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Published online: 17 Nov 2020.

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RESEARCH PAPER

Taking the National(ism) out of the National Health Service: re-locating agency to amongst ourselves

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ABSTRACT

Campaigns against the privatisation of healthcare in the UK have often focused on saving, or preserving, the post-war National Health Service (NHS) of the 1950s. They talk of it as a 'national treasure', which has long given the UK some moral high ground over countries such as the United States. I argue that seductively simplified campaign slogans can also be blunt – they can carry with them more opaque messages such as those that encourage the maintenance of a patriarchal healthcare system. As a result, campaigns to save the NHS of the 1950s also preserve the nationalism, as well as the class and gendered staffing hierarchies, which (as I illustrate) come to reproduce inequalities in the care that is delivered. Through a multi-cited ethnography focused on the delivery of hip replacements in the NHS, I argue that a more complex form of political activism is needed to bring about the equality in healthcare that the NHS promises. In this paper, I flatten assumed hierarchies of power, to high-light some ethnographic examples of how everyday actions can come to reshape antiquated power structures. I conclude by suggesting we look to how power is pieced together across networks – and how we can re-locate collective agency to within and amongst ourselves to bring about a more equal, and less nationalistic, healthcare service.

Introduction

On saving the NHS

The National Health Service (NHS) is a source of pride for many in the UK. Established after World War 2, the NHS promised to provide healthcare to everyone, free at the point of use, paid for through progressive taxation. After the experience of people from different socioeconomic backgrounds fighting together during wartime, the NHS was (and is still) seen as a way of rebuilding Britain as a more equal society (Pilger, 2019; Thomas-Symonds, 2018). Bevan, the UK Minister credited with its conception, suggested that 'we now have the moral leadership of the world' (Guardian Archive, 1948). And indeed the NHS is a model of healthcare which has been exported in various forms around the globe. On its 70th birthday, hospitals handed out party invitations to celebratory fêtes, and television hosts reaffirmed that the NHS 'makes many proud to be British' (Bagnall, 2018). There has been more than one love poem written for the NHS, and the strong sense of post-war nostalgia was exemplified no better than in Great Britain's Olympic Opening Ceremony, where a 1950s version of the NHS was celebrated through dance (Boyle, 2012). The NHS is more than just a particular way of

organising healthcare. It is a symbol of the UK's attempts to bring about equality as a more civilised nation. It is, as I will go on to suggest, an ingrained part of the UK's 'imagined community', the basis of nationalism (Anderson, 1983).

It is perhaps then no surprise that there has been a backlash from healthcare activists when an international policy trend to contract healthcare out to (often multinational) private companies began to threaten the NHS. UK scholars are still taking 'moral leadership' in the project for more equitable healthcare, with the publication of a plethora of academic-come-activist texts such as *NHS Plc* (Pollock, 2004), *NHS SOS* (Davis & Tallis, 2013), and *The Plot Against the NHS* (Leys & Player, 2011). These scholars have demonstrated that privatisation is undoubtedly harming health and causing more inequalities. But in this paper, I will critique how mainstream healthcare activism, certainly in the UK, has taken on a nationalistic pride in their campaigns, and in doing so, obscures the main objective of bringing about more equitable healthcare for all.

The main fighting slogans in the campaign have all been about *saving* or *defending* the NHS. The threat of privatisation has put healthcare activism on the back foot, resulting in activists suggesting that the NHS should be 'preserved like a jewel' (McFadyen, 2019), and, like Bevan, they campaign to make the NHS 'the envy of the world' (The Labour Party, 2017, p. 5). The film *The Dirty War on the NHS* (Pilger, 2019), even ended with a hymn called Jerusalem – a sort of unofficial UK national anthem. Crucially, these back-foot campaign tactics *also* do other work. In the first half of this paper I unpack what it means for NHS campaigns to have taken on nationalistic rhetoric, and how this contributes to the maintenance of many inequalities in healthcare as well as the potential production of others. Just to be clear, this isn't a paper about whether or not the NHS should be privatised, but rather a paper looking for the best stratagems to bring about more equality in healthcare practices – an aim which I believe is shared by current 'Save the NHS' campaigns.

Crucially, I came to this research as a healthcare campaigner myself, and I have also marched through streets trying to 'save' the NHS. When I turned to the NHS and healthcare activism as an object of ethnographic study, I was horrified to realise that I may be contributing to some 'imagined community' of a morally superior nation. As Smith (2001) argues, even nationalism that tries to be based on a 'civic' rather than an 'ethnic' identity, always ends up creating a very problematic 'other' through emotive collective beliefs. Coming from a critical feminist perspective, I join Smith (2001), Firestone (1970), and Scott (2012a, p. 77) as seeing the institution of the nation-state as being built on an extended patriarchal family model, where the few are expected to govern with an oppressive form of care, whilst everyone else (usually women, black and brown people, men with less money, or anyone else who is cast as 'other') are supposed to follow. Crucially, I argue that it is through nationalism that we can see how the intersection of ableism, sexism, racism, classism and all these other attempts to create a 'normal' come to intersect in state power. As Piepzna-Samarasinha (2018) suggests, 'all those systems of oppression are locked up tight'.

Breaking away from this nationalistic vision of the NHS, however, allows me to turn my attention not to what the NHS *is*, but what it *does*, and how healthcare is practiced on an everyday basis. Here I draw on a set of heterogenous sociological and anthropological literatures on medical power which thus far have only really worked in parallel to debates on healthcare privatisation. I look to how Accident and Emergency Departments, for example, have long differentiated between 'bad or rubbish' (Jeffery, 1979, p. 92), and 'worthy' or 'less worthy', patients (Higashi et al., 2013). I also look to how the 'hidden curriculum' of medical professionals to practice detached concern (Underman & Hirshfield, 2016), a patriarchal authority (Michalec & Hafferty, 2013; Sinclair, 1997), and everyday sexism (Arnold-Forster, 2019) still play an important part in making up the NHS. I turn to this literature alongside a methodological commitment to looking at practice-based assemblages, inspired by Deleuze and Guattari (1987), Tsing (2015), and John Law and colleagues (Law & Lien, 2012; Law & Singleton, 2015; Singleton & Law, 2013). In doing so I hope to illustrate how power is not made up of big structural terms such as neoliberalism, patriarchy, and nationalism, but how it is pieced together through everyday alignments between people and things.

Activism, I argue, is about attempts to redistribute power. And like healthcare campaigners, I am committed to try and create more even distributions of power through healthcare. But to do this, I argue, healthcare activists need to acknowledge that slogans can also be dangerous. They are necessarily blunt instruments, which can carry with them different meanings than those that are intended. As I illustrate in my own data, the NHS is more complicated than the love poems, campaign placards, and activist academic literature imply. In this paper, I suggest that we need to rethink healthcare activism in a more complex way, to see how minor, or everyday, actions come to shape the world in which we live.

Approach

Putting down the placards

I began studying the NHS because I was also a campaigner angered by privatisation, trying to save the NHS. I went on marches outside the Houses of Parliament and saw the literature from Pollock and colleagues as my ammunition. But I am also trained in an anthropological tradition where we question everything seen as a given – especially those things we hold dearest to our hearts. I sat uncomfortably with the campaign literature in one hand, and the literature which critiqued medical power in the other, and decided I needed to find a way to put them together.

I did this by unsettling what I thought the NHS *was* – I had known it, like other campaigners, to be a beacon of equality. But here, I took on Law and colleagues' (Law & Lien, 2012; Law & Mol, 2008; Singleton & Law, 2013) ontological shift, to get to know the NHS through what it *does*, or how it gets *done*. Along with Tsing (2015), and Mol et al. (2010), this group of scholars suggest we need to view the world as networks, or assemblages of human and non-human actors which make up the NHS, rather than act within it. This repositions the medical power literature as examples of NHS practices that make up the NHS, rather than things that happen in a kind of organisational shell. Tsing (pp. 23–24) asks us to pay attention to the way in which assemblages are both constantly changing, and polyphonic – there is not one singular direction, whether this be the pursuit of equality or capitalism. By following these lines of thought, I found that the NHS is no longer then a fetishized symbol, centred in the middle of the room, but something that continually gets made in heterogenous ways by everyday practices, including those made by researchers themselves.

Focusing on assemblages is central to theorising activism in this paper. Activism is, I would suggest, always about attempts to redistribute power, and to do this, it is important to be able to see how power is pieced together. An assemblaged worldview allows researchers to unpack the big terms such as neoliberalism, capitalism, and patriarchy, to see how alignments of people and things come about through everyday practices. Whilst Tsing suggests 'assemblages drag political economy inside them' (p. 23), I would suggest these assemblages *make* political economy; there is no political economy, no patriarchy, no nationalism that isn't formed out of everyday actions. Flattening the world is crucial here – as Deleuze and Guattari (1987) suggest, seeing rhizomatic connections, rather than tree-like structures, ensures that we don't assume any power relations are inherent from the outset. All actors can be realigned to produce different power relations between people and things. No one, no thing, is inherently more powerful than another.

This examination of power is crucial for understanding how different forms of activism attempt to, and *could*, rearrange these relations of power. Here, I draw on Scott's (2012a) theorisation of infrapolitics, where open rebellion is too dangerous, so material relations of power are redistributed locally through evading taxes, poaching, and guerrilla gardening. Tsing (2015) also urges us to forage for practices which work against or separate to capitalism in the polyphony of relations; practices which she suggests capitalism ironically depends on. Alongside Mol et al.'s (2010) search for more feminised but potentially rebellious practices of care, these ideas of activism urge us to look not just at the loud outspoken campaigns, but at the more mundane everyday practices which can work against more dense and connected accumulations of power.

This is not to say that campaigning with slogans and placards isn't a form of activism. This is an important practice like any other. Discourses come about because people speak, write, communicate stories as an everyday practice in itself. My aim in this paper is to interrogate how healthcare activism is best practiced. Activism is of course a nihilistic term – some may attempt to redistribute power in ways we do not like. It is therefore important to reveal my normative pursuits from the outset; that healthcare activism should be about attempting to redistribute power in more even ways across society. This pursuit of equality is also one which I believe many healthcare activists would agree with. In this paper, I merely hope to pull apart which activist practices contribute to the aim of a more equal healthcare service, and which ones may act against it.

Methods

Seeing the NHS as an assemblage means that it's a much more complex matter to study. Ethnography therefore allowed me to look at the everyday relations between people and things, and to maintain this complexity rather than work to simplify it. The complexity did, however, mean I needed an anchor; a way to make the NHS more tangible. I chose routine hip replacements as my hook because they are seen by policy makers as a discrete, single episode of care, meaning they are more easily packaged to contract out to the private sector. It was a case study chosen for its potential to challenge my own concerns about privatisation. Orthopaedics, however, also turned out to be a good example of where 1950s-style class and gender relations are still readily played out.

The data I present in this paper is in some ways from quite a classic hospital ethnography tradition, where I shadowed various members of staff in their everyday work and had conversations with them as I went. However, this data comes from a PhD project where hips were a hook that took me to many different places – orthopaedic surgeons' conferences; local arthritis support groups; people's homes during recovery; and up to Wrightington where the renowned Sir John Charnley first invented modern-day hip replacements in the 1950s and 60s. Delving into the history of hip replacements through oral histories and written memoirs allowed me to place my recent ethnographic insights in relation to a more historical view of the NHS.

The majority of field work took place between 2016 and 2018. Whilst I was not in hospitals or talking to patients every day, I made regular visits to field sites, and was constantly talking to people who had received hip replacements or worked in relation with them. This more fragmented style of fieldwork gave me time to reflect and analyse data in between visits. Crucially, in the UK, the NHS is a difficult field site to escape. Every healthcare visit for myself, my friends, and relatives, is a visit to the NHS. It is pervasive in public discussion, particularly around the numerous elections and referendums between 2015–2019, and of course during the celebration of the NHS's 70th birthday in 2018.

In analysing my data I looked for how everyday practices seemed to distribute power. Data was coded by hand, and through telling and retelling stories in different ways, to different people, with different kinds of relations with the NHS. This included healthcare staff, patients, colleagues, and healthcare activists themselves. This storytelling not only allowed me to analyse the data more iteratively and collaboratively with those I was essentially studying, but also acted as a method to constantly challenge my own predispositions towards the NHS. Ethical approval was granted by both the London School of Hygiene and Tropical Medicine, and the NHS Research Ethics Committee.

Rethinking healthcare activism

The NHS: a beacon of (in)equality

As I started fieldwork, I began to realise that the NHS was far from the beacon of equality that the campaign slogans have you imagine. You just have to step into the canteen to see the militaristic order of command, which is materialised, as ever, in uniform; the colours denoting 'Grades' of pay,

formal education, and status, were neatly separated onto different tables. In the operating theatre it is abundantly clear who is in charge. The operation was described to me as a 'ballet' as everyone moves almost without words, the scrub nurse automatically in sync with the surgeon's every move. Even when the surgery is over, conversations start and stop on the surgeon's command; even if he decides to mock women, talk of the #metoo scandal, or comment on the anaesthetised patient's physique.

The translation of the patriarchal family model to everyday practices that make up the NHS is more than apparent in the gendered division of labour. Whilst surgeons still speak about needing emotional detachments from their work, more feminised workforces such as nurses, healthcare assistants, and even physios are required to do the care, despite the fact they could also harm patients and have to deal with mortality and morbidity in their roles. The skills of care and emotional support are not valued, however, because they are seen as instinctual 'values' and 'attributes' rather than trained and considered practices. These caring practices, however, *are* skills which are learned predominantly by women from a young age through the patriarchal nuclear family model.

These alignments travel both beyond the hospital walls and through time. In my fieldwork I found surgeons both past and present to be in relation with fast cars, expensive restaurants, caviar, and international travel, where other members of the so-called 'team' are excluded. Even Charnley's scrub nurse, who worked with him in the theatre every day for many years, wasn't invited to his dinners and garden parties. Rather than work to understand different social and material relations, surgeons and medical professionals are focused on distinguishing themselves with medals and society ties named after dead surgeons, and endorsed by the royal family.

Whilst I would suggest that the unequal relations between staff is enough to challenge the nationalistic sentiment that the NHS is a beacon of equality, it is important to note that these inequalities get transcribed through practices to patient care.

In the hip replacement recovery ward I was introduced to the Rapid Recovery Programme; 'it's like a conveyer belt!' some of the physios told me excitedly. The ethos is that patients can now leave the hospital more quickly because they are asked to prepare for surgery with the aid of a one-hour-long 'hip school' and an information booklet that I'm told patients call their 'bibles'.

Some of the physios introduced me to what they called 'model patients'. These patients recovered quickly, and could be sent home under the 2.7 day average that the hospital was trying to maintain. These patients were up, dressed, and out of bed the day after surgery, pushing themselves through their exercises with positive self-determination. But I also noticed that patients are required to have social and material alignments which correspond to Bourdieu's (1977) social, cultural and economic capital, to succeed in the Rapid Recovery Programme. The bible expects patients to have a nuclear family with patriarchal relations – for there to be a woman without a job, a healthy retired partner, or even perhaps paid help to, 'leave the vacuuming to someone else' and 'to have somebody else in the house to help you' when you shower, for example. It also suggests that patients will be able to purchase a new chair, will have a freezer big enough to take two weeks' worth of meals for when they return home, and, from the casual tip about 'wearing silk pyjamas', may even be able to afford some expensive new nightwear. It didn't take long to realise that those who had more of a drive to get better, had previously experienced a world where their own agency got them places.

On the other hand, patients without these alignments became the problematic 'overstays'. As a result, the protocols are made malleable, to send patients such as Bet home. Bet came to the hospital already frail, and after the operation she was still struggling to get around on a walking frame. She couldn't do the stairs, but it was okay because she could set herself up to live downstairs in her own home. She persistently told the physio that her son wasn't actually very present, but he was checked-off as family support anyway. She didn't have the resources to pay for care herself.

These kinds of inequalities, which align with those identified by Higashi et al. (2013) and Jeffery (1979), come about, I suggest, because of the patriarchal and militaristic relations between NHS staff. The Rapid Recovery programme does not account for the private sphere; concerns about family relations and materialities in the home are subjugated as women's concerns. Where surgeons and

senior staff actively distance themselves from their patients through detached concern and a drive to distinguish themselves from others, it is no wonder that the healthcare programmes they design assume the same social and material relations that they have come to enjoy (Michalec & Hafferty, 2013; Sinclair, 1997). Some people spend time and associate within assemblages of caviar, steak, grand homes, and nuclear families, whilst others are aligned with narrow staircases, box freezers, and fragmented social relations which they can't plaster with paid help. Importantly, these hierarchies in the NHS are not new, meaning the kind of recovery that is expected of patients also isn't new. Just as Charnley, the inventor of hip replacements, told patients off for not recovering well, and caused his trainees to be so scared they would hide failing patients in the sluice room (Grobbelaar, 2016), patients are now pushed off the end of a conveyer belt.

In this section I have illustrated that the idea that the NHS is a beacon of equality is more of a nationalistic folk tale than it is a material reality. Rather, the NHS is a complex and multiplicitous assemblage, which has long been made up of practices which produce inequality. The 'national' in the NHS is about more than denoting its geo-political spread, it is about the everyday practices based on patriarchal, colonial, militaristic models. It is no wonder that these assemblages have also disadvantaged people such as Bet: as Berne (2015) suggests, 'we cannot comprehend ableism without grasping its interrelations with heteropatriarchy, white supremacy, colonialism and capitalism, each system co-creating an ideal bodymind built upon the exclusion and elimination of a subjugated "other"'. The folk tale that the NHS brings about equality is an important part of the UK's nationalistic imagined community, but nationalism also shapes the NHS with patriarchal and militaristic relations of power sanctioned by the state. If activism is about finding ways to redistribute power, then efforts to 'save the NHS' are therefore in danger of reproducing these rather repetitive assemblages of power.

However, as I go on to illustrate, these practices that make up the NHS are still polyphonic. If our everyday practices can produce inequality, then by definition, they must also be able to act against inequality being produced in the NHS.

The Cinderella unit – breaking boundaries

After seeing that activism to save the NHS is also preserving some very problematic practices, I began to look for other forms of activism; forms of agency which work against the patriarchal hierarchies that make up this national treasure.

Like Tsing (2015), I found these alternate practices in the most unexpected of places. Through my rhizomatic style of fieldwork, I found myself looking for the Sterile Services Department (SSD), where all the surgical instruments get cleaned and returned back to theatre for safe use on another patient. I struggled to find the department until Dean came and found me to take me down to the security-protected basement. 'We're a Cinderella unit down here', he told me as we descended in the lift, 'everyone just thinks the surgical instruments magically appear. They just don't know we exist.'

On my second visit I followed the hip instruments round the process. First, I met Tom in the 'dirty room'. After removing the large pieces of flesh and bone, and washing off the blood by hand, Tom had to count every instrument against a list to make sure none of them were missing – potentially left in the patient. There were no pictures, he had to know every one of them by name. There was the Mead, Heath, and Partsch mallets, and the Williger and Halle bone curettes. It was all way over my head. Even if there were pictures it would be tricky – the differences between some of the instruments is so slight. As he went through, he checked each of the instruments for damage (even if the instruments are tarnished they may not sterilise properly), and placed them in the trays ready for disinfection. In the next room, with a change of shoes, caps, gloves, and gowns, Jo showed me how the instruments have to be put back together after they have been washed, which she seemed to do from muscle memory. Again, all the instruments are checked off as present and in no need of repair, before being put into the sterilisation machine.

Although every medic is taught that sterilisation only takes a few minutes at a high temperature, in practice, it takes a long time to ensure that every inch of the autoclave has reached the right temperature. Both the disinfection and sterilisation machines have to be checked and calibrated each day; they take about a week to calibrate when they are new. It's a careful and delicate science even to ensure the water being used is sterile; the pipes are regularly checked for infection.

Yet when I first visited, Tom, Jo, and their colleagues, were paid as ancillary workers on the lowest rungs of the NHS pay scale – between £15,404 and £18,157 per year.[1] 'Ancillary?!', Dean remarked, 'if these people aren't doing their jobs properly, people could die!' Dean's mission was to get them recognised and paid more as Health Scientists. By the last time I visited, Dean had succeeded – Tom and Jo would soon be Health Scientists paid between £16,968 and £22,683 per year. A small win, perhaps, but one that will make thousands of pounds difference to the employees, and will gives more credit to the labour going on in this Cinderella unit. This is a very different form of activism to the one set out by the campaigns to 'save the NHS'. It is a more complicated form of activism, which is critical and reflective of everyday practices. Dean's activity realigned the value attached to the feminised labour practices of cleaning by breaking connections with the label of 'ancillary', and realigning it as a central scientific process.

Dean wasn't the only one practicing forms of activism which challenge current hierarchies and divisions of labour. Karen, one of Dean's colleagues, told me she almost got fired in a previous hospital for running into theatre to delay the start of an operation. In this hospital they'd localised the sterilisation equipment for use by the theatre team, but they treated the machines 'like a dish-washer' – pulling the instruments out halfway through the cycle to save time. These high-paid surgeons clearly didn't know anything about cleaning. In running in to stop this potentially life-threatening procedure, Karen had physically broken the boundary of the surgeon's territory. With the patient anaesthetised on the table, and the surgeon dressed and present, it is meant to be the surgeon that orchestrates. Karen had reassembled the relations in the room to an almost sackable extent, and put her knowledge, skills, and resources into the centre of play. Through realigning the value of feminised labour, and undermining the value of very highly paid surgeons, both Dean and Karen intervened on the material assemblages which keep the socio-material worlds of patients like Bet side-lined.

Closing doors – making boundaries

'It's like a conveyer belt!' I heard the same phrase from Charlie and some of the other physios, but rather than saying it with excitement, they said it with disdain. Some healthcare workers on the ward are more sceptical of the 2.7 day target. Charlie was particularly good at ensuring the patient, rather than the target, guided her work. Juliette, for example, hadn't reacted well to the anaesthetics, she started to feel sick and dizzy every time she stood up. When this happened to other patients, they were swiftly put into a wheelchair and taken to the physio class. But Charlie slowly tried to get Juliette out of bed throughout the course of the day. When it became obvious Juliette needed more rest, she told her not to worry, and that they can try again tomorrow. Charlie stayed to make sure she was okay, and then left it until another time.

Unlike some of the other physios, Charlie had closed the door, closed the network on the data and the drive to get people out of hospital as quickly as possible. Only the immediate comfort of the patient was at stake. As a result, the directions of travel for Bet, who was constantly pushed along the conveyer belt, and Juliette, were very different. These contrary practices had an effect on how Bet and Juliette experienced the Rapid Recovery Programme, and the effects the current government, past legislation, and the culture of efficiency have on the NHS – these physios do politics. It wasn't that Charlie was being deliberately 'Political'; she wasn't a campaigner or even on a particular side of the argument on the NHS. She was, though, always curious and clearly enjoyed reflecting on her practice and questions of power and organisation during our conversations. As a result, she attended to the parts of the assemblage that others do not.

There were other moments, too, when Charlie acted against the grain – and like Dean, she redistributed wealth in the process. When the hospital started charging £15 for the grabber, the shoehorn, and the sock-putter-onner, she occasionally gave the pack away for free. The patient was clearly in need of it and had expressed a discomfort at the price. Similarly, when there was a non-patient visitor to the hospital who was struggling to keep a sprained arm in position without a sling, Charlie went to the store cupboard and found one for her. She saw someone in her assemblage in need, and found ways to redistribute resources to them. A nurse from another hospital, Jude, redistributed resources by insisting on making home visits to some patients to check they were okay, despite the fact that the hospital was trying to stop this. She collapsed, or at least evaded, the hierarchical order, and moved NHS resources to the private homes of patients that needed attending to. Through breaking, making, and realigning material relationships through everyday practices, Dean, Karen, Charlie, and Jude all managed to redistribute power to those who suffer within a patriarchal institution. Whilst still sparse, these minor political actions begin to unsettle or rock the relations which piece it together.

Discussion

Campaigns to save the NHS from privatisation hold the NHS up as a beacon of equality. In the first half of this paper, I have argued that fighting to 'save' or 'defend' the NHS contributes to a nationalistic folk tale which prohibits researchers and healthcare activists from criticising everyday healthcare practices. Whilst it is important to acknowledge that the very real threat of privatisation has put campaigners on the back foot, and I do not want to contribute to discourses which discard healthcare campaigners as 'the loony left' (Piyush and Tomkow, this issue), this stratagem has required healthcare campaigners to settle for the status quo rather than hope for better.

Secondly, I have illustrated that the nationalist underpinnings of the NHS reproduce inequalities through patriarchal, militaristic relations of power. A feminist conception of nationalism is vital here, because it disputes the idea of a 'safe', civic form of nationalism. Rather, the nation itself is the epitome of an institution which uses the intersections of sexism, ableism, racism, classism etc. to subject the 'other' to an oppressive form of care/governance. Through looking at what the NHS does, rather than imagining what is, I saw that everyday practices create inequalities amongst staff. The traditionally feminised labour of care and cleaning is devalued next to the work of surgeons or managers, and whilst surgeons and managers participate in assemblages of fast cars, caviar, and expensive restaurants, nurses and theatre assistants' are not invited to the party. Whilst I argue that this is enough in itself to dispute the folk tale that the NHS brings about equality, I go on to illustrate how these classed and gendered inequalities amongst staff, produce inequalities in the way patients are treated.

Here, I suggest that there isn't an overarching inescapable discourse called neoliberalism, nationalism, or patriarchy that causes inequalities; there are a series of actions and interactions which come to make some people receive better care than others. These actions, I argue, are often based on more habitual accumulations of more highly valued people and materialities in one place, and lower valued people and materialities in another. Those concerned with fast cars and silk pyjamas never step into or acknowledge the box freezers and narrow staircases of patients like Bet.

Thirdly, it is important to note that politics in the UK has been taking a fascistic turn, where migrants are being interned and healthcare workers are now obliged to work as a border force (Younis & Jadhav, 2019). Whilst I was unable to comment on intersections of ethnicity in this paper due to the geographical positioning of my research, maintaining nationalist sentiment in healthcare activism is only further likely to legitimise Brexit campaigns and NHS levies for migrants.

It is for these three reasons, that I suggest the use of use proxy national anthems and metaphors of colonial riches, as well as the project to 'save' the NHS in dominant healthcare activism is so problematic. If equality is the goal, then I argue, the Nationalism needs to be taken out of the NHS.

In the second half of this paper, I piece together the beginnings of an alternative form of healthcare activism. Crucially, I argue that if everyday practices produce inequalities then, by

definition, similarly everyday (though sometimes difficult-to-recognise) practices can also act to unmake them. We are all active agents who work in and on the world whether we like it or not – it is just a question of what alignments we decide to make. In this paper, I show how Dean, Karen, Charlie, and Jude, all worked to break connections, make connections, hit back, or evade them. In doing so they began to knock down and disperse accumulated assemblages into many different directions, constantly thinking about how their actions make up the world, and redistribute who and what gets cared for. They realigned the value we place on people, labour, and things, to ensure that people in need are attended to, and resources are redistributed to them. Importantly, this anarchistic form of activism is not just about breaking rules, as seems to be emphasised by Scott (2012a; 2012b), but also about making them – reformulating them in ways that distribute power more evenly.

If the shared aim of healthcare activists is to redistribute power more equitably, then I suggest we should explore the assemblaged composition of power, to strategize and locate the places to make change. This isn't to say that slogans are never useful, and that some healthcare activists don't also take on more practice-based activism. It is the practices, rather than particular people I am critiquing. But I would suggest this more complex analysis needs to be done more widely to consider the consequences of potentially blunt slogans and to see them as just one of many potential activist practices. I have also argued that these kinds of action are not aligned to current institutional norms such as the NHS Change Day movement (Moskovitz & Garcia-Lorenzo, 2016), or even trade union politics (see Scott, 2012b, p. 20). Rather, the healthcare activism which is most successful in bringing about more equitable distributions of power acts out against entrenched hierarchies and established institutional logics. This means that the kind of activism I have advocated here isn't always easy. Not only can it result in putting your job in jeopardy, but it also takes a lot of work to be constantly reflective and not to slip back into the habits of enacting the NHS as a strict tree-like hierarchy. Of course, in an assemblaged worldview we are inevitably a collective; we are all part of each other's actor-worlds. But this is where collectivity could really come to hand. As every ethnographer will know, reflecting on our impact on the world is always better done out loud with others. The more people discuss and see others dispersing or realigning material things, then the more it will strengthen others' ability to act in a similar vein. There is clearly a lot of energy and passion about the NHS and public healthcare systems around the world which I documented in the very introduction to this paper; but we must allow more complex and heterogenous workings to ensure a more equal society is really what healthcare activists are working towards.

Note

1. The median average earnings for a full-time employee in 2017 was £28,677 per year according to the Office for National Statistics (2017).

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