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Caring ecologies 3 - Catalogue, Transition, Enterprise

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Catalogue

“If you are a nurse, we can understand each other, not like with these sociologists!” Federico jokes (or not?) with Irene. In their conversations, there is a shared set of knowledge and competencies, not only linguistic, but, more importantly, in the concrete experience of modes of action and logics that govern the ecology of care. We are in the core of the caring ecologies of Trieste, the Distretto Sanitario (Healthcare District) located in the old general hospital, now almost dismantled (another, more modern one is up the hill, in a less central area).

The Healthcare District is the device through which the healthcare system tries to move the practice of care from the hospital to the spatial dynamics of the city, moving technical practices as well as human resources from the institutional site to urban life, and responding to the challenge of *taking charge* of the complex life of the citizen in relation to the plural ecology of care. In sum, the district contests protocols as the tool to organise care and proposes a catalogue of practices that can be arranged differently according to each situation.

There are four Healthcare Districts in the city, each tending to a population of approximately fifty thousand people. The Districts coordinate with general practitioners (who in Italy have a private contract with the state, although their consultancy is free for all residents), and provide home-care and personalised care through a system of resources including people, objects and assets: nurses, specialists, physiotherapists, and other professional figures; ambulatories, temporary care residencies, rehabilitation sites, cars and consultancy facilities; and, finally, grants, specific budgets, and social benefits, managed by the Districts in coordination with other institutions.

Although it acts through the hierarchies of institutional healthcare, the Healthcare District aims to disrupt the institutional logic as separate from social life and to re-knit the fragmentation of the different parts of the institution itself. The District is a device that simultaneously acknowledges and manages the boundaries between the different agencies in the system and contests and destabilises them.

Calling these practices territorialised medicine (*medicina di territorio*, in Italian) irritates the categories and presumptions of healthcare intervention in two ways. First, it grounds the idea of primary healthcare in spatial rather than communitarian dynamics, thus placing the practice of care in social reproduction rather than making it dependent upon an identitarian membership in one community. Territorialised medicine helps sustain social reproduction by investing public resources to hold together a system of common living. Second, territorialised medicine actively contests the separation between public health and medicine, which rarely meet and collaborate. Territorialised medicine makes the endeavour of care, and importantly doctors and other healthcare professionals, into an ecology, one in which different resources,

agents, sites, objects move and adjust to temporary balances, unstable equilibriums. It is an ecology of perceptions, knowledges, and negotiations, of actions and durations.

Federico tells us, and Ofelia Altomare enriches his description the next day, about some of the Healthcare District's activities. He starts the story from the moment in which the citizen enters into contact with the totalising experience of the hospital and therefore when the critical practice of care joins in the effort of disarticulating the institutionalisation: the moment when the practice of territorialised medicine encounters its nemesis, the general hospital.

Healthcare District staff are already present at the site of most intensive care, as a few workers from each district follow inhabitants when they are hospitalised. They visit the patient in the ward, contact the doctors to follow the patient's hospital stay, and discuss the situation with the rest of the Healthcare District staff and the patients' relatives or friends. Their presence allows them to start mobilising the resources that will guarantee the patient/citizen's dignity and the right to health after discharge in the context of her life. This involves mobilising social and economic resources to support her, configuring caring and healing devices in her apartment, thoroughly and safely displacing the practice of care from the institution back into social life. Finally, Federico stresses how important it is that everyone involved understand the specificity of each technical practice and the web of knowledge and actions that allow it to be most efficient: "Reading a radiography or putting in a pace-maker does not involve a permanent relation with the patient, or any continuity. The patient expects his radiographies to be promptly executed and correctly interpreted [...]. Your general practitioner on the other hand has to

act in the opposite way, leaving the technology to the specialist, but taking charge of all the aspects of care that affect your life."

The practices of the Healthcare District cannot be normalised into a fixed set of protocols: there is not one practice, but an ever-shifting set of practices that intervene and develop in a living world. This permanent destabilisation/organisation challenges the institutional tendency to segmentation so that the citizen has a better chance to enjoy her "right to health." This is not a formal entitlement, but a relational experience immersed in social life and sustained by the coextensive action of the various agencies of the healthcare system. "Care is organised as an existential experience for both poles of the binomial carer/cared, and therefore contaminations and cross-overs are continuously constructed through the contradictions of normality" (Signorelli, 1998).

Contradictions, yet again. If earlier, we have encountered the contradiction of fabulation, here another matter emerges. This contradiction is that created by being part of the apparatus that institutionalises while trying to be a radical and responsive agent in the ecology of care. The question is how to maintain this tension, as a transformative "care for the past": one that acknowledges the existing institutional practices not as something to be destroyed altogether but as the starting reality one has to confront to transform them. This implies thinking of them as *ecologies* that perform a certain way of living, but that can transition to new forms of social and material organisation.

Another way to think about instituent practice is as a critical denial of the instituted and the governing of the contingent equilibriums of transition: a subsistential territory (Raunig, 2016). Instituent practice aims to compose care around/with all the singularities involved: the pathology, the life of the citizen, her social networks,

the political, institutional and administrative resources around care, or the knowledges, cultures, technologies and individual singularities (of the workers as well as the citizens) involved in the enacting of care. In other words, composing these material, social and institutional agencies is not about ordering, but about encountering.

In an interview with the research group *Entering Outside*, Franco Rotelli says: "I am always astonished when I speak with a young doctor and I ask him what he does, and he tells me his actions. If I ask him about the context in which he enacts this practice, either he knows nothing, or he refuses to know. Sometimes he has a vague idea about it, but there is nothing more overdetermined than what happens in the field of health: huge institutional assets, big economic interests, powerful professional corporations shape all. But the citizens as users should also matter. There are enormous issues on the political, organisational, administrative and cultural levels that play around this doctor who does these actions. But he ignores all this. In the best scenario, he cares about enacting a scientifically correct practice; his competence starts and finishes there. We think this is deeply wrong" (2019).

The caring ecologies are a plural and multiple logic of care. They are plural as far as they combine seemingly simple objects – always composed in a different way – according to their singular properties, until they perhaps find an unstable, temporary and partial equilibrium of competences, experiences, contingencies. This composition, this combination, is multiple in the sense that this plurality of competences would be destructive if it fragments the ecology of care. The responsibilities of care overlap, collaborate and conflict; the ecology of care is intersection of worlds, processes of interaction, where change emerges out of collaboration and conflict, in the simultaneous and intertwined acting of many

worlds, each with its own culture, population, history, but still interdependent with the rest.

As Dimitris Papadopoulos proposes when speaking of technoscience, the ecology of care "is continuous with instituted [care] and vice versa, a continuation that unfolds across disparate and fragmented worlds" (2018). A network of possibilities that is the crafting of desiring, technical, social, and administrative dynamics that act around the contingency of care into a living system that takes care of singular and multiple parts *of itself*. A city that heals, an ecology that cares. All of this is the challenge the Healthcare District tries to organise: not by ordering prescribed protocols, but by enriching the open catalogues of the caring ecologies.

Transitions

"It is about guaranteeing the right to health of the citizen, not about responding to the needs of the patient," Ofelia says. "I don't understand the difference," Irene responds. "It is about taking charge" Ofelia offers. And the ball goes back and forth a few times before a common language re-emerges: not a technical one, but one made of ethics, experiences, politics, doubts, efforts and failures. Ofelia Altomare is the director of a Healthcare District on the periphery of the city. She is a nurse, the first appointed to this role. Along with other executives who come from the nursing profession (usually highly subordinated and gendered in the governance of care), she plays a significant role in Trieste's contemporary ecology of care.

The incomprehension between Ofelia and Irene is powerful, a shared wrestling with the matter at stake, rooted in the intention

of understanding the full meaning of words and the materialities attached to them. Irene is not interested in understanding just the molar signification of “presa in carico” (take charge), but in confronting the molecular unfolding of this expression within the ambivalences of reality. The molar understanding would open a different conversation about the linguistic and material implications of paternalism and objectivation. The molecular thread instead takes us through concrete assemblages, continuities, transversalities, a discussion of how this practice respects the patient’s privacy, how it becomes a habit for staff and the citizen, how you reorganise the ecology of care around the guaranteeing of rights, as a relational experience, rather than the covering of needs, which so quickly leads to the objectification of the person as illness.

Ofelia first refers to the continuity of care as the model that allows the District staff to construct the transition from the hospital to the patient’s home, but what is difficult to grasp is how this process happens concretely. The molar “naming” and the molecular “acting” intertwine in Ofelia’s explanations: some of the actions cannot be solidified into one example, because the action is related to contingencies and is always a singular production. Nonetheless they need to be enunciated as statements, to be affirmed and constituted, even if they will inevitably be manipulated according to each situation. This is catalogue, not protocol.

Ofelia talks about how they are managing a situation right then. Someone has been hospitalised and after the home care team visited the apartment and talked with the family, it is evident that biomedical attention alone will not be sufficient or sustainable. Her account resonates with Federico's words the day before, but this time the account takes up the material details. The question is how to bring people together, coordinate their actions, organise the

different objects and subjects of care. In other terms, instead of segmenting the practice of care, for example calling the social care department so they can take charge of their specific area of competence, the Healthcare District aims to knit the different competences into a common responsibility. Call the care workers, find somebody to refurbish the house according to the new needs and dignity of the person, help the family find a way to afford a carer. All these separate acts work to break down medical care as independent and univocal, or, at best, bilateral: the patient and the doctor alone in the consultancy room.

This common effort, this common hold on the ecology of care, is the result of a long transition, the forging, negotiation and affirmation of a different institutional practice. If the space of the asylum was one of violence and rebellion, the Healthcare District is one of molecular revolutions, of moving from competence to response-ability, a shared ability to respond (Haraway, 2016). Irene asks how this can happen, how the material culture of labour can change. How do the commons unfold in the endeavour of care?

“Slowly” Ofelia says, and through experiments, discussions and negotiations. Franco Rotelli refers to this process as a process capable of enacting a minor practice and making it hegemonic, building autonomy inside the state through material consistency, and by opening spaces of radical instituency. In the relation of capitalist-determined antagonism, “non possiamo vincere, dobbiamo convincere” (We cannot win, so we must persuade) (Basaglia, 1979).

The possibility of the common effort is constituted in the technical; the polity is located in the “operative” dimension, shaping the enactment of policies. Words, statements and questions circulate in a space of discussion rather than vertically

ordering practices. It is a space of "minor hegemony," that is the capacity of constituting within the institution a certain culture and a certain capacity of acting together. This minor practice is not *oppositional* to a *majoritarian* process, but it sheds light on the effect, rather than the rationality, of the state: how can we enact emancipatory public policies, staying in a contradictory way in the state?

This transition is always at risk of being reversed, Rotelli cautions, if it is not sustained by a practice of continuous and common engagement with both the inside, the institutional practices, and the outside, in urban life.

It is not only the patients who need to be guaranteed a process of de-institutionalisation. Ofelia Altomare recalls her own journey through de-institutionalisation in relation to the practices *within*. First, it is about putting oneself at risk as the leading group aiming to change the institution's functioning ("sharing our doubts and our challenges, democratising the space of decision, disrupting hierarchies, especially because we were the ones at the top"); second, it requires affirming new ethics and discussing their importance, not only in principle, but in most material terms ("for example one of the issues we raised was the time table of nurses: if the citizen is the core of care, you cannot provide home care just from 8 to 14; it must become a 24/7 service. But this raised a number of concerns around which we had to negotiate and reorganise institutional practices"); thirdly, "it is a matter of crafting how each worker is going to participate and work in the Healthcare District, taking into account his or her singular situation and knowledges: one is a single mother; the other has to take care of a relative, and so on; one can work in a certain area or on a certain issue, etcetera.

However, the boundaries of the institution are not the limits of care. In fact it is the opposite: thinking of the ecology of care implies affirming a dispersive engagement of the institution throughout urban life and requires the institutions to invest to support the city's commonwealth. The care "for the past" – that is the work of changing existing institutional practices and investing in open dynamics – is accompanied by a care for the present. Care is a relational experience that overflows the dynamics of healthcare, that participates in the city, and sustaining the right to health sustains social reproduction and urban life as well.

Enterprise

The term "presa" is an interesting one for understanding what is at stake here: it means seizure, grasp, hold. *Prise* in French. It holds the moment and a variety of possibilities folded through experience and unfolded each time in a different configuration. Presa involves having a catalogue of practices and tuning them in with the situation, configuring spaces made of contradictions and ambivalences. The seizure holds a complex reality together, displaying a collective effort in a contingency in which the healthcare institution is just one actor among many, and where a "continuous folding of the private, the public, and the commons into each other creates a condition where designating one of these three domains as the primary force [...] becomes almost impossible" (Papadopoulos, 2018).

The word they use in Trieste is *im-presa*, Impresa Sociale (Rotelli, 1992). Not just a common seizure, but also a common enterprise. The enterprise as adventure and challenge resonates with Leigh Star and Griesemer's (1989) conceptualisation of the entrepreneurial effort as a common, affirmative and composite

practice that deals with institutional dynamics as an ecological assemblage: a collection of limits, memories and practices, a complex overlapping of points of view and perceptions. Such a collection allows the institution to enact the broken equilibrium of its own reproduction in its permanent transformation, thus preventing the institution from being drained by its tendency to autonomy and separation from society.

Inventing institutional practices therefore means acting in the changing institution, aware of the institutional drift to internal reproduction, but also feeding the molecular tensions that move a common enterprise to organise and respond to needs and desires. In Trieste, the common enterprise found its organisation through the 1991 Italian law on social cooperatives that guarantees economic support and fiscal privileges to cooperative enterprises in which at least a third of the members have disadvantages of some kind.

One of these common enterprises is the tailoring cooperative Lister. It is configured as a space of up-cycling where broken umbrellas, old textiles, out-of-date banners and other objects can be reused: it is organised to be inclusive, not only in its management, but throughout the production process. The production processes are organised to allow people with diverse mobilities to participate: for instance, the pace of production can be regulated to correspond to the rhythms of the people working, their distress and anxieties. The principles of up-cycling, the attention to places and to aesthetic qualities, are also used to construct a narrative around abandoned objects: the production of the objects becomes a *ritual* that embodies the practices of deinstitutionalisation, as Pino Rosati calls it, that reinvent the objects' role in social reproduction.

Housed in the premises of the former asylum, today the Cultural Park of San Giovanni, Lister is an artistic, political, economic and institutional reality that participates in the common enterprise of care, along with other social cooperatives and associations, including Agricola Monte San Pantaleone, which manages the most beautiful parks of Trieste and the city's seven-faith cemetery as well as the rose garden of San Giovanni, one of the most important in Europe. There are others, too, cooperatives and associations: CLU Basaglia, La Collina, Radio Fragola, Reset, Articolo 32 and more: a cooperative, associative, entrepreneurial movement that employs hundreds of people and accounts for almost 1% of the local gross production.

The first social cooperative in Trieste was born in 1972, as the first act to dismantle the asylum and give back civil and economic rights to the people sectioned there. It was an invention, in Basaglia's terms (2005), a *machiavelli,* to trick the law and avoid forced internment. It started from a common sense: that of paying a stipend to the sectioned instead of imposing unpaid labour on them through the logic of occupational therapy. This gave patients a salary and a legal membership in a cooperative, helping to rebuild their social, civil and political rights in (and beyond) the asylum.

At the same time, the cooperative movement is a practice of health and care, because making beautiful and useful things makes you feel better, as Giancarlo Carena, president of the Social Cooperative Agricola Monte San Pantaleone says. In the 1980s, in fact, new enterprises were needed to build institutional practices in the derelict space of the asylum, to invent new forms of care not only against the return of segregation, but also privatisation, abandonment, and misery.

What was at stake was, and is, the invention of institutions as common enterprises, or *commoning enterprises,* in the middle of social reproduction: in the middle of troubles. Felix Guattari described the rise of social cooperatives in Trieste as opening not just the psychiatric practice beyond the asylum but also inserting them in social and urban life, "no longer artificially separated [from social life and] moving in the direction of a general desegregation". "One can create light psychiatric facilities in the midst of the urban fabric without necessarily working in the social field. One has simply miniaturised the old, segregative structures and, despite oneself, internalised them. The practice being developed today in Trieste is different. Without denying the specificity of the problems posed by the mentally ill, the institutions created, like the cooperatives, concern other categories of the population that are also in need of assistance [like] drug-addiction, ex-convicts, troubled youths, etc" (1984)

But when this practice of emancipation is in the neoliberal city, another contradiction emerges. In this uncertain unfolding of the common enterprise within the urban ecology, un-commoning is also always going on (Papadopoulos, 2018) and the social cooperatives are part of that. The common enterprise is immersed in precarisation, because its workers have temporary contracts and difficult conditions. It is trapped in the process of privatisation of care, since the cooperatives can become the tool to outsource the public delivery of services. If entrepreneurial practice is appropriated to unfold the commons in the life of the city, alertness must be taken to ensure that it does not become a gateway to privatisation. The common enterprise needs to think of itself as a garrison in open social space. A manifestation against the processes, pushed by private economic interests, that can annihilate the caring ecology.

In this process of annihilation, *privatisation* gains its full meaning as a biopolitical and micropolitical process. It deprives each person of the capacity of enjoying the common good by making the disposal of care an exclusive good doled out in the name of scarcity. At the same time, the privatisation of practices disrupts the social responsibility around care and makes it a matter of competence and consumption, imposing the linear logic of choice in the asymmetric spaces of caring (Mol, 2008).

The social cooperatives movement can be a space that counters the growing privatisation of care, that opens new ways to manage the public endeavour of care. But this happens only by staying in the troubles of social reproduction; not by separating the endeavour of care from the urban ecology, but rather by immersing the enterprise of care in the struggles of the city.

This tension between enterprise and commonality is always at risk of tipping either toward enterprise, by the accelerating logic of the market that expels singularities through economic competition, or towards the institution, by the entropic logic of institutionalisation that tends to organise care around the efficiency of the institution rather than the effectiveness of care. But the productive tension of social transformation can be sustained by making cross-cutting institutional programmes (*transversal*), by offering public resources to sustain the difficult freedom of vulnerable times and people within the social life of the city.

The ecology of care can find the most fertile sites on the edges where different worlds intersect, not only breaking the separation between the different parts of the institutional assemblage and between the state and society, but also sustaining the empowerment of social life in the management of the enterprise of care.