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Article

Cooperation and contention in psychiatric work

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Abstract
This article discusses the social organization of psychiatric work in the psychiatric emergency department of a public general hospital located in New York City, based on ethnographic research conducted from 1999 to 2001. Case studies of the care of two patients with ambiguous symptoms are discussed. The analysis applies the "differences approach" developed by Mol and colleagues which focuses on the way different professions provide divergent explanations and ontologies for symptoms and illness. The cases illustrate the ways in which social structural constraints are compelling psychiatry to become a multidisciplinary specialty.

Keywords
cities, political economy, psychiatry, public hospitals, social organization of work

Many patients who present to psychiatric emergency departments in large urban centers in the US have multiple problems, which go beyond the disciplinary range of psychiatry and require the services of other occupations that thus far have served in positions subordinate or ancillary to psychiatrists (Freidson, 1988). These problems include co-morbidity of mental illness and drug or alcohol dependence, and problems including unemployment, poverty, homelessness, and other social ills. The presence of this wide variety of co-morbidities coupled with a relative scarcity of hospital inpatient beds has altered the social landscape of psychiatry. Once ancillary occupation groups, like addiction counseling, now have a claim on the provision of beds which are key hospital resources as well as access to networks of placements through outpatient substance abuse rehabilitation programs. This gives members of these ancillary groups greater professional authority, creating the conditions where they are able to reorganize their working relationships with

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psychiatrists. At times, these collaborative efforts can be described as cooperation. Alternatively, these once ancillary clinical occupational groups can thwart the efforts of psychiatrists to diagnose and admit patients to the inpatient unit, causing contention. In this article, I will illustrate these processes through a close reading of two patients' experiences in the psychiatric emergency department.

The argument that I present here claims that in order to understand how psychiatry is practiced in settings where a variety of pressures such as social service cuts, scarcity of beds and other resources, along with challenges facing indigent and largely underserved patients, we must investigate this practice not as a singular profession but as a multidisciplinary one. Berg and Mol's (1998) "differences approach" emphasizes on how different clinical specialties can focus on the same organ or dysfunction yet have ontological distinctions that critically shape their practice. This approach is particularly useful in understanding the challenges faced by clinicians in the psychiatric emergency department, in which psychiatrists work to understand their patients' distress as products of endogenous disorders, while addiction counselors, social workers and psychologists view this distress as a product of the patients' entanglements in a complex social world. These two groups of clinical workers negotiate diagnoses and treatment plans through their cooperation, or alternatively, through intense debates over the key question: "what is wrong with the patient" (Luhrmann, 2000).

The "differences" approach is concerned with how different clinical specialties approach the disease or bodily organ from distinct ontological perspectives, as well as with how multidisciplinary clinical programs approach complex therapeutic challenges (Berg & Mol, 1998; Mol, 1998, 2003). Two examples of this approach to the study of clinical work are germane to the issues I discuss in this article. Mol (1998, 2003) investigates the different modes of diagnosis and clinical understanding when various medical specialties identify atherosclerosis. She traces the distinctions in ways of knowing atherosclerosis across different medical specialties illustrating how this disorder is enacted by practitioners in relation to a shifting terrain that is dependent on the context of where atherosclerosis is observed (in the thickened walls of the artery by a pathologist or in a patient's complaint by an outpatient physician).

Gremillion's (2003) ethnographic work on a treatment unit for adolescents with anorexia nervosa provides an example of how conflict emerges between clinicians where different professional perspectives exist uneasily. In an account of a debate between a psychiatrist and a pediatrician over whether a particular patient could be discharged from the unit, the pediatrician staked her position on the basis of the patient's weight, arguing that it was still dangerously low. The psychiatrist agreed about the low weight but argued that the patient had developed increased insight into her situation and had strengthened her determination to eat. Here the anorectic patient is perceived in two distinct ways: the pediatrician is addressing the biomedical problem of an underweight individual who is at risk for malnutrition. In contrast, the psychiatrist is looking at the complex

transformation being wrought by the patient and endorsing an emerging will to eat that should be supported despite continuing low weight (Gremillion 2003, p. 65).

Among the psychiatrists in the Urban Hospital psychiatric emergency department, mental illness was understood along strict biomedical lines. Disorders and diagnostic criteria were laid out in weekly seminars where attending psychiatrists taught residents how to identify symptoms and to understand their relationships to each other and to specific disorders. In contrast during morning report and in other conferences members of the ancillary professions, including addiction counselors and social workers, added a more complex perspective, discussing patient symptoms in terms of their drug use, family situations, employment status and social networks (among other factors). The realities of specific patient's experience of distress were constructed in ways that reflected the ontological positions constructed from the standpoint of these different professions. These ontological distinctions set the stage for the forms of cooperation and contention that I will describe.

Setting

This study was conducted between 1999 and 2001 at Urban Hospital, a public hospital in New York City. Urban serves a primarily low income population of African Americans, Latinos, a sizable immigrant community originating in the Caribbean and Africa, as well as substantial numbers of undocumented immigrants.

Urban Hospital is a major institution for the neighborhood. The hospital has been the site where generations of community residents have been born, treated for illnesses, and died. However, by the year 2000, many community members felt the hospital was surviving on borrowed time. Adding to their anxiety, a new ambulatory care unit was built raising fears that a shift in the hospital's mission was imminent and that the number of beds might soon be reduced. People from the hospital and the neighborhood were also concerned that Urban Hospital's relationship with two private medical centers was a harbinger for its transformation from a community hospital to a research center.

Urban Hospital was connected to a network that included two private hospitals. These private hospitals were in a much stronger position to control their flow of work. In busy periods their psychiatric emergency departments could go "on diversion," which meant that ambulances transporting patients were directed to alternative hospitals, often Urban. During my fieldwork, Urban's 16 bed psychiatric emergency department frequently would have over 20 patients. These patients would be placed on beds in the hallway or were placed in reclining chairs that were made up as beds in a patient lounge area. In these situations, which occurred when the inpatient psychiatric units were filled or overfilled, psychiatrists and addiction counselors and social workers would huddle together working out dispositions to the community's network of substance abuse rehabilitation agencies or

to longer-term state psychiatric facilities. As Rhodes (1991) pointed out in her ethnography of a psychiatric acute care center, the scarcity of inpatient beds and the challenge of locating an open admission slot for a difficult patient provides a constant struggle for clinicians. The end result in a place like Urban Hospital is that the ability to locate or reserve admission slots confers a significant amount of prestige and influence.

Urban Hospital's psychiatry department, like many of its other clinical departments, is largely made up of physicians who trained in foreign medical schools and immigrated to the United States, often after several years of medical work abroad (Katz, 1992).[1] Nearly all the resident psychiatrists accepted a slot in the residency program because it was available, not because it was a first choice. Most had also applied to internal medicine or some other non-surgical specialty. The fact that many of the residents are "accidental" psychiatrists makes Urban a compelling place to conduct a study of issues of training, professional socialization, and the practice of psychiatry. Urban's status as a public hospital means that it serves a very diverse array of patients. As a public hospital Urban would presumably have the largest diversity of psychiatric illness to treat, making it a rich training environment for the residents (cf. Mizrahi, 1986).

Methods

Using participant observation in the context of an ethnographic investigation of the social organization of work, training environments, and clinical practice, I collected data on a daily basis between 1999 and 2001. The research involved observation of emergency department practices and interviews with the clinical staff members. I was able to attend morning report meetings and had access to all the clinicians. I also had access to the patient areas of the emergency department and was able to observe patients when they were not being physically examined or receiving treatment. However, if a patient had signed a consent form I was able to sit in with them on some meetings with psychiatrists or other clinicians after receiving oral permission from both the patient and the clinician. In this article all names are pseudonyms (including the hospital name). Measures to ensure confidentiality included anonymous codes and pseudonyms that were provided as a rule.[2] The study was approved by the Institutional Review Board (IRB) at both Teachers College, Columbia University and at the hospital site. All participants were informed about the objectives and gave informed consent.

Results

While Urban Hospital kept a sequential log of admissions to its psychiatric emergency department it did not collect data tracking repeat admissions, admissions by diagnoses, or other historical information. That said, during the period of my

research it appeared that the majority of patients treated in the Urban Hospital psychiatric emergency department had a history of previous psychiatric contact. These patients were generally regarded as easy to diagnose and were generally perceived as offering little challenge in the development of a treatment plan. This was because in most cases their existing diagnoses were reapplied and their links to outpatient care were reestablished. In contrast, the two patients that I discuss below had no record of contact with Urban Hospital's psychiatric department and they did not report being treated at other facilities. As I will illustrate these patients are more likely to engender the kinds of inter-clinical debate which lead to cooperation or contention among the various clinicians in the emergency department. The two cases that are the focus of this paper represent the common distinctions made between patients without a psychiatric history. The first case is representative of patients who present with psychiatric symptoms and a positive toxicology screen for alcohol and/or drugs. The second case represents patients with symptoms that have unclear origins and which do not lend themselves to existing psychiatric disorders and which ultimately are seen to fall under the category of "problems with living."

Cooperation

The first case study provides an example of multi-disciplinary cooperation in which clinicians came together to address the particular challenges in developing a diagnosis, treatment plan and disposition. These challenges include the opacity of the patient's symptoms in the context of chronic drug and alcohol use as well as his unstable housing situation and intangible elements of his personality that made him difficult to place in an inpatient bed or treatment facility.

Late one evening, an African American man in his 40s arrived at the locked doors of the Urban Hospital psychiatric emergency department. He was let into the triage area where he was initially searched by a hospital police officer. After waiting a few moments he was interviewed by a psychiatric resident accompanied by a nurse who measured his blood pressure and his temperature. During the interview the man, who said his name was Avery, gave a complex and detailed account of a series of interpersonal conflicts that had frightened him enough to seek help. He had first gone to the medical emergency department around the corner and they had suggested he come here.

Avery described a series of escalating conflicts with his neighbors and with the building superintendent in his apartment building. These conflicts stemmed from his separation from his girlfriend. According to Avery they had broken up and she had moved into the basement of the building. He said that she then had a series of sexual encounters with neighbors and the building superintendent, and that when these men had discovered that she had HIV they blamed Avery for their exposure. Avery said that he thought they were planning to assault him and that he could hear them planning it through the walls and the floor of his apartment. He also said that he was being watched all the time because he heard voices describing his

activities. For example, when he was brushing his teeth he could hear a voice saying "now he is brushing his teeth" or when he was walking through his apartment he could hear a voice saying "he's going from the kitchen to the living room."

In order to help Avery feel more calm, the resident who interviewed him gave him an injection of a standard medication combination often administered at Urban Hospital that was referred to as "a five and two" meaning five milligrams of haloperidol (a neuroleptic) and two of lorazepam (an anxiolytic). After he was "medically cleared" through a brief physical examination, Avery had blood drawn in order for the psychiatrists to get a toxicology screen. Avery was assigned to a bed and promptly fell asleep. After I left, the resident wrote up his notes to present Avery's case to the team the next day at morning report.

The morning report is the most elaborate "rounds" presentation of the day in the psychiatric emergency department. In attendance are the attending psychiatrists, two or three psychiatric residents, Dr. Maye the psychologist, Ms. Crusoe, the addiction counselor, one of the social workers, and one of the nursing staff. In addition, medical students, physician assistant students, psychology and social work interns, case managers from outside agencies (who may have clients in the emergency department). The morning after Avery came to the emergency department the admitting resident Dr. Oba, presented the details of his case to the assembled team. Overnight the hospital lab returned the results of Avery's bloodwork showing the presence of heroin. Furthermore, in a subsequent interview with him conducted by a nurse it was reported that he was a habitual heavy user of cocaine and heroin as well as alcohol.

The discussion of Avery in morning report, which took about 15 minutes, ranged across several diagnostic possibilities. Dr. Oba took Avery's belief that he was going to be assaulted as evidence of a paranoid delusion. He also presented Avery's report of hearing his neighbors angrily talking about him and describing his activities as two forms of auditory hallucination, which were clear evidence of schizophrenia (American Psychiatric Association [APA], 2000).

Ms. Crusoe disagreed with Dr. Oba and told the group that the patient had "talked about cocaine and alcohol use both of which could be responsible for the hallucinations." The attending psychiatrist also supported her position reminding Dr. Oba that, "While you're right... the commenting voices are a powerful sign of schizophrenia, until we know more about him I agree with Ms. Crusoe. Alcohol alone has been associated with auditory hallucinations including those that seem to be commenting or describing the patient's activities."

At the conclusion of the discussion, the morning report team agreed that the diagnosis for Avery could only be "substance induced psychotic disorder." This led to a brief discussion of the various disposition options. One possibility was to admit Avery to the inpatient unit at Urban Hospital, but the social worker mentioned that, in light of Avery's report about conflict with his neighbors and building superintendent, they might have to consider Avery as unstably housed or homeless, which meant that he could not be discharged without a home or a residential facility to go to. This led to a brief renewal of the possible diagnosis discussion

because the choice of problem to emphasize (psychiatric disorder versus substance dependence disorder) would have implications for where Avery could be sent.

Over the rest of that day and the following I was able to talk to two psychiatric residents and to Ms. Crusoe (the addiction counselor) about Avery and about what would likely happen to him. The psychiatric residents continued to argue that Avery likely had schizophrenia, pointing to the commenting hallucination as well as to the persistence of his delusional belief that there was a plot to assault him. Added to this, the daytime resident, Dr. Randolph, argued that Avery had a delusional denial of illness which was further evidence of a primary psychotic disorder.

In contrast, Ms. Crusoe argued that Avery was a drug addict and that his symptoms needed to be understood in that context. She was determined to have Avery admitted either to the inpatient unit or to a residential treatment facility because, in her view, only in a secured, structured institutional setting could Avery receive the kind of care he needed.

Although, Ms. Crusoe agreed with the psychiatrists that Avery had a mental illness, she disagreed over the specifics, seeing it as an addiction disorder rather than a psychotic disorder, but she had no doubt that it was persistent and intractable. What distinguished her position from the psychiatrists was that she did not locate the disorder in Avery's body or brain but in the social context within which he lived. Interestingly, while she defined his problem as one stemming from social factors, her notion of social context was limited to immediate behavioral consequences. She did not identify poverty, unemployment, or other more obviously social structural factors in her analysis of Avery's situation. She advocated admitting Avery to the hospital or to a similar setting because, in her professional view, he needed the structure to develop new habits and a new social identity and network that was based on being sober.

During the four days that Avery was in the emergency department, Ms. Crusoe and the psychiatrists negotiated his disposition. Avery also became involved in these decisions at least indirectly through his actions. While his first day was largely spent sleeping or being interviewed, over the next three days the nurses found his behavior challenging. He complained vocally about the food, had loud arguments on the pay phone, and was found smoking a cigarette butt in the men's room. Ms. Crusoe bitterly joked that she was less inclined to accept that Avery's story about being the target of an assault was delusional: "he's a tremendous pain in the ass; I'd be looking to hurt him too."

Ms. Crusoe's perspective about Avery's diagnosis and the best treatment options available for him emerged as the predominate view held by the team. This shift from debate to cooperation was based on the evidence that the team collected from Avery's narrative about his fears, the voices he heard, and his description of his drug and alcohol use, complemented by the laboratory toxicology tests. One of the residents mentioned that Avery's behavior in the emergency department had also led him to change his mind. "There is something about how he intrudes on the nurses, what he complains about, that does not seem like a symptom of psychosis. I'm not sure what is wrong with him in the whole picture, but I don't think a psych

unit is the right place for him.'' The residents and physician assistants sped up their efforts with Avery, working with him on the proper medication dosages to take as well as running a number of physical tests to make sure he had no health issues that would obstruct his admission to a drug rehabilitation program. Ms. Crusoe and her social work colleagues started working through their networks to find a place for him. Despite these efforts, there were no available beds either in the programs that they contacted or, for that matter, in the hospital's detoxification unit.

The attending psychiatrist and Ms. Crusoe met with Avery and encouraged him to accept an admission to the hospital's inpatient psychiatric unit to begin the detoxification process, pending the availability of a bed in a residential treatment facility. Avery agreed to this and was admitted to one of the two inpatient units. However, according to the attending psychiatrist assigned to the inpatient unit, Avery immediately requested to be discharged and provided his apartment address as his home. He was released and did not go to a residential drug rehabilitation program. I draw attention to this in order to point out that the kind of interdisciplinary cooperation that I am describing does not automatically entail a desirable clinical outcome, rather it illustrates the fluid and distributed nature of authority that can influence both diagnosis and treatment planning.

Patients like Avery are increasingly present in psychiatric emergency departments (Larkin, Claassen, Emond, Pelletier, & Camargo, 2005). They often present with a combination of symptoms of psychiatric disorders and drug and alcohol use. These patients fall between the discrete boundaries of specific clinical occupational groups like psychiatry and addiction counselors. As in the case with the clinical occupational groups discussed by Mol and others, these patients straddle the ontological divide between the biomedical psychiatric model of mental illness being in the head, and the addiction counseling model, which sees these pathologies as rooted in social systems. Beyond the diagnostic difficulties and limited treatment options, there are substantial constraints on the broader hospital and residential treatment facilities that make it increasingly difficult to find a place for patients in these situations. Whether a consequence of deinstitutionalization or a byproduct of recent neoliberal innovations throughout municipal governance, there is both a decline in fiscal support for the expansion of public hospital psychiatric inpatient beds as well as an increased push to close or privatize public hospitals. Psychiatric departments have had to adjust to face these new circumstances. One way in which they have adjusted is to distribute diagnostic and treatment authority to previously ancillary clinical occupational groups, in part out of recognition that non-medical and non-psychiatric treatment approaches can be effective for the patients who are increasingly looking to psychiatric emergency departments for help.

Contention

This second case study provides an example of contention between representatives of clinical occupational groups. ''Caroline,'' like Avery, came to the emergency department with symptoms that led to divergent diagnostic conclusions.

However, the context of her symptoms again revealed a divide between ways of seeing and understanding psychiatric symptoms. In this case, the resulting contention in practice led to a kind of diagnostic and therapeutic stasis.

Early one evening Caroline, an 18-year-old woman, was brought to the psychiatric emergency department by police officers, who were accompanied by her mother. According to her mother, Caroline had suffered a series of emotional losses in recent days. Her boyfriend of several months, who she felt very strongly about, broke up with her to go out with Caroline's cousin, who was also her best friend. As a result of these events, Caroline became increasingly withdrawn, never leaving her apartment and rarely leaving her bedroom. She also refused to eat. According to Caroline's mother, who was interviewed by the social worker, after a few days of this she encouraged Caroline to "get over it." Caroline became intensely angry. She began to "tear apart" the apartment, breaking pictures, throwing things around her bedroom and the family living room. When she threw a clock through the window looking out over the balcony her mother called the police. When the police arrived Caroline was standing on the balcony amidst shattered glass leaning out over the building court several floors below. She did not resist the entreaties of a police officer to come into the apartment. When she did she was handcuffed and brought down to the patrol car which took her to Urban Hospital. At the hospital, she was released from the handcuffs and was interviewed separately by a nurse, a social worker, and a psychiatric resident. She was medicated with lorazepam and given a bed.

During the next morning report, the psychiatric resident who had admitted her, Dr. Odinma, presented her case to the treatment team. He reported the narrative above, and added that during his interview with her she was tearful. However, he also said that her behavior was erratic, she would become suddenly angry, then suddenly laugh. She also gave evidence of being paranoid by suggesting that her cousin and her boyfriend had planned this in order to hurt and humiliate her. The resident explained he had given Caroline a provisional diagnosis of brief psychotic disorder (APA, 2000, pp. 329–332) with a rule out for schizophreniform disorder. When other clinical workers expressed surprise about this rule out diagnosis, the resident explained that coupled with Caroline's violent outburst in her apartment and her labile mood during her interview she might be exhibiting the schizophrenia symptoms of "disorganized behavior" (APA, 2000, p. 314) and "bizarre thought" (APA, 2000, p. 324). Both of these symptoms need to be recurring in order for the diagnosis of schizophrenia, but at Urban Hospital it was common practice for a one-time occurrence leading to a hospital admission to be sufficient for the diagnosis.

After the morning meeting ended Dr. Maye, the psychologist, interviewed Caroline. The interview, which Dr. Maye described for me, led her to discount the violent behaviors that led to the patient's admission to the emergency department. Dr. Maye preferred to elicit the patient's own report about her emotional state during her recent interpersonal upheaval. During morning report the next day, Dr. Maye suggested that Caroline's behavior needed to be seen in the context

of her recent relationship losses. The psychologist argued that the patient was suffering from an ''adjustment disorder'' and was having difficulty accommodating her new interpersonal circumstances. Dr. Maye also suggested that the patient might have a personality disorder. She recommended that the patient be taken off her medications and referred to the outpatient program for intensive psychotherapy, arguing that medication had little to offer in such a situation. Dr. Maye included her recommendation in Caroline's chart. This frustrated Dr. Odinma, the resident, who afterward told me that the contradictory recommendation in the chart was ''particularly vexing.'' I asked him what it could mean:

> Probably it won't matter, but if she sues us or if there is any kind of investigation it makes it possible to doubt the care. The chart is too serious to meddle with because we [members of the clinical team] disagree. We can change things in the chart, but in another way.

He explained that rather than have the dispute appear in the chart, the diagnosis could be shifted ''as we developed our ideas.'' He went on to explain that he felt particularly vulnerable given his status as a resident, and his fear that nothing should threaten his future plans to practice medicine.

Caroline's case was as a continuing source of conflict between the psychologist and the psychiatrists. Both Dr. Odinma and Dr. Maye argued that Caroline's problem was fleeting. Some clinicians were surprised that she had even been admitted and the reception to her was decidedly cool. One nurse commented that ''all she needs is a smack.'' When I asked why she thought that way the nurse said, ''Well, it's not really fair, but she seems kind of spoiled to me.'' The crux of the debate between Dr. Odinma and Dr. Maye was whether Caroline's symptoms could be explained with reference to her brain, for lack of a better word, or to her situation.

For Dr. Odinma the evidence to diagnose Caroline as psychotic stemmed from her violent, disorganized behavior and ''bizarre'' delusions. Dr. Maye saw Caroline's actions as being poorly described by a psychiatric system of symptoms and disorders.[3] Dr. Maye argued that Caroline's behavior, although inappropriate and extreme, was an expression of frustration and humiliation at being treated badly by her boyfriend and cousin. Dr. Maye agreed that her violent outburst was problematic, but felt that in essence it was a temper tantrum and to see it as evidence of psychosis was out of proportion. ''What's next, every time a kid flips out because his parent won't buy him a toy, we're going to put him on Haldol?'' She argued that once you cross over into the emergency department the question becomes ''what kind of crazy are you?'' Instead, she said, they should be open to the possibility that some patients were brought to the emergency department by mistake. ''Maybe she should have been arrested. I hope not, but she doesn't belong here.''

Physicians, in both their practice and in their training of residents, inculcate the idea that medical knowledge is a pre-eminent, real knowledge and that other knowledges, experiential in this case, are subordinate or secondary knowledge

(Taylor, 2003, p. 556). Dr. Odinma crafted a narrative of what was wrong with Caroline excluding both Caroline's own account of the events leading up to her being brought to the emergency department, and the latent or experiential story that Dr. Maye invoked. Dr. Odinma's narrative served to establish his authority as a representative of medical science, as well as to address his perceived vulnerability to challenges to his status as a physician and as a competent professional.[4]

By the second day in the emergency department, the attending psychiatrist presented Caroline with the option of going into the inpatient unit or leaving with a referral to an outpatient program. She rejected both options and left without a prescription to continue the antipsychotic medication that she had been given while in the emergency department. The chief of the emergency department was not disappointed to see her go. He wrote in her chart that she was discharged rather than that she had left "against medical advice."

Discussion

The "differences" in medical practice perspective offers important insights into the social organization of clinical work. Medical workers from the different clinical occupational groups in Urban Hospital's psychiatric emergency department are engaged in practical questions over how to treat the suffering of patients and this work leads to ongoing efforts to interpret what is wrong with patients. The question of where mental illness comes from, the mind and body of the patient, or the social system in which he or she acts, is as salient as ever in debates between psychiatrists and members of other clinical occupational groups. This debate often pits psychiatrists using a biomedical perspective against clinicians from social work, addiction counseling, occupational therapy, and others who emphasize the social context.

Patients who come into Urban Hospital present a variety of symptoms, which emerge from mental distress and from substance use. This basic issue is widely agreed upon by the clinical team members. But where psychiatrists perceive mental distress to have its origin in the brain, a psychologist may seek the cause of mental distress in the maladaptive social interactions in which patients are embedded, and addiction counselors may see its roots in a toxic social system involving drugs and crime. These perspectives are not strictly occupational differences but are also ontological ones. The "differences" approach encourages researchers to see this kind of conflict as a sort of clinical politics with shifting coalitions and resources coming into and out of play.

The "differences" perspective offers the possibility of a new model of psychiatry as a multidisciplinary medical specialty. The other clinical occupational groups offer understandings of illness and logics of care that directly impinge on patients' experience. Medical workers from the so-called ancillary clinical occupational groups like addiction counseling and psychology are all concerned with the way that patients fit into the larger social system beyond the hospital. They offer a more

widely elaborated psychiatry, which provides the possibility of confronting the messy realities of social life as causal factors in mental disorders.

This article provides an example of how the ''differences'' approach to understanding the social organization of medical work can be applied to the ethnographic study of a psychiatric emergency department. This study foregrounds the plural nature of psychiatry more generally as displayed in episodes of cooperation and contention between physicians and non-physicians in the negotiation of decisions about diagnosis, treatment plan, and disposition.

The differences approach to the study of the social organization of clinical work presents a new way to understand psychiatric practice in local clinical settings. However, recognizing the distribution of clinical authority to diagnose, develop treatment approaches, and arrange dispositions, to previously subordinate groups also creates new possibilities for psychiatry as a discipline. This possibility addresses Luhrmann's concern that the biomedical research agenda, which investigates organic causes for mental illness has led psychiatry to diminish its potential to ''meaningfully encounter psychic suffering'' (Lakoff, 2006; Luhrmann, 2000). Allowing previously subordinate clinical occupational groups to oversee all aspects of patient care creates an approach to recognize the subjective and ''essential'' (Luhrmann's term) way that suffering occurs as part of experiencing a particular affliction.

Successful psychiatric work could benefit from this complex form, while providing numerous avenues of research. For example, studying ''difference'' helps us to illuminate a paradox of contemporary psychiatric practice as it occurs in general hospitals. This paradox is that even as psychiatry as a discipline turns to strict interpretations of biomedical models of illness, the continuing effects of deinstitutionalization and the rise of managed care, as well as the reductions in spending on social services at all levels of government, have created conditions where psychiatrists must confront a renewed responsibility for managing social ills reminiscent of the age of the asylum; that is, poverty and social marginalization translated into symptoms of mental illness.

Conclusion

In this article I have described an example of what can be called a ''differences'' approach to the study of the social organization of medical work. Differences is a way of investigating medical work developed in part by Mol and others who seek to illuminate the ontological distinctions in perceiving pathology in different clinical specialties whose work overlaps through their encounters with organs, patients, or disease and disorders. For instance Mol (2003) describes the incommensurate ways that pathologists diagnose atherosclerosis (through identifying thickened arterial walls) and primary care physicians who ''see'' this disorder in the presentation of the signs and symptoms of patients they encounter in their examination rooms. Gremillion (2003) describes how debate, or contention as I have described it in one of the examples included in this paper, intrudes on the discharge planning

associated with a particular patient in an eating disorder inpatient unit. In this example anorexia is understood in two fundamentally different ways. The psychiatrist is concerned with the patient's progress towards gaining insight into her disorder, developing the will to overcome it, and creating healthy eating habits. The pediatrician is concerned with the patient's malnourishment and continuing low weight. Anorexia, as a disorder, is split into a mental and physical disorder by these clinical specialties.

The research I present here supports the importance of the differences approach. Here I present two patients who are representative of the kinds of patients that are flowing into psychiatric emergency departments, particularly those of public hospitals. Where my research takes the differences approach into new areas, is in my focus on the contrasts between psychiatrists and non-physician clinical staff. Psychiatrists, particularly residents, at Urban Hospital approach the reports of their patients' symptoms through an understanding that fixes mental illness in the brain. Symptoms are seen, by the residents, as reflecting the diagnoses that they are being trained to identify. In contrast to this, the addiction counselor, the psychologist and the social workers and nurses understand that the symptoms described by the patients can often have their roots in the complex social worlds that these individuals inhabit, which are often a nexus of poverty, substance abuse and dependence, as well as interpersonal disruptions. The ontological distinction is between a psychiatric understanding of mental illness as something in the body (specifically the brain) and this alternative approach, which sees mental illness, or perhaps better termed, emotional upheaval, as something in the social system or community.

The two cases that I discuss, while quite different share a key similarity: they presented in the psychiatric emergency department with opaque or ambiguous symptoms that could lead to a variety of potential diagnoses. In both cases the psychiatric residents considered their symptoms in light of psychotic disorders, particularly schizophrenia. In contrast non-physician clinicians posed alternative theories that were grounded in the social context inhabited by these patients. In the case of Avery, his long-term drug and alcohol use were considered in light of his auditory hallucinations and delusional beliefs. In the case of Caroline, her emotional upset and destructive behavior in the context of experiencing humiliation around the loss of her significant other was contrasted with the psychiatric resident's impression that her upset and behavior could be seen as emerging from the spectrum of symptoms of psychosis. In the first case, the clinicians drew together in their understanding of Avery's problem as they collaborated on developing a diagnosis and treatment plan for him. In the second case the psychiatric residents were pitted against the psychologist and the nursing team. The result was that they were not able to negotiate a diagnosis or treatment plan leading to Caroline being discharged with little if any follow up planned.

Looking at these cases through the lens of what I have termed "the differences approach" is important for three reasons. The first is that it acknowledges a reality of practice in Urban Hospital's psychiatric emergency department, which is that

psychiatry is increasingly a multidisciplinary specialty drawing together the efforts of physicians and non-physician clinicians. Second, this approach recognizes the complexity of the lives of the patients who seek care in the emergency department. They present with a mix of symptoms that are, on the one hand, evidence of psychiatric illness and on the other hand push beyond the boundaries of discrete psychiatric disorders requiring complex interventions. Last, these complex interventions are located both inside of and outside of the hospital. They require psychiatrists to work closely with addiction counselors and social workers to find placements in an array of programs that are paradoxically diverse and scarce; they do not merely rely on the question of what is the appropriate or ''right'' psychiatric diagnosis. The contributions of non-physician clinical workers are an important feature of psychiatric practice and without their input as we can see in the case of Caroline the proper disposition and treatment plan may never fully be reached. It is only through a deeper understanding of the ontological distinctions that separate clinical from ancillary groups that we can begin to gain insight into the problems faced by their shared patients.

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Notes

1. See, Katz, 1992, p. 365. Katz's work looked at international medical graduates (IMG) who practiced psychiatry in the Maryland State psychiatric hospitals. Her conclusions were that culture issues generated both by the region of origin of the IMG psychiatrists and the culture of the state mental health system contributed to a lower standard of care than offered by US medical graduates.
2. To protect confidentiality, there was no audio-recoding and interviews were recorded by hand. Thus, except for brief quotations, I describe talk rather than reproduce it verbatim.
3. See Horwitz and Wakefield (2007) for a discussion on the transformation of normal emotion into psychiatric disorder.
4. Barrett (1996) describes a similar process in his book on the narrative construction of schizophrenia in an inpatient unit.

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