdieu. But they share a common interest in how people, materiality and bodyliness interact to bring something about. Theodore Schatzki (1996: 289) typifies a practice as: 'a temporary unfolding and spatially dispersed sets (or nexuses) of doings and sayings'.

Schatzki installs a tension between the agency of participants on the one hand and the doing of a practice that 'befalls' participants on the other hand (Schatzki, 2010: 170). Participants are *in* a practice and in that sense the practice is upon them, comprises them; they are not sovereign leaders of a practice. Manidis and Scheeres (2013) have shown how this is a fruitful view on how physicians and nurses act institutionally. It is exactly this distribution of (moral) responsibility over both participants and the practice itself which provides an entry to conceptualize the ethics of good caring practices. Similarly, the work of German sociologist Robert Schmidt is helpful to conceive of care as a practice, leaving the idea of morality concentrated in human actorship behind. This postponement of normativity allows arriving at a more apt ethical understanding of care work (like the work done by nurses, physicians and managers), as we are not bothered by what Schmidt – with Bourdieu – calls a 'scholastic ethical misapprehension' (Schmidt, 2012: 35–37). The scholastic position means that actors are seen as dominating action, the normative wish that free will of man reigns over action and is projected on the reality of action, which Schmidt calls 'misleading' (Schmidt, 2012: 37). The praxeological view is that acts and their actors are part of a practice. One cannot follow up acts and actors as long as we see them as sovereign to a practice, which evidently they are not, imbued as they are in a practice, reacting, instead of being free floating minds. We can thus leave (scholastic) ethics behind in order to establish a kind of ethics that fits to complexity, after reframing action within practice. In this respect, Caldwell (2012) speaks of a *paradox*: in order to reclaim agency in an organization, to impose responsibilities on agents in a field, notions like individual intensionality should be replaced by their acting as meshed in a practice. Thus following a practice approach does not mean to dump normativity, but rather (1) making a detour of analysis what a practice is about; (2) of reframing action within practice; and (3) then at another position than previously thought and conceptually imposed, recast moral concerns.

In practice theory, the idea of sovereign actors is replaced by the idea of participants being co-actors, intervening in the environment with other participants and with materiality: the technology and physical space that shape their acting. Schmidt (2012) indicates that nobody acts in isolation, we always ground our doings on what others did before us. In a general hospital, 365 days a year and 24 hours a day, this is quite evident. We can add: shift after shift takes over and passes on. According to Schmidt there is no 'zero zone': there is no such thing as 'the' blueprint hospital care practice, a zero zone before the actual practice takes place. Doctors, nurses enter a practice that was already there. They are just participating in labour that was going on already and will go on after them. It is important to note that this analytical, non-normative view does not remove initiative, nor some kind of freedom, nor responsibilities from participants. Rather, the 'subject' enacts a game that has been played already before the enactment. There is no *auctor originalis* outside the practice, all on the field have the game within themselves. Schmidt resists the separation between ideas and action, as the practice itself, the interplay on the field, determines what is done (Schmidt,

2012: 38–40). Practices are thus a cluster of bodily and mental activities. But the mental activity is quite bodily and it is social: it should not be granted a separate realm, nor should it be individualized as all action, both mental and bodily, originate from practices (Schmidt, 2012: 55). Andreas Reckwitz (2002: 251) argues that 'Practices are routinized bodily activities; as interconnected complexes of behavioral acts they are movements of the body.… A practice can be understood as the regular, skillful "performance" of (human) bodies'. People do not use their bodies to perform an act, 'routinized actions are themselves bodily performances'. Schmidt also draws attention to the idea that artefacts, like a medical instrument, a computerized system, the very hospital building (with the order it imposes on activities: e.g. dying patients are put in a separate room, thus channelling the care work) are subjects of practices too (Schmidt, 2012: 65).

Let us provide an example: in a newly constructed ward two patients, each with a private room, instead of with four or two in one room have to share one bathroom. This architecture influences not only the patients but the nurses as well: on the neurology ward elderly patients report loneliness, and nurses indicate that they only go inside the patients room to perform a specific action, there is no such thing as a casual talk. These nurses' encompassing gaze (as they walk around on the ward, they are acting purposively and at the same time they see a lot) no longer fits the practice due to the physical setting, as Hanneke van der Meide *et al.* (2015) have shown with regard to elderly patients and nurses at the neurology ward.

Schmidt (2012: 38–44) develops the idea of the interconnectedness of complexes of acts: a practice can be seen as a game and a field of play. He uses this idea of a game, e.g. football, as a heuristic (non-definitional) device: in order to make the phenomena under inquiry understandable as 'praktische Vollzugswirklichkeiten', i.e. as practical realities as they happen. In this way, Schmidt enables us to first see what happens, how phenomena present themselves in a Gestalt. Before we discuss these analytical claims in more detail, we will first present some observations from our empirical research. We have shadowed a physician, a young neurologist, during several shifts as he was doing his daily work on the neurology ward.

> Scene 1.
> 8.45 a.m., in a small room in the corner of the ward, with windows on two sides, the physician together with a nurse performs a lumbar puncture with a slender young man of about 32 years. There is a lot of daylight. As we are on the fourth floor, we look into the sky, the trees surrounding this wing show their leaves as they flutter in the summer breeze. This patient was taken from the four bed room to this angle of the ward. As the physician entered, the young man was lying on a bed, a nurse was with him who had given him information and instruction on what was going to come. At a small table nearby all the equipment lies spread out. The patient faces the windows and the table with equipment. The physician invites the patient to

lie down and relax, with his back to him, whereas the nurse is facing the patient. The doctor tries to make the puncture. The procedure fails. The patient gets even more tense than he already was, the lines in his face getting tight. The doctor tells him to relax, tries again, another failure. The doctor then asks the young man to sit up on the bed, with his face towards the nurse, and asks to arch his back. As the doctor prepares for the third attempt the nurse silently holds the left shoulder of the patient, puts her other hand at the right temple, she caresses his head with her thumb, almost unobtrusively. The puncture succeeds, within seconds the fluid is out and the physician cleans the back of the patient and leaves the small room, up to his next activity, leaving the patient and the nurse behind, I hear her talking in a subdued voice to the young man, still somewhat in shock. He has not said a single word, but his body has done the talking.

Scene 2.
12.15 a.m. the same physician performs another lumbar puncture. This time it is at the ward, in a four bed room, with indeed four patients, three women and a young man in and around their beds. The young man, in his mid thirties, lies in his bed as the physician tells him that he will make a puncture. The patient puts his headphones away. A nurse, another person than this morning, assists, pulling the curtain around the bed. This patient is a knowledgeable patient, he has been on the ward several times and the lumbar puncture is not his first. As the doctor fiddles around with needle, the lab tube and a shallow metal bowl, a nurse from another ward comes in, and says something to one of the other patients. In the meantime hot food is delivered by the team responsible for that: tablets are brought for all four patients, the lady patients are asked what they would like to drink. The odour of a detergent mingles with the smell of the hot food. The nurse stands at the foot of the bed. The doctor tries his best to perform a puncture, as the patient lies on the bed with his back towards the doctor and his face towards the curtain. After two failures the young man shrieks in the local dialect 'doctor, doctor, stop, I don't want this anymore, if things are like this than I do not want to have the medical exam'. The doctor convinces him to give it a last try. The patient gives in, but one can see that he is upset and angry. The third try fails as well, the doctor gives up and says, 'we'll see this afternoon' and leaves the room.

What is it that we see? We are not referring to the why question (causes and effects), like the competence of the physician: during the many shifts we have seen the neurologist at work performing the punctures frequently and with success. Thus there are many why's (circumstances, cooperation, time pressure, etcetera). When we talked afterwards about our observation to the care professionals of this ward they immediately started looking for causes and for possible quick changes, or they debased the story: 'you know, this is what happens'. The

what question is another question than the why question. What do we see? On an organizational level one can see the density of the second scene compared with the first one: many people, more sounds, more turbulence on the field and activities separated from each other, not taking notice of what activity takes place next to you. If we try to answer the ethnographic question what is done and how, and how the phenomena show themselves while using the practice theory approach, we can see doctors, nurses, patients acting together, reacting or not (at least in a visible, noticeable way) to each other. We can also see, thanks to the comparison of both scenes, what is lacking on the field; so to say the shadow of acts not committed and of positions not taken. Indeed, the nurse in the second scene does not face the patient and does not take a position in eye sight of the patient. If we go one step further we see the co-acting in a diagnostic practice. This does not necessarily imply bringing a practice to some accomplishment. In scene one it seems that the tiniest little gesture of the nurse, striking the patients face, without a word, is part of the practice: she just knows what to do. In the second scene it is striking that even if the same technical procedure is followed there is no co-acting: physician and nurse are not attuned to each other. They do not play the game of getting the intervention done, whilst minimalizing the harm for the patient. One may say that in the second scene all are on the field but the play is no co-enactment. Materiality acts here in a clear way: the small, light room compared with the four bed room does its work.

Schmidt (2012: 30–33) stresses the heuristic character of his idea of practices as games on a field. Schmidt uses the expression 'Sehhilfe' (ibid.: 76). Rather than a definition, the notion of a game as a heuristic tool stands for the ability to see the *what and how* of actions and of events in situ. Observing care practices as a game on a field opens up what is happening in a situated here and now: the positions on the field, who is there, the interactions or the non-existence of interaction, the materiality and how it acts back, how bodyliness works, how the physical presence of the players functions in the game, how their senses (looking, touching and in the hospital often: smelling) are at work. Furthermore, Schmidt (2012: 103ff.) adds the idea of antagonistic play on the field. The co-acting, of a nurse with a physician, can be maladjusted or antagonistic. When a senior nurse guides a young neurologist, who has just started his work on the ward, she gently directs his actions: 'it is advisable to ask for the consultancy of the opthalmogist before 10 a.m., no, do not wait, do it right away, otherwise he'll come only tomorrow'. But in another case she surreptitiously infringes his orders to arrange a meeting with the family of the patient tomorrow afternoon and organizes the meeting for the very same day. 'He [the neurologist] finds it hard to understand that things are deteriorating so quickly; this family has to know asap'. And she takes the heat that very afternoon when the family is there and he says angrily that he has 'other things to do' until he blends in. Patients can be opponents to caregivers as well, even while they are in the hospital for good cause. Nurses have a striking expression for that: these patients are 'not adequate', they do not blend in into what patients are expected to do, say, or how

they should cope, take drugs and prepare themselves for a next step. Feldman and Orlikowski (2011) in their analysis of the emergence of practice theories, point to the attention paid to power and inequality. Asymmetry in particular, however, i.e. asymmetric positions in the field, seems to be an important clue for practice theory. Asymmetry may arise when some participants have more opportunities to use materialities and their bodies in the practice and to determine what is being transformed in the practice than other participants. In the case of care practices, nurses and physicians and patients co-act, and materiality acts upon them, but these participants do not have equal opportunities to enact the practice. However, can this heuristic approach, with the idea of a game and of the asymmetrical co-acting on the field, harbour the good of the patient? Can it take into account what the patient has undergone?

Passibility in care practices

Now, on the level of content, with regard to passibility, Schmidt opens up to that dimension, first, as he reflects on the social visibility of what shows itself in the game on the field, and second, as he reflects on what unites all on the field, i.e. bodily knowledge of the game.

In their own way, patients undergo the care practices they participate in: the way they move, speak or remain silent, the very fact that they accept undergoing these practices as such. But they undergo illness at the same time: their disease is a process that just takes place. We recall Ricoeur's ([1960] 1986) *passibilité*. Patients are actors but they are sentient and passible beings as well. Undergoing does not imply reflection, it does imply being subjected to what comes to us and it brings about inner movements, experiences and emotions. The patient of scene 1 does not have to reflect on the light flooding into the room, nor does the patient of scene 2 have to reflect on the noise level or on the smells in the room. Yet they undergo what is done and said. The body knows this, in an experiential way: 'we have been here before, and therefore…'. Passibility is also about painful undergoing, about suffering and dying, phenomena people don't do but undergo. The heuristic approach of a practice should thus not only expose the doings and sayings but the undergoings as well. This seems to be crucial to understand hospital care practices. A lot of these practices are intrusive, be it diagnostical or therapeutical. In the hospital, patients enter a world that molds them, not only via medical practices but also by the web of practices that comprise the organizational molding of everyday life in the hospital. Patients suffer and some will die. In this regard patients are in a really different position than nurses and physicians on the field. Surely, all are vulnerable, patients ánd doctors, but complaints of a serious nature made patients into specific kinds of participants in medical caring practices: they participate in the mode of enduring both the disease and the care process. The heuristics of these care practices have to be able to notice where in the field the undergoing of treatment emerges, where they announce themselves. Using the expression 'announce' does not mean to give a voice to what the

patient is undergoing, what he (or she) is 'experiencing'. Mostly the undergoing of treatment announces itself in a silent way, in inner speech, or in the murmuring between patients: 'I get irritated because of the loud snores of that old rattler at the window'; 'I always get upset when that doctor comes in, he is so icy'. 'The pain in my bowels is excruciating, throbbing'. Rarely does it come out loud. The enduring does not become an autonomous kind of participation by voicing these experiences: the passible continues to be there, whether outspoken or silent. Even if official hospital knowledge translates much of the passibility of the patients in words of action (e.g. patients making their complaints known, making a decision and the other way around, reacting on possibility via action of caregivers: informing patients, autonomy, choices, shared decision making), these phenomena are precisely non-active. Any theory, that immediately starts translating passibility into action, moves away from realities that come upon a patient. If we pursue the practice approach of care in order to open up complexity and cope with it, passibility deserves a proper conceptual place, precisely because we are dealing with caring for and being cared for. Otherwise we lose the very essence of the experience of being a patient.

Conclusion: praxeology and passibility

Let us return to our opening question whether practice theory can open up to what we are seeing in complex hospital care practices, notably signs of pain, illness and suffering and of the undergoing of treatment in general. First, Schmidt's (2012: 231ff.) account of how to conduct praxeological research entails that researchers should take an interest in how bodies present themselves, how they make themselves visible for observation. This is not just a matter of a researcher looking at a phenomenon, instead the inquiry is about the practical bringing about of social visibility. Seeing and acknowledging what is seen (by the participants in a practice, a researcher included) are part of the practice itself. When observing a patient lying down for diagnostics, we are in a position to observe a scene that is basically open to other participants in the practice. Drawing on Hannah Arendt's (1958: 63) basic understanding of what is 'public', namely that what can be seen, what is perceivable by all, Schmidt states that there is a plurality of positions: all are basically in a position to share the attention for what shows itself. What seems to be intimate (getting a puncture) is at the same time social visibility. Looking at the puncture is not just observation in an encounter. According to Schmidt observing means taking part in joined attention to what shows itself in a practice. But then what about the not blatantly visible passibility, these inner movements, the inner speech and experiences that befall people? While passibility is often not manifestly open to the immediate gaze, its latency can be turned into a focus of attention. This is because passibility is part of the 'Verweisungszusammenhang' (Schmidt, 2012: 236–237; 244), the network of cross-references of all that makes the practice a practice, including the unspoken and the unseen. Thus there is an opening for silent passibility.

Second, patients in their bodyliness are participants of care practices. We must add that this vision is more radical than the policy views that attribute a larger role to patients, such as in 'sharing in decision making', or turning patients into 'co-practitioners'. Such statements are often perfunctory: they are about the organizational hassle physicians and nurses have to go through, a job where they can use the help of patients. While appealing to patients and their own will is potentially favourable and may be useful to get care givers out of their self-referential organizational problems, this kind of 'cooperation' is something different than acknowledging that patients are participants in care practices. From a praxeological perspective, the practice is, so to say, *in* the patient: they carry the practice in a bodily way. They are not the objects of a practice, as one might think. Without them there is no game and no field. Yet patients are constantly evicted from the practice. As a manager of the hospital remarked in a quasi-cynical way in a board meeting, 'it is such a pity that we cannot carry on, on our own, and we have to deal with patients' (i.e. without patients we could do things much more efficiently). She was thus critically pointing at the marginalization of patients from the practice of care in the hospital. Patients in their suffering are often seen as object of 'our', i.e. caretakers practices. However, all participants of the practice can acknowledge the suffering and more broadly speaking the passibility of ill people. Such acknowledgement is not a matter of empathy, but a matter of consciousness about positions, including a participant in the practice who is ill, and the possibility to change one's position and take the perspective of the patient. Once again we postpone an immediate normative nor a psychological interpretation (empathy) and advocate realistic heuristics: what shows itself? Taking the perspective of the participant-patient means switching to that particular position, taking that perspective and realizing that apart from complaints (about illness) and of concerns (of what the disease means to the patient) passibility is at work. Participation is not just about autonomy and decisions, it is about being on the field as a sufferer.

We have two leads now with regard to suffering. The first is the social visibility of a practice, i.e. the visibility of the 'what and how' for the participants in the game. Performing as well as getting a puncture is taking part in one single care practice. The patient with his or her suffering is in the practice and can be acknowledged, as all in the practice can be aware of their position in the field and the possibility of changing their position. This is not a matter of psychology, of empathy, or the realm of the inner world. We should not retreat to psychology but remain within the praxeological approach. The position-taking is about awareness about one's position on the field and allowing stepping to another position, stepping behind the patients as co-actors, taking their perspective and getting in touch with passibility as it acts, even if it is in a muffled way. The second lead is that suffering, undergoing pain, disease, being mesmerized by worries is part of the practice of care, as patients in their bodily presence show themselves in the practice. In fact the acknowledgment is an act of identifying what the practice is about; it is about acting on the field, about positions and about what shows itself on the field.

Our proposal is to broaden the sayings and doings of a practice with the undergoing of treatment. This fits into Schmidt's theory, as he emphasizes the occurrences on the field, the positions and the relations between the positions. Our proposal is to replace the subjective-objective dichotomies with the language of acknowledging positions on the field. As we try to include the enormous complexity of hospital care by framing it in a practice theory approach, we could recast the very idea of actorship. Physicians and nurses are not isolated actors. They are partakers in a practice in which materiality (such as technologies) co-act. We can also view patients as partakers of that very same practice. The very fact of suffering and of being sentient passible beings points to a dimension of practice that should be taken into account in practice theory: undergoing treatment next to doings and sayings. We envisage a much broader use of this idea than only in care practices. Indeed, the concept of embodiment, so central in practice theory, can be rethought, including passibility. For instance, if the work done by a 'rational', 'brain centred' engineer is seen as a bodily performance in praxeological terms, this view could also conceptually incorporate the passibility of the engineers' work. Surely our proposition with regard to undergoing treatment is just one step in coping with complexity. With regard to care practices, however, this step helps to uncover what this practice is about.

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