

**Bureaucracy, Power, and Conflict: The Politics of  
Managing a Transcultural Community Mental Healthcare  
Clinic in the Netherlands**

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Master of Philosophy

by

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# Abstract

This thesis investigates the ways in which a transcultural mental healthcare clinic in the Netherlands faces various challenges. Using rhetoric culture theory as the main theoretical framework, it looks at aspects of the organisation and its quality control system through examples derived from participant observation. The research shows that the quality control system is open to interpretation and that culture is an important aspect of the organisation. It also shows that there is disparity in power between both insurance companies and the state on the one hand, and the healthcare providers on the other. In this thesis, further attention is given to the particular way the clinic was organised, whereby people close to the board were given management positions thanks to kin-like relationships. This led to a division among staff which came to the fore during frequent conflicts and arguments. Another aspect that is highlighted in the thesis is the way audits produce stress, anxiety and even panic among staff and have not significantly increased the quality of care at the clinic.

Tags: mental healthcare; the Netherlands; migrants; quality control systems; audit; rhetoric culture

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*To my dear wife, Müge*

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# CHAPTER 1 — Introduction

## 1.1 INTRODUCTION: THE CLINIC

In the summer of 2012, my wife and I moved back to the Netherlands, which we left in 2005 to work, live and study in the UK. The reason we moved back to Holland had to do with my aim to do fieldwork for my anthropological research. Although we had made regular visits (once or twice a year) to my native country, after having lived in London for about 7 years, it felt strange being back. Most people I know in Britain had this idea about Holland that it was very liberal, free and open society, but my own view of Holland was that it had become more and more polarised and that politically it had moved more to the right over the past decade. Elections were in full swing as I arrived after the collapse of a coalition between the liberal party Volkspartij voor Vrijheid en Democratie VVD<sup>1</sup> and the Christian-democrat party Christen Democratisch Appèl CDA<sup>2</sup>, which had been propped up by the extreme rightwing party Partij Voor de Vrijheid PVV<sup>3</sup> led by the divisive and controversial Geert Wilders. His rhetoric was mainly aimed against migrants, particularly Muslims, and I was curious how this would affect the migrant communities across the Netherlands. During this time, I came across a mental healthcare clinic that was treating mostly Turkish patients, through my wife Müge, who is a Turkish doctor and trained as a psychiatrist in the UK. She arranged an interview for me with Monica, an Iranian woman in her early 30's who ran this mental healthcare clinic, near one of the large urban areas. Monica was looking for a quality coordinator for her clinic, to manage the clinic in her absence, and to deal with the bureaucratic part of the organisation, to make sure that the clinic provided quality care. I thought it would be a great opportunity for me to do research in a clinic that was run by and for migrants and I told her about my research. She accepted the condition for me to do my research there and we decided I would start in September that year.

This thesis is about the above mentioned “transcultural”<sup>4</sup> community mental healthcare clinic, its challenges and how it struggled for survival. The clinic had some serious problems, socially, structurally and financially. My starting point is the structure of the clinic. Rather than a technical description of how the clinic is organised, I will look at how the culture of the clinic influences the structure, that is, how people working there, or coming for treatment, were giving colour to the structure by their daily routines, the intense moments, the rows and arguments, the threats, but

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<sup>1</sup> People’s Party for Freedom and Democracy

<sup>2</sup> Christian Democratic Appeal

<sup>3</sup> Party for Freedom

<sup>4</sup> “Transcultural” is a term used in the literature on mental healthcare (c.f. Kortmann 2008; Johansen 2014), although in daily conversations with informants and other healthcare professionals the term “intercultural” is being used instead. I will explain more about transcultural psychiatry later in this thesis, but for now I will contend that the clinic was run by and for people with a migrant background.

also how people were connecting to each other, supporting each other and how they continued doing their job, despite some difficult circumstances. The culture of the clinic is central to this thesis, which is why I will consider and evaluate different theories on culture, because these theories provide both a social explanation, while at the same time allowing agency to the actors. I will particularly focus on rhetoric culture, as has been advanced by for instance Strecker and Tyler (2009) and Carrithers (2009). According to Tyler and Strecker (2009), culture and rhetoric interact with each other, but also co-constitute each other. The link between language and culture has been observed by other anthropologists as well (c.f. Levi-Strauss 1962; Bourdieu 1991), but what is different about rhetoric culture is that rather than looking at the interaction between language and culture as a dialectic process between object and instrument, Tyler and Strecker argue that 'there is instead a kind of alternation between object and instrument that may produce change but no necessary development' (Tyler and Strecker 2009: location 646<sup>5</sup>). I will explore this further later in this chapter and in chapter 2.

In the words of Tyler and Strecker (2009), 'the rhetoric culture project explores the possibilities afforded by rhetoric to explain culture [...] by paying more attention to the hidden in social discourse, the unsaid behind the said, the latent beneath the manifest, and the unreasonable as well as the reasonable sides of human existence' (Tyler and Strecker 2009: location 659).

This introduction only serves to introduce the main themes and I will go into the full theoretical discussion in the respective chapters. In chapter 2 I will engage with a number of theories, in which I will explore different theoretical approaches and engage in the theoretical discussions within anthropology, sociology and organisational studies. My aim is to explain how the culture of the clinic, which is the main thread throughout this thesis, is shaped and how it is shaping the actions of my informants. I will also consider the politics of the clinic, and the role gossip played in this. In the following chapters I will turn to ethnographic examples and will go deeper into the complaints procedure, how the organisation is constructed through kin relations, and the effect of audit culture on the clinic. In this introduction I will first explain more about the clinic, its organisation, and my role in this organisation. I will then elucidate on the anthropology of organisations and then introduce the culture of the clinic. Furthermore, I will expand on the neoliberal system in which the clinic operated, as this had a direct influence on how the clinic was set up and how it performed. I will then briefly touch on the role of gossip, before I will move onto the methodology section. In the last part of this introduction I will summarise each chapter of this thesis.

The clinic, which I will call "GGZ Connections", was a relatively small outpatient clinic (between tier 2 and tier 3, which means that it is the second or third line after the GP), compared to some of the other transcultural clinics (who can serve around 1000 patients), with one main branch located near a large urban area and a smaller second branch opening in a nearby town. The clinic served around 300 patients and had about 15 employees around the time I started working there. During

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<sup>5</sup> Location refers to the location in Kindle book version

my year of research, another 15 staff joined, and at times, the clinic was a busy hub, full with patients coming and going, people having interviews for a new job, or visits from other companies trying to do some business. The location was a bit out of sight, tucked away on a small business park, amidst warehouses, call centres and financial services providers. GGZ Connections offered outpatient mental healthcare services, with most of the patients having a Turkish or Iranian background. Members of staff comprised an eclectic mix of people with Turkish, Iranian, Afghan, Moroccan or Dutch background, and also with different educational backgrounds: psychiatrists, psychologists, child therapists (“*orthopedagoog*”), social workers and other types of socio-therapists. In my position as a quality coordinator and manager, I was acutely aware of the responsibilities to which I could be held accountable, which included ensuring adequate administration, making sure that systems of quality control are in place and making sure the people follow the rules and procedures that are described in the quality handbook, or HKZ<sup>6</sup> book. I will provide a full discussion of the merits and problems of these kinds of bureaucratic techniques in Chapter 5.

While I will explain more about the pros and cons of working as a quality coordinator while doing research, I will say for now that it put me in a good position to observe the clinic from an organisational point of view. One of the things I will look at in this thesis is the bureaucratic mechanisms, but as noted above I will also consider the culture of the clinic. Culture is a phenomenon, of which the examination traditionally rests firmly in the discipline of anthropology, though, as I will show, anthropological theories have inspired writers in the field of organisational studies. The cultural theories in organisational studies are a bit different from their original influence, in that they are narrower and more aimed at the corporate world. Despite this, I find it nonetheless useful to incorporate them into my own research, as they tell us a lot about the interactions between individual actors, the state and private businesses such as the clinic or the health insurance companies. As I mentioned, I will consider “rhetoric culture” (Carrithers 2009), which looks at how culture is made and remade through the rhetoric of actors. Carrithers (ibid) suggests that culture is not only made through the expectations that people have; he also looks at culture in the face of conflicts, crises and emergencies, or in his words, ‘the vicissitudes’ (Carrithers 2009: location 167) of life. According to Carrithers, culture is a concept that is contested, but in general ‘comprises a repertoire of things learned, including mental schemes and images, values and attitudes, dispositions, forms of speech and organization, narratives, and commonplace knowledge’ (ibid: 229). With regard to rhetoric, Carrithers refers not only to speech, but also to what he calls ‘*the rhetorical edge of culture*’ (ibid: 279, italics original), which means that actions of individual actors with the intention of showing a particular effort should be considered as rhetoric

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<sup>6</sup> HKZ stands for Harmonizatie Kwaliteitsbeoordeling in de Zorgsector, or Harmonisation Quality Appraisal in the Healthcare Sector. The clinic had obtained the HKZ quality certificate after it voluntarily signed up for the program with the aim to show to the public that the clinic provides quality care. The HKZ system is specially designed for the healthcare sector and includes a guide for the clinic to ensure that quality is guaranteed by drawing up protocols and procedures. Assessments are done through regular audits and by means of several techniques to assess risk.



as well. I will touch on the culture of the organisation further below in this introduction, but will fully engage with its concepts and theoretical implications in Chapter 2.

This thesis will describe how GGZ Connections was both a 'regular', and at the same time, a unique clinic, both in composition of staff, and in ways of organising. By 'regular', I mean that the clinic was organised just like any other Dutch clinic: it had statutes in accordance with Dutch law, the business model was following the current liberalised structure of the Dutch health "market", most people were trained at Dutch universities in diverse disciplines and they were working according to the guidelines that their Dutch professional bodies had drawn up. On the other hand, people working at the clinic came from multi-ethnic backgrounds, something I had not seen before in the Netherlands, despite having worked in many different jobs and sectors in Holland for over 15 years. The clinic was set up by *and* for migrants and was treating patients at different international locations, in Holland, Turkey and Spain. Additionally, the clinic had some unique challenges, being a 'transcultural' clinic, a term that I will explain in the next paragraph. While looking at the daily way of working, I noticed that there was a difference between what is done in practice, and how this is later represented externally, for instance towards auditors or the state. Goffman's (1990 [1959]) 'frontstage-backstage' theory is one of the approaches that I will use in analysing the differences between what is portrayed externally and what is going on behind the scenes of the clinic. I will show that despite the many conflicts that took place backstage between team members, towards the outside world (the front stage) the members of the clinic showed remarkable unity for most of the time. Goffman (*ibid*) describes how individual actors behave differently in a group when faced with a public (frontstage), compared to when there is no public (backstage). He argues that frontstage, people seem to work together in a team, following the hierarchic structure, because that is what is expected of them, while backstage they can challenge the authority on which the hierarchy rests. At the clinic, members of staff were performing well during the audits, for instance, as this was expected of them, but backstage there were tensions, discussions and conflicts that were threatening the authority of Monica, who was a board member and was managing the clinic.

One thing that made the clinic unique is the shared experience of discrimination and prejudice, something that most patients and staff at GGZ Connections experienced at some point in their lives. I argue that this shared experience is an important part of the legitimacy of the clinic, as it is something that binds the different lives and backgrounds of different individuals from vastly different countries together. The clinic specifically focused on providing "intercultural psychiatry", that is, they mainly treated patients with a migrant background. Intercultural psychiatry is not the official term that is used in the discipline of psychiatry. Rather, in psychiatric literature the term "transcultural psychiatry" is used. According to Johansen (2014), transcultural psychiatry can either mean that "Western" biomedical model of psychiatry is introduced in a different system or that migrants from developing countries encounter biomedical psychiatry. The main premise for this distinction is that there is a difference of perspectives about mental health. However, intercultural psychiatry is a term that is often intermixed with transcultural psychiatry and aims to address some of the language and cultural barriers that people from ethnic minorities encounter when dealing

with psychiatric services. Transcultural psychiatry is an arm of psychiatry that has its main influence in medical anthropology, as the psychiatrist Kortmann (2008) explains. He illustrates that the medical anthropologist Arthur Kleinman has had the most influence on transcultural psychiatry and says that before the arrival of DSM IV, the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders in 1994, psychiatrists were using DSM III, which was intended to be culture free and based on the hypothesis of universality of medicine. Kleinman however argued that this hypothesis, based on “Western” biomedical categories, is wrong and that people express illnesses in culturally appropriate ways. His most influential work is cited as ‘Rethinking Psychiatry’, published in 1988, which was the basis for the appendix on cultural illnesses in the DSM IV. The main purpose of this appendix is to enhance the diagnostic tools for physicians, who should take the cultural differences and attributes seriously. Kortmann summarises the important factors that should be taken into account: ‘(1) The cultural identity of the patient, (2) his own cultural explanation of the illness, (3) the cultural stressors and support from his own environment related to his functioning and (4) the cultural aspects of his relation with his therapist’ (Kortmann 2008: 147, own translation). In practice, this often means the care is mostly provided by people of a similar ethnic background, as can be seen in GGZ Connections, but of course there are also many native Dutch therapists who provide transcultural psychiatric care.

After this brief synopsis about the clinic, my place at the clinic, the bureaucratic system, how the clinic worked and how the clinic was presenting itself, I will now turn to a brief explanation about the theoretical approach and introduce the themes that I will engage with throughout this thesis.

## **1.2 THE ANTHROPOLOGY OF ORGANISATIONS**

Throughout this thesis, I will engage with a number of themes, which I will briefly set out in this short introduction, all within the scope of the anthropology of organisations. As a sub theme, organisational anthropology has been looking at the way businesses, corporations and other commercial and non-commercial organisations have operated. Anthropologists and sociologists have theorised about social organisation from different perspectives. According to Morgan (1990), Weber saw the ideal type of bureaucracy as a ‘rational-legal bureaucracy’ (Morgan 1990: 9), which is superior to the more traditional bureaucracy where family and friends played a more prominent role. In Weber’s ideal model (1946), a clear hierarchy exists in the structure of the organisation, in which different positions are occupied by officials who have the necessary skill and expertise that is required to do the job in a professional manner. Furthermore, according to Weber (ibid), the bureaucrat is expected to make the most rational decisions, based on the available information, and he is expected to be devoted to his profession as a neutral party that favours no one in particular. Although Weber’s theory is very influential on how modern bureaucracies are constructed, in practice bureaucracies are not as ideal as Weber’s analytical construct. Symbolic power (Bourdieu 1991), which relates to the legitimacy of the bureaucratic structure, lies within this construction. According to Bourdieu, bureaucratic structures depend on symbolic power for their legitimacy, but symbolic power is not something that is immediately visible. It consists of different kinds of capital (social, economic, symbolic) and resides in the relationship between ‘those who

exercise power and those who submit to it' (Bourdieu 1991: 170). Symbolic power is a precursor to symbolic violence, through the practice of auditing, a fairly new technique that is spreading in different areas of modern bureaucracy, whereby fear, intimidation and terror are instilled in the subjects of the audit, as I will show. Furthermore, I will argue that the audit, is a panoptic device (Foucault 1991), in which subjects internalise the gaze of the inspectors of IGZ<sup>7</sup>, through the construction of "regular internal audits", in which the clinic would be subject to critical reflection of their own practices. For the anthropology of organisations, these theories provide a lens to analyse organised work, the basis for hierarchy and power structures and it can be a starting point for ethnographic research.

Doing ethnographic research in a clinic is a very interesting experience, in the sense that it provides the ethnographer a window into a diverse and engaged organisation. One of the things I will show is that clinics and hospitals, following Van der Geest and Finkler (2004), are not the uniformly organised, identical places that people think they are. This idea is based on the perception that hospitals operate within uniform Western biomedical practices. Instead, as Van der Geest and Finkler (2004:1996) argue, '*there is a variety of hospital cultures across different countries*' and that '*biomedicine, and the hospital as its foremost institution, is the domain where the core values and beliefs of a culture come into view*' (italics original). In addition, the body of literature on ill patients in medical anthropology is substantial, but not a lot of work has focused on hospital ethnography. Long, Hunter and van der Geest (2008) emphasise the importance of doing fieldwork inside a hospital. In the literature, they stress, hospitals have been portrayed as islands within a community (c.f. Coser 1962), while others (c.f. Zaman 2005) recognise and place hospitals firmly within their communities as culturally embedded practices. The writers argue that it is important to recognise the ambiguous state of the clinic or hospital. Furthermore Long, Hunter and van der Geest (2008) assert that in the research done so far, little attention has been given to stakeholders other than patients and doctors and argue for a more broad kind of ethnographic fieldwork. This research aims to address this particular lacuna within the context of the anthropology of organisations.

As I mentioned earlier, although the ethnography that forms the basis of the dissertation is about the people working at GGZ Connections, the analytical thread throughout the dissertation will be the "culture" of the clinic — something I flesh out further below. I am interested in the structures of the clinic, in particular to see how different stakeholders are interacting, relating to and objecting to these frameworks. As such, I will look at the formal and the informal spheres of the organisation (or clinic), as Wright (1994) suggests. She argues that formal and informal are connected, through the interaction of actors with the system, but Wright suggests that the context of this connectedness matters. According to Wright, 'the formal system is the map of the organizational structure' (Wright 1994: 17), whereas the 'informal system is the way individuals and groups in the organization relate to each other, which might influence the formal system and achievement of the

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<sup>7</sup> Inspectie voor de Gezondheidszorg, Inspection of Healthcare  
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organization's aims' (ibid: 17). To put this in context of my own research, at GGZ Connections the formal structure, which was written down in the quality handbook, is how the clinic was officially set up, with a board of directors, and its whole hierarchical structure. The informal system is the system of social relations between co-workers, managers, and other people involved at the clinic. Wright (1994) observes, along with Cullen in the same volume, that there is a double standard towards organisations in developing countries, in that they are held against the Weberian ideal of formal, rational-legal structures, while developed countries are not strictly following these Weberian ideals themselves.

Similarly, Nicholson (in Wright 1994) argues that it is necessary, when implementing new bureaucratic structures, to consider the social context in which these changes are to take place. She looks at Papua New Guinean forms of indigenous management, how decisions are made and resources distributed 'in the context of clearly defined obligations between specifically identified agnatic or affinal groups' (in Wright 1994: 76). According to Nicholson, government services attempt to prevent or reduce the influence of this kind of indigenous management, but she argues that there are actually clear advantages of this kind of management system. She says that indigenous management 'clearly has social value in the economic security of those who are included, both in traditional life, and in the context of development and urbanization where employment and housing is limited' (ibid: 77). This brings me to another major theme in this thesis, kinship, or as I prefer to call it, following Carsten (1995; 2000), relatedness. As we shall see, at GGZ Connections, kinship relations were an important part of the structure of the clinic, in that the clinic rested on two sets of relationships that were central to the foundation of the clinic. These people were not always related through blood, but, as I will argue related nonetheless through the sharing of substance. In addition, the people who were central to the foundation of the clinic were also using their personal networks for helping them manage the clinic. When dealing with a transcultural clinic in the Netherlands, should we consider similar ideas of "indigenous management" as Nicholson (in Wright 1994) considered? What is "indigenous" in Holland and how do other clinics operate in this system?

From a sociological point of view, the study of organisations looks at both agency of actors as well as systems. According to Morgan (1990) there is a tension between the individual actors with their own personal interests and the 'organisation as a structure of control and coordination which is trying to guide those actors to act 'for' the organisation as a system' (Morgan 1990: 7-8). Although Weber's theories are influential, one of the main critiques is that he idealised modern bureaucracy as a structure in which agents act according to *rational* motives. In a subfield of sociology that specialises in the study of decision-making, this idea has been challenged. Morgan (1990) states that decision-making studies are critical of the rationality of the decision-makers, as they cannot take everything into account in the complex world. Instead of making the best choice, the decisions that are made are best described as being 'good enough' (Morgan 1990: 73). Furthermore, a differentiation can be made between decision rationality and action rationality (Brunsson 1986, quoted in Morgan 1990). According to Morgan 'decision rationality depends on time and expertise

to search out and evaluate different alternatives. Action, on the other hand, depends particularly on motivation and commitment' (Morgan 1990: 80). During my own fieldwork, it would appear that the process of decision making would (ideally) follow the guidelines in the quality handbook, which, in Weberian style, would "ensure" the most rational decision would be taken. However, as we shall see later on, the quality handbook was not always followed by the board and at times completely ignored. Decisions made by the board therefore had the impression at times of being arbitrary or based on emotive reasoning. On other issues, action plans were installed, for instance to improve the administration, but despite the fact that everyone saw the necessity of good administration, the implementation of these action plans were never able to catch up with the administrative backlog. The advantage of the anthropological perspective when researching organisations is that it attempts to represent the voices that are usually not heard, in this case mostly staff members who were trying their best to provide good care, but were caught in a web of different power struggles. In the next segment, I will look at culture of the clinic, and how the rhetoric and actions of individuals, have an influence on the clinic in a pervasive way.

### **1.3 CULTURE OF THE ORGANISATION**

Anthropologists have long struggled and debated about the concept of culture. In general, the word "culture" can mean many things. It can refer to art and artistic expressions (c.f. Said 1994), it can refer to specific ethnic communities (c.f. Baumann 1996), or it can indicate certain traditions (c.f. Hobsbawm 1983). As I will explain, within the field of organisational studies, organisations are thought to have their own culture and indicate "the way things are done". As I will illustrate further in this thesis, it is considered a given by some of the organisational studies academics (c.f. Deal and Kennedy 1982; Hofstede, Hofstede and Minkov 2010; Wittenkamp 2014) that organisations have a culture, without any further explanation or analysis where culture comes from. It is clear that anthropology has had an influence on this idea, but within organisational studies the term "culture" has started getting a life of its own. Using anthropological theory, I will critically address the "culture of the clinic".

In anthropological theory, culture includes what our informants call "common sense", which makes it so difficult for them to describe the unique specifics of their culture. Despite, or perhaps thanks to, the absence of an all-encompassing definition, studying the "culture" of our informants is an exercise that shows complexity due to its variability and simultaneously its consistency. Variability across cultures, as well as within cultures, makes it especially challenging to find the common ground that unites members of a certain community. As LeVine puts it: 'it must be emphasised that members of a community can vary greatly in thoughts, feelings, and behaviour, yet hold in common understandings of the symbols and representations through which they communicate' (Shweder and LeVine 1984: 68). According to LeVine, culture is an 'organization of ideas' (ibid: 73) that can be found in the meaning of 'symbolic activities' (ibid) of certain specific social conventions and ideas. An influential, albeit contended, way of describing culture was written by Geertz, who said that 'believing, with Max Weber, that man is an animal suspended in webs of significance he himself has spun, I take culture to be those webs, and the analysis of it to be

therefore not an experimental science in search of law but an interpretive one in search of meaning' (Geertz 1993: 5). Beatty (2006) correctly observed that Geertz' influence has reached beyond anthropology, but he has also drawn criticism, by empiricists as he preferred meaning over matter, and by the postmodernists by being too committed to 'scientific respectability' (Beatty 2006: 4) and by the more radical voices for 'his lack of political engagement' (ibid).

While organisations may have cultures of their own, based on what people working there bring into the organisation, it should be emphasised that organisational culture is not (necessarily) the same as national cultures. The social psychologists Hofstede, Hofstede and Minkov (2010) argue that the key difference between the two is that people who work in certain places did not grow up in them, as they did in their national culture. What makes, forms and shapes the culture in a particular working place? How do ways of doing things become institutionalised in a business, corporation, or in this case, a clinic? Hine (2001), who has done fieldwork in a laboratory, poses that a lab is an organisation and therefore has order. People have tasks which have specific purposes, created through explicit rules, but also 'through the working practices and embodied culture of the members' (Hine 2001: 62). Hine explores the kind of science that is produced in the lab and suggests that this is shaped by the members of the lab. While doing her fieldwork, she found that people learn new lab techniques by copying others in an almost ritualistic way. Her conclusion is therefore that science should be seen as an embodied system within a certain culture, in which the participants working in the lab are shaping the scientific practice. In other words, it is important to look at what people bring into an organisation, where they come from, what education they had, and which function they have within the organisation. However, what if the person who leads the clinic on paper, is not really a board member, but a patient, as was the case at GGZ Connections? Also, what is the social order in a clinic that is run by members of different ethnic minorities? Is there one specific culture in a transcultural clinic that deals with five different ethnicities and how to untangle this mix of national cultures? And finally how do people from different minority cultures interact with the dominant culture, i.e. Dutch culture? Throughout this thesis I will address these questions.

Sometimes, when members of staff were commenting on how certain things were arranged at the clinic, references were made that it was a "typical Turkish or Iranian ways of doing things", such as for instance how some problems were solved, certain behaviour was explained, or how authority was asserted. This kind of explanation inspired me to consider "cultural hybridity" as a way to explain how people working at the clinic, despite being raised and educated in the Netherlands, were aware of their cultural roots outside Holland (c.f. Baumann 1996; Modood and Werbner 1997; Werbner and Modood 2015). Cultural hybridity accounts for the complexities of a person's identity and recognises that identities are not singular entities, but are made up from a complex multitude of cultural identities. However, Caglar (1997), following Abu Lughod, who famously argued for anthropologists to 'write against culture' (Abu-Lughod 2006), was particularly critical of the hyphenated identity, as it confirms, rather than contests the cultural constructs that it is comprised of. She finds it particularly unhelpful that ethnic identities seem to be bound to particular

geographical areas, as this suggests that it is impossible to change that identity. As a starting point for further research, Caglar argues that it would be useful to look at patterns and relations of consumption of commodities, rather than focusing on these essentialist ideas. Commodities, she argues, have a cultural value, which is negotiated, not by individuals, but by 'collectivities operating in historically specific social and cultural contexts' (Caglar 1997: 180). She further argues that 'commodities embody a wider social and symbolic framework and it is not possible to study person-object relations outside the contexts in which they are socially embedded' (ibid: 181). I find this point very useful, as the clinic is in essence a business that sells the 'commodity' healthcare. Patients are often referred to as clients, suggesting that they are consumers of healthcare, and the current healthcare system reifies this idea of patients as consumers on a free market. At the clinic, seeing patients was called "production", and it was vital for the clinic to have as much production as possible. Almost every member of the care team was required to fill in a form stating how many hours they had spent with their "clients". Healthcare as a commodity is shared between patients and therapists and has meaning in the wider social context. However, what does that say about one's identity and how would one best describe these kinds of cultural expressions? In the neoliberal setting, is it really possible to create clients from patients, with clearly expressed rights, and negate the power of the physician? This brings me to the next part of the introduction, neoliberalism.

#### **1.4 THE NEOLIBERAL INFLUENCE ON DUTCH HEALTHCARE**

The (semi-)privatisation<sup>8</sup> of the Dutch healthcare system is a result of increased neoliberalisation processes taking place throughout the Netherlands, in which the emphasis lies on a free market economy and free trade. In the neoliberal paradigm, the state is expected to retreat from sectors run by them, in favour of the private sector (Harvey 2005). The idea is, according to Harvey (ibid), that 'privatization and deregulation combined with competition, it is claimed, eliminate bureaucratic red tape, increase efficiency and productivity, improve quality, and reduce costs, both directly to the consumer, through cheaper commodities and services and indirectly through reduction of the tax burden' (Harvey 2005: 65). Harvey (ibid) explains how neoliberal thought became a big influence on Thatcher and Reagan in the 1980s and resulted in policies that were privatising some of the state's assets, such as social housing and railways. He continues that Reagan and Thatcher were able to mobilise, through democratic means, public support, by means of the media, and public institutions and professional associations to create political consent.

'Increased patient rights' is a phrase that was introduced when neoliberal policies were introduced in the healthcare system, as McGregor (2001) indicates. According to McGregor (ibid), 'the welfare of the consumer in a health care system relates to issues such as safety, choice (. . .), information, redress, having a voice, and health education' (McGregor 2001: 82). Individualism is one of the central tenets in the neoliberal framework. McGregor is highly critical of the neoliberal framework,

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<sup>8</sup> I use the word semi-privatisation, because many of the clinics and hospitals remained non-profit, but were nonetheless not under state control anymore.

in which she unreservedly portrays the “neoliberalists” as autocratic, selfish and unethical. It is undeniable that the neoliberal framework has had a huge impact on the healthcare sector, although it should be kept in mind that neoliberal reforms are often the result of political and social debates. As a result, privatisation, although it can be witnessed globally, can have a different outcome in every country. The general gist however is, as McGregor puts it, that neoliberal policies include privatisation, deregulation and decentralisation (ibid 2001). The changing rhetoric, in which “patients” became “consumers”, or “clients”, does have the potential to allow people with an illness to take more control over their treatment. On the other hand however, one wonders if more choice really does lead to a better quality of care and a better quality of life. An apt example of this is for instance ‘The Logic of Care’ by Mol (2008), in which she argues against the notion that increased patient choice automatically translates into increased patient care. Rather, Mol (ibid) argues that what a patient wants is not always the same as what a patient needs. So, in practice, in an age where patients are supposed to make informed choices and take control over their own lives (and illness), there is a discrepancy between the two.

In 2005, a new healthcare act was introduced in the Netherlands, which gave an opportunity for entrepreneurs to set up clinics any way they wanted and cater for specific needs. Since then, the Netherlands has seen the introduction of many clinics and private practices to help people of minority communities. Unlike in the UK, where most healthcare is still organised and funded by the state (despite the neoliberal reforms in Britain in many other sectors), in the Netherlands there has been a push towards a market economy, in which patients are able to choose which health insurance they prefer. According to proponents of neoliberalisation, this system allows people to ensure that the costs of healthcare are not escalating. This neoliberal or capitalistic drive has had a big impact on the different stakeholders. Although every resident in the Netherlands always had to pay for health insurance for instance, in which the premium depended on one’s annual income, after 2005 this distinction between patients from lower and lower-middle income classes and upper-middle and upper classes disappeared. Before 2005, the contribution towards health insurance was paid to the state by deductions from salaries and benefits (which was called ‘ziekenfonds’). People who had high salaries were obligated to take part in a private health insurance scheme. After this distinction disappeared, everyone paid the same, although there are different insurance policies to choose from, ranging from basic to very extensive. For people on lower income this meant a big increase in premium, while people on higher income paid less, or the same, which today is around €100 per month for a basic insurance.

Within the context of my own fieldwork, I found that the neoliberal framework has accommodated the development of transcultural psychiatric clinics in the Netherlands, which is in essence a niche type of healthcare for minorities. On the other hand however, I have also seen how profit has become a big motive for providing care within this neoliberal framework. For example, sometimes one of the Turkish psychiatrists, Herman, was trying to “sell” a more expensive kind of treatment, such as admission to a private clinic in Turkey. He was making a sales pitch, trying to convince the patient that it would allow him to visit his relatives as well, while there was no clear indication that



admission was necessary. In another example, Herman was trying to convince a fellow psychiatrist, whose second opinion was needed, that a patient was suffering from low self-esteem and that the patient needed to have some plastic surgery at the cost of the health insurance. The health insurance usually does not cover plastic surgery and Herman had agreed with the patient that he would write a statement for the health insurance company. The second psychiatrist however found no indication of low self-esteem as a result of her weight and Herman could not write the statement, but the point is that Herman saw a business opportunity there. These so-called 'perverse incentives' (van Riel 2012: 17) are a distinct reality in this kind of neoliberal environment.

For the insurance companies the shift towards neoliberal practices meant an opportunity to increase their business. Today there are about ten umbrella organisations in the Netherlands, which represent around 30 insurance companies<sup>9</sup>, or companies that offer health insurance<sup>10</sup>. As every resident is obligated to have health insurance, their revenues increased dramatically. To ensure that their power did not become too big, the government put an independent monitoring body in place, the '*Nederlandse Zorg Autoriteit*', or the Dutch Care Authority, which can be compared to the Care Quality Commission in the United Kingdom. Other stakeholders in the healthcare system are the healthcare professionals, clinics and other organisations that provide care, which are responsible for providing quality care, but are implicitly required to look at the cost. While in principle they are independent and can decide about which treatment is best for their patients, the insurance company has the final say in this, as I will explain in the next paragraph. While there have always been private practices, the neoliberal impetus created the expectation that healthcare providers would compete with each other and become entrepreneurs. Some clinics remained a non-profit organisation, but started setting up private businesses who would give the treatments. As we shall see, GGZ Connections also had an elaborate network of proxy clinics, and patients and staff would migrate between the different clinics, in order to get as much financial benefit as possible, and also to try to fly under the radar of the insurance companies when declaring for services rendered to patients.

All insurance companies offer two different types of cover for their clients. The first one is called '*natura polis*', which literally means 'in kind', as in paying in kind. This is the cheaper version and allows the client to get treatment from healthcare professionals and clinics that have contracts with the insurance companies. The second one is called '*restitutie polis*', which means reimbursement

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<sup>9</sup> [http://kassa.vara.nl/fileadmin/user\\_upload/attachments/Overzicht\\_zorgverzekeraars.pdf](http://kassa.vara.nl/fileadmin/user_upload/attachments/Overzicht_zorgverzekeraars.pdf), [accessed on 8 October 2015]

<sup>10</sup> Four of those umbrella organisations roughly control 95% of the market and around 80% of people in the Netherlands have a health insurance with one of the six biggest insurance companies. The four biggest insurance companies had a profit of around €1.1 billion in 2014, according to Financieel Dagblad of 29 April 2015. Part of the profit is returned to the clients in the form of cheaper premiums, while another part is used to create bigger buffers, which they are required to have from "*De Nederlandsche Bank*", the Dutch central bank.

policy. This is more expensive, but allows the client to go to any clinic and pay the costs upfront (or ask for the bill and pay a month later), after which the insurance company will reimburse 100% of the costs. Most patients of GGZ Connections however, opted for the cheaper “natura polis”. In principle, people who have a “natura” policy can also go to any clinic for treatment and get the costs reimbursed by the insurance company, but they will typically only get around 60%-70% reimbursed. The clinic can then choose either to offer care at a cheaper rate, or ask the patient to pay the rest on top out of their own pocket. For clinics and other medical practices, it is important to get a contract with the insurance companies, as it will mean more financial certainty. In addition, clinics that have contracts can get monthly advance payments for treatments given, whereas clinics without contracts complete the treatment first (which sometimes takes up to one year or longer), before any payments are made by the insurance companies. This puts new clinics particularly in a difficult position and they need to have some substantial reserves if they are hiring any additional personnel. When GGZ Connections started, staff agreed to get their salaries a bit later, until payments were received one or two months later.

Insurance companies do not give contracts to new clinics, but only after a year and they will give contracts based on the number of patients the clinic has treated in that first year. Often this means that they will give a maximum amount per year to the clinic, which means that clinics will have to turn down patients to prevent them from going over the limit. This way the insurance companies are trying to get control over what they spend per year on healthcare. For an organisation like GGZ Connections this meant, according to the board, a severe restriction on how many patients they could treat. The board did not agree to sign such a contract. Instead, the board preferred to try without contract and get 60% reimbursement for treatments, but with no limitation on the number of patients the clinic would treat. Getting a contract was a very cumbersome process, which meant a lot of planning and perseverance. A clinic already has to send an email to the insurance companies by April or May the year before the contract is given, and provide a detailed quote about the services they provide and the costs. Then in October the “negotiation process” starts, which is ironical, as there is little room for any negotiation for the clinics (Consumentenbond and VvAA 2016). Then at last in January the following year, the contracts start for 12 months, each year repeating the same procedure.

There are a few reasons why I included this rather technical information about the insurance companies. First, it is relevant to the broader discussion/argument of this thesis, as it informs about the general system in healthcare professionals on a daily basis operate. In addition, through this information it becomes clear that the insurance companies are very powerful. While the insurers claim that they represent their clients and act on their behalf, healthcare providers feel limited in their freedom to treat these clients, as they are not always sure that they will be paid. If a healthcare provider spends more time on a specific kind of illness than the average, the insurance companies can decide to start investigating the claims, and sometimes order the healthcare providers to pay part of it back. As we shall see, in relation to my own research, GGZ Connections had difficulty with the insurers. The insurance companies are very vigilant when it comes to

tackling fraud and, as the report from the Consumentenbond and VvAA (2016) suggests, they use their power to intimidate healthcare providers, sometimes successfully, to retain part of the claims. For GGZ Connections, this approach eventually led to their bankruptcy.

GGZ Connections originally started as a private practice set up by Herman, a Turkish psychiatrist, and his ex-wife, and later was taken over by Monica. Herman's Turkish background was a good reason for many Turkish people with psychiatric problems to go to his practice for treatment. Soon his practice became quite successful and, as Herman explained, he had around €500,000 annual turnover. This money was made by providing specialist psychiatric services, which would then be claimed from the insurance companies of the patients. However, GGZ Connections got into trouble when some insurance companies became suspicious that fraud might be committed and at some point during my time there, they refused to pay for some of the treatments, which brought GGZ Connections into financial trouble.

The power of the insurers is a complaint from most healthcare providers. According to a recent survey among healthcare professionals (Consumentenbond and VvAA 2016), about three-quarter of respondents thought that the insurance companies were limiting their treatment possibilities, which had an immediate effect on patient choice and the quality of care. Therapists could be punished or lose their contract if they would provide treatments beyond the conditions of the contracts they receive, while they have no influence over the content of these contracts in the first place. Ironically, the NZA (Nederlandse Zorgautoriteit 2016) reports that the insurers are doing a good job in guarding that the insured get the right information, proper access to insurance products and that insurance premiums are spent proficiently. In any case, next to the powerful position of insurance companies, issues related to experiences of discrimination and prejudice feature pervasively in the lives of the patients, and the impact of prejudice and discrimination towards ethnic minorities on the establishment and the identity of the mental healthcare clinic is something I will consider as well. Although everyone's experience is different, everybody working at GGZ Connections, was aware of the disadvantaged position of migrants in the Netherlands in general, often due to personal experience, which is one of the meaningful symbols within the clinic that made sense and allowed people to have a shared understanding of what it is to be a migrant in Holland. In other words, as I shall show the migrant experience has an impact on the culture of the clinic. At the same time, there are other considerations as well, such as gossip, which I will explain in the next section, 1.4.

Going back to GGZ Connections, one of the salient aspects in this ethnography is the allegations around fraud at the clinic. Fraud is described by the Oxford dictionary as 'the crime of cheating somebody in order to get money or goods illegally' (Hornsby 2005). In the Dutch healthcare system, fraud usually referred to declarations for treatments that were not given, or sometimes by something called "upcoding", in which a treatment is given, but in the declaration a more expensive treatment is declared. I first became aware of the severity of the allegations at GGZ Connections after a visit from the Inspection of the Ministry of Health in December 2012. Fraud in the healthcare

sector in the Netherlands was uncovered in the media in 2011 and 2012, in which it became clear that fraud was something that was happening on a wide scale in many different clinics and the Dutch parliament had a public debate about how to combat fraud in 2013. It is in this context that I did my fieldwork, slowly becoming more aware of the scale of fraud in the clinic and in the Netherlands as a whole. Within the clinic, initially only one person seemed to be involved in potential fraud, but later I realised that a few more people might be involved or at least, were aware of the situation. This had a huge impact on the functioning of the clinic. At the same time I should stress that many people working at the clinic were, as far as I could tell, not involved, or even interested in fraud and were focusing on delivering care to their patients. One of the things I wish to highlight in this thesis is the strained relationship between GGZ Connections and the insurance companies, as I believe it affected some of the aspects of fraud, in the sense that the relationship made the board feel very powerless against the insurance companies. As I will demonstrate, by committing fraud, through excessive claims, the board was attempting to take that power back. To create more cashflow, the board was also very creative about finding new ways to get more patients and the quickest way of completing treatments. For instance, it would set up group treatments for a group of patients, send them to Spain for two weeks, in which the patients would get intensive treatments, led by around 5 therapists. Upon return, claims would be filed with the insurance companies. This is not fraud as such (unless patients would not need treatment, but I cannot comment on that), but it was a quick way to complete treatments and get money fast. In addition to that, the treatments abroad were cheaper, creating an additional profit.

The board had big plans for the clinic, with the aim to grow the business and set up new branches. They understood that to be able to become more powerful as an organisation, they needed to get more patients and they were using people in their network to get that. In that sense, they were creating a sort of “hybrid” bureaucracy, changing it from a rational to what best can be described as a relational bureaucracy (c.f. Gittell and Douglass 2012), which I will briefly explain here. As I previously mentioned, Weber theorised about a change from more traditional societies, in which family and friends were very much involved in organisations, to a more rational bureaucratic society, in which there is more of a hierarchical and rigid structure, functions are fulfilled by qualified personnel and in which conflicts of interest are avoided. Relational bureaucracy however brings back those reciprocal relations into bureaucracy, creating a more versatile dynamic that ‘integrates the strengths of the relational form (reciprocal relationships) with the strengths of the bureaucratic form (role-based relationships) while counteracting their weaknesses — excessive reliance on personal relationships on the one hand and excessive reliance on fragmented, hierarchical relationships on the other’ (Gittell and Douglass 2012: 714). The board of GGZ Connections was able to combine those two sides. The clinic itself was set up according to a way that is expected in the Netherlands, very much according to the Weberian model of a bureaucratic organisation: a hierarchical structure, led by strict rules about how to operate within the structure, in which functions and responsibilities are fixed and whereby people are hired according to their educational qualifications and their relevant experience. However, the way things worked in practice involved a number of close relatives of Monica and Herman, who had wide networks in

their own communities. GGZ Connections was very successful when it came to attracting clients, although there were some voices from within the therapist team saying it is very unusual for a tier two clinic<sup>11</sup> to actively look for clients.

Before I move onto the methodology section, I first want to mention a few things about the role of gossip at the clinic, as this was an important part of the rhetoric and culture of the clinic.

### **1.5 THE ROLE OF GOSSIP**

Participating in gossip, which was an almost daily occurrence, was a useful instrument to be able to observe the power dynamic at the clinic. GGZ Connections went through a difficult period during my time there. As I mentioned in the previous section, accusations of fraud were troubling the clinic and although the accusations were portrayed as false by Monica and Herman, over the course of the year, the pressure increased on the clinic and its team. The clinic became divided into roughly two groups, which resulted in more gossip, as the flow of information decreased from the board. As I will expand on the reasons why and how, one group consisted of people surrounding Monica and Herman (the central group), and the other group consisted mostly of therapists and were not close to Monica and Herman (the peripheral group). Gluckman (1963) acknowledged the importance of gossip in social discourse and argued that gossip increases social cohesion, as it confirms insiders, those participating in the gossip, and outsiders, who cannot participate. Gossip reaffirms moral standards, as participating in gossip requires awareness of these moral standards. People who participate in gossip tend to talk about people who do not live up the moral values, such as fraud for instance, as a way to disapprove. At GGZ Connections, the people who participated in gossip were usually in the peripheral group, who liked to talk about some of the things they witnessed, but lacked all the information that was required to understand what had actually happened. Gossip filled in the gaps of inside knowledge, which allowed people to make sense of what was happening around them. As such, gossip does not provide an accurate account of what happened, but it can inform participants of the social relations of people working at the clinic. Sometimes the gossip came from patients, or ex-patients, who had been involved in some of Herman's business.

All this suggests a power dynamic that is in constant motion. Besnier (2009) describes how gossip was an important social activity in the production of daily politics in the atoll of Nukulaelae in the Pacific. He argues that language, through the use of gossip, is an important political tool. On the atoll there is a tension between egalitarianism and authoritarianism, in which people are expected not to be too pretentious on one hand, but at the same time people are nostalgic for an era where chieftainship was the main form of authority. By analysing gossip as a form of political discourse in daily life, he shows that gossip is more than just "weapons of the weak". Although people working at the clinic were calling each other by their first name, as is very common in the Netherlands, at the clinic management was quite authoritarian at times, in which Monica would not expect any

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<sup>11</sup> This means that people need to have a referral from the GP before they can visit the clinic.

opposition to her plans. As such, gossip created a way for staff to negate the authoritarian attitude, while also creating a sense of moral superiority towards Monica and Herman. As such, the gossiping could be considered a “subculture”, in that it was a way for the staff members to protest against the current type of management.

To briefly summarise before I move onto the methods section, this thesis will look into the daily politics of a transcultural mental healthcare clinic in the Netherlands. I will specifically look at organisational anthropology and the culture of the organisation. While the bureaucratic systems provide mechanisms, such as the audit, to ensure a uniform way of governing the clinic, I will show that the rules and regulations were interpreted according to the needs of the clinic. In addition, I will look into issues of fraud and corruption, which were putting a huge strain on the clinic in various ways. As the clinic struggled for survival, pressure was put on people to perform and produce by seeing as many patients as possible, while at the same excluding people, creating a division between a centre group and a peripheral group. Theoretically, the main thread will be around the culture of the clinic, particularly rhetorical culture, in light of the ‘vicissitudes of life’ (Carrithers 2009) at the clinic.

I will now turn to the methods section and close off with a brief summary of each chapter.

## **1.6 METHOD**

It is tempting to pose that this thesis is a representation of the healthcare system in the Netherlands, but I am aware that the sample is quite limited, which makes it more difficult to paint a broader picture and make assumptions about the whole mental health sector. Nevertheless, despite its limitations, this thesis does provide a lens into some of the aspects of the organisation of the mental healthcare sector. My fieldwork consisted of a total of 16 months of research, in which I spent 12 months dividing my time between doing ethnographic research on the one hand, and working at the clinic as a quality coordinator on the other hand. I made field notes usually at the end of the day, which allowed me to process the information to some extent. After I finished the fieldwork, I stayed in touch with a number of my informants and had regular conversations with some of them. Although I primarily focused on GGZ Connections, I also engaged with healthcare professionals outside the clinic, and kept an eye on the events that happened regionally and nationally, through news and other media, to provide a wider context in which events took place. Participant observation allows the anthropologist to fully immerse oneself into a social group. I did become a full member of a team of professionals, talked to patients, observed how the state and other organisations interacted with the clinic and its members, and observed how the politics of running a clinic led to a certain division among staff. I witnessed many arguments, listened to the latest gossip and saw all kinds of emotions as events unfolded throughout the year.

I experienced being a member of the clinic as an emotional rollercoaster, whereby at some point I decided to have some Cognitive Behavioural Therapy (CBT), to be able to take a step back, and deal with the stress of work and study. Balancing between the “job” and the research has been

difficult, but as time passed, I have been able to deal with the intricacies of fieldwork and make sense of the whole experience. I also had to balance and manage the different groups that emerged throughout my fieldwork, in which one group was formed closely around Monica, the board member of the clinic, and those who were not so close. Although I tried to stay in the middle as much as possible, it proved impossible to stay neutral, because I was unable to recognise the politics and was made oblivious to the hidden agendas in the clinic that were going on at the time. The clinic was already going through turbulent times, due to the aforementioned fraud allegations, when I joined the clinic, although this was underplayed at my time of joining. Like most people working at GGZ Connections, I only found out about a lot of the information through informal channels, such as gossip or participating in group conversations. Later I realised however that the informal channels played a big role into how the clinic was run. Although I cannot go further into the fraud allegations, as it might identify the clinic where I did my research, this experience allowed me to study the clinic from a unique perspective. As time passed, going through my field notes, talking to my fellow PhD students and supervisors, and writing up different versions of my chapters have led to the current thesis. Writing down the ethnography has led to an increased understanding on an emotional and intellectual level of both my own actions, and the actions of others. I have always endeavoured to be as objective as possible. Rigorous introspection, along with feedback and critique from fellow anthropologists, has allowed me to come to this point.

Nevertheless, by far the most difficult exercise was creating and maintaining a balance between my research interests and the demands of the job, which were not always straightforward. I had more power than I would have as a “mere” researcher, and I was trying to keep this in mind. As time progressed however, I came to realise that my power was restricted and that Monica kept tight control over the ship. Being an employee does limit one’s scope and flexibility in terms of switching between research interests. For instance, I would have loved to talk to people working for the insurance companies, but being an employee of a clinic that is suspected of fraud, this became much more difficult to pursue. In addition, as a quality coordinator I was expected to take my job seriously, which meant that I was not always able to take a step back at the time and critically look at the bureaucratic structures. If I would have been able to focus solely on my research, the ethnography would have been much broader and detailed. Nevertheless, due to the constraints of self-funded research, the extra income was welcome and allowed me to complete it. On the other hand, because I was part of the team, with a recognisable role, I was able to find my place at the clinic and gain trust, as I was considered an “insider”. Another implication of working as a quality coordinator is that it was very difficult for me to do research on the patients. Being a quality coordinator gave me perfect access and allowed me to engage with the organisational parts of the clinic. It would have been very difficult for me to focus on patients, although I did have frequent contact with them, just not in a clinical context. Patients I had most contact with were some of the closer patients of Herman, people that considered Herman more of a friend than a therapist. The stories of patients I have included in the dissertation are used solely for the purpose of highlighting some of the issues in the organisational structure of the clinic.

While doing ethnographic research, it is always important to consider the ethical implications of doing fieldwork (Madden 2010). As researchers we are in a position of power, and it is important that we do not harm our informants or lose their trust. At all times in this research, before, during and after fieldwork, I have endeavoured to fulfil these obligations towards the people I have worked with. Working in an environment where corruption and fraud is suspected, is particularly complicated. According to Haller and Shore (2005), research in this kind of environment 'invites us to reflect critically not only wider questions of morality, ethics and accountability, but also on our own assumptions about the morality of corruption or whether it is a unitary phenomenon cross-culturally' (Haller and Shore 2005: 8). Doing research at the clinic has certainly raised questions within me about my own perception of these contentious issues. While I was fascinated by the fraud allegations and eager to find out more about it as my research evolved, I also found myself struggling at times about what to do. My own preconceptions about notions of right and wrong were challenged and while I have done my best not to judge on my informants and their role in this, it was harder still to remain completely impartial.

Nevertheless, I have managed to navigate between these ethical issues. My approach was to look at fraud and corruption as separate issues. With regards to fraud, as these were merely allegations for which I did not see proof myself, I have not focused on this issue, although it also seemed important not to ignore the issue completely. When it came to corruption, I have written about this, because I thought it was relevant to the structure of the organisation. However, in this I have always strived towards providing a detailed, balanced and contextualised analysis. Furthermore, as I will explain in the next paragraph, during my fieldwork I have always sought to explain to informants about my research and emphasised that participation is purely on a voluntary basis.

One of the most important aspects of research is without doubt the need to have consent of one's informants. I have always endeavoured to be completely open about my research. I informed everyone officially during one of the weekly meetings with the entire team in case someone was not aware that I was doing research, and later into my fieldwork, I always tried to make it clear that people understand that cooperation with the research was purely voluntary exercise and that refusal to cooperate would not result in any negative or adverse consequences for their work and further career, from my part at least. I have always made sure that people understood that they remain anonymous throughout the ethnography. I have reiterated the point of voluntary cooperation several times individually as well to members of staff, including people who joined later on. No one has ever expressed any doubts about my intentions, nor have they expressed any concerns about my research. Throughout my fieldwork, there were a number of informants on which I relied for information. I will briefly introduce them here, although I should mention that for purposes of anonymity I changed their names. For a full list of my informants, I refer to Appendix 1.

First, there is Monica, who is on the board of GGZ Connections. Monica is a young woman of Iranian descent. Monica was in a relationship with Herman, a Turkish psychiatrist, who had his own practice until Monica took it over. Rob is Monica's father-in-law. He is also Iranian and was working



in different roles at the clinic, sometimes finding patients, other times on the board. Marloes (Turkish) is a close friend (and ex-patient) of Herman and she was doing mostly secretarial work, although she was also a board member on paper at some point. Kees, a close friend of Monica, is a young Iranian man and was working in various administrative roles at the clinic. Gerard, an Iranian man in his thirties was also a friend of Monica. He was the general director and also quality coordinator at the clinic. Cornelis was a Dutch psychiatrist, whose role was to supervise Herman, as he was under close observation of the Inspectors of the Ministry of Health. Roger was the third psychiatrist, originally from Libya, who joined the clinic later. Maria was an Iranian clinical psychologist who did group therapy with patients, while her sister Sophie was working as a social worker. One of the two social pedagogues was Agatha, who was Turkish with “Arabic roots”. Leontien was one of the psychologists, who had come to Holland from Afghanistan at a young age. GGZ Connections also had a Dutch child psychologist (*orthopedagoog*), who was one of the few people with a substantive contract. Marijke was one of the Turkish speaking secretaries, who was married to Alain. Alain was one of Herman’s ex-patients and was involved in the clinic before I started my research and who got into conflict with Monica. Sanne was an Iranian social worker, one of the few people who was hired after an application process, as was Carolien, a Dutch medical secretary. Dineke on the other hand, was an Iranian psychologist who did not go through the application process, like many others. Kees for instance had introduced Robin to the organisation, who had studied Human Resources Management. Another ex-patient of Herman is Theresa, who at one point was also a member of the board (on paper). Finally there is Donna, who was a patient of Herman, but had a big conflict with Monica, after which she was referred to another healthcare provider. Although more people were working at the clinic, I have only introduced the ones who feature in this ethnography.

## **1.7 OUTLINE OF THE THESIS**

The outline of this thesis is organised around the anthropology of organisations. A number of themes will be explored that are relevant to this, beginning with Chapter 2, which will focus more deeply on the theory of the “culture” of the organisation. GGZ Connections as a clinic was an interesting place, in the sense that people of a range of ethnic backgrounds came together and worked next to each other. In this chapter I will look critically at the notion of the “culture of the organisation”, as some of the sociological and anthropological literature suggest (c.f. Hofstede, Hofstede and Minkov 2010; Garsten and Nyqvist 2013; Caulkins and Jordan 2013; Braun and Kramer 2015), as systems of meaning, ways of doing things, identity and how culture is (re)produced in an organisation. Could the clinic’s identity be considered a hyphenated identity, that is, a combination of two different identities, for instance, Dutch-Turkish or Iranian-Dutch? Or is it perhaps better to look at modes of consumption? Some businesses like to profile themselves as having a “community”. As staff had different ethnic backgrounds, it is difficult to talk about a “unified” culture. Rather, I look at culture as a phenomenon that is produced and reproduced through rhetoric, and is shaped by events and the reactions to these events by actors.

Chapter 3 will look at one particular procedure of the quality handbook, the complaints procedure, which is set around the physician-patient relationship. By looking at this procedure, I will consider a number of issues. First, the procedures that are meticulously described in the handbook, are open to interpretation, allowing for different stakeholders to act according to the requirements of the situation. Furthermore, it shows that the procedures, which seem to exist in a vacuum, are actually embedded in the wider community. Finally, looking at the physician-patient relationship, it becomes clear that this relationship is also embedded in social relations and is not separate.

Chapter 4 looks at relatedness, relations, networks and connections that are an intricate part of the organisation. Herman and Monica, who were at the centre of the clinic, involved their networks to run the clinic. Using kinship and relatedness theories, I will follow the networks that were involved in running the clinic. I will explore how social networks created alliances and were a cause for conflicts. By disproportionately favouring family and close friends by giving them better jobs and pay, a corrupt system ensued, which led to a division among staff.

Chapter 5 will look at the bureaucratic obligations of the clinic towards the state and the insurance companies and how it dealt with the practicalities of these bureaucratic hurdles. In the quality handbook bureaucratic procedures played a big part in daily life at the clinic, for instance through regular audits. Audits are used to “measure” the quality of care given to patients, but while my ethnographic research shows that the organisation of the clinic is not following its own quality guidelines, they still were able to pass internal and external audits. I aim to show that large parts of the audit were essentially based on the quality of “performance” on the day of the audit. Furthermore, I will show that the bureaucratic system contributes to suffering as a result of symbolic violence.

In this ethnographic focus on the culture of an organisation, I will show that the clinic is embedded in its social environment, but that the relationship between the clinic and that environment is shaped by the neoliberal forces that have been part of the Dutch healthcare system for over a decade. Furthermore, I will show that the clinic is organised according to different cultural mechanisms, but despite these different cultural influences, overall that the organisation is constructed according to the contemporary Dutch situation, while keeping in mind that there is no such thing as one bounded culture. While the people who work at the clinic are active agents, who have influence on shaping their own environment, outside influences that are beyond their control, the so-called vicissitudes of life, are factors that can prove to be too powerful to get a grip on. The clinic was subjected to these outside forces and this is a narrative of how people dealt with adversity.

# CHAPTER 2 — “Culture” at the Clinic: a Theoretical Approach

## 2.1 INTRODUCTION

As my main theoretical approach I will look at the culture of the organisation. This is not only because this is a recurring concept in the literature of organisational studies, but also because anthropologists have long had an intrinsic interest in the concept of culture. At the same time, the term "culture" has often been considered problematic (cf. Abu Lughod (1991); Wright (1994); Baumann 1996; Carrithers 2009). Abu Lughod proposes to write against culture (1991), as it can lead to essentialist ideas about particular groups. Within organisational studies, "culture" often means nothing more than 'how we do things around here' (Deal and Kennedy 1982: 4), a phrase that is more relevant towards showing other businesses how valuable they are. Wright (1994) critiqued this particular notion of culture and argued that within anthropological discourse it is more contentious and concepts are often not fixed. She therefore suggested that anthropologists, apart from doing fieldwork, should also be actively involved in the 'process of problematising' (Wright 1994: 4). According to Carrithers (2009) culture is described by anthropologists as something that 'comprises a repertoire of things learned, including mental schemes and images, values and attitudes, dispositions, forms of speech and organization, narratives, and commonplace knowledge' (Carrithers 2009: 231). The main theory I will use is rhetoric culture, as explained by Tyler and Strecker (2009) and Carrithers (2009). While building up the argument for this choice, I will first consider a number of other theories and perspectives, to give an overview of the ideas and discussions over time.

There are many different ways to look at and analyse culture. For instance, one can look at culture as a way of artistic expression, as Said (1994) has demonstrated in his work on the influence of imperialism on classic writers, by analysing their most influential works. Said rightly observed that authors are 'very much in the history of their societies, shaping and shaped by that history and their social experience in different measures' (Said 1994: xxiv). Although I could delve deeper into the works of writers within the field of organisational studies to try and understand their notions of corporate culture, as I do with Deal and Kennedy (1982), I will mainly consider anthropological theory, as I think this will provide me with the most comprehensive tools for describing and analysing the things that were happening on the floor at the clinic. Throughout this chapter I will first consider different concepts of culture in anthropological terms, its theoretical aims and its critiques. I realise that I am making things more complex than perhaps needed, but my intention is to start with a broad understanding of culture, following the discussion over the years, and then gradually narrow it down as I critically engage with these other theories. By considering different intellectual traditions, I wish to provide a window into the different ways of looking at culture that anthropologists over the years have adopted and show that culture is a concept that is contested and interpreted differently. Among these traditions I have also included Geertz, whose theory I do

not find particularly useful for this thesis, but I have included nonetheless, because he has had a major influence on the corporate culture theories.

After the discussion of culture as theoretical discourse, I will move on to the notion of the “culture of the organisation” and its problematic use, and I will close off by considering the value of using the concept ‘rhetoric culture’. Through the use of “rhetoric culture”, as I aim to show, culture in an organisation becomes both a meaningful and a useful concept. Meaningful, because it follows the trail of words and actions, and vice versa, thereby giving real meaning to the cultural dispositions, while also taking into account the many unpredictable events that occurred throughout the existence of this clinic. Useful, because it allows culture to be an analytical concept, without being in danger of using essentialist ideas. In this chapter I will discuss and analyse the different theoretical approaches towards the concept of “culture” and explain why I have decided to use rhetorical culture. In addition, I will also put the research into the social, political and economic context, and I will explain the importance of ethnography of a transcultural clinic. More specifically, by identifying the clinic as a transcultural psychiatric clinic, the clinic put itself in a more vulnerable position, as migrants in the Netherlands often suffer from what Goffman (1990) would call a ‘spoiled identity’. Although people working at the clinic came from different backgrounds, what united them was the experience of being considered an outsider in the Netherlands. This can be seen on different levels, both in political discourse as well as in the economic context. While some have managed to get a good education (for instance as doctor or psychologist), others have worked themselves up to managerial positions. Yet despite these successes, they also struggled, either in finding a job, or, more seriously, with the law. According to Dagevos and Veenman (1992), migrants who followed Dutch education had more success than migrants with a foreign education, which is considered as having a lower status. Compared to native Dutch, however, it was more difficult for a migrant to get a higher position without a higher education. As a result, Dagevos and Veenman (ibid) claim, it is fairly common for someone with a migrant background to work within their own community. Despite the fact that many people at the clinic loved working with migrants, the culture at the clinic was often experienced as something negative and stressful, in which they were often blamed for the problems of the clinic. Following the concept of rhetorical culture, I will show that there was a “culture of fear” at the clinic, which affected people’s motivation, trust and confidence.

## **2.2 CULTURE AS THEORY**

Trying to understand the theoretical underpinnings of the concept of “culture” is important and relevant to my own research, as it shows the complexity of the debate. Furthermore, despite its complexity and the fluid notions that theory provides, “culture” remains an important aspect of one’s identity and it also provides us with a system of classification. While it remains important not to take on a reductionist and essentialist view of someone’s culture, the concept of culture provides a useful tool for (e.g.) psychiatrists to help their patients, as it gives some awareness that people can express their problems in culturally specific ways (Keesing 1998). Furthermore, it provides me as an anthropologist with a tool to look at and explain how this clinic on the one hand was quite

common, in its structural setup, but on the other hand was quite unique in the ways it actually worked, adding layers of cultural tapestries. The ways the clinic dealt with adverse situations, with powerful opponents, such as the state and powerful insurance companies, and discord among staff, can be explained through cultural analysis. Furthermore, the anthropological eye can look at culture and cultural change within organisations in a way that provides much more depth than organisational studies have done so far, and gives a context to the way the organisation is run, by looking at the 'symbolic and ideational systems of staff and patient' as the forensic psychiatrist and medical anthropologist Bartlett (2015: location 5366) puts it. Bartlett did research in a high secure hospital in Britain and critically analysed the view of management of the hospital on culture and their appropriation of culture. She argues that the management, who were trying to "change the culture", were mistaking institutional change for cultural change and as a result of this, the staff were resisting change in fear of loss of power. Bartlett identified culture both as 'intrinsic ideational norms manifesting themselves in the "out there" social world, whose appearance they inform' (Bartlett 2015: location 4346), as well as 'culture as primary observable phenomena' (ibid).

Shweder (1984) posed that generally there are two different approaches towards culture. One is universalistic, rational and looks at unity and uniformity. The other is a 'romantic rebellion against the enlightenment' (Shweder 1984: 28), where there is a sense of deep structure, while action is semiotic. The latter type is mostly promoted by Clifford Geertz, who wrote extensively on the concept of culture (c.f. Geertz 1993 [1973]). For Geertz, looking at culture was a way to explore human diversity, what makes us different, but also what unites us. Geertz sought to interpret our behaviour in depth through "thick description", by taking into account that variability is the most prominent thing that unites human beings (Geertz 1993 [1973]: 40). He sought to make sense of culture by looking at what it means to those who practice and experience it. Geertz argued that culture is interpreted by the "natives", and as such, anthropologists should interpret culture as well. Through the interpreting of culture, his main goal was to find the semiotic concepts, the meaning of the symbols through ethnographic research. Geertz' theories were an important influence on the development of the notion of culture in organisational studies, according to Wright (1994), particularly his phrase that 'man is an animal suspended in webs he himself has spun' (Geertz 1993 [1973]: 5), which started to have a life of its own in organisational studies. Some of his concepts were rephrased to match the language of business, with the aim of creating or inventing the culture of business; for instance, "vision statement" was inspired by "web of meaning", according to Wright (1994: 23). Wright criticised this appropriation, in which she observed that 'culture has turned from being something that an organization *is* into something an organization *has*, and from being a process embedded in context to an objectified tool of management control' (ibid: 4).

The other approach towards culture can be seen in Mary Douglas' work, which also had an important influence on organisational studies. Douglas' approach towards culture is influenced by Durkheim and Levi-Strauss and is based on systems of classification. On the foundation of social institutions Douglas (2011 [1987]) argues that both a social and a cognitive process is required.

According to Douglas (ibid), functionalist theories from Durkheim and Fleck were not taking individual action and agency into account. Her starting point is binary oppositions, whereby 'individuals entrench in their minds a model of the social order' (Douglas 2011 [1987]: 45). However, this classificatory system requires a social dimension to be able to become institutionalised. Only in the social context do these systems become meaningful, whereby 'institutions bestow sameness' (ibid: 63). As Douglas puts it: 'the intellectual requirements that must be met for social institutions to be stable are matched by social requirements for classification' (ibid: 63). Douglas' approach towards the culture of institutions (rather than organisations) is interesting, as it argues that social cohesion is influenced by cognitive processes on which institutions are built. In other words, as Wright puts it: 'an individual's cognitive processes are influenced by social institutions' (Wright 1994: 21). However, it can be questioned how cohesive groups or organisations really are. In addition, the contacts that employees have with organisations can be quite fluid, through different roles. Furthermore, as I will explain in the next segment, hybrid cultures show how cultures influence each other and adapt according to the social context, while still being rooted in their own specific social relations.

Before I move on, I briefly want to touch on one publication in organisational studies which has been quite influential in my research, Deal and Kennedy's 'Corporate Culture' (1982), as a way to contrast their theory of culture with the anthropological debate. Deal and Kennedy (1982) write about culture in a very different way. While it is not my intention to pin the entire literature on business studies on just one publication, I am using their publication for illustrative purposes. Deal and Kennedy's approach towards culture is much more pragmatic, with the aim to help businesses become successful. They argue that corporate culture is an important facet of the success of any business, which is illustrated in slogans and motivational proverbs. Values, for instance, are 'the bedrock of any corporate culture' (ibid: 21), while rites and rituals are considered to be 'culture in action' (ibid: 59). The problem with this kind of approach is that culture is seen as an asset to a business to become successful that can be changed at the manager's will. Having a "good" culture can increase production and sales, but the culture of the business is generally seen as separate from the wider social and cultural environment. As such, it is useful to look at the anthropological debate and see what influences the culture of the business, in this case the clinic.

### **2.3 HYBRID CULTURES**

More recent studies of "hybrid cultures" (Baumann 1995; Baumann 1996, Werbner and Modood 1997), show that "culture" consists of a mix of what different actors from different social and ethnic groups add to local discourse. Hybrid culture is a way of explaining what happens when two different cultures interact, for instance with second generation migrants, who adopt cultural practices both from their parent's culture as well as the host culture. As an example of this, we might consider Baumann's ethnography on the use of kinship terms in poly-ethnic Southall (West-London), which shows a complex, multi-layered network of social relations. He argues that 'culture is not a real thing, but an abstract and purely analytical notion' (Baumann 1996: 11). He also contends that 'it does not cause behaviour, but summarises an abstraction from it, and is thus

neither normative, nor predictive' (ibid). However, Baumann does suggest that culture from outside anthropology is perceived as something real and more concrete. According to Baumann, in the dominant discourse "culture" is equated to community, which in itself is a polite alternative for "ethnic minority" and in a similar way, "culture" is often considered synonymous to "nationality". This kind of discourse is problematic, as it paints a very singular picture of a certain group, which is often within itself diversified and does not allow for agency of the individual and it suggests that cultures are strictly bounded entities.

Sahlins (1999), on the other hand, is not impressed by hybridity. Instead he prefers to reflect on the way cultures change all the time. He rejects the claim of anthropologists that people resist change and that they lose their distinctiveness and their own identity, particularly in the face of capitalism. Rather, Sahlins argues that despite these changes, people, while taking on some of modernity's inventions, retain some of their culturally distinct features, such as kinship patterns, division of labour and ways of distributing goods. In Sahlins' words, 'this is not so much the culture of resistance as it is the resistance culture' (Sahlins 1999: xvi). He claims that modernity is indigenised, in which people appropriate some of modernity's inventions, but in a very practical way, so that they can work more effectively in their own subsistence economy. He also comments on circular migration, in which migrant communities living in urban centres keep close contact with their rural centres of origin. He comments that 'circular migration is creating a new kind of cultural formation: a determinate community without entity, extending transculturally and often transnationally from a rural centre in the Third World to "homes abroad" in the metropolis, the whole united by the to-and-fro of goods, ideas and people on the move' (ibid: xviii). These transcultural and transnational ties show the interdependence and complementary nature of these relations. What Sahlins shows is that instead of seeing cultural change as hybridity, he suggests that people have been culturally adaptive long before and the notion of cultural change and hybridity should not be seen as something new. I am considering Baumann's approach towards cultural hybridity, because the clinic could be described as a "Turkish-Iranian-Dutch" clinic, but at the same time, I am wondering if this approach could help explain some of the things that happened at the clinic. In that sense, Sahlins' suggestion that cultural change has been happening continuously, while retaining some of their own culturally distinctive features, strikes a note with my own research. For instance, the way the clinic adopted the Dutch quality regulations, while still maintaining a structure based on kin relations, as I will show in chapter 4, is a good example of this.

## **2.4 AGAINST CULTURE**

Abu-Lughod (1991) argued that anthropologists should even write *against* culture, as the term is not inclusive enough and even suggests a certain hierarchy, as it "others" those not included (feminists and "halfies", anthropologists of mixed heritage). She argues that one of the ways to counter the use of the term "culture" is by talking about "discourse" and "practice", which she considers more suitable. Abu-Lughod argues that these terms 'were intended to enable us to analyse social life without presuming the degree of coherence that the culture concept has come to

carry' (Abu-Lughod 1991: 472), which stands in contrast to the static and coherent notion of culture. Bourdieu (1977) has written at length about practice and discourse. Bourdieu argues that throughout their lives, people acquire habitus, 'the durably installed generative principle of regulated improvisations' (Bourdieu 1977: 78). Actions are produced and reproduced in a structured way, but where Bourdieu distinguishes himself from theories about culture, he sought to leave room for individual agency within those structures. While it is important to look at the different sets of relations within the organisation, the *habitus* accounts for the sets of practices that people take into that organisation.

Another way of looking at hyphenated identities, which are often cited as the effect of the essentialisation of cultural identities, is promoted by Caglar (1997). Caglar argues that the use of hyphenated identities confirms rather than rejects these essentialist ideas. The problem with hyphenation or creolisation is that, in Caglar's words, 'they fail to question some of the basic assumptions informing the critique of cultural holism' (Caglar 1997: 172). Furthermore, the starting point is the assumption that an identity consists of two cultural heterogeneous entities. It also implies a continuation of attachment to a specific area (e.g., Germany and Turkey). Caglar recognises that people identify themselves according to ideas of having 'roots' in a specific geographical position, but she argues that anthropologists should not limit themselves to this. In addition, by arguing for hyphenation, it is also a way of accepting dual loyalties membership of two different communities. One of the Turkish therapists, Agatha, for instance, admitted that sometimes she prefers to call herself Turkish, as her parents were born there, but at other times, she prefers to identify as Dutch, in similar fashion as for instance Eriksen (2002) has posed. Another example which I found quite poignant was when Kees, the Iranian intern administrator, one day came to work with some typical Dutch food, *Hollandse nieuwe*<sup>12</sup>, as opposed to Iranian food, something that other Iranian co-workers or patients would sometimes bring along. The treat was eagerly eaten by almost all staff (except me, as I do not like fish, something most people find very ironic, since I come from a region that is known for its fishing industry). The fact that Kees and other staff loved the Dutch herring suggests that they are open to (some of the) Dutch cultural characteristics. It also shows that cultural dispositions are not fixed and that ethnic identities are not monolithic, unchanging constructs, but rather that they consist of different essences.

Following Caglar (1997), I therefore argue that, ethnic identity based on a geographical location is not useful, as this suggests that ethnic identity is in essence not able to change. Caglar believes that 'trying to disassociate culture from territory is in an important sense 'writing against culture'' (1997: 174). As a starting point for further social studies, rather than focusing on the essentialist ideas, Caglar argues that it is useful to look at patterns and relations of consumption of commodities. Commodities, she argues, have a cultural value, which is negotiated, not by individuals, she argues, but by 'collectivities operating in historically specific social and cultural contexts' (ibid: 180). She further argues that 'commodities embody a wider social and symbolic

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<sup>12</sup> Hollandse nieuwe is herring, which is eaten raw with onions.



framework and it is not possible to study person-object relations outside the contexts in which they are socially embedded' (ibid: 181). This approach could be an interesting way to highlight some of the myriad ways in which social relations in a neoliberal healthcare system are forged. It is possible to look at the healthcare system as a pattern of consumption, in which patients are clients and therapists are selling their therapies, but I find it a bit troubling to reduce one's health to a commodity. Although I agree that Caglar's etic approach is important for the need to disassociate culture from territory, and that looking at patterns of consumption can provide some interesting case studies, the problem with this approach is that there is still a need to explain consumption in a theoretical framework, to put it into the cultural context or provide the discourse around it. With relation to the use of the term discourse in this thesis, despite this nuanced and elaborate approach, I prefer to use the term "culture". The advantage to sticking with the term "culture" is that it can be considered a "social reality" according to the informants, but also because it is commonly used in organisational studies. In short, even though the concept of "culture" can never completely explain the social phenomena that occurred during the research, I will continue using this concept, which brings me to rhetoric culture.

## **2.5 RHETORIC CULTURE**

Rhetoric Culture is a term proposed by Tyler and Strecker (2009), when they started the Rhetoric Culture Project, whereby they argue for 'a program of research whose basic topics are the interrelationships between cultural forms of practice, passion, and reason; and it seeks to understand the culturally generated orders of discourse — and their technologies of production' (Tyler and Strecker 2009: location 619). Linking language and culture is nothing new (c.f. Levi-Strauss 1962; Bourdieu 1991), and was even discredited for a while, but Strecker, Meyer and Tyler (2003) argue that with new communication technologies, rhetoric has gained prominence over other theories such as cognitive, symbolic, dialogic and other theories. According to Tyler and Strecker (2009), rather than arguing against culture, as Abu-Lughod proposed (1991), it is more productive to rethink culture and put it back 'in the domain where it ultimately belongs — that is, rhetoric' (Tyler and Strecker 2009: 191). Where rhetoric is used to explain culture, the main difference with social discourse is that the Rhetoric Culture Project focuses more on 'the hidden in social discourse, the unsaid behind the said, the latent beneath the manifest, and the unreasonable as well as the reasonable sides of human existence' (ibid: location 659). This means that rhetoric is used in a very broad way, in a way that seems to bridge the gap between agency, hermeneutics and structuralism. What the Rhetoric Culture Project specifically aims to show is how 'cultures are interactive, autopoietic, self-organised configurations' (ibid: location 695). In their model, intentions impact and are impacted by performances of actors, while at the same time cultural competence mediates intentions and performance. In addition, rhetoric is not limited to external rhetoric, but also includes internal rhetoric, in the form of internal deliberations and motivations. While internal rhetoric is difficult to portray as it is more hidden, it is an important part of the considerations before action.

Carrithers (2009) analyses the relationship between rhetoric and culture, and how the “vicissitudes” of life affect rhetoric, and therefore culture, and vice versa. Rhetoric, Carrithers argues, can influence others to take action, which can induce change in a culture, describing “rhetoric” as a way how people use the tools to shape their reaction to the unexpected emergencies that happen in life. The basis of Carrithers’ theory lies in expectations, which ‘is in part a matter of conscious thought, but also of implicit assumption, being built into the collective acquired sensibilities of our various societies’ (Carrithers 2009: location 185) and the certainty of the erratic nature of life with its constant challenges and upheavals, and how these two constant features of life constantly interact with each other. He acknowledges that the concept of culture is contested and agrees that within cultures there are many ‘alternative schemas, narratives, and values, so that no one is able to simply read off the appropriate actions or statements from some table of right things to think, do and say which they have learned’ (Carrithers 2009: location 239). Nevertheless, Carrithers argues, ‘culture comprises a repertoire of things learned, including mental schemes and images, values and attitudes, dispositions, forms of speech and organization, narratives, and commonplace knowledge’ (ibid: location 232), whereby “culture’ (or any related notion such as ‘discourse’) exists as a set of potentials and possibilities’ (ibid: location 202). With regard to the term “rhetoric”, Carrithers argues that its definition is not only about speech, but more generally refers to any way of expressing oneself meaningfully, including through actions. What is important here is the presence of an audience, and the ways in which the audience can act and interact through the use of rhetoric, something which is called ‘addressivity’ (ibid: location 289). As human beings, we have the need to express ourselves towards others to interact with them. To be able to understand culture, Carrithers argues, we need to understand ‘culture’s rhetorical edge’ (ibid: location 218). What makes it different from the social theories on discourse is that the emphasis of discourse lies on relational action through the concept of habitus, as Bourdieu (1991) argued. While Bourdieu acknowledged the importance of language in daily discourse, his emphasis on language is as part of cultural capital, which is used to express power relations.

Through rhetoric culture we are able to recognise the interactive and pluralistic ways in which social and rhetorical action takes place and the different roles that people play. People can be agents one time, while being patients the next, which is a departure of previous theories. In the vicissitudes of life, rhetoric can be and is used to react to events that people do not expect to happen. It is the unpredictability of the vicissitudes of life that shapes people’s reactions to be able to make sense of these events. In Carrithers’ words: ‘human beings are constantly vulnerable to accident and the unforeseen, and wield rhetoric and culture against those accidents in order to render intelligible and operable what may at first seem incomprehensible and incomprehensibly disastrous’ (ibid: location 374). People have the ability to react in different ways, by means of their creativity. In addition, while rhetoric is not necessarily moral in tone, morality is often involved in rhetoric, in which ‘moral evaluation is a consequence of the pervasiveness of moral judgement in human life’ (ibid: location 465). According to Carrithers this is the result of a unique feature of human beings, that is, ‘moral pedagogy’ (ibid: location 473).

Morality can in itself be a reason for vicissitudes in life, and some of the people at GGZ Connections encountered instances of moral disapproval after their family or colleagues heard about the fraud allegations, causing more stress, anxiety and also resistance against management. As I will show in my thesis, rhetoric had a huge impact on the daily routine, whereby different actors react to events that are beyond their control. The clinic was going through a rough time and was under enormous pressure to perform their duties “as normal”. Monica’s words were often leading to stress and put pressure on people, which produced a culture of fear and intimidation. At the same time, through the rhetoric of gossip, there was a certain level of counterculture. Each actor played a role in the daily discourse, but some were more convincing than others, which meant that they had a major impact on the culture of the clinic. In the next part, I will explain how rhetoric culture can contribute to the discussion on organisational anthropology and how to view and describe corporate cultures<sup>13</sup>.

## **2.6 CULTURE OF THE ORGANISATION**

It would be easy to typify and identify the clinic where I did my fieldwork as being a “Turkish” or Turkish-Iranian” clinic, considering that the people running the clinic identified themselves as Turkish and Iranian, similar to most of its staff and patients. Talk about “Dutch culture” and “Turkish culture” is often cited in daily public and political discourse in the Netherlands. As I have mentioned before, it is neither correct, nor useful to look at culture as something particularly national that follows distinct, arbitrary borders, even though sometimes people working at the clinic themselves referred to certain ways of doing as being “typical Turkish”. Culture also transcends ethnic identity, as cultures are always changing (c.f. Barth 1998; Sahlins 1999; Baumann 1996). Nevertheless, it cannot be ignored that people self-identify as Turkish, Dutch, Iranian, etc. I suggest that these “national identities”, which can be based on certain cultural dispositions and related to certain geographic locations, should not be confused with culture itself, as they are linked to a singular person rather than a set of social relations. In this section on the culture of organisations however, “culture” has an entirely different meaning.

The “culture of an organisation” is a term that can be mostly found in organisational studies. Organisational anthropology has sought to deal with the complexities of an organisation and has had a definite influence on organisational studies. Organisational anthropology is a fairly new branch within anthropology, that started to grow in the 1980s, although its origins go back to the 1920s and 1930s, when the “Hawthorne studies” took place at the University of Chicago (Wright 1994). The “Hawthorne studies” took place in the 1920s at the Western Electric Hawthorne plant in Chicago and in Cicero, Illinois and were designed to look at the production process from a more scientific perspective. As Wright (1994) explains, ‘production processes were divided into strictly demarcated tasks. The details of each task were investigated, and if physical conditions for the

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<sup>13</sup> I realise that I could have chosen to use Bourdieu’s theories on habitus and social discourse instead of using rhetoric culture theory. By adopting rhetoric culture I deliberately chose for theoretical continuation, as I believe that I can make a more effective and meaningful contribution to the literature in organisational anthropology and organisational studies in general.

work were correct, the appropriate human behaviour and performance were meant to follow automatically' (Wright 1994: 5). Wright continues that anthropologists involved in the research helped discredit these ideas, as they laid bare the social organisation of the workplace. The Hawthorne studies contributed to the understanding of social relations within organisations (Caulkins and Jordan 2012) and lay the foundations for the Human Relations School. One of the merits of this school was, according to Caulkins and Jordan (2012: location 3), 'the appreciation of the informal structure in organizations'. The informal structure of the clinic is one of the things I have been looking at in my own research, which has also considered how people interact with the formalities and how they interpret the rules.

Despite the influence of anthropology on human relations studies, the two disciplines took different directions in terms of theory. This can explain the different perspectives on, for instance, what culture entails. Within organisational studies, there is less of a discussion about what culture is, what it does, sometimes to the extent that it is considered a given that organisations have cultures. In fact, the term "culture" in the literature on organisational studies exists without any problematic considerations or theoretical challenge. Other influences within organisational studies are social psychology (c.f. Hofstede, Hofstede and Minkov 2010) and cultural sociology (c.f. Clegg 2008). According to the organisational anthropologist Batteau (2013), other influences of organisational studies include business management and cultural psychology. Batteau traces the changes of rhetoric regarding the concept of the "culture of an organisation", which came into use as the IT industry grew in the late 1980s and into the 90s. Batteau claims that initially, only a few selected industries were thought to have "cultures, that is 'IT firms, arts and entertainment, and banking' (Batteau 2012: 57). A successful business was supposed to have its "own" specific culture. Although identity is an important part of this drive to having an own culture, it also became important for business purposes, as having your "own" culture could actually increase the value of the company, through the "vision" that the company emits (Batteau 2013). While Batteau acknowledges that this idea of culture can be quite superficial for anthropologists, he argues that for those working in large corporations, this idea of "culture of their organisation" is quite a real sense and it has the same meaning: "culture" is the way we do things around here.

I agree with Batteau that the sense of "culture" is experienced as real in the corporate world, as can be witnessed from some of the management literature (cf. Braun and Kramer 2015; Hofstede, Hofstede and Minkov 2010; Wittenkamp 2014; Schein 2004; Deal and Kennedy 1982). As anthropologists, we need to look beyond these superficial notions of "culture". Superficial or not, "made up" or "real", for our informants, according to Baumann (1996), "culture" is experienced as something very visceral and real. In most organisations, culture has fallen under the responsibility of Human Resources. Even though Human Resource managers may falsely think that they can adjust the culture of their organisation by turning some dials, as Bartlett (2016) has shown, it is interesting to see how they communicate with culture, as if it is a living thing, and how they relate to it. Culture has become firmly established in organisational studies, in which culture has become synonymous to "efficiency", "meaning" and about creating a marketable identity through branding

(c.f. Laegaard 2006). Wright (1994) clearly sees that the term “culture” has a different meaning for anthropology and organisational studies, and although both cite the same sources (Geertz and Douglas most notably), Wright says that the writers of organisational studies do not have the same sense of context of these sources. She argues that

‘the distinctive anthropological process of ‘problematizing’ relies on continually testing the ability of existing ideas or theories about society to explain the detail of what is experienced in the field. Out of this interplay analytical concepts like culture are generated and progressively refined’ (Wright 1994: 4).

This also highlights the importance of doing fieldwork, the distinctive research method which was pioneered by Malinowski in the Trobriands (1984 [1922]) and whose example has been followed by anthropologists since. Gellner and Hirsch (2001) contemplate the implications and problems of doing ethnographic fieldwork in modern organisations. They argue that access to businesses is often a problem, which needs thorough negotiation with regard to the level of access, timeframe and focus of the research, as well as gaining trust of informants, who might fear negative consequences as a result of the research. Then there are ethical concerns about whether to commit to ‘*methodological*’ holism — that is, to accepting that in principle anything in the research context can be relevant and could potentially be taken into account — while simultaneously recognising that *descriptive* holism — the assumption that all social contexts are tightly interconnected social wholes (cf Clifford 1988: 104) - is in most cases misleading’ (Gellner and Hirsch 2001: 7, italics original). This leads the researcher, according to Gellner and Hirsch (ibid), to look at anything that could be important, while at the same time keeping an eye on the research topic. Gellner and Hirsch (ibid) argue that when writing about organisations, Latour’s ‘symmetrical anthropology’ (Gellner and Hirsch 2001: 11) is an interesting approach towards the research. Latour suggested that anthropologists should look at complex and high-tech organisations the same way as they would look at small villages or islands. According to Gellner and Hirsch, organisations ‘are not just the sum of their participants’ interactions: organizations acquire a life and a momentum independent of the people who make them up’ (ibid: 12). One example of this is for instance when one looks at audit culture, which I will discuss in the next part.

## **2.7 AUDIT CULTURE**

I will go deeper into audits and bureaucracy in chapter 5, but I would like to highlight the implications of audits on the culture of the clinic. ‘Audit culture,’ according to Shore and Wright (2015: 422), ‘refers to contexts where auditing has become a central organising principle of society’. It is one of the things that has a direct influence on how a clinic is run, by restraining the movement of the people working at the clinic. The audit is actually a technique that is imported from the accounting sector that has been introduced in many other sectors, such as for instance education and medicine (Shore and Wright 1999). Strathern (2000) stated that the audit is a mechanism which replaces direct involvement from the state. Rather, the state is intervening at a level before that, where people check themselves. The state is only involved in checking the

results of these self-checks. According to Strathern (ibid) it is justified to speak of “auditing *culture*” as auditing has become more than just a tedious part of bureaucratic processes. She argues that ‘procedures for assessment have social consequences, locking up time, personnel and resources, as well as locking into the moralities of public management (Strathern 2000: 2). In practice, at the clinic this means that audits have a direct and pervasive effect on its structure and its expectations, on which a considerable amount of time, money and effort is spent. Shore and Wright (1999) assert that ‘an audit is essentially a *relationship of power* between scrutiniser and scrutinised’ (Shore and Wright 1999: 558). As neoliberalism was introduced in British Higher Education, they observed a change in power relations, in which academics lost their autonomy in favour of a focus on competitive ranking. Universities were required to police themselves and internalise their new way of self-governing. This meant that disciplines were re-organised ‘to be more centralised, accountable and therefore auditable’ (ibid: 566). New roles were introduced as well, particularly the role of “quality coordinator”, which aimed ‘to bring their procedures into line with the anticipated standards demanded by the external auditors’ (Shore and Wright 2000: 72).

At GGZ Connections the quality coordinator role was introduced when they applied for the HKZ quality certificate scheme, which was just before I started my research there. Monica was the first quality coordinator and I was asked to take it over from her. Having had no previous experience as a quality coordinator, I was trained on the job. I read the quality handbook from cover to cover, but I realised that some of these procedures had a different practice, which was the biggest challenge: to bring the practice of GGZ Connections in line with the regulations and procedures as described in the quality handbook. The biggest challenge lay in filling the gap in its administration. There were many patient files that lacked basic information, such as address, insurance details and date of birth, but also details about the treatment. But while audits were highlighting these shortcomings (albeit on a small scale), no change came from these observations. Staff were criticised and scolded by Monica, but whatever plan was set up, problems remained, because the audits did not highlight the causes of these black holes in the administration, which were probably inherited from the time when Herman was running his own private practice with his ex-wife.

In a revision of their paper of 1999, Shore and Wright (2015) account for the times when the hierarchical bureaucratic, number crunching performance that resembled the audit system was useful, but also for the times when this system failed. At the Westpoint Military Academy in the United States for instance, a system was introduced in 1817 that was based on ‘regular and systemized reports including students’ grades’ (Shore and Wright 2015: 423). As a result of these reports, students knew exactly what they needed to do to improve and it transformed them into ‘calculative, self-disciplined selves’ (ibid), not to mention the best engineers. However, in the 1950s, when the president of the Ford factories, Robert McNamara, used statistical methods to calculate and increase the efficiency of the work flow, Shore and Wright argue that ‘this system became counterproductive and dysfunctional when concern for internal competition and intrigue far outweighed any overall vision of the quality of the car or the satisfaction of the customer’ (Shore and Wright 2015: 424). In other words, the internal politics of the organisation became an obstacle

for the numeric system to succeed. Similarly, at GGZ Connections, I argue that the politics of management of the clinic was in the way of a successful implementation of the audit system, meaning that the audit system did not achieve what it was meant to achieve, i.e. to improve the quality of care. Although the clinic was subjected to audit culture, it also resisted to adapt to this 'individualizing and totalizing' (Foucault in Shore and Wright 2015: 425) system.

What is particularly striking about the audit culture is its rhetoric: words like quality, transparency and efficiency are part of daily discourse. At GGZ Connections, these key words were also used, but I found that the meaning of these words could change according to the circumstances, or that the substance was completely missing. For instance, during one of the internal audits, Gerard, my fellow quality coordinator, was talking about transparency as if GGZ Connections was a very open and transparent organisation. He said that we need to be transparent as an organisation in order to show that we provide good care for our patients, that we are not some sort of "dodgy clinic". While his words were precise and measured towards the internal auditor, I found that the clinic was anything but an open and transparent organisation. When you look at who has been in the board for instance, no one knew actually at any time who was really a board member. Everyone assumed that Monica was and has always been a board member, but this was not always the case. Sometimes this was Monica, but intermittently it was Herman's friend Marloes, who worked as a secretary, Monica's father in law Rob, and sometimes (ex) patients. Despite this lack of transparent structure, the clinic was always able to pass the audits, because of the boldness of Monica and Herman. They never doubted in their language that Monica was in charge, towards staff and towards external parties. Hence, I argue that rhetoric played an important role in the creation of culture at the clinic.

## **2.8 SAFETY CULTURE**

Similarly, when I introduced and implemented new regulations that were intended to create a "safety culture", which was one of the new requirements initiated by the Inspection of the Ministry of Health, the reaction of Gerard and Monica was rather indifferent and disinterested. According to these new requirements, hospitals and clinics were required to provide a safe environment for anyone to highlight unsafe practices. It was calling on organisations to facilitate this safe environment by allowing people to come forward about their own practice without any repercussions. Monica's response however to this approach was short and straightforward. When I mentioned this to her, she said: "Not punishing people when they make a mistake? Yeah right". Yet despite this approach from Monica, I was still expected to implement the new regulations, and create the safety culture. Gerard and Monica left this very much to me, and I felt that it was the expectation that I could simply "install" this in the organisation without any further input from the people working there. For Monica it was enough for the new regulations to appear in the quality handbook that was enough proof that we had a safety culture. This approach suggests that she was not interested in regulations at all, and was more concerned with how the clinic could survive without actually taking the regulations seriously. Regulations appeared to be more of a screen that she could show to auditors and other stakeholders (patients, insurers) that the clinic adhered to all

the rules. She would often cite the quality handbook to state that they provided quality care, but her actions would often speak otherwise.

Overall, safety was more of a concern to staff than to the board. One day I met up with Roger, one of the new psychiatrists, as we needed to assess the risks in the clinic, which needed to be done yearly. The exercise was called “Failure Mode and Effects Analysis” (FMEA) and was meant to be a subjective way to get an overall view of possible risks, for which an organisation can then take precautions. For this analysis, first a team needs to be assembled (in this case, only containing two people), who then sit down together and methodically think of any potential problems or threats to the continuity of management and care of the clinic in the worst case scenario. Roger and I looked at the previous FMEA and concluded that the risks had increased, as many events had happened since the last time the FMEA was done. As we went through a list of potential dangers, we thought about the worst possible outcomes, for instance, what would happen if the board would be incapacitated, what would happen if complaints would not be followed up, or what would happen if staff would not know who would be in the board. We needed to rate each outcome and give it a score. At the end of the process, the score was significantly higher than the previous FMEA. When I emailed the results to Gerard and Monica, they were not impressed however, and no reaction was given, even when I talked about it to Gerard. Perhaps it was because they already knew that the risks in the clinic were higher than usual, and the past events (some of which are described in this thesis) had desensitised them. For Roger however, it was important to have these risks put in writing, as he thought it was a way to cover his back in case anything went wrong. The reactionary politics of the clinic were counterproductive in the creation of a safe environment. The main reason of this reactionary direction was related to, as Carrithers (2009) would say, the ‘vicissitudes of life’.

When I first started working at the clinic, there was a more familial atmosphere than a work atmosphere according to the people working there already. The environment was friendly, people were having lunch together, whereby food was shared, and people were enjoying being there. However, a number of events that followed hardened Monica’s approach towards this familial atmosphere, she withdrew herself more from daily life at the clinic, in which I took over parts of her public role (later Gerard took over from me), but whenever she was there, there was tension among people that felt very uncomfortable. Monica became more confrontational in her rhetoric, telling people that they should work harder, be more meticulous in their administration and that failure was not accepted. She was threatening people to fire them, or to hire a private detective to check their administrative mistakes. These threats were received by staff with shock and created a reaction whereby people would be more cautious in how they present their work towards Monica and Gerard. Other events, a few of which are more elaborated on this thesis, further increased suspicion, paranoia and fear at the clinic.



## 2.9 CONCLUSION

In this chapter I have looked at the anthropological debate on culture and I also touched on the use of culture of an organisation as used in organisational studies. Within organisational studies, the culture of the organisation has received prominent attention and I focused on two main influences, Clifford Geertz and Mary Douglas. Geertz' approach is more fixated on trying to read the meaning of symbols and actions, through the interpretation of "thick description" (Geertz 1993 [1973]). Douglas on the other hand, had a more structuralist approach. She saw culture more as systems of classification, whereby the meaning of these systems are socially produced. Douglas also looked at the culture of institutions and argued that culture is influenced by both social and cognitive forces. However, within anthropology, culture is a contested term, as shown through the theories of hybrid culture. In hybrid culture theory, different social systems interact with each other on various levels, whereby cultural artefacts, such as for instance kin relations, are introduced in other cultural settings, which create a hybrid culture (c.f. Baumann 1996). Yet, at the same time, cultural hybridity implies that there is such a thing as one unified culture. Abu-Lughod argued that the term "culture" should be replaced by the term "discourse", which suggests a more fluid approach to describing social phenomena, as it does not presuppose a fixed notion of culture. However, even though the term "culture" is contested and considered not to be a real thing by anthropologists, for many of our informants it is a real and viscerally experienced phenomenon. As such, I prefer to continue using "culture", as it seems closer to the social reality as experienced by my informants. I therefore favour the use of rhetorical culture as advocated by Carrithers (2009), which accounts for both the structural part of culture, as well as agency in a very sharp and analytical way. According to Carrithers (ibid), rhetoric can induce action from agents, which in turn can shape culture. Furthermore, Carrithers also considers how meaningful action is also a form of rhetoric, so people can speak with actions as well. By taking into account the vicissitudes of life, the unpredictable events that people experience in life, rhetoric culture is a useful tool to explain and analyse traumatic events that influence people's lives. By combining rhetoric culture with organisational culture, I have tried to explain what has affected the culture of the clinic. I argue that the culture of clinic was shaped by a number of events that happened while I was there. Throughout this thesis, I will use rhetoric culture as an overall framework.

In the following chapter, I will present a few ethnographic cases in light of one of the procedures in the quality handbook, the complaints procedure. As I will show, this procedure is open to interpretation, which, I argue, is the result of rhetoric culture. At GGZ Connections complaints were getting registered if it is in the interest of the clinic but sometimes patients were dissuaded, even barred from making a formal complaint, which suggests that the events shape the course of action, not the rules themselves.

# CHAPTER 3 — Quality Control in Practice: The Complaints Procedure

## 3.1 INTRODUCTION

As noted in the Introduction, in tandem with being a researcher, I was also a quality coordinator. My responsibilities were centred around updating the “*HKZ boek*”, the quality handbook, which described the organisational aspects of the clinic, the protocols and procedures, and the ways of working. The idea behind the quality handbook is to ensure that the clinic is “well-organised” and “produces reliable results”<sup>14</sup>, which supposedly is the way to improve and maintain the quality of care in the mental healthcare clinic. I was very much intrigued by how a set of procedures and processes were used in a practical way. I was also curious about how the tools described in the handbook, many of which seemed quite arbitrary and open to interpretation, would enable the quality coordinator to *measure* the quality of the clinic.

One important procedure in the quality handbook is the complaints procedure, which is set around one of the most central relationships within the clinical setting: the relationship between a doctor/therapist and his patient/client. As part of the quality handbook, the complaints procedure was intended as a fundamental part and an important tool for patients’ rights, protecting them against any misuse from the power of physicians or the institution of the clinic. I do not wish to imply that patients with mental health issues cannot stand up for themselves, or that they cannot make “rational” decisions, but it is important to keep in mind that there is a power dynamic to the advantage of the doctor. In this chapter, I will discuss this dynamic relationship, specifically with relation to the different cultural contexts in which they took place. The idea behind the complaints procedure is that the doctor-patient relationship is built on trust, but if that trust is somehow broken, the complaints procedure gives an opportunity for the patient to make a grievance against the doctor or the clinic.

The purpose of this chapter is to see how this tool is being utilised by various stakeholders, which will give us an idea about how social relations in the clinic, and in the mental healthcare sector more broadly, are composed and how power is distributed and negotiated between different stakeholders. Reading through the complaints procedure (see Appendix 2), it appears as if the procedure exists in a vacuum, not embedded in wider social and cultural practices. It appears, in other words, to exist without any context and seems to follow its own bureaucratic “logic” in a Weberian way. Weber stressed the technical advantages of bureaucratic management, because of its “rational” approach towards organisation (Weber in Gerth and Mills 1946). This chapter will look deeper at the rationale “on the ground” and provide an ethnographic context, by giving concrete and detailed examples of how some of the complaints came about and how these were settled or

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<sup>14</sup> <http://www.hkzcertificaat.nl/index.php?id=2>

dealt with. More broadly, it will show that “quality of care” was not always top priority and that other considerations can influence the procedures and the outcome. The conflicts that are being described here indicate that the clinic was under huge strain for most of the time, with power struggles and several actors trying to influence the way the clinic was run. It shows an organisation in disarray, that was trying to emanate “business as usual”.

Although my contact with patients was fairly limited in most cases, at least within the clinical context, I was still involved with patients in a non-therapeutical manner, through my position as quality coordinator, for instance when patients were unhappy with the service. In this chapter I will compare two ethnographic examples, which, following the very broad definition of a complaint in the clinic’s own quality handbook, should have resulted in an official complaint. My aim is not to criticise the clinic, but merely to look at how the clinic reacted to the events, how they interpreted their own procedure, and more broadly, how the politics around the events shaped the results or actions taken. I argue that the formal procedure is interpreted according to cultural preferences and is shaped by the relationship between the different stakeholders, which is ultimately culturally informed. Furthermore, the complaints procedure has the intention (and the potential) to make the relationship between physician and patient equal, as the physician has a higher social status, while the patient is in a particularly vulnerable moment in his/her life. As I will show, in some cases the filed complaints served as a pretext for further action, rather than a worry for patient wellbeing, while in other cases (the severity of) events were ignored to an extent.

In other words, what I find interesting in these cases is not necessarily the events themselves, but how the clinic dealt with them. This allows me to look and analyse the disparate ways in which the clinic sought to “solve” some of the problems it encountered and will shed light on some of intricacies of the relationship between physicians and their patients, but also how the clinic looked at these patients. So by comparing the complaints that were filed (or not filed in some cases), it also allows me to look at the doctor-patient relationship and the wider social context in which these relationships are embedded. Finally, I should emphasise that the accuracy of the stories is not the main objective of the ethnographic accounts; rather I focus more on the bureaucratic context and interaction with the bureaucratic procedure. Hence, for the purpose of comparing the ethnographic cases, I will look purely at whether a patient was unhappy with the service, which is the central part in the procedure. I am more interested in why my informants made the statements they did, rather than what they said. What I wish to show here, is not so much the way the quality handbook can be used as a way to measure the quality of the service, but rather, the way the processes and procedures are negotiated to fit the way a certain situation requires. This, in turn, allows me to put these bureaucratic processes into the social context in which it operates. What is particularly relevant about this is that, in Garsten and Nyqvist’s words,

‘Understanding bureaucracy as a social phenomenon is largely to understand how conventions of rationality, formalism and indifference come into play, but also to understand

people's ways of relating to bureaucracy as expressions of collectively moulded feelings and conventions' (Garsten and Nyqvist 2013: 8).

In other words, rather than looking at bureaucracy as something that is rational, formal and indifferent as Weber envisioned it, bureaucratic rules and processes are culturally shaped and their practices are embedded in the social order of complex organisations. This chapter seeks to provide examples of how rhetoric is causing a shift in perspective with regard to the interpretation of regulations in the quality handbook, and as such, has an impact on the culture of the organisation.

### **3.2 THE COMPLAINTS PROCEDURE EXPLAINED**

In the quality handbook, a complaint was defined as; 'the expression of discontentment with regard to the service and/or conduct of the clinic' (translation my own). The complaints procedure itself was described quite meticulously, with a flow chart and step by step instructions<sup>15</sup> for the complaints officer. The whole procedure looks quite technical and precise, giving it almost scientific credence. In a nutshell, the procedure goes as follows: If a patient is unhappy with the service that the clinic provides, the patient (with help of staff) needs to fill in a complaints form and pass this on to the complaints officer within GGZ Connections. The complaints officer will first see if immediate action is required and if necessary, take action (this will depend on the seriousness of the complaint). He will then move on to assess the complaint's content and hear the different perspectives from people involved, to see if he can address the issues raised by the patient and see whether any (further) measures need to be taken. The complaints officer can decide whether the complaint will be discussed in the weekly *Multi Disciplinair Overleg* (MDO<sup>16</sup>). To close off the complaint, the complaints officer will write to the patient with the outcome of the complaint. If the patient is unhappy with the outcome, the patient can go to the independent complaints committee. The independent complaints committee was a service provided by an independent company, to which the clinic subscribed<sup>17</sup>. This is, in short, how the procedure *should* work according to its own regulations.

The clinic often obtained the advice from a professional consulting agency, which specialises in giving legal advice and advice on quality issues, and which was the "brain" behind obtaining the quality certificate. I had a number of meetings with them and they assisted me with some of the internal audits and the preparations for the external audits. The philosophy behind the complaints procedure, according to the legal advisors, and according to the external auditor who visits the clinic once a year, is that you cannot make everyone happy and mistakes happen, but by providing a standardised process for complaints, the clinic can learn from its mistakes, thus improving the quality of care. To be able to show this, they argue, it is important to have a good administration of

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<sup>15</sup> See attachment 1.1.6. Klachtenprocedure in Appendix 2

<sup>16</sup> Multi Disciplinary Meeting, weekly meeting where all medical staff would meet to discuss patients

<sup>17</sup> As far as I am aware, the services of the independent complaints committee have never been used.

the complaints, that shows what the specific complaint was, what was done about it to solve it and how the clinic “learnt” from this experience. Their logic suggests that having a good registration system will show that the clinic is performing well, which can then be demonstrated during an audit. That is also why the definition of a complaint is so generic and broad, so that the clinic can show at an audit that it is taking complaints serious and is taking appropriate steps to address any complaints. The independent auditor actually looked favourably on the clinic having had complaints. In practice however, the need for registering discontentment was not always perceived to be necessary by Monica, in her capacity as member of the board of the clinic.

Monica often appeared quite apprehensive about receiving complaints. Sometimes her argument for this would be “well, it’s solved now, so there is no need to register it”. At other times, as I will show, the argument was, “we need to file complaints as much as possible, so we can address this issue”. Monica looked at complaints from a different perspective and was not convinced by the argument that “the more complaints you file the better care you provide”. She perceived complaints as a threat towards the existence of the clinic and was often more worried that its name might be further damaged. On a number of occasions she expressed that she does not want to have any registered complaints, as it would “look bad” for the clinic. Judging by Monica’s vehement opposition to complaints in many cases, it would seem that patient rights were seen as a nuisance, and sometimes even as a threat to the existence of the clinic, as I will show in the next example. As I mentioned in the introduction, increased patient rights is one of the changes that neoliberal developments of the healthcare system has contributed to, in which the patient has transformed from a person with a specific illness to a customer, a client, with specific needs. This transformation was intended to be more empowering towards the patients, in which they are expected to be active participants in their own healing process. Many of the staff members at GGZ Connections were actively trying to achieve this, as I understood from them, but most patients at GGZ Connections preferred to stick to the paternalistic model, which I will explain in this chapter, in which the doctor takes the lead in the healing process, and the patients are passive recipients. Not all staff were looking favourably to the new empowering transformation, as I will show in this chapter. Particularly Monica was actively trying to influence the complaints that would be (or would not be) filed.

By comparison, Bartlett (2015), who did research in a high security hospital in Britain, also describes how increased patient rights have changed the social relationship between staff and patients. She describes how patients in the maximum security hospitals always had the right to complain, but that in the 1980s and ‘90s complaints from patients were often internally handled, in which most of the complaints were not upheld because the staff would for instance not cooperate with the investigation. A change could be observed when new policies were introduced, according to Bartlett (*ibid*), where the staff was obligated to cooperate with any investigation. Patients in high secure hospitals now have the right to complain about any part of the service they receive, much to the discontent of staff, who perceived the increased rights as unfair. Whereas previously complaining patients were disbelieved and often portrayed as liars, after the introduction of increased patient rights the roles were changed, whereby there was a distinct possibility that staff

could be dismissed. At the same time however, Bartlett (ibid) observed, increased patient rights were not always viewed favourably by patients either, who sometimes thought it was dangerous or detrimental to them, if they thought that they could be identified as the complainant. Instead, she asserts, patients would only complain if they thought it would be in their advantage. Similarly, I observed that some patients were reluctant to make official complaints, even if they were offered the chance. On one occasion for instance, Cornelis, the Dutch psychiatrist, became verbally abusive towards a female patient, who was using the toilet room for ritual washing before prayer (*abdest*). I talked to the patient and said that Cornelis's behaviour is not acceptable and offered the patient the opportunity to file a complaint, but the patient actually apologised and had no intention to pursue a complaint, after which I left it for what it was.

To sum up, I am interested in the complaints procedure because it shows different interpretations of the rules, allowing space for negotiation. I argue that this space for negotiation is related to the culture of the clinic. Following rhetoric culture theory, language can be used to creatively alter cultural concepts, but in order to be creative, it is required that one knows that culture and rules. I will show how the rules work in the favour of the person(s) who has the power to change the meaning of the rules. In addition, the complaints procedure also shows us the different perspectives on patient-doctor relationship, whereby the shift towards increased patient rights is sometimes leading to an uneasy relationship. The implications of increased patient rights are clear: the clinic has more chance of being held accountable to any mistake they make, while at the same time, there are moments when the patient does not want to disadvantage the clinic and can be very apprehensive about using the right to complain. In the next segment, I will describe two cases in which patients' rights were interpreted in two different ways. In both cases, however, the interests of the clinic were vigorously defended and aggressively justified by Monica.

### **3.3 DONNA'S COMPLAINT**

Donna was a Turkish patient of Herman and came to me to make a complaint, which I elaborate on below, about how she had been treated by GGZ Connections, after a turbulent week at the clinic. All week, people had been talking about Donna in meetings and in the corridors, how she had been upsetting the clinic the whole time by her constant cry for help. Monica had discovered that Herman spent hours talking to Donna on the phone, even in the evenings after the clinic was closed, and Monica was furious when she found out. After her discovery, Monica came to see me and Müge, asking for advice. I suggested that she should talk to Herman and Donna separately, and then discuss it further jointly. The next day however, everyone at the clinic received an email from Monica, stating that Herman was suspended with immediate effect. She had taken his mobile phones from him and for a while no one could reach him. From conversations in the corridors, it was clear that people were shocked and did feel unfavourable about Donna, as she took up too much time from Herman. They said it would be best "to get rid of" Donna as soon as possible, which was quite a contrast to how Donna was treated before. Herman had often spoken about Donna as a "special patient" because she had a big network, meaning that she was very active in her community, and could bring in lots of patients. People with big networks play an important part

within their respective communities, for instance, they can be active in voluntary organisations, such as a cultural centre, or they can be active in the mosque. This means that they know a lot of people and their advice weighs very heavily. If someone in Donna's network would have some health problems, they would ask Donna if she would know a good clinic. If she is happy with the service at GGZ Connections, she will make a recommendation, which means the clinic gets more clients. As a result, Herman did his very best to make sure that Donna was happy. He would often see her, even if she came without an appointment.

At the same time, Donna would sometimes bring homemade food with her, for the staff. One time, she even brought homemade *manti*<sup>18</sup>, which was shared among staff and eaten together in the meeting room with Donna and some of her friends. Sharing meals between patients and staff is quite unusual in a biomedical setting perhaps, but it was not that uncommon at GGZ Connections. It decreased the distance between therapist and patient and allowed them, momentarily, to connect on another level. Following Douglas (1972), meals have special meanings, with bounded qualities. The idea of sharing a meal is to focus on being together for a certain amount of time, as 'meals require a table, a seating order, restriction on movement and on alternative occupations' (Douglas 1972: 66). Douglas further explains that 'meals are for family, close friends, honored guests' (ibid). In these moments of sharing a home cooked meal with the patients, it was hard to resist this reciprocal gift, and everybody happily joined in, accepting implicitly the gratitude of a (at that time satisfied) client. This gave the idea that the clinic was quite an "intimate" place, in which patients became friends with staff. I asked some staff members whether this was ok and whether there were any rules about this, with the "professional distance" between staff and patients in mind, but I was told that it is "typically Turkish" to bring food to the clinic. Rutz and Balkan (2010) confirm the importance of food in Turkish culture, usually in a family setting, where it 'plays a central role in keeping members of the big family informed about everyone's activities, problems, and successes' (Rutz and Balkan 2010: 58).

Donna was certainly not the only patient who brought food to the clinic. Other patients, or patient's wives, would sometimes also bring food along for Herman and share it among staff. Sharing food decreased the distance between patients and therapists, creating a permeable divide. During the meal, everybody was chatting about lighthearted topics, food, the weather, holidays, and the atmosphere was friendly and relaxed. When the meal was finished, people cleared up and went back to work. To me it felt as a way of "breaking the normal pattern", to step away from this dynamic where the patient only comes to the clinic to ask help from the therapists with their particular situation or illness. However, there are some pitfalls, even though Mauss suggests 'it is in the nature of food to be shared out' (Mauss 2002 [1950]: 73). He warns of the dangers of accepting food as gift, by saying that 'the thing that is given itself forges a bilateral, irrevocable bond, above all when it consists of food. The recipient is dependent on the anger of the

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<sup>18</sup> Dumplings with mince meat inside, served with Turkish yoghurt and a spicy red sauce.

donor' (Mauss 2002 [1950]: 76). After problems began between Donna and the clinic, people became less inclined to accept food and no meals were shared with patients anymore.

In the Netherlands it is quite unusual to accept gifts from patients, although there are no clear guidelines. In a column on a website for doctors in the Netherlands, a Dutch Specialist Registrar admits feeling very uncomfortable accepting gifts from patients<sup>19</sup>. Despite the lack of clear guidelines prohibiting the acceptance of gifts, it is generally not encouraged to accept gifts, but outright refusing might harm the relationship that therapists had with their patients<sup>20</sup>. While working at GGZ Connections, I never observed any hesitation towards accepting gifts from patients. Of course, every clinic may have its own policy, but I understood from the Turkish coworkers that it is "quite common for Turkish patients to bring food as gift", with the implicit understanding that it is acceptable within the Turkish context to consume the gifts, thereby creating and maintaining reciprocal bonds (Mauss 2002 [1950]). In other words, although most patients did not bring food or other gifts for staff, it was not considered strange or inappropriate if they did.

Despite the seemingly good relationship that Donna had with Herman and other members of the team, after Monica's intervention, the relationship immediately turned negative. Donna was very unhappy with the service and she came to me, in tears, saying 'she had been treated like an animal' ("*hayvan gibi muamele edildim*"). I talked to her for about half an hour, in which she told me about her problems, how Herman had been helping and supporting her, but that she suddenly could not reach Herman, which made her panic. I was aware of the situation which Donna was in. Her son had recently died and she was trying to divorce her jealous and abusive husband, who was also one of Herman's patients. As I spoke to her, I had some of the conversations and gossip about Donna in the back of my mind. Monica had told staff that Donna knew some confidential and incriminating information about Herman's brother, which she used against him to be able to receive extra attention and care. It seemed that Herman's brother, who lives in Turkey, had been in prison for a while and Monica said that Herman felt pressured if this information would become public. Nevertheless, I listened to Donna and acknowledged that she must have felt very stressed not being able to reach Herman. However, rather than taking her grievance forward, I promised her I would talk to Monica and try and resolve this. I did this because I knew that Monica would not accept a formal complaint, but I was hoping to persuade her otherwise, or at least to find some sort of compromise. Monica however, was undeterred and said that Donna needs to find a new therapist immediately. Herman on the other hand, went back to work the following day, after admitting that Donna had power over him. I am aware that this raises a whole lot of issues related to power, authority and control. I will discuss the implications of Monica's authority and the power dynamic in the next segment on doctors' and patients' relationship.

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<sup>19</sup> <http://medischcontact.artsennet.nl/Opinie/Columns/Column/126332/Cadeaus.htm>

<sup>20</sup> <http://careers.bmj.com/careers/advice/view-article.html?id=20021003>



Donna was never given the opportunity to explain her story to Monica, or to file an official complaint. It was also clear that both Donna and Monica were very apt at using rhetoric, but that Monica won the argument due to her position of power. Monica was able to gossip effectively to shape the public opinion within the clinic, which gave her the moral advantage and confirmed her authority as a board member. She provided some specific information about the event (Donna had misused the vulnerable situation Herman is in), while omitting other parts with relation to Herman's own contributions due to his behaviour. The gossip that ensued made sure that people's perception of Donna was very negative. In this case, gossip was able to maintain unity and social cohesion of the clinic as a group, as Gluckman (1963) argued. Although most people were aware of Donna's personal situation (which was discussed regularly in the multidisciplinary team meetings), Monica wanted to ensure that no one would feel compassion or understanding for Donna's situation, or the fact that she was diagnosed as a "borderline patient"<sup>21</sup>, which could explain why she craved extra attention and crossed boundaries. As a result, the perception was shifted from Herman being a "bad psychiatrist" (right after his suspension) to Donna being a "bad patient", who tried to blackmail Herman. This crisis shows that rhetoric is a powerful weapon.

What this incident further shows is that the doctor-patient line is quite permeable and negotiable, and even fragile. Despite strict guidelines from the KNMG<sup>22</sup>, and the attention that is given to the doctor-patient relationship during doctor's training (as I will explain in the next paragraph), circumstances can always change the nature of the relationship, in the sense that the otherwise powerful position of the physician was (temporarily) overturned. Monica, as board member, chose to protect the position of the physician, probably partly due to their personal relationship, and partly due to their professional relationship. Monica's argument was that without Herman, the clinic would be in a difficult situation financially, as he attracted most patients. This seems a rather peculiar position, as Herman was also the cause of a lot of negative attention and the cause of problems with the insurance companies, who refused to pay for treatments given by Herman due to the fraud allegations.

The way Monica dealt with this problem is reminiscent of Goffman's (1990 [1959]) theory of front-stage/backstage. According to Goffman (ibid), a group of people, a team, often present themselves differently when an audience is present. Towards an audience, people or actors can be seen to act in unity, with resolve and determination, but when the audience is absent, the team effort may be completely gone. Goffman (ibid) attributes these different presentations to the different roles that people play socially within the group. A group leader, such as Monica, is expected to play a more "dominant" role, while a therapist is expected to be more "subordinate" frontstage. Backstage however, these roles can be contested, and it is often not as straightforward as it seems. The

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<sup>21</sup> Generally borderline patients have difficulty in having relations and keeping them, their mood is often unstable and they are afraid of being abandoned.

<sup>22</sup> Koninklijke Nederlandsche Maatschappij ter bevordering der Geneeskunst, (Royal Dutch Association for the promotion of Medicine), federation representing doctors in the Netherlands

politics of dealing with a client like Donna needed the unified response of the clinic and Monica made sure that everyone thought and said the same to Donna, by laying the blame at Donna. This way, any complaint that the patient might have would not be taken seriously, as she crossed the boundary and put the psychiatrist and the clinic in jeopardy.

### **3.4 DOCTOR-PATIENT RELATIONSHIP IN THEORY AND PRACTICE**

This case also highlights another dimension in the complex doctor-patient relationship that is a personal dimension. In their training, doctors are taught to take an impersonal position towards the patient, by looking at a “case”, rather than a “person”. The anthropologists Good and DelVecchio Good (1993) argue that the patient-doctor relationship is surrounded by a number of juxtaposed positions, in which ‘the medical gaze is directed to a reconstituted person — a patient, a case, or a body — which is juxtaposed to a commonsense person who is suffering’ (Good and DelVecchio Good 1992: 102). They observe that throughout the study, the emphasis lies on caring and competence, two opposites, of which students are constantly reminded. Competence is related to clinical knowledge, which arouses a lot of anxiety among students, in which they fear they will never be good enough. Caring, however, is not so much taught, but is expected to be transformed from an ‘innate human quality’ (ibid: 93) to learning about relationships, attitudes and emotions. It is important at this juncture to keep in mind that despite the “scientific” qualities of the medical training, this method is also a cultural expression of Western values of individuality. Herman however, took a different approach, in which he did not seem to uphold any boundaries with respect to his relationships with patients. He asked regularly favours from his patients, such as doing jobs (e.g. painting, cleaning, etc) or chores for him, or even to become an official board member for a short period if for some reason Monica was not able to take a place on the board, while at the same time if patients asked him a favour, he would often say he would do his best to help them. This puts an almost reciprocal quality to his relationships with his patients. Cornelis, the Dutch psychiatrist, would sometimes complain about Herman’s “clientelistic” relationships, which always seemed to bring him trouble. I will look at these claims later in this chapter.

According to the bioethicist Ezekiel Emanuel and his wife, the physician Linda Emanuel (1992), doctors are being taught during their training about the different aspects of the relationships they form with their patients. This relationship is very dynamic, and they describe four different types of relationships. The first is the ‘paternalistic model’ (Emanuel and Emanuel 1992: 1), in which the physician acts more as a parent, by simply explaining what the best treatment is, without discussing this with the patient. This model was described as being outdated and only applicable in emergency situations. The second model is called the ‘informative model’ (ibid: 2), in which the physician provides all there is to know about the illness, treatments, risks, after which the patient can make an informed choice. The third model is the ‘interpretive model’ (ibid), whereby the physician finds out the values the patient adheres to, and, based on these values, helps the patient make a choice about treatment. In the fourth and final model, called the ‘deliberative model’ (ibid), the physician is in dialogue with the patient and helps them to shape the best health related values. These models are intended to account for patients with different levels of values and

autonomy. According to some of the therapists of GGZ Connections, most of their patients preferred the paternalistic model, in which the doctor takes on a leading role to make the patient better, or at least, that is the role that Turkish patients are familiar with and this is embedded in their cultural expectations.

The paternalistic medical model is a strong force in Turkey, which is perhaps not surprising considering that paternalism in Turkey is quite pervasive (c.f. Delaney 1991; Altinay 2004; White 2013). In a paper on the ethico-legal aspects of healthcare (Sert and Guven 2013), it is argued that, although there are provisions in the law that give patients a choice about their treatment (or the refusal of it), ambiguous passages suggest that essentially important decisions are put in the hand of the clinicians rather than the patient (ibid). So, despite increased patient rights, as I discussed earlier in this chapter, the physician's power is still present, albeit at a more subtle and inconspicuous level. At GGZ Connections, despite the adoption of the paternalistic model by Herman, the official motto of the clinic was more in line with the deliberative model, that is, to be in a constant dialogue with the patient, and to help the patient help themselves. Sophie, one of the social workers, for instance, would help the patient where necessary, but encourage them to do things themselves. This was also the approach of other psychiatrists, both Cornelis and Roger, who were sometimes quite critical of Herman's style. Twenty years after Emanuel and Emanuel's paper, the physicians Agarwal and Murinson (2012) suggested that the latest social developments require the physician-patient relationship to change once again, as a result of globalisation and technology developments, in which patients can find information more easily on the internet.

According to Agarwal and Murinson (2012), medical education still teaches the "old" models, drawn up by Emanuel and Emanuel, and is in need of a review. Their proposed model argues for taking a "multi-ethnic" society in consideration, whereby with some patients, the extended family needs to be involved before a decision can be made about treatment. Next to that, they argue that it is important to keep in mind the internet revolution, whereby the likelihood of having a well-informed patient has significantly grown over the past decade. Most of GGZ Connections' older patients however, were not very computer literate. Many of them were of the older generation, who migrated from Turkey in the 70's to do low-paid jobs. They had little education and the expectations they had of their physician followed the more paternalistic models. Another factor that seems to be ignored is the power of the clinic, via the board, which is also a powerful entity, as I have shown in Donna's example. Monica used her influence to protect Herman and unilaterally decided that Donna was a threat and needed to be removed. Her position allowed her to override Donna's complaint, without any consequences. The rhetoric she used, was both forceful and uncompromising, a style she used in many different conflicts. By portraying Donna, literally, as a "mental patient", she effectively managed to remove Donna from the clinic, which shows that Monica's power is not only based on her position as a board member, but she also tried to draw strength from a morally superior position.

To briefly sum up, despite the arguments for different models on patient-physician relationships, the paternalistic model is still prominent in some clinics or for some healthcare systems. As a result, the physician still has power, that is sometimes discretionary, but at other times quite strong. Yet, as I aim to show in the next segment, this power can be shattered through the complaints procedure, provided that the institute facilitates the space for complaints, or in this case, amplifies the complaints.

### **3.5 THE MYSTERIOUS CASE OF THE COMPLAINTS AGAINST DR. ROGER**

Being a physician often goes hand in hand with a special social status and is bound by strict ethical guidelines. As medical professionals, doctors have power because of their social status and because they have the ability to have influence on people's health and their lives. These guidelines state that they are there for the protection of the patient and provide a framework for the professional approach that a patient can expect from a healthcare professional. In the UK, these guidelines are published in the Good Medical Practice Guide (General Medical Council 2013), while in Holland the KNMG<sup>23</sup> is the organisation that has written down the rules for professional ethic. While these guidelines may fit well in the Dutch cultural context, they seem to be more problematic in some instances within the Turkish cultural context. In the previous case we saw that the doctor-patient relationship is closer than would be advised according to the guidelines from KNMG (2013). Gifts are not forbidden, but a doctor is encouraged to refuse gifts. Having been trained as a psychiatrist in the Netherlands, Herman must have been aware of these guidelines, but appeared to be ignoring a number of rules. In the next case however, the guidelines became more prominent.

Roger became our new Clinical Director in May 2013, shortly after he had joined GGZ Connections. He was originally from Libya, where he had graduated from medical school and then moved to Germany, where he became specialist. He then moved to Holland and has been working in psychiatry for many years. Roger understood the issues that the clinic struggled with and he was very clear and outspoken in his criticism, in order to improve the services. A number of people thought he was quite rude at times, as he spoke quite loudly, and he had a number of discussions with Gerard, a member of Monica's inner circle, who had become the general director in January that same year. Gerard was thought to be a strong character himself, but he was very close to Monica, unlike Roger, who frequently expressed the idea that "Monica is a dictator". One day, Roger criticised Gerard, indicating that he lacks the quality for being a director. Gerard was so offended that he resigned instantly. Some people expressed relief, as Gerard himself was not too popular either. His approach was often perceived as brusque, rude and he showed little empathy. However, Monica was able to persuade Gerard to return to his duties and the next day he was back at work, as if nothing had happened. Roger's action did not make him many friends, but he was extremely cautious and expressed more concern about making sure that the clinic worked

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<sup>23</sup> Koninklijke Nederlandsche Maatschappij tot bevordering der Geneeskunst, Royal Dutch Association for the Advancement of Medicine

according to rules and guidelines, as he had the medical responsibility. As the clinic had a bad name (due to the fraud allegations), he was extremely cautious. Towards some patients this meant that he was sometimes very forthright and told them to go home if he saw no medical reason for treatment, or some other patients he advised them to go to another institution that would better fit their medical, social or psychological needs.

In other words, Roger was actually trying to get rid of patients who, in his view, were not really sick, but had for instance a mild depression, which could be treated by a first line psychologist<sup>24</sup>. Monica was not happy with this, as the clinic was losing patients. Most of these patients were part of the group of patients who would receive intensive group therapy in Spain. This program was set up by Monica and was led by Maria, the Iranian clinical psychologist. Roger was very strict about who would be allowed to go to Spain for treatment and rejected a number of patients. Many of these patients had been “found” by Rob, Monica’s father in law, who was also working at GGZ Connections as a “communication advisor”, which is a sort of marketing role<sup>25</sup>. I heard from a number of people that Rob had been consistently profiling these treatments as “free holidays”. In addition, Rob had consistently introduced himself as a doctor, and on that authority he told people that they were eligible. It may not come as a surprise that there were a number of patients who were quite disappointed when they were told by Roger that they were not allowed to go.

During Ramadan, Roger was on annual leave for the entire month. Upon his return, he had a meeting with Gerard and Robin (the HR manager, who had taken over my complaints officer duties), which was a fierce discussion. Half an hour later after the meeting started, everybody received an email from Robin that Roger was dismissed from his duties with immediate effect. Details emerged that during the time Roger was on holiday, the clinic received 20 complaints from patients, compared to zero complaints up until the time he went on a holiday. I called Roger in the evening and asked him what had happened. Roger told me that during the meeting, Gerard and Robin wanted him to explain about the complaints. During the meeting Roger became very angry, as it became obvious to him that they wanted to get rid of him. As reason he said that they had tried to misuse his position as a psychiatrist by using false diagnoses so that they could send people who were not sick to Spain for treatment, and then claim money from the insurance companies. I agreed with him that twenty complaints is a lot, especially when you consider that there had been none (recorded) complaints before he went on annual leave. In Roger’s case, the complaints just stacked up within a month’s time. Later it appeared that Gerard had been actively collecting complaints by directly approaching patients. He also tried to elicit complaints from staff, but was unsuccessful in this attempt.

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<sup>24</sup> Tier 1 psychologists can see patients without GP referral. GGZ Connections was a tier 2 clinic, which meant the patients needed to be seen by a GP first.

<sup>25</sup> I will go deeper into Rob’s position in the next chapter on kinship

Gerard was very eager to prove to me that the complaints were legitimate complaints. A day after Roger was fired he showed me a stack of complaint forms, all from patients who had complained about Roger. The complaints ranged from Roger being rude to patients to the refusal to prescribe the medicine the patient wanted. Another patient claimed to have fainted after taking medication that Roger had prescribed. Gerard told me that he was shocked and it was enough reason to fire him with immediate effect. When I asked why these complaints were all filed within the same month (as Roger had been practicing for a few months), Gerard said that the patients had been afraid to come forward, as they felt intimidated by Roger. I also suggested that, as some complaints were regarding prescriptions, the Inspection should perhaps be informed, as there might be an issue of medical negligence, but Gerard rebutted, saying if the Inspection finds out what Roger had done, "it would look really bad for the clinic". To most people I talked to, it seemed obvious that something was not right. Gerard then commented on Roger's state of mind, seemingly with the aim to question Roger's fitness to practice. Gerard recounted that during the meeting, Roger became very angry, pointing a finger at Gerard and Robin. He dryly commented that "this guy is supposed to treat patients!" Cornelis, the previous Clinical Director, openly supported Roger, especially since Gerard was not able to comment on whether patients were taking the right medicine or not, but his remarks were not taken seriously.

This case highlights a completely different approach towards patients from another psychiatrist. In this case, the director of the clinic proactively called people and asked if they would like to file a complaint against their psychiatrist. It is possible that people were not completely happy with Roger for various reasons, but the intention seemed somewhat more sinister, to be able to get rid of a powerful dissident voice. Roger went to court over his dismissal and won the case, in which GGZ Connections had to pay several thousand euros in compensation. Rather than a tool to protect patient rights, the complaints procedure seemed to be used as a tool to play a political game.

### **3.6 CONCLUSION**

In this chapter I first explained how the complaints procedure should work, according to guidelines and legal requirements, with the aim to protect patient rights. I then tested how this works in practice, before concluding that the complaints procedure of the quality handbook is open to interpretation and that it does not negate the power of the clinic. Rather, the clinic was able to use the procedure to its own benefit, by aggressively asserting its power and influence by turning people working at the clinic against the patient, suggesting that the patient is dangerous and by ignoring the complaint from the patient. However, in the second case, the complaint procedure was used against the psychiatrist, whereby the patients were actively approached to file a complaint, to protect the clinic from the psychiatrist. Furthermore, I reviewed the doctor-patient relationship, how the power dynamic is shaped and came to the conclusion that power is still in the advantage of the physician, as well as the clinic. What is perhaps remarkable is that people working at the clinic sometimes make use of certain rhetoric questioning the mental state of any opponents. In addition, I have tried to show that the events that happened in these examples are not separated from the

community, but embedded in it. Bureaucratic management is an active part of social life and can change according to the need. The rules do not dictate the course of action, but rather, events shape the interpretation of the rules. Doctors and patients are connected to each other beyond the diagnosis and treatment and they have reciprocal relations with each other. At GGZ Connections, the relationship did not always have a clear cut line. Following Douglas' structural approach, it would be required to look both at the Turkish and the Dutch societal context for us to be able to make sense of the relationship between doctors and patients in GGZ Connections. This shows the cultural complexities of the organisation, which is defined by the events that have thrown themselves on the clinic. The personal relationships, that are formed when people work together, have a significant impact on these events and any personal grudge can throw the fate of staff into a disarray of events that can further escalate. In this chapter, I have shown that the politics of the organisation can provide the organisation with a platform to favour certain people over others. At the same time, I have shown that people use the tools that they have at their disposal, such as in this case the complaints procedure, to get rid of opponents. In the next chapter, I will further explain the personal relations at the clinic and how these relations influence the culture of the clinic.

# CHAPTER 4 — The Politics of Relatedness, Organisation and Corruption

## 4.1 INTRODUCTION

This chapter will consider kinship and relatedness in the clinic, GGZ Connections. Although many people at the clinic were not related, kinship relations were an important part of the structure of its organisation. With kinship I do not mean necessarily “related by blood”, but also fictive kin<sup>26</sup>. According to Carsten, ‘the study of kinship was the very heart of anthropology for nearly a century’ (Carsten 2000: 2). Kinship studies have been thoroughly critiqued by Schneider (1980), who argued that kinship theories are ethnocentric, as they are based on Euro-American biological notions of procreation, thereby ignoring some culture-specific alternatives. As a result of Schneider’s critique, kinship studies featured less prominently in anthropological research (Stone 2004), until Strathern (1988) and Carsten (2000) revived kinship studies, and introduced a new theoretical angle by introducing indigenous views and taking into account the various meaningful relationships that people engage in. In this chapter, I will discuss and use the term “relatedness”, introduced by Carsten (*ibid*), which refers to how people relate to each other, to ensure an inclusive perspective, and not solely look at how people are connected “by blood”. At the clinic not everybody was related by blood to each other, but social relatedness was an important feature. These relationships were by no means straightforward and were at times both the cause for an alliance and the reason for conflict.

In the previous chapter I mentioned how the clinic has dealt with complaints in certain situations, namely in the context of doctor-patient relationships and how the person considered as an “outsider” was dealt with and effectively removed from the clinic. In this chapter I will look more closely at some of the alliances that were made through (fictive and non-fictive) kin relations. I am focusing specifically on issues of relatedness, as it will show that these relations sometimes led to corruption, in which some people were favoured over others, particularly with relation to position and the accompanying salary. In addition, the structure of the clinic was not always transparent, particularly with regard to who was on the board on paper and who was actually running it. I will argue that the use of affinal networks were problematic at the clinic, as it obscured the real power relations and redirected valuable resources in a disproportionate manner to a select few. This chapter is also inevitably about power and power relations that are buried within kin relations, but also within Dutch society, due to a continued exclusion of migrant communities on different levels. I argue that one of the reasons why the clinic sought to employ people from within their own networks and communities was because, despite having a good education and speaking Dutch

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<sup>26</sup> According to Barnard and Spencer (2002), fictive kin are ‘social relations which are perceived as analogous to kinship, but which are based on some other criterion, e.g. godparenthood, bloodbrotherhood, or ‘fraternal’ solidarity in the trade union movement’ (Barnard and Spencer 2002: 605)



fluently, they were still largely excluded from the job market, which forced them to seek support from existing networks within their communities. At the same time, as I will show, new networks were created across different ethnic groups, from Turkish to Iranian, Moroccan, Afghan, Dutch, etc., thereby giving a 'transcultural edge' to the clinic<sup>27</sup>. Although I am not certain as to why Monica put this structure in place, I believe that her main motivation was for financial reasons, for herself and for those around her. Monica hinted a number of times that she had been through a personal bankruptcy and she was determined not to let this happen again. Another reason is related to trust, because of the fraud allegations against the clinic, she was very reluctant to hire people "from outside". Instead, she preferred to hire people who were close to her, either people who were related to her, or who she had known for a long time.

In this chapter I begin by explaining how networking affected the structure of the clinic, followed by a case study about how the organisation of the clinic was built on two sets of kin relationships. I will then analyse this structure from a theoretical point of view, before I move on to explain how this affected the culture of the clinic. Finally I will expand on the anthropological perspective on corruption and how corruption affected wider relations around the clinic.

#### **4.2 NETWORKING AT THE CLINIC: KIN AS A COMMODITY OR A LIABILITY?**

GGZ Connections brought in many new staff members through informal channels, people who knew other people who needed a job. Not every person that came to work for GGZ Connections was recruited through networking, but it was quite common for someone to get in that way, for various jobs. GGZ Connections did not have a problem finding people outside their networks. As quality coordinator I regularly received open applications for psychologists and other jobs, and although I forwarded these to Monica, she never responded to these. There were a few people who were recruited through an advertisement, amongst others Sanne, an Iranian social worker, and Carolien, a Dutch medical secretary, but this chapter will focus on the network and kin connections of other members of staff. What happened most of the times was that Monica would walk in together with another person next to her and introduce that person to the rest of the team, including the HR manager. My own appointment as quality coordinator went in a similar way as I had an interview at her home the day after my wife had talked to Monica about the fact that I was doing research. I had a nice talk with Monica and she said I would be an excellent quality coordinator. The next day I was introduced to the rest of the team. In any case, it was clear to me that Monica was firmly at the helm and she had a clear picture about what (and who) she wanted. Hiring staff through informal networks is not an illegal activity, as the clinic essentially works as a private company, and although it does affect transparency, the big advantage is that hiring through the informal channels is a cheaper way to find new qualified staff.

The HR Manager, Robin, was very surprised that one day Monica introduced a new psychologist, Dineke, but he could do nothing more than process the paperwork and accept that things work

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<sup>27</sup> I am aware that this covers a lot of ground (kinship, gender, ethnicity and power relations) and I will not be able to expand on all of these issues in this chapter. However, I will briefly touch upon these issues in highlighting the context

differently at GGZ Connections. Other times I noticed that there was a new face on the floor, which happened a few times towards the end of my fieldwork. Sometimes I would introduce myself, but could not get a lot of information, other than a name. When I asked Robin one day about the new co-worker (as one of my duties was to do an induction for new colleagues), he responded: “Oh, I think he is a cousin of Monica or something. He will be driving around with patients.” There is nothing problematic or wrong about drawing from one’s own social network of co-workers. In fact, as Castilla, Lan and Rissing (2013) show, there is ample research supporting the use of social networks to find new opportunities. According to their paper, social networks are an important source of information, learning, influence and support, and people who make use of their networks are more successful in finding quality jobs, compared to people who do not use these networks. In my own personal career it has happened frequently that I was able to get a job through a friend or acquaintance in my own network. Professional websites such as LinkedIn have their business model based on people finding work through networks. In addition, as discrimination is a serious problem in the Netherlands and many other European countries, as a recent meta-study has shown (Zschirnt and Ruedin 2016), it is hardly surprising to see that migrants, or people with a different ethnic background, rely on networks within their own communities.

Poros (2001) shows that social networks play an important role in migration patterns, as she links migrant networks with local labour markets. She argues that ‘labour markets are embedded in networks of social relations (and vice versa) that often do the business of matching’ (Poros 2001: 243). One of the advantages of drawing from one’s own network, according to Poros (ibid), is that trust is ensured through ‘personal relations and social obligations’ (ibid: 256). As such, it is not surprising that Monica and Herman were looking in their own networks to find people they can trust. What was quite unusual though was the fact that they were not limiting themselves to their own “ethnic” community, but were also looking in the larger pool of ethnic minorities. This “transcultural edge” made GGZ Connections a very diverse place to work and drew people of different ethnic backgrounds closer together. Research on group diversity in the workplace is very inconclusive about whether it improves group performance or not (cf. Christian, Porter and Moffitt 2006; Ozgen, Nijkamp and Poot 2015) and while I do not aim to contribute to the expansive literature on diversity in the workplace, I found that most (if not all) co-workers loved working in this multicultural environment, despite its myriad problems and conflicts. At the clinic, the alliances and friendships that formed over the course of the year were not following ethnic or religious lines, but were more focusing on their place within the organisation. As I will show in the next part, where I will go a bit deeper into the networks they were relying on, kin was as much a reason for alliance as it was for conflict.

#### **4.3 A CASE STUDY: THE “NUCLEAR FAMILY”**

Herman and Monica can be considered the “nuclear family” of GGZ Connections. Although they were not married, they were in a long-term relationship and although they had some furious arguments, they were running the clinic together. Monica took care of the business side of the clinic, while Herman was looking after the clinical side. Most people working at the clinic were unaware of their relationship, as they were both saying that they were neighbours, which was

technically correct, as Herman's villa contained two homes under one roof, but they occupied only one part of that. Nevertheless, their relationship stood at the core of the formation of the clinic, after Monica took over Herman's private practice. Monica had hired Rob, her father-in-law,<sup>28</sup> to help out with managing the clinic. Neither Monica nor Rob had any experience in healthcare, but Rob had a large network in the Iranian community in the Netherlands, and he was trying to find patients for the clinic. Officially his job title was 'communication employee' (*communicatie medewerker*), and his function was specifically created to "communicate with the Iranian community". Many people working at GGZ Connections were often wondering about Rob's position, sometimes questioning why they had a communication employee. People were not certain about what he was doing, apart from interfering with some of their work. Marijke and Marloes, the secretaries, for instance were often annoyed with Rob, as he interfered with their job when booking patient appointments. Rob was telling them when certain patients should be booked, as he had made promises to them, even if it meant that other patients' appointments had to be shifted. Sometimes the secretaries were scolded by other staff when the appointments were done in an "unusual" way, for instance, if the appointment was first booked with the psychiatrist for an assessment, rather than with one of the other therapists<sup>29</sup>.

Rob was not only annoying the secretaries. Even Monica was often annoyed with Rob, even though she hired him. She was often wondering what Rob was doing. Yet she never expressed any thoughts of firing Rob, or at least having a job evaluation. Compared to Leontien for instance, a psychologist from Afghanistan, Rob did not have to explain to others what he was doing. In contrast, when I first started at GGZ Connections, Leontien was severely criticised by Monica for not having a full diary, and Leontien was ordered to make up for it in a series of meetings. It is of course possible that Rob and Monica had a private talk about this, but there was no official meeting. By the time I left GGZ Connections, Rob had gotten a new position as board member of a newly setup clinic by Monica. This was surprising for many people, particularly since people did not believe he would be a good manager, for instance because his Dutch was fairly limited. They were wondering how he was going to deal with an inspection if the inspectors would come and visit. The appointment of Rob as a member of the board seemed to be a practical solution to a problem that was caused by the insurance companies, as the name "GGZ Connections" was tainted due to fraud allegations. Throughout the year, GGZ Connections had an increased number of Iranian patients. A majority of them were sent to Spain by GGZ Connections for intensive treatments in the form of group therapy. The advantage of these group therapies was that the clinic was able to finish their treatments and close their patient files shortly after they returned from Spain, which meant that the declarations, the invoices for treatments, could be sent out to the insurance companies soon after. As the insurance companies were treating these declarations as suspicious,

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<sup>28</sup> Monica was officially divorced from Barend, Rob's son. Barend was working with Monica as well, he was their contact point in Spain.

<sup>29</sup> A certain hierarchy is in place, whereby a patient is first seen by a psychologist, or other therapist, and the patient is last seen by the psychiatrist.

Monica quickly set up a new clinic, under a different name and with a different address, to be able to do the declarations from the newly set up clinic.

Rob's appointment, as the person who had brought in these patients, and who also had a different surname, must have seemed a logical solution. Despite Rob being a member of the board on paper, it did not necessarily mean that he actually would be running the clinic. It is quite well possible that Monica would be running that clinic as well, as happened before when someone else other than Monica was officially on the board. Marloes for instance was working as a secretary, but on paper she was a board member. Marloes is one of Herman's confidantes and he knew her for many years. They were about the same age, in their early fifties. Marloes was the babysitter for Herman's children since they were little until they were teenagers and provided some other domestic services to the family. As such, she was considered to be a part of the family. Since Herman's divorce, she continued supporting Herman and filled some jobs, such as for instance as a secretary for GGZ Connections. Her membership of the board was always hidden from other co-workers. Marloes herself denied she was a board member when I asked her about this (even though this was public information through the website from the Dutch Chamber of Commerce<sup>30</sup>), nor, as far as I am aware, did she have the ambition to become one. Marloes was also often criticised by Monica, but she never had any job evaluation, similar to Rob. Even though Marloes was not doing any management function in practice, she was still receiving the salary of a board member, roughly around €9,500 per month (£8000) before tax.

Marloes was close to Herman, in the sense that she was always helping and supporting him throughout difficult times. As Herman was going through a divorce, Marloes was supporting Herman, rather than his ex-wife, whom she called 'crazy' (*deli*). Two years after the clinic closed down due to bankruptcy, I met up with Herman. He was seeing patients privately throughout the country, hiring small offices in different towns. As I was visiting him in one of those offices, Marloes was there as well, serving coffee and doing administrative work. Vice versa, Herman had helped Marloes a number of times as well. Marloes had been Herman's patient, as well as her children. Their relationship was not equal, but it certainly was reciprocal. Being almost the same age (Marloes being slightly older), their relationship is reminiscent of siblings. In Turkey, it is very common for people to refer to each other in kin terms, such as *abi* (older brother) or *abla* (older sister), *amca* (uncle) or *teyze* (aunt), as Delaney confirms (Delaney 1991). I argue that Herman and Marloes were fictive kin, related through their shared history, and by having shared substance over a long period of time, which I will explain in the next segment on the theoretical aspects of kinship. Furthermore, I will show how Monica and Rob were connected and how they, despite Monica's divorce from Rob's son, were still related.

#### 4.4 KINSHIP IN THEORY

Schneider's (1980 [1968]; 1984) critique of "traditional" kinship theories, whereby he argued that kinship studies in anthropology were largely based on ethnocentric notions of kinship, sent

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<sup>30</sup> Kamer van Koophandel, [www.kvk.nl](http://www.kvk.nl)

shockwaves through the anthropological landscape. Since then, kinship studies were featured far less prominently in ethnographic studies and started focusing more for instance on gender (c.f. Delaney 1991) and reproductive technologies (c.f. Ginsburg and Rapp 1995). Carsten (2000), who proposed a shift from focusing on rights within kinship towards meaning of kinship relations, introduced the term “relatedness”. This term is a more inclusive term, which ‘makes possible comparisons between Iñupiat and English or Nuer ways of being related without relying on an arbitrary distinction between biology and culture, and without presupposing what constitutes kinship’ (Carsten 2000: 5). In other words, the term relatedness aims at getting rid of the bias of previous models of kinship. According to Carsten, there are many different grounds for relatedness, such as ‘affection, shared substance, and nurturance’ (ibid: 22). There are many cultures, Carsten (2000) claims, that do not make a distinction between biological and social relatives and it is clear now that there is an overlap between the two domains. New studies have shown that in some cultures, relatedness is created and maintained through everyday practices, for instance through sharing food or substance. The use of the term relatedness also allows us to talk about relations both within and outside ethnic groups.

However, Carsten has been criticised that her notion of relatedness is too loose a term to be able to differentiate between kin and non-kin (Galvin 2001). Galvin (2001) therefore suggests finding a middle ground between the biological model and Carsten’s model. Based on the ideas of Schneider, Galvin suggests it is important to consider an ‘order of sharing’ and an ‘order of ratification’ (Galvin 2001: 119), based on Schneider’s concept of “order of law” (Schneider 1968). Sharing substance, which is tangible, includes sharing genes, food, body fluids, and shelter, as opposed to sharing pollution and space, which is intangible. By comparing three ethnographic examples - (Weismantel 1995), Parish (1994) and Carsten (1995) - she concludes that the sharing of substance can create kinship, in which she differentiates between sharing of food ‘as sustenance and as conduit’ (Galvin 2001: 119). Sharing as sustenance suggests ‘the willingness of the sharers to further subdivide and share family resources and subsistence’ (ibid), while sharing as conduit, the intangible side, can include concepts such as pollution and space. On the other hand, the order of ratification includes the legal aspects, which legitimises the relationship, as well as time, which can account for enduring relationships. Relatedness can be shown by a combination of the two strands, for instance, sharing of substance or space over a long period of time can indicate a kin relation.

Carsten (2000) and Galvin (2001) show that people can consider each other relatives without the connection through “blood”. However, they were looking at relatedness within a singular community and simply because people within the same community can consider each other relatives without the presence of a connection through “blood”, does not mean that people can be related outside their own community. Nevertheless, according to Baumann (1995) this is possible as well. Baumann (1995) shows that in a poly-ethnic area in West-London kinship terms are used by informants from different ethnic groups. People living in the same area of Southall consistently refer to others as cousin, irrespective of their ethnic identity or cultural affiliation. According to Baumann (ibid) this is the result of convergence, which is ‘a process of cultural homogenization in

which separate traditions [...] come to approximate a further tradition [...], originally alien to both of them' (Baumann 1995: 730). He continues to say that 'such processes of convergence clearly do not develop in a power vacuum. Rather, they unfold in a social and cultural context within which certain practices or conceptions [...] are considered desirable or are accorded a hegemonic influence' (ibid). Baumann finds that referring to someone as cousin can invoke certain loyalties or expectations, such as avenging or protecting each other, and in this context it is useful to have many cousins. In addition, cousins are close enough to command such loyalties, without the possibility of discrediting one's own immediate family. The Netherlands is also a multi-ethnic society and in the larger urban centres there are also areas that are inhabited by a diverse group of minorities. Of course, many migrants live outside of these concentrated areas as well, but as the Netherlands is a fairly small geographical area, it is very easy for migrants to connect to people within the urban areas.

For GGZ Connections, this sense of relatedness was an important part of the construction of its organisation, as it depended on loyalty and trust to be able to survive. Dubetsky (1976) describes how many small businesses set up by rural-to-urban migrants in Turkey mostly hire staff from a network of relatives or people who are from the same rural area (*Hemserilik*). People that originate from the same rural area have a strong sense of solidarity with each other, as they are away from the homeland. He argues that the reason why the patrons do not hire exclusively kinsmen is to ensure that the business has enough skilled workers. He continues saying that people from the same area have an obligation to help each other and that trust plays an important role. Writing on women working and living in a squatter area in Istanbul (which are mostly inhabited by rural-to-urban migrants), White (2000) argues that kin is created by working together and sharing reciprocal values. According to White (2000: 128) 'generalised reciprocity — mutual assistance without cancellation of return — is a crucial part of the definition of kinship, and for women kinship relations are enacted in large part through labour obligations'. These relationships, consisting of actual and fictive kin, are important to ensure some form of security among poor working class people. White argues that indebtedness increased this bond, as it is 'necessary for maintaining the open-endedness of the social relations upon which social solidarity (and consequent security) rests' (ibid: 135). As White puts it, 'both real and 'fictive' kinship act as positive forces for economic survival, as metaphoric ties pull in resources from unrelated others' (White 2000: 130). She argues that by making use of metaphoric kinship terms, it creates a relationship that includes reciprocal obligations.

Although both Dubetsky and White were talking about rural-to-urban migrants, I find parallels with migrants in the Netherlands. To put it simply, I argue that there is a similar sense of solidarity among Turkish migrants in the Netherlands. This is not entirely their own choice, as I already mentioned that there is discrimination towards minorities in the labour market. Furthermore, I should mention that at the same time there is also a lot of division within the Turkish community in Holland, along ethnic, religious and political lines, which adds a few layers of complexity to this argument. Similarly, among the Iranian community there is also a division, for instance between opponents and supporters of the current Iranian political system. During my fieldwork, Maria, the

Iranian clinical psychologist, was very upset, when she heard that Dineke, one of the new Iranian psychologists who had been hired by Monica, was connected to the Iranian regime. Maria was worried that many of their patients, some of whom had been tortured and were suffering from PTSD<sup>31</sup>, would provide information to someone close to the regime, without them knowing about it.

Nevertheless, I have witnessed countless times when people from local Turkish communities were supporting and helping each other with a variety of things, ranging from support in child rearing to financial support, because of solidarity and people's trust in each other. This was, I argue, also the basis for the relationships at GGZ Connections, whereby new employees were drawn from a pool within one's own community. Monica was often depending on Rob, and vice versa, for running the business, either on paper, or to find new customers. Despite the fact that Monica had divorced Rob's son Barend, they were still related, because Rob and his wife for instance were regularly visiting Monica, because of Monica's and Barend's 5 year old son. Also Herman's and Marloes' relationship went beyond friendship, as it was reciprocal, enduring and considering that Marloes helped to raise his children, it shows that they had shared substance (food and also shelter). These two relationships were at the core of GGZ Connections, they were the basic pillars the organisation was resting on. Both sets of relationships were drawing on their own extensive networks to find more people, people they thought they could trust. Particularly Rob was using rhetoric that was intended to invoke kin ties, even towards people he had not personally met. Rob was not only trying to find patients through his networks, but also new staff members. After I completed my fieldwork, I spoke to an Iranian psychiatrist, Emma, who recalled being approached by Rob. She told me how he was trying to persuade her to work for GGZ Connections using metaphorical kin terminology, by asking her to help her "Iranian brothers and sisters". Emma was not interested, and declined the offer, but felt very uncomfortable, even guilty for refusing to work together, because of the rhetoric Rob used. This example suggests that Rob took this sense of relatedness to other Iranians for granted, as a "natural" bond between people. He was drawing on the reciprocal nature of relatedness, even though the kin ties were metaphorical.

With these examples, I have shown that the ties between people rested on the assumption that they were related. The clinic worked like a family, in the sense that people that were drawn in, were considered to be related, brothers, sisters, who were called on to help their other relatives. What they were not aware of however, that they were inadvertently creating a divide, which I will expand on in the next segment.

#### **4.5 DIVISION AMONG STAFF**

GGZ Connections was quite progressive in the sense that it welcomed people from different nationalities and ethnic groups, including native Dutch, like myself and a few others. Several studies show that although there is definitely room for diversity in mental healthcare in the Netherlands, it is not necessarily a priority (c.f. Kaya 2013; Kocak and Jonkman 2016). Hence diversity on the work floor in the Dutch mental healthcare system is lacking the required attention.

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<sup>31</sup> Post Traumatic Stress Disorder

At the same time, the organisation also made a differentiation within itself and the clinic was roughly divided into two main groups. Ironically this was partly the result of using kin and networks, which created an inner circle of people in managerial or administrative positions that Monica and Herman trusted. The people who did not belong to the inner circle, which were mostly therapists, felt that they were left out somehow; they felt left in the dark about how the organisation was run, and they were increasingly suspicious that fraud was going on at the clinic, an idea that was reinforced after a few incidents. This came forward in the yearly employee satisfaction study (*medewerkerstevredenheidsonderzoek*), which was one of the requirements of the quality handbook, in which employees were asked to fill in (anonymously) a questionnaire. The questions ranged on a host of issues, such as how people see their own work, how they experience the work pressure, what they think of their manager and what they think of the planning of the organisation. According to the findings of this questionnaire, people were critical of the lack of transparency in the organisation, as some people even did not know who their manager was, they thought the board behaved capricious at times, as Monica often made snap decisions and changed her mind, that agreements were not always honoured and that people experienced that they were harshly treated if they made mistakes, and even that they were criticised when they did not make any mistakes. The study took place at the end of my fieldwork, and as quality coordinator I reviewed and analysed the results, which confirmed my idea about the organisation. I wrote a report intended for the board, and concluded that teamwork, support towards each other, the career opportunities and the multicultural environment were experienced as positive within GGZ Connections, while the “challenges” remained an improved and better structured organisation, better agreements, better career opportunities (again), improved communication and improved administration. Interestingly, career opportunities were both cited as a positive and a negative attribute to GGZ Connections, which suggests a disparity among staff members.

No one mentioned suspicions of fraud in this study, but I know when talking to people, some were really worried about this. Leontien, one of the psychologists, for instance, told me that for her it is important that the salary she earns is *halal*<sup>32</sup>, while Marijke, one of the Turkish secretaries, told me that she found out that GGZ Connections had actually made a claim on her health insurance, without providing treatment. One year before she started working for GGZ Connections she had been to GGZ Connections for an assessment for her daughter. However, after the assessment, she decided not to get treatment at GGZ Connections. After she started working for GGZ Connections she was able to find her daughter’s details in the system, but rather than one assessment, she found out that GGZ Connections had declared a whole treatment as well. When she confronted Monica about this, she was ignored and Marijke felt that her work was scrutinised more and more, in which she would be criticised more often and more harshly, without clear evidence of any wrong doing. As a result, Marijke was really feeling alienated, which made her very critical of GGZ Connections as an organisation, questioning the credentials of management, and about how they treat people. She was finding a lot of support from a number of co-workers, who empathised with her and were similarly worried about how GGZ Connections was run by

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<sup>32</sup> Halal means in accordance with her religious (Islamic) principles



people they did not really know and who were hired without any clear and transparent system. As such, throughout the year I was there, I saw the establishment of an inner circle of people Monica trusted and an outer circle.

Knowledge about certain facts can be a powerful thing, particularly facts which Goffman phrases as 'destructive information' (Goffman 1990 [1959]: 141). Goffman differentiates between different kinds of information, dark secrets, strategic secrets and inside secrets, that teams can hold, which I will explain. Destructive information is information that, if disclosed, can affect team performance. While dark secrets are facts that can affect the image a team tries to project, strategic secrets are facts that are meant to design 'future actions against the opposition' (ibid: 142). Finally, Goffman identifies inside secrets, which is information that helps deciding who is part of which team. Information as such has an 'exclusion function' (ibid: 142). I found both dark secrets and inside secrets applicable to GGZ Connections, as dark secrets could apply to information about fraud, the corruption and the way the clinic was managed, while inside secrets were related to determine who was part of the inner circle. However, information alone is not enough, as the use of information depends on the different types of types of functions in the group. Goffman mentions the informer, someone who pretends to be part of the inside group, but when presented with destructive information, discloses this information outside. One could count Alain, one of Herman's former patients, to this group, as he was telling me what had happened behind the scenes and how his trust had been misused. Then, Goffman continues, there is the shill, someone 'who acts as though he is an ordinary member of the audience but is in fact in league with the performers' (ibid: 145). I recognised a few "shills" at GGZ Connections. Marloes for instance was always pretending to be part of the audience, someone who knew nothing, but was actually on the inside of the organisation, but I also thought Agatha, one of the therapists, was switching side from time to time. Agatha was often critical of Monica while in other therapists' presence, but I also found that sometimes, she was very close to Herman and actually critical of some of other therapists.

This dichotomy of inner and outer circle was central to how the clinic was run, and coloured the culture of the clinic, following Douglas' system of classification (Douglas 2011 [1987]). According to Douglas (ibid) binary oppositions are the basis for social institutions, whereby similar elements are classed together. It is then in the social context that these classifications receive specific meaning, through analogies. In order to survive as a business, Monica counted on certain people from within her network to protect and if necessary "avenge" or "punish" others outside the inner circle. This in turn, created an aversion towards some people in the inner circle and increased suspicion that "something was wrong", which implicitly meant that the fraud accusations must be real. One day for instance, Wendy, a young Dutch woman who was working as a child psychologist, was going through the electronic diary. In the diary all information about patients could be found, including their personal data, where they were insured, when they had appointments and it contained their full medical file. Through the software of the electronic diary, the clinic could directly claim money from the insurance companies. Wendy found some discrepancies in the appointments from one of her patients, which were many more than she actually had with this patient. She talked to other therapists first, to ask if they knew anything about it. As no one knew, she decided to write to

Monica about this. The same day, Wendy was summoned by Monica, who was furious at Wendy that she had talked to the others first. Wendy felt very intimidated by her behaviour and language. In addition, she was not convinced by Monica's statement that she wanted to "try and test something". Wendy was told to come to Monica immediately if she saw something similar, but this incident increased the level of distrust between Wendy and Monica, but also between Monica and other members of the team. Many such incidences followed each other, which caused Monica to be more authoritarian, take more distance from the therapists, while also turning more towards people from her network, looking for people she could trust.

This kind of dichotomous development had an impact on the culture of the clinic. As rhetoric became more intense, intimidating and challenging, people felt that the atmosphere was really going bad, as could be seen from the results of the employee satisfaction study. The lack of structure was also affecting morale, as people did not know who to go to with their problems. Trust was lacking, and this had an effect on the formation of distinct groups. In addition, as I will explain in the last part of this chapter, it became clear to me that corruption was also part of this organisation, which made me understand why some people thought that they did not have any clear career opportunities at the clinic, while others praised it. The lack of transparency did accommodate corrupt practices and unfortunately I was not able to get full access to the inner circle to get a complete picture. As researcher it was difficult to gain some people's trust, which is one of the main problems when doing research on issues of fraud and corruption (Haller and Shore 2005).

Nevertheless, what I can say with certainty is that a number of people close to Monica received large salaries, more than their function normally would warrant, which suggests that corruption was part of the organisation. According to the OECD<sup>33</sup>, the average disposable net income in the Netherlands in 2015 was around \$30,000 per annum, which is roughly £20,000. Most people at GGZ Connections received a salary based on the Collective Labour Agreements, CAO (GGZ Nederland 2011), but a few people working for GGZ Connections received a much higher remuneration. People close to Monica received between €48,000 and €96,000 per annum (before tax), which is roughly between £35,000 and £70,000 per annum. The only exception however was Herman, who received the minimum salary of around €14,500 per annum (around £11,000). He said that as he was going through a divorce and was reluctant to pay alimony, he wanted to receive the bare minimum. Considering that income tax is around a third of one's annual income, people close to Monica earned 150% to 200% more than the national average and to the salary index of the CAO. I have the impression that receiving this kind of salary was normalised among the fortunate group in everyday discourse. Just before he started as an intern, Kees, one of Monica's closest friends, was telling me that it was quite normal for interns to earn a little extra on the side, despite the fact that his allowance could not be more than around €300 per month before tax (around £250). When I asked this question to one of the other interns, Floortje, for instance, she said that all she gets was €200 per month. Later in the year, after I discovered that Kees never

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<sup>33</sup> OECD360, Nederland 2015

told his school about his internship at GGZ Connections, he got a new official function as administrator, with a salary of around €6000 per month.

In this section I have explained what the main reasons were for the division that was based on an inner-outer circle dichotomy at the clinic. I have also expanded on the consequences of the division between the two groups. While management of the clinic drew on kin ties and its network to find new staff, there was a clear distinction to how some members, who were close to Monica, were treated, particularly with regard to function and salary. In the last part of this chapter, I will expand on the link between kinship/relatedness and corruption.

#### **4.6 KINSHIP AND CORRUPTION**

In this final section, I begin by first explaining what corruption is and how I use this term. According to Haller and Shore (2005), the definition the World Bank uses, which states that 'corruption [...] is the abuse of public office for private gain' (World bank 2002, quoted in Haller and Shore 2005: 2), is very problematic. Not only does it not account for structural and institutional corruption, they also suggest that there is a problem with differentiating between what is "public" and "private". Within the anthropology of the state and bureaucracy, corruption is a theme that, according to Haller and Shore (2005), has received both structural and interactional attention from social scientists. Furthermore, they argue that corruption is often unfairly portrayed in popular media as something that is typical of "non-modern" and "uncivilised" societies. Typically, when looking from a structural point of view, corruption is viewed as something that is done outside the Western world, mostly in developing or underdeveloped countries, due to their perceived lack of morality and stability (Haller and Shore 2005). Haller and Shore (ibid) suggest that corruption has a morality of its own and is often done for reasons other than just personal gain (c.f. Olivier de Sardan 1999). As a result, they argue that it is necessary for researchers to look at corruption in its wider context.

Also Gupta (2012), who did research in India, where corruption is both pervasive and persistent, has problems with most definitions of corruption. Gupta (2012) argues that corruption is a form of structural violence, as it 'discriminates against all those who do not have the monetary resources' (Gupta 2012: 76). As a result, he prefers to look at the myriad meanings that corruption invokes 'in the context of structural violence' (Gupta 2012: 80). On another level, Smith (2001) for instance identifies the kinship patterns that are a social part of corruption in Nigeria. According to Smith, people in Nigeria 'use ideas of lineal descent and kinship to create and maintain relationships of duty and obligation that structure morality and behaviour in powerful ways' (Smith 2001: 350). He continues that 'throughout the life course, individuals benefit from the help of their lineagemates' and 'every person is expected to assist members of his/her patrilineage' (ibid).

I appreciate Gupta's approach and for GGZ Connections I think it would be appropriate to combine Gupta's and Smith's perspective and look at corruption in the context of kin relations at the clinic. Corruption at the clinic was, to some extent, preventing people who were not part of the inner circle, to fully take advantage of a career development program, and as such, can be accounted as structural violence. The combination of corruption and kinship is possibly best described as

“nepotism”, in which Monica was favouring people who were close to her when it came to hiring people and also to allow them to develop professionally.

At GGZ Connections however, it is relevant to consider the neoliberal context in which corruption takes place. The state has effectively withdrawn from the healthcare sector, allowing it to have the freedom to design the sector according to market principles. Despite its absence, the state still has the institutional responsibility for the quality of care. For this purpose, the healthcare sector is required to have a strong bureaucratic structure to ensure accountability and transparency. According to Shore (2005), there is a perception that ‘corruption thrives mostly in contexts where bureaucratic norms and rational administrative structures are either absent or under-developed’ (Shore 2005: 131). He comments on a corruption scandal within the EU and shows that within the EU there was a culture of fraud, nepotism and cronyism in which the monitoring body, the European Parliament, failed to step in to prevent the irregularities. Although the Netherlands scores as “very clean” on the world corruption list<sup>34</sup>, corruption had been popping up in Dutch news when I was doing my fieldwork. In the Netherlands, corruption is prevalent at any level of society, despite being one of the least corrupt countries in the world, according to Transparency International<sup>35</sup>. One of the most public cases throughout 2013 - 2015 was the case against the Dutch politician Jos van Rey, who was found guilty of corruption and money laundering and was sentenced to 240 hours community service. Despite the public outcry, the court acknowledged that there were many shades of grey, in which it recognised that the politician had fulfilled many years of public service with mostly good intentions and the friends he had favoured while in office, were mostly lifelong friends<sup>36</sup>. As such, the verdict was a mild reflection of these observations by the court. I have cited this example to show that corruption (and nepotism) is certainly not absent in Dutch society and politics and to provide some contextual background.

As I already mentioned and have shown, corruption at GGZ Connections consisted of Monica favouring certain individuals, people she regarded as kin, whom she considered trustworthy and on whom she relied to help her run GGZ Connections. She ensured that they were in positions of power (administrator, director, etc.) and paid them a salary that can be regarded as excessive. The main problem with corruption that occurred at the clinic was that, apart from the fact that it was illegal and that it had some serious moral implications, it drained valuable resources that could be used for the benefit of the clinic. As the insurance companies became more cautious and sometimes refused to reimburse some of the declarations, the income of the clinic decreased. This contributed significantly towards the bankruptcy of the clinic about two years later. Within the current healthcare system, the absence of the state allows for people working in this sector the freedom to arrange management structures according to specific needs. In addition, according to Satz (2013), privatisation encourages corruption, as the private entrepreneur has other priorities

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<sup>34</sup> <http://www.transparency.org/cpi2015> [accessed 1 October 2016]

<sup>35</sup> <http://www.transparency.org/cpi2015#results-table> [accessed 24 June 2016]

<sup>36</sup> <http://uitspraken.rechtspraak.nl/inziendocument?id=ECLI:NL:RBROT:2016:5281> [Accessed 1 October 2016]

than the government bureaucrat. The reward structure at GGZ Connections, in which it favoured some of its members financially, was a way for the clinic to protect one's own interests, but also a way to resist the power of the (often wealthy) insurance companies. The perception of these insurance companies was that they were able to make or break a clinic, and in the case of GGZ Connections, they choose to break it by not paying for treatments. The power relation between the insurance companies and the clinic was inherently unequal and by the generous reward system, this was somehow mitigated. At the same time, by providing big salaries to a few members, and obtaining expensive cars via the clinic, the board also disadvantaged the rest of the people working at the clinic, as well as the patients, who had to find new therapists, sometimes in the middle of their treatment.

#### **4.7 CONCLUSION**

In this chapter, I have described how relatedness was one of the main causes of some of the problems that GGZ Connections faced. I have shown that people working at GGZ Connections faced particular challenges when it comes to finding work on the Dutch labour market, due to prejudice and discrimination. The problem however was not that people were relying on their networks to find work, rather it lies with the fact that some people were favoured over others, creating a division among staff at the clinic. One of the strengths of GGZ Connections was its multiethnic character, which was experienced as very positive for people working there. At the same time, people were aware that not everything was perfect. I have also shown that the foundations of GGZ Connections were largely resting on two sets of relations, between Rob and Monica, and between Herman and Marloes, whereby Monica and Herman could be considered the "Nuclear Family". At the start of the clinic, people were experiencing a family like environment, in which staff were supportive, also between staff and patients (as I showed in the previous chapter), but rather than extending the family "values" and "ethos" to the entire clinic, Monica turned increasingly within herself and her own closed circle, providing them with benefits that were out of reach for others. In fact, by allowing others to disproportionately benefit by better jobs and better salaries, corruption was an inherent part of the organisation and culture of the clinic. This caused distress and disappointment among staff, as well as distrust and the creation of two distinct circles. In the end, corruption and nepotism, which became part of the culture of the clinic, were one of the main reasons why the clinic failed and was bankrupt within a few years. In the next and final chapter, I will look at how the clinic dealt with the bureaucratic challenges in the daily practice of the clinic and particularly in audit situations.

# CHAPTER 5 — Bureaucracy at the Clinic: Audits, the State, and Resistance

## 5.1 INTRODUCTION

In this final chapter I will look at the bureaucratic aspects of the organisation, the wider power structures in which these processes are embedded, and how people working at the clinic dealt with and reacted to these structures. Bureaucracy has received considerable attention from social scientists, starting with Weber (1946), who theorises about the ideal type of organisation. He describes bureaucracy as something that is totalising and the most ideal system to govern, without favouring anyone. Furthermore, bureaucracy is the best tool for those in power, which is used to harness and transform action from its people. This rational-legal bureaucracy as Weber saw it, was a move away from previous types of organisation in which family and friends played an important role (Morgan 1990). As I showed in the previous chapter, kinship relations remained an important part of the clinic, as the organisation was depending on a set of relationships of people that were related by (fictive) kin. In this chapter I aim to show that there are several faces of bureaucracy, in which actors face different challenges on multiple levels. As rules were interpreted in different ways, actors face a major challenge in dealing with the stresses if things go wrong. This struggle was exacerbated, as the bureaucratic system is essentially intolerant towards minorities (Herzfeld 1992), and the clinic identified itself, and was identified by others, as an “intercultural clinic” treating mostly migrants.

Hierarchy is an important feature of bureaucracy, and the basis of what Bourdieu would call “symbolic power” as Emmerich et al. (2015) propose. They argue that organisations like the Care Quality Commission (CQC) have symbolic power over healthcare organisations and professionals that could potentially result in symbolic violence. With ethnographic examples, I will show that visits from the inspectors were experienced by members of staff of the clinic as “violent”. At the same time, I will argue that the internal audits had the same effect as Foucault’s description of the panopticon (1991). While obtaining a quality certificate is deemed to be purely on a “voluntary basis” (clinics are not required to get a certificate), organisations might feel it is advantageous because it prepares the clinic for the unplanned and unannounced visits of the inspectors, thereby adopting the method to discipline themselves. But, following Strathern (2000), is the audit the result of a bureaucratic indifference, as Herzfeld (1992) puts it, or of ‘obsessive concern’ as Shore (in Strathern 2000: 15) argues? Another important point is related to why audits are performed, in which I will critically evaluate whether the audit culture had an effect on the quality of care. I will argue that audits are techniques that are used by the state that are evaluating performance rather than evaluating the quality of care. As the clinic struggled with keeping good and accurate administration, I remember feeling overwhelmed by the huge backlog I inherited when I first started my job as a quality coordinator and, even when Gerard was appointed as second quality coordinator, the backlog was never resolved. I ask whether the audits that were performed were

able to “measure” and assess the quality of care. Finally, I will look at how people on the ground were dealing with the bureaucratic hurdles and were resisting the audits. The purpose of this chapter is to show how bureaucracy helped shape the culture of the clinic, but also how the power structures within the Dutch bureaucratic healthcare system were unfavourable towards minorities.

## **5.2 THE ADMINISTRATIVE PRACTICE**

Administration is an important, yet tedious, part of running a clinic. Whether it is patient notes, treatment plans or medication charts, or correspondence with fellow healthcare professionals, these are considered basic and essential requirements in medicine. A small-to medium-sized clinic in or near a big city can easily have around 500 patients, with 15-20 staff members. To be able to keep good communication about the sometimes very complex needs of the patients, it is essential to write letters, notes and have meetings to assess and discuss individual patients.

Another reason for having a good administration in Holland is financial purposes. Having an accurate administration is important to be able to get payments from the insurance companies. To be able to get a bit more financial stability, clinics can try to get contracts with insurance companies, which mean that they can get paid the full amount they charge, as opposed to 60-70%, and clinics can get advance payments, rather than having to wait until the patient completed the treatment. In an attempt to get a contract with these insurance companies, GGZ Connections obtained a quality certificate, called HKZ certificate. As I mentioned in the introduction of this thesis, this certificate is obtained through a rigorous two-day audit, which looked at different kinds of procedures, regulations and guidelines for the clinic. To be able to get the certificate, GGZ Connections invested a lot of money by getting professional help from a consultancy agency specialised in these kinds of certificates. They helped to write the extensive quality handbook, and prepared the clinic for the audit. While GGZ Connections was successful at the two-day audit and obtained the quality certificate, it failed in getting any contracts with any of the insurance companies. One of the insurance companies offered a contract to reimburse up to €500K, but Monica rejected this, as this would mean that they would have to turn away patients once this threshold was reached. I am aware that there are other clinics that do not have contracts because of these limitations and as a result they prefer to work without any contract. This way, there is no limit to the number of patients one can have.

This had consequences for the Turkish and Iranian patients, because insurance companies prefer their clients to go to healthcare providers that are contracted, to be able get some control over the costs of care. Some insurance policies allow patients to go to any healthcare provider, but these are the more expensive policies, and were not often held by the migrant patients from GGZ Connections. As a result, this restricted the freedom of choice for many migrant patients, as many of them came from the lower socio-economic classes. Although insurance companies are not owned by the state, these powerful institutions are in fact a proxy for the state, in that they have been delegated with the task of ensuring that everybody in the Netherlands has access to healthcare. Healthcare for everyone is one of the fundamental rights for Dutch residents, but this

construction transforms this right into an obligation: an obligation to contribute, as not participating will result in penalties. Another implication of this construction is that for healthcare professionals, this means that they are restricted in providing care to certain patients. Every year, they have to negotiate for a new contract, although there has been criticism that there is not much to negotiate and that they are paid lip-service only (Consumentenbond and VvAA 2016).

The implication of this power of the insurance companies is that clinics do their best to jump through numerous hoops, like getting a quality certificate, to be eligible for a contract. Since the introduction of the 2005 Health Insurance Act, which opened up the healthcare market in Holland, the insurance companies are monitored by the *Nederlandse Zorgautoriteit (NZA<sup>37</sup>)*, the *Dutch Quality Care Authority*. This organisation works under auspices of the *Ministerie van Volksgezondheid, Welzijn en Sport (VWS<sup>38</sup>)* and works together with a number of other institutions, such as the *Inspectie voor de Gezondheidszorg (IGZ<sup>39</sup>)*, which is the Dutch equivalent of CQC. At GGZ Connections, the inspectors of the IGZ were mostly referred to as “the Inspection”. The Minister of VWS is politically responsible for the healthcare system and the NZa regulates the entire market, including insurance companies and healthcare providers. The inspectors from the IGZ are the people who execute the inspections, or audits. They have the power to put clinics under intensified supervision, investigate criminal charges, strike physicians off the register and close clinics. In the next segment, I will present a number of ethnographic examples, and I will argue that because the state has retracted its presence from the healthcare system, healthcare providers have been encouraged to regulate themselves. The internal audits that clinics perform are designed to discipline the clinics, rather than “liberalising” them. I will argue that the internal audits have a similar construction to Bentham’s “Panopticon”. The purpose of this is that self-regulation allows the state to take a step back and “interfere” in the healthcare system minimally. Withdrawal of the state is one of the hallmarks of neoliberalism (Harvey 2005), and this allows for private companies to move forward. The audits allow the state to withdraw, while at the same time maintaining the overall responsibility about the quality of healthcare.

### **5.3 THE INTERNAL AUDIT: PREPARING FOR THE “REAL” TERROR**

GGZ Connections made use of a consultancy company to help out with getting and keeping the HKZ quality certificate. This company, which I will not call by name, sent one or sometimes two of its consultants, typically people with law degrees, to give advice. There are numerous firms in the Netherlands that are specialised in providing consultancy for healthcare providers and they can charge quite hefty fees. The investment into acquiring a quality certificate is therefore substantial. As the yearly external audit was coming up, the consultancy firm sent Hanna to do an internal audit as preparation. Gerard and I were planning to meet with her to go through the newly adapted quality handbook. I had been changing and adjusting the handbook for many weeks, while other

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<sup>37</sup> <https://www.nza.nl/> [accessed on 27 April 2016]

<sup>38</sup> Ministry of Public Health, Wellbeing and Sports

<sup>39</sup> Inspection for Healthcare



people (mostly in managerial posts) had been preparing as well for the internal audit. Most adjustments were related to the organisational changes and not so much about care plans. For instance, I had adjusted organisational charts, according to the new functions that had been added since the beginning of the year, added a few things about new meetings that were supposed to happen frequently and designed a number of forms to be used during different processes. In addition, Robin, the fresh HR Manager, had expanded on the existing function profiles and written new ones, which I also included in the quality handbook.

All these changes were about to be tested in the internal audit by Hanna. She was a native Dutch woman, wearing thick framed glasses and with an austere look. As we were waiting for Gerard, who was both quality coordinator and general director of the clinic, I asked her how her journey to the clinic had been, but realised that she preferred silence over small talk. Hanna was accompanied by Iris, the regular consultant, who was friendlier and gave some general information about how to prepare for the external audit. Gerard asked half-laughingly whether we could really lose the certificate, but Iris cautioned him that not much was needed to lose it. She said that it was important to look at the audit from last year, as it was very important to show that we had done something about the concerns that were raised then. Unfortunately, I had never seen the previous audit, despite repeated requests for it, so I had given up. Gerard asked me to find the external audit. Rather than telling him directly I never got it, I looked for it anyway and after about 30 minutes I replied to Gerard that I sent a number of emails addressed to him asking if he could send me last year's external audit. He then replied he did not have it, which is why he did not send it, but he never told me that before. Sometime later, we found out that Monica had it all along.

A few days before the internal audit, Hanna had sent me an agenda with timetable, which allowed me to plan things ahead. Unfortunately, both the consultants and Monica arrived late, so the whole program was changed. Sometime in the afternoon, after Iris and Hanna had meetings with Monica and Gerard, Hanna came to me to ask me questions about the quality handbook. Gerard joined us as well. Hanna asked direct questions, was sometimes confrontational and was frankly quite blunt in her assessments and arguments. She challenged us mostly about why we had done certain things in particular ways, and said that we should follow the guidelines that are also part of the handbook under section 1.2.2. I could see that Gerard was quite irritated by her, but he held himself together as much as he could. When it came to the function profiles<sup>40</sup>, Robin was asked to join, to explain why he made the profiles very extensive, when all this information is already mentioned in the CAO<sup>41</sup>. Robin became really defensive, he was trained as a HR manager and put in practice what he had learned, but eventually he mumbled that he will look at it again and left, clearly frustrated by the process. When Hanna left briefly to ask a quick question to Monica,

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<sup>40</sup> Function profiles are the formal requirements for each position at the clinic. In the quality handbook there is a section that provides detailed descriptions of each position held at the clinic

<sup>41</sup> CAO stands for Collective Labour Agreements. Each sector in Holland has their own CAO, including mental healthcare, in which salary scales, pension contributions, holidays and other kinds of labour conditions are agreed between employers and employees.

Gerard blew off pressure and told me that she was driving him crazy. Only five more points to go, I replied. He rolled his eyes and sighed.

Unfortunately, one of the points was about Rob's job (Monica's father-in-law) and his job description, which was a bit vague and caught Hanna's attention. His official function was "communication employee" and his main activity was to "contribute to the preparation and execution of internal and external communication, the main aim being attracting new clients". I understood from other colleagues that such a job is quite unusual in GGZ<sup>42</sup>, especially in tier two/three mental healthcare, as our patients were supposed to be referred by General Practitioners and other referrers, whereas at GGZ Connections, patients were coming to the clinic directly. Although I tried to speed up the process, this was an important point, as I was not sure about what Rob's job was either, so we spent quite a lot of time discussing the chart flow and Rob's work, his credentials and what we could do to improve the screening. I told Hanna that when patients do not have a referral letter, they are first seen by Rob. I thought that it was a good way to match the entry process with Rob's position as it was described. However, Gerard was hammering on putting it 'right' so he was explaining why and how patients come to Rob. So Hanna had put it down like this: A patient calls GGZ Connections, and does not have a referral letter yet. The secretary then transfers the patient to Rob, who screens the patient, sees if the patient does not fall under the exclusion criteria and gives information about GGZ Connections. If we can help the patient, Rob advises the patient to go the GP and get a referral letter and make an appointment for a real assessment. Gerard explained that patients do not call GGZ Connections directly, but call Rob directly. Hanna was surprised and asked how they got his mobile number. Gerard then explained it was cultural thing and that they got his mobile number from other patients through relatives and friends. That was the way it works for Iranian people. Hanna asked whether this was his private mobile number, Gerard confirmed this. 'So does he keep his private life separate from his professional life?' Hanna asked. 'Well,' Gerard replied, 'that's difficult, because patients also call in the evening'. I suggested giving Rob a company phone, so that he could switch off the work phone after 5pm, but then Hanna and Gerard both said that he did not call patients from his private phone, so there was no need for it. That was the end of the discussion.

The internal audit was quite rigorous, in the sense that Hanna was quite strict and she was harsh in her criticism. The topics she raised were mostly related to the organisational structure of the clinic. She was, for instance, trying to determine whether all functions were written down according to the guidelines. She was also curious *how* I had made changes to the documents in the quality handbook (although that is not described here). Perhaps surprisingly, she did not ask any questions directly related to care, or quality of care. At most she was interested in the processes and protocols that were in place when a patient first contacts the clinic to make an appointment. Yet while the clinic had the "correct" framework, as stated according to guidelines of quality care, and as could be witnessed from the quality certificate that the clinic obtained, in practice the

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<sup>42</sup> Geestelijke Gezondheidszorg, Mental Healthcare

protocols were only partly followed. In the audit, the messiness of daily management, the chaos in administration and the clueless attitude of staff did not come to the fore at all. Neither was there any focus on the treatments that were given to patients. What was more important, it seemed, was the function of Rob. This suggests that the audit is not really designed to “measure” the quality of care; rather the audit’s purpose is to discipline the clinic to adopt a style of governing and management.

#### **5.4 THE AUDIT AS BUREAUCRATIC INSTRUMENT**

Following Weber’s theory (1946) about the ideal type “rational” kind of bureaucracy, which he labelled rational-legal bureaucracy, the audit fits in neatly. According to Weber (ibid), modern bureaucratic management rests on the premise that it should follow strict rules and regulations and is governed quite rigidly. The official, who should see his office as being a ‘vocation’ (Weber 1946: 198), is hired on his expertise and skill, and is expected to be absolutely devoted to the administrative tasks, without favouring anyone. Weber argues that

‘bureaucracy is *the* means of carrying ‘community action’ over into rationally ordered ‘societal action’. Therefore, as an instrument for ‘societalizing’ relations of power, bureaucracy has been and is a power instrument of the first order—for the one who controls the bureaucratic apparatus’ (Weber 1946: 228, italics original).

The social relations in a bureaucratic society according to Weber are rational, impersonal, hierarchical and efficient. The audit as it was performed by Hanna, with her seemingly detached “objective” approach, the directness and harshness of her words, and a lack of empathy suggests that she had internalised the bureaucratic rationale of Weber, whereas Gerard for instance was really annoyed by her approach. I am not able to comment further on Hanna’s views on bureaucracy, because she was not very talkative, but I found myself to be closer to Hanna than to Gerard with regard to my own approach towards bureaucracy. I started to wonder why Gerard became a quality coordinator in the first place. Even though he had studied law, his approach and attitude towards the bureaucratic processes and procedures was quite different, almost intolerant.

According to Morgan (1990), rational-legal bureaucracy stands opposite the more “traditional” organisations, in which friends and family play an important role. But while Weber’s theory on bureaucracy has been influential, it has also been subject to serious critique. Morgan (1990) cites several studies that are critical of Weber and for instance questions the rationality of decisions that are made within a bureaucratic environment, as the decision makers cannot take everything into account. Instead of making the best decision, Morgan argues, the decisions made are mostly not more than ‘good enough’ decisions (Morgan 1990: 73). Another part of a bureaucratic organisation (Morgan 1990) is the political behaviour within the organisation. In conflict situations, managers try to improve their own position by informal manoeuvres, whereby ‘informal relations modify the official power structure’ (Morgan 1990: 87). Such an informal manoeuvre came to the fore for instance when Monica was trying to change the position of the quality coordinator, as my position

shifted more towards the periphery of her “inner circle” as I explained in chapter 4. First she appointed Gerard, one of her close friends, as general director *and* quality coordinator, after which they tried to put the position of quality coordinator lower in the hierarchical organisational chart. This move was stopped by Hanna’s interference, who suggested that according to the HKZ rules, the quality coordinator’s position is fixed in the hierarchy. It is interesting to notice that both Hanna and I (though we did not know each other well) were both having the same ideas about how we thought bureaucracy should inform us, while Monica, Gerard and Kees had different notions. This can perhaps best be summed up by a difference in opinion that Kees and I had about the use of the HKZ book. I was arguing, rather naively, that the rules and procedures were there to help the organisation run its business, while Kees was asserting that the rules should be built up around the business and should be changed if necessary. I am aware that at the time, my own ethnocentric views were not helpful, but my perspective as quality coordinator was sometimes leading, in the sense that I had responsibilities as a quality coordinator and I took these responsibilities seriously. However, I did feel that, being a quality coordinator, I was in an uncomfortable position between the state and the clinic: although I was hired by the clinic, I felt responsibility for ensuring that the clinic adhered to all the rules, regulations and procedures.

Getting back to the key issue, the audit is considered very important by auditors and regulators as a way to “measure” the quality of the service provided. Strathern (2000) argues that the audit is a mechanism that replaces direct involvement of the state. Rather, the state is intervening at a level before this, where people have to check themselves. All the state needs to do is check the results of the audit. According to Strathern, it is justified to speak of an *audit culture* (Strathern 2000: 2), as auditing has become much more than a tedious part of bureaucratic processes. She stresses that ‘procedures for assessment have social consequences, locking up time, personnel and resources, as well as locking into the moralities of public management’ (Strathern 2000: 2). As former quality coordinator, I am deeply aware of the mundane, seemingly harmless, parts of audit and other tools that I had at my disposal, such as doing risk assessments or making changes to existing documents. The position of quality coordinator was brought to life only a few months before I took up the position, as a result of the procedure of the quality certificate and was initially taken up by Monica. I will come back to problems that bureaucracy, and particularly the audit, created to the clinic later in this chapter, but first I will consider another important theorist, Michel Foucault and the panopticon, to analyse the bureaucratic system.

## **5.5 THE AUDIT AS PANOPTIC INSTRUMENT**

The internal audit is instrumental in “internalising” this type of governance in a similar way as Jeremy Bentham’s Panopticon. The Panopticon, as extensively described by Foucault (1991), was a structure designed for prison, in which a central tower occupied by the guards, dominates the cells which are located around the tower. The prisoners cannot see the guards in the tower, but they know that the guards can see them. This sort of control, according to Foucault (1991), instills a certain discipline of the prisoners to monitor themselves. The internal audit is a technique that shows that clinics are similarly adopting the discipline themselves to “behave”. They cannot see

the “guards” (in this case, the inspectors of the IGZ), and the state is not dominantly present; but the awareness that the state can at any time check on them urges them to prepare themselves for possible interventions. Rather than the state having to control all aspects of public and private life, the panoptic mechanism allows the state to retreat to the background, while its subjects monitor themselves, whilst knowing that they can be checked on anytime, and be punished if required.

Panopticism is responsible for the change of social relations and marks a shift in power relations from using brutal force to more subtle, yet insidious, pressure (Foucault 1991). Discipline, Foucault contends, ‘assures an infinitesimal distribution of the power relations’ (ibid: 216). Shore and Wright (2000) observe that ‘audit encourages the displacement of a system based on autonomy and trust by one based on visibility and coercive accountability’ (Shore and Wright 2000: 77). The gaze of the inspection, through random visits, allowed them to assert their authority over the clinic, while the clinic adopted the structure of regular audits, as a way of self-flagellation. At the same time while doing its best to fit in the rigid structure of the audit, the clinic was clearly not performing well. A major gap in its administration was often reiterated by Monica, who became furious that staff was not able to do all the basic checks when dealing with their side of the admin. Simultaneously, staff was complaining, though never openly, that they were certain they had done their bit of administration, but that management was interfering and messing up notes. Yet while the administration was the weakest point of the clinic, as I will show with the following ethnographic examples, the clinic was coping with the audits, desperate for survival.

## **5.6 THE SYMBOLIC VIOLENCE OF EXTERNAL AUDITS**

In similar vein, Emmerich et al (2015) argue that audits do not really contribute to improving the quality of care and equates audits to acts of symbolic violence, or at least to something that has the potential for symbolic violence, stating that ‘it is always *possible* for our activities to involve the domination of others’ (Emmerich et al 2015: 7, italics original). Symbolic violence is a term used by Bourdieu (1977; 1991), indicating the potential for violence in a social system, as a result of symbolic power. Symbolic power rests on the legitimate structure that a given society relies upon, but is more hidden than other forms of power. It can be observed for instance when looking at economic power, which divides rich and poor classes into distinct entities, but where different sides accept the logic behind the reason for this, thereby creating its legitimacy (Bourdieu 1977; 1991). Rather than being primarily concerned about quality of care, Emmerich et al (ibid) assert that the system devised around the quality of care is more about political accountability, in which organisations such as the Quality Care Commission (CQC) have what Bourdieu calls symbolic power over the healthcare professionals and care organisations. Furthermore, they contend that the CQC’s so-called impartiality, or in Bourdieuean terms, disinterest (Bourdieu 1998), creates a distance between those in power and the practice of care, which can lead to symbolic violence. In their own words, ‘the distance that the practice of disinterest creates generates the conditions within which bureaucratic exercises can become symbolically violent and therefore come to place structural constraints on the caring practices they are supposed to promote (Emmerich et al. 2015: 7).

Similarly, according to the website of the IGZ, it states that they are independent, and that they are concerned with ensuring the quality and safety of care<sup>43</sup>. If measures are taken against a particular clinic or healthcare professional, they publish an announcement of the actions they have taken. While these publications have the appearance of transparency, under the guise of “being objective” they also have the side effect of naming and shaming, thereby alluding to symbolic violence. I will come back to this point after the ethnographic examples.

I agree with Emmerich et al (2015) that audits are not really designed to improve the quality of care, as the audits are very much performance based. If one performs well, it is deemed that the clinic or person provides qualitative care. In addition, the extra bureaucratic load of having a quality certificate means that clinicians and therapists need to spend more time doing administration, rather than spending time with their patients, which is only partly paid for by the insurance companies. This can be an explanation why some clinics are charging for more time than they actually spent with the patient from the insurance companies, to be able to get the money they are due. When they do that, they are resisting the current system and resenting the power of insurance companies.

The next ethnographic example highlights the possibility for symbolic violence during the external audit. In contrast to the internal audit, the external audit, which took place a few weeks later, seemed much more relaxed. At the same time, people were still stressed, as this was “the real thing”, but the way the external auditor handled the audit was very different in approach. This audit was done by another company, which specialises in doing audits and which awards the certificate after successful completion. In other words, it is in their interest to “sell” certificates, and although I do not wish to imply that the company’s audit practices are easy to be able to sell more certificates, there is a double standard. The auditor, a Dutch man called Gilbert, could be described as very understanding, humane and empathic. He smiled most of the time, was very talkative, had a relaxed demeanour and gave advice to how the clinic could improve things. His approach, he said, was mostly based on how things worked in practice, which seemed to be the opposite of Hanna’s approach, whose starting point was the guidelines. Gilbert listened to the answers to his questions patiently and seemingly non-judgmentally. He put mistakes into perspective, saying that this was something that happened more often. For instance, when talking about the complaints procedure and the low number of complaints, he said that other organisations also found it difficult and sometimes counterintuitive, to fill in complaint forms, when the problem had been solved. He advised that there was nothing wrong with filing complaints, as it helped the auditor to get a better picture of how the clinic addressed complaints. He said that it was almost a bonus if complaints were filed. Of course, Gilbert was not aware that clients were dissuaded, sometimes even barred from filing complaints, as I have shown in the previous chapter on the complaints procedure.

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<sup>43</sup> <http://www.igz.nl/> [accessed on 27 April 2016)

GGZ Connections passed the audit without any problem, with only a few minor items to change, something to work on for the next audit. One explanation in the difference in approach between Hanna and Gilbert was that for Hanna it was her responsibility to ensure that GGZ Connections passed the audit, while Gilbert did not have this pressure. In addition, Hanna might have had a better insight into the workings of GGZ Connections, with all its problems regarding fraud allegations, while Gilbert might not have been completely aware of the extent of this. Another point is that Hanna was also preparing the clinic for any visits from the inspection, which I will turn to in the next section. Nevertheless, despite these different approaches, both were working towards the ultimate goal of an audit; to hold the organisation accountable to its quality standards, and both seemed in agreement, in that they perceived the clinic to be up to that standard. Considering what I have witnessed at the clinic, behind the screens, I was in a way surprised that they did pass, as the administration was really not in accordance with the way it should have been, but also the way conflicts were solved, complaints handled, staff were unhappy and the way the clinic was managed, could have been enough for any auditor to at least raise some serious concerns.

However, the audit assesses the performance of the clinic and during the audit GGZ Connections performed well. The success of this performance lies perhaps, as Goffman suggests (1990 [1959]), due to control of the setting, which 'may give the controlling team a sense of security' (Goffman 1990 [1959]: 99). According to Goffman (*ibid*: 98), 'control allows a team to introduce strategic devices for determining the information the audience is able to acquire'. In other words, GGZ Connections was able to control the flow of information to the auditors. Staff presented themselves as a team of professionals, who knew their task very well. The performance of "professionals" gives credibility to the institution, because of the 'strict code of etiquette' (Goffman 1990 [1959]: 95), which ensures that everything is done to prevent the doctor from being publicly criticised by the rest of staff. No one (including myself) would want to take the blame for failing the clinic by publicly addressing the problems with Herman or Monica, risk losing the quality certificate, and most of all, risk infuriating Monica. Monica's anger could result in a person being scolded and losing their job. The effort to maintain the status quo was well orchestrated and everyone knew how to apply the etiquette of professionalism.

One might wonder why the audit is still considered a useful tool. Shore and Wright (2015) observe that the reason why governments and management prefer the audit system is because 'its techniques provide indispensable tools of contemporary management that are extremely effective insofar as they align individuals, institutions, and wholesale sectors within a space of government' (Shore and Wright 2015: 429-30). But while it may seem that the clinic got off easy, it is worthwhile remembering that preparing for an audit can be stressful and gruelling. Having the stain of being seen as an untrustworthy clinic, it appears that for GGZ Connections the pressure was enormous. As a result, the clinic "volunteered" to invest a lot of money into getting a quality certificate. For GGZ Connections, it was important to show to the public that they were delivering high quality care and the certificate was the tool to achieve that. Despite the humane approach from Gilbert, the potential for symbolic violence was still present, in the sense that Gilbert had the

power to take away the quality certificate and as such, the clinic would be seen as what they fear the most: appearing to provide poor quality care, as one would expect from a dishonest clinic. Having a quality certificate, however, was not enough to convince insurance companies or the state that the clinic was performing adequately, which seems to suggest that they were not convinced that the quality certificate actually improves the quality of care either. Visits from the inspectors could be expected at any time, in Panoptic fashion, and they could be brutal. In the next segment I will describe one such visit.

## **5.7 THE STATE AND THE CLINIC**

Inspectors of the IGZ had already paid a few visits to GGZ Connections before I joined them and they made another surprise visit just before Christmas. Although everyone at the clinic knew that there would be an “unannounced” visit by the inspectors, when they were actually at the door, I saw colleagues become worried and I was not completely at ease either. We were in the middle of our weekly MDO meeting<sup>44</sup>, discussing patients, when Kees, who was doing finance, broke the news. I asked him to call Monica and Herman, who were both absent, and said that we would finish the MDO first. Initially I was glad that at least Cornelis, our other psychiatrist, was present, but his mood was getting worse as well, so he was not much help. As our meeting came to an end, I went to the waiting room to meet the inspectors. I saw two men, one middle aged and another slightly older. The middle aged man was on the phone with Monica, I understood from the older man. As I introduced myself as the quality coordinator, he said that he understood that Monica was abroad. I could not hide my surprise, as about a month ago I had asked Monica what I should do when the inspection would come. She told me that I should just call her and she would help me through.

In the meantime, Herman, I understood, was on his way to the airport, apparently on his way to join Monica, but he said he would be there as soon as possible. He was not happy at all. Then Agatha, one of the therapists, seemed to have lost her nerve and was shouting in the administration room, “they will find the mess in the administration” and “we are doomed” while the inspectors were still in the waiting room next door. She was eventually calmed down by her colleagues, but she made everyone more nervous. The inspectors decided to speak to Cornelis first, while Herman was on the way back. As they went into the meeting room, I was waiting with the other staff in the administration room. When Herman arrived, he was fuming, as Cornelis had been critical of Herman for not telling him that he would be away. I tried to calm Herman down, who was shouting at me before he went in the meeting room. Then, after an hour or so, I was called in as well. The inspectors asked about my credentials first and I told them where I graduated from and that I was doing a PhD research at the clinic as well. Then they started asking a barrage of questions, about the personnel management, about information on our website, to check if it was correct (which it was not). They also asked if we knew the board member, Theresa, and while Cornelis and I were very surprised that it was not Monica, Herman mentioned he had met Theresa

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<sup>44</sup> Multi Disciplinary Meeting



once, briefly. The inspectors reprimanded us for not knowing who was on the board. Then, after these intensive questions, they wanted to go through some of the patient files. They checked these on my pc, and they picked patients randomly. Some of the files were incomplete, and in one case, a file was completely empty. I tried to find the physical file, but this was also not present. I told the inspectors that this file was most probably in our other branch, as this patient was seen there. Initially they said they wanted to visit the other branch as well, but as it had become late, they changed their minds.

This very brief account of the visit of the inspection shows the sheer horror of being confronted by the inspectors. Of course, it did not help that everyone at the clinic knew that the administration was a mess, which heightened the stress. The visit felt like a complete shock to everyone and was experienced as emotionally intense, in which people would point the finger at each other. At the next MDO, in which everyone was present, I was directly blamed for a number of mistakes by Kees, as he pointed out that the backlog in the administration was my responsibility. Agatha became very emotional and blamed me for leaving too soon after the inspectors left, which had affected her entire holiday.

Bourdieu's notion of *symbolic violence* is in short an appropriate term to describe the effect of the inspectors on staff. As I mentioned before, symbolic violence is the result of symbolic power, which Bourdieu (1991) describes as the structure that is in place through which those in power assert their authority over dominated classes. Bourdieu's premise suggests that suffering is one of the consequences of all kinds of violence, including symbolic violence, and after the inspectors had left, it was clear that people were in pain, they were panicky, anxious and even traumatised. The visit of the inspection was followed up with a letter, stating that they required a number of things from the clinic, such as a list of staff, list of the Board and supervisory board, with all responsibilities, tasks and competencies. The difference between the HKZ audit and the Inspection is considerable, although Hanna's approach came nearer to what the inspection did. Gilbert's approach however, was quite different, was closer to the daily practice of running a clinic and although caused some nervousness among some people, he was able to calm them down. The inspection on the other hand was strict, critical and the inspectors were clear in their demands. They induced panic and the mere thought of them increased the stress levels of people drastically, eager to wash off any responsibility and blame each other. The display of symbolic violence of the inspectors' visit created a tension that affected the already fragile harmony and cohesion of the clinic and resulted in the fracture of the clinic in discrete groups, as trust between people imploded. Most people had an idea that something was not right, but no one spoke out against it and continued doing their job, helping (and caring for) patients. Although this kind of symbolic violence can potentially threaten any clinic, I found that the suffering it imposed on this transcultural clinic was very dramatic and probably unique, in that other clinics run by the native Dutch might not experience. In the next and final section I will look closer at the relationship of minorities towards bureaucracy.

## 5.8 BUREAUCRACY AND MINORITIES

Many migrants I have talked to over the years, and particularly in the year I did my research, had a story to tell about their migration to Holland. Being married to a Turkish doctor made me more aware that minorities have to go through extra bureaucratic hurdles. After having obtained a residence permit, which can be a major hurdle, the next step is to get one's qualifications acknowledged, which can take years and is hardly ever in the favour of the migrant. Rather, qualifications of people trained overseas were often not recognised, despite some people being highly educated. It was almost as if having been educated abroad was a stain on one's profession, as I mentioned in Chapter 4. Herman was still pretty lucky: when he came to Holland, he was only required to work under supervision of a Dutch psychiatrist for a short period of time before he got his registration. However, when Herman's wife came to Holland, about a year later, her diploma was not recognised and she was required to get additional education and extensive supervision before she was allowed to practice in Holland. I argue that this kind of "spoiled identity" as Goffman (1991 [1961]) would put it, was a disadvantage for the clinic, in that having migrant doctors and other migrant therapists might have made it more difficult for them to operate.

Herzfeld (1992) argued that bureaucracy is essentially intolerant towards minorities who are therefore more likely to be exposed to the "evil" of bureaucracy in a ritualistic manner that is designed to make them part of the rest. Herzfeld's main paradigm is that he draws a parallel between religion and bureaucracy, whereby he makes use of the 'theme of secular theodicy' (Herzfeld 1992: 5), in similar fashion to Weber's use of the term religious theodicy. Theodicy is a term mostly used in religion, in which the evil in the world is used as an explanation for the existence of God. He explains however that 'where Weber posts theodicy as a way of propping up belief against the evidence of a flawed world, I suggest that secular theodicy, at least, serves a more pragmatic goal. It provides people with a social means of coping with disappointment' (ibid: 7). He claims that bureaucratic procedures are highly ritualistic, in which bureaucrats are similar to sorcerers, whereby nationalism is the religion. In addition, he rejects the notion of a rational approach, arguing that both bureaucrats and agents are able to make use of the system for their own personal gain. Bureaucracy has, in Herzfeld's mind, the potential for repression, and he asks the uncomfortable question why totalitarian states and democracies have the same system.

I do agree with Herzfeld, based on my own experience and observations. For instance, migrants who do not have a Dutch passport, do really feel that they are treated differently, particularly migrants with a high education, such as doctors. From my own voluntary work over many years in several non-profit organisations (both in Holland, the UK and even at EU level) that aimed to ensure that non-EU doctors are treated equally, I am acutely aware of the discrepancies in treatment between highly educated native Dutch and non-native Dutch. The foreign education is treated by Dutch officials as something that is potentially dangerous, from which the Dutch public needs to be protected. This was a point that came up in numerous meetings I had with Dutch officials in relation to recognition of my wife's Turkish medical doctor diploma. In one particular

meeting we had with civil servants from the Ministry of Health, one official admitted that they did not think that for instance Greek or even British diplomas were of the same standard as Dutch medical degrees, but because of European regulations, they were obligated to accept these diplomas (c.f. Smeets 2002).

The notion that ethnic minorities are disadvantaged in this bureaucratic system is therefore a valid point, although it may not always be obvious from first glance. The bureaucratic system is designed to at least appear to treat everybody equally, in a Weberian way, but the way an organisation is supposed to work, suggests that there is a bias in this system, as it is not open to any alternative ways to organise. Eidheim (1969) wrote about the problems that the Lapps in Norway face, due the stigma of their ethnic identity, in which Norwegians are dominating the administrative and social services. Similarly, the Turkish identity in the Netherlands is also a stigmatised, “spoiled” (Goffmann 1990 [1963]) identity, in a country that has been increasingly hostile towards Muslim migrants. Around the time of my fieldwork, many newspaper articles appeared about migrant fraudsters, showing examples of clinics that were treating “fake” patients, to be able to con the system. The focus of the media on these particular cases supports the notion that there is a bias against migrants.

Herzfeld (1992) further argues that the concept of secular theodicy accounts for the emergence of indifference, to the extent that people become resigned to the idea that it is some kind of “fate” that one has to deal with bureaucracy. The notion of indifference is an important point, but according to Gupta (2012) indifference is only part of the problem. He argues that arbitrariness is also produced by bureaucracy, but he says that ‘such arbitrariness is not itself arbitrary; rather it is systematically produced by the very mechanisms that are meant to ameliorate social suffering’ (Gupta 2012: 24). In other words, while indifference causes suffering, the arbitrariness exacerbates suffering. At the same time, while bureaucratic mechanisms lead to indifference and arbitrariness, following Shore and Wright (2000), who take the Foucauldian panoptic perspective, the audit is obsessed with trying to control people. The audit actively changes the structure of the organisation, to ensure that people are ‘auditable’ (Shore and Wright 2000: 72), while the panoptic scheme ensures ‘constant surveillance’ (ibid: 77). These two viewpoints seem to contradict each other; on the one hand, there is a sense of distance, helplessness and arbitrariness, while on the other hand there is constant control. As such, there appears to be a huge gap between bureaucracy in general and the audit culture of a bureaucratic entity. However, bureaucracy can inflict suffering on so many different levels, that it is not inconceivable that arbitrariness, indifference and obsessive concern are all present within the vast structure of bureaucratic power.

## **5.9 CONCLUSION**

Throughout this chapter, I have tried to critically analyse the bureaucratic mechanisms that are present when running a mental healthcare clinic in the Netherlands. I have shown that the bureaucracy leads to symbolic violence that causes real suffering. Next to that, I have also shown that the audit system, which is a technique that originated from the finance world, is focusing mainly on the performance of the clinic, rather than actually looking at the quality of care. Furthermore, the audits themselves induce fear, panic and even conflict. Despite the fact that the clinic was in disarray on many different levels, the clinic did not fail the audits and maintained its status as a clinic that provides quality care. Finally, I have also highlighted that bureaucracy is essentially intolerant towards minorities. Throughout this chapter I have argued that the audit system was not accurately assessing how well the clinic was performing and that the bureaucratic system is not as rational as it pretends to be. This thesis has focused primarily on the cultural aspects of the organisation, and explored the ways in which bureaucracy contributes to the culture of the clinic. The clinic voluntarily signed up to get a quality certificate, as it was trying to build up a good name. The HKZ handbook played a big role in how the clinic organised itself. Although they eventually failed in their attempt to appease the big insurance companies, they did their best to manipulate the rules, and change them where necessary.

# CHAPTER 6 Conclusion — Healthcare, Quality and the Need for Culture

## 6.1 INTRODUCTION

In this thesis, I have described how a transcultural mental healthcare clinic in the Netherlands weathered the storm and managed to sail through the bureaucratic challenges that come with the legal requirements of running a clinic. I have tried to explain how the processes of quality management were interpreted by various stakeholders, and used by the clinic's management team to be able to show to insurers and the state that they were providing quality care. I have explained this from the perspective of rhetoric culture, and tried to show that events, rhetoric and culture influenced each other on different levels. I have also shown how the change in the organisational culture of the clinic was affected by conflicts, division, and other events that had a negative impact, in one word called vicissitudes, whereby the clinic had difficulty to meet its expectations. By looking at the cultural components of the organisation I have shown that both rhetorical and non-rhetorical influences affected the culture of the clinic, whereby particularly intentions and actions of actors are closely linked. I have critically looked at and evaluated different cultural theories, with particular focus on the culture of the organisation. I argue that existing cultural theories, although insightful, tend to over-stress conformity and underplay factionalism, while rhetoric culture is looking at both the said and the unsaid. This has allowed me to take conflict, discord and politics into consideration.

Building on other existing theories, including Goffman's frontstage/backstage theory (1990), Foucault's panoptic theory (1991) and Bourdieu's theory of symbolic violence (1991), I have incorporated rhetorical culture theories, with the aim of providing a new angle that will help explain how organisations shape and are shaped by internal and external cultural forces. In organisational studies, anthropologists such as Geertz and Douglas have had a prominent influence, but their theories have not been applied, as I argue, in a useful and representative manner, to the field of organisational studies. Organisational anthropology has been more thoughtful and reflective in its approach and has shown the complexities that exist for instance when looking at the difference between policy change and cultural change (c.f. Bartlett 2015). Through the use of rhetorical culture theories I have thus attempted to show how conflict, (symbolic) power and rhetoric act and react to each other, shaping an organisational culture that is based on some form of shared ideas and experiences and also a culture that is contentious, challenged and changing. According to Carrithers (2009), 'expectation is in part a matter of conscious thought, but also of implicit assumption, being built in the collective acquired sensibilities' (Carrithers 2009: location 179). Drawing on material in the quality handbook and by analysing some of its processes, I have explained what is expected of the clinic and the discrepancy between these expectations and the reality of how the clinic was really run. Yet despite these discrepancies, the clinic managed to obtain the quality certificate, suggesting that it did fulfil some of its expectations.

This conundrum shows the complexities of the clinic and the world it operated in. The networks of the clinic were both enduring and whimsical, meaning that good relationships could turn sour overnight, creating massive arguments, conflicts and even violence. These conflicts were counterproductive, resulting in stress and causing unrest among staff. This unrest was exacerbated whenever the clinic was under scrutiny from the state. However, while being exposed to the whimsical nature of the clinic's board, I have shown that some of the staff members were resisting, whilst feeling excluded and powerless. Particularly the therapists, who were under pressure to perform well during audits, be productive and most of all, not be critical, were focusing on what they thought was most important: to provide treatment to patients. Through the politics of managing this mental healthcare clinic it is easy to forget about the patients and their problems. Although I have not given particular attention to the patients of the clinic, for reasons I have explained, I have shown how this clinic, following van der Geest et al (2008), served as an important part of the Turkish and Iranian community, through the networks of Monica, Rob and Herman. The organisation partly depended on the cooperation of some of their (ex) patients for various (and sometimes unclear) reasons — for instance, when ex-patients were listed as part of the board. In this conclusion, I will explain what the events described in this thesis can tell us about some of the obstacles in the mental healthcare sector in the Netherlands.

What remains in this conclusion is to consider the issues that were central in this thesis and reflect on them. I will first expand a bit on what happened after I left the clinic after finishing my fieldwork in 2013 and then pause briefly at the rhetorical culture of the clinic. I will then talk about the quality system in practice, building on the chapters about the complaints procedure and other sections throughout the thesis. In the next segment my focus will go towards the politics of relatedness and its influence on the organisation of the clinic, before discussing the neoliberal framework of the healthcare system in the Netherlands, and the implications of bureaucracy and audit culture on the clinic.

## **6.2 THE DEMISE OF THE CLINIC**

This thesis has also shown the ways in which a number of people working at a mental healthcare clinic in the Netherlands tried to face the challenges of running a clinic. I have tried to evoke images of the daily running of the clinic, how people worked and interacted with each other in Chapters 3 and 4, with the state and the powerful insurance companies in Chapter 5. I did this from the perspective of a researcher who was at the same time working as a quality coordinator, with responsibilities towards ensuring that the clinic obtained and retained the quality certificate. By looking at some of the problems the clinic faced, for instance the scrutiny of the inspectors, but also how the clinic dealt with unhappy patients, I have explained some of the different ingredients that makes the culture of the clinic, and how agents were negotiating and reinterpreting the rules as they were recorded in the quality handbook. Furthermore, I also described how various events have shaped a culture of fear, while at the same time the culture had an influence on some of the events. I started the thesis by explaining about the different views on culture and the various

intellectual traditions that have theorised about culture in general, and narrowed this debate down to a relatively new concept, rhetorical culture, as proposed by Tyler and Strecker (2009) and Carrithers (2009), which I used as my main theoretical framework. Although I have used other theories as well, I have made it clear that it is not helpful to talk about a Dutch-Turkish-Iranian clinic, as culture cannot be bound to a specific geographical area. While the link between culture and language has been used before, what is different about rhetorical culture is the focus on the unsaid, the actions that speak.

The transcultural clinic where most of the research took place went bankrupt about two years after I finished my fieldwork, due to decreased revenues as a result of conflicts with some insurance companies. Some of the staff members I remained in contact with were shocked when it went bankrupt, and a number of colleagues tried to hold Monica personally responsible for its bankruptcy. The legal structure from GGZ Connections was *Stichting* (Foundation), which means that (normally) board members cannot be held personally accountable, *unless* it can be shown that they were negligent in their work. After the clinic was declared bankrupt, the curator who was in charge of filing the bankruptcy contacted some former staff members to testify against Monica. According to the curator, there were clear signs that the administration was not in order, that GP referral letters were missing or not signed and that patient files were not in order, which is one reason why the insurance companies would not to pay out any declarations. Although a few of the staff were eager to testify, I learned later that eventually Monica was not held accountable, and according to Herman, whom I spoke to after the clinic went bankrupt, she did agree to pay back €2 million to the authorities. Despite restrictions imposed by the inspection, Herman was still seeing patients, but not in any formal position or at any fixed location. He was hiring offices for a day in different places and was struggling on a personal and professional level. Other staff members moved on to other jobs. Those with whom I kept in regular contact all expressed a sense of relief that they are now working elsewhere.

There were a number of reasons that contributed to the demise of GGZ Connections. As I have shown throughout the thesis, the clinic was struggling on many fronts — financially and administratively, but also on a personal level, there were many conflicts, and I have shown how the clinic sought to solve these problems, which sometimes brought even more challenges. Despite these many problems, the clinic was still able to successfully obtain (and retain) the quality certificate HKZ. I have also described how Monica, as chair of the board of directors, became more and more suspicious of people, leading her to isolate herself and surround herself with the few people whom she trusted (or at least seemed to trust more than others). What I found striking about the clinic, and this was a feeling shared by others working at the clinic, was that any given day, anything could happen. This made working at GGZ Connections very difficult and challenging, as one did not know what to expect next. Although I have only described a number of events in detail, there were many more things happening, which made the clinic an unsettling place. At some point I felt anxious just driving to work, and relieved if I finished the day without anything serious happening. This anxiety came from confrontations with Monica (and later Gerard), but also from

meetings with inspectors or auditors. The culture of the clinic was not inspiring people to take the lead, or to make them feel proud of where they worked, as some of the organisational studies publications were suggesting. Instead, the culture of the clinic changed over the course of one year from a place where there were informal relationships between staff and patients, reciprocal gifts in the form of sharing food, to a place that was essentially divided in two (albeit rather indistinct) groups.

### **6.3 RHETORIC AND CULTURE AT THE CLINIC**

Following Carrithers (2009), rhetoric culture can be used to see how people use rhetoric and culture to react to events that they do not expect to happen. Creativity plays a large part of this and we have seen that Monica was very creative in dealing with people that were making her life hard. She was making full use of her power and influence as a board member and her strong character became even stronger over time when dealing with dissidence and adversity. It also meant that she was increasingly more absent from the clinic and she let other people manage the clinic for her, people that were close to her, while she kept others in the dark about new developments. This lack of transparency stands opposed to the notion that transparency is one of the key ambitions stipulated as important within the quality handbook. Instead, as can be seen in chapter 3 on the complaints procedure, transparency is actually seen by the board as a liability and a risk. Yet at the same time, people like Gerard insist that their goal is to be transparent, which can only be interpreted as a way to deceive the audience, in this case, the auditors. The words they utter are enough for the auditors to provide the quality certificate, even though their actions, 'culture's rhetorical edge' as Carrithers (2009: 218) puts it, or 'the unsaid behind the said' as Tyler and Strecker (2009: 659) put it, speak otherwise. With Tyler and Strecker's (ibid) statement in mind, I have shown how gossip contributed to the production of culture, as gossip was sometimes intentionally used to create a sphere of cohesion, for instance against the patient Donna. Monica was projecting negative stereotypes about Donna's mental illness (personality disorder), with the aim of uniting staff against the patient and to support Herman, the psychiatrist.

Monica was very hands-on in her management style and her language was often confrontational if someone did not meet up to her expectations. In terms of rhetoric culture, Monica's rhetoric was not just aimed at inducing action from people, it was aimed at *forcing* people into action, thereby instilling anxiety that at any time she could use her rhetoric force to move people into action. Her words were creating a culture that would not allow any critique and that could sanction people by not paying their wages on time, threatening to hire a private detective to find out any wrongdoing, or forcing people out of the clinic, whether patient or staff, at any cost. This approach led to the production of a culture where initiative and responsibility were largely absent, because people were in a way frozen by fear for standing up and asserting their worries. Instead, it led to a culture where people were trying to be invisible, avoid attracting attention and standing up for themselves. Of course, as I explained, this did not happen from the beginning and I have tried to show how over time the culture of the clinic transformed towards this more autocratic regime. I have explained how a number of events have contributed towards this change of culture. Some of the



events were the result of internal conflict, which made Monica more distrustful towards people, while other conflicts were the result of exterior problems, for instance with the inspectors and insurance companies.

#### **6.4 THE QUALITY SYSTEM IN PRACTICE**

In Chapter 3 I have shown a practical example of how the Quality System works in practice, by critically looking at the complaints procedure. Through the example about the patient Donna, I have shown that patient rights, which were an important tenet of the quality handbook, could be completely ignored. At the same time, the psychiatrist could never be certain about his own position either, as the case of Roger shows, and although he won a legal challenge, the clinic's main objective was to get rid of a critic, which succeeded. Through these two examples I portrayed the weaknesses of the system, as the rules could be interpreted, utilised and abused towards the interests of the clinic. A fundamental question about the use of the quality handbook is what the principal purpose of the quality handbook is. I have shown that the clinic saw the handbook as a utensil for the purposes of running the clinic. This is probably best highlighted by the discussion I had with Kees, the intern, in Chapter 5, when we were talking about the purpose of the HKZ book. According to Kees the quality handbook, should be built up around the clinic and if necessary, be adjusted if there were parts that did not serve the needs and interests of the clinic.

Also in other chapters, the point of view of the clinic towards the HKZ quality system came forward as something that should be used towards their own ends, for instance, on how the organisation of the clinic is set up. Although they were following the structure as indicated in the handbook, as I mentioned in Chapter 5, some of the places in the hierarchical structure were either filled by people that were related to them, or by people that were not going to assert any authority over Monica, for instance ex-patients. At the same time however, during the audit, this viewpoint was not asserted towards the auditor, suggesting that they were aware that they auditors, or inspectors, would have a different point of view on this matter.

The struggles of the clinic were part of the daily reality and any crisis could be a prelude to the next. Herman disclosed to me on numerous occasions that he was in "survival mode", meaning that he was doing whatever it took to save his career as a psychiatrist. This also meant that he was taking legal shortcuts, for instance by making use of some of his (ex) patients, by making them board members on paper while the clinic was run by someone else. As I show in Chapter 5, Theresa, one of Herman's former patients, was asked for instance to be a part of the board, but was never in control of the clinic. As such, Herman was misusing his position as a doctor, something that might get his registration suspended, and which made his position probably worse. His survival as a psychiatrist was also the main condition for the survival of the clinic, although the clinic had to hire other psychiatrists to be able to claim their declarations with the insurance companies. Even if Herman was suspended after the debacle with Donna, he went back to work the next day. This shows that Herman and the clinic were in fact synonymous, as it is hard to imagine that a psychiatrist or any staff member would be allowed to stay on after the events that I

described. What was linking Monica with Herman was their romantic relationship. Despite the many arguments between them, their loyalty towards each other was very strong, which is why I argued that they were the nuclear family around which the whole business was built on. Furthermore, I have described a few more kin-like relations, between Herman and Marloes, and Monica and Rob, both of whom were involved in some of the more ambiguous parts of the organisation. Marloes had been a board member on paper, while actually doing secretarial work. Meanwhile Rob was actively recruiting patients and later became board member of the new clinic.

Monica's worries that people might have a negative view on migrants is partly justified, as there is disparity between people from the migrant population of Holland and "native" Dutch people in terms of economic, educational and professional perspectives. Most people working at the clinic were well aware of these disparities and a number of them had experienced some form of discrimination, for instance when it came to educational aspirations, some of them found some extra barriers before they moved onto higher education. This form of symbolic violence, as Bourdieu (1977) puts it, has real consequences for migrants and is one of the reasons why this transcultural clinic was set up. Although research is inconclusive about whether or not an ethnically matched therapist is favourable and better for patients (c.f. Knipscheer and Kleber 2004a; Knipscheer and Kleber 2004b), many people working for GGZ Connections seemed to enjoy working with people from their own or other migrant communities.

## **6.5 THE POLITICS OF RELATEDNESS**

In this thesis I have also highlighted the politics that form a large part of managing a clinic. I have shown a number of collusions, for instance to dispose of a "difficult" psychiatrist, or how networks were formed within the clinic. The politics involved techniques to manipulate others for a particular goal, either more power, to win an argument, or sometimes just to hide specific information, so-called 'destructive information' (Goffman 1990 [1959]: 141), for instance about who was officially a board member. At the same time, there were many staff members who were focusing on the therapeutic aspects of the clinic and doing their best to treat patients.

The clinic was operating at different levels in that sense and, although this divide may not have been intentional, knowing people in key positions at the clinic could determine where one would stand in the organisation. However, it should be kept in mind that migrants in the Netherlands are often in disadvantaged positions themselves when applying for jobs. Studies about the level of ethnic discrimination in the Netherlands have suggested that migrants in the Netherlands have a disadvantage when it comes to professional development and social mobility (c.f. Zschirnt and Ruedin 2016). As Castilla, Lan and Rissing (2013) argue, networks are important resources for employment possibilities. Therefore it should not be too surprising that for people with a migrant background, it is easier to find positions within the migrant communities. GGZ Connections acknowledged the strengths of working with migrants (particularly language skills) and was actively hiring staff with a migrant background. While the clinic did provide opportunities for migrant professionals to gain important experience, as the organisation of the clinic was so divided, it was

simultaneously limiting them, depending on how close they were with Monica (or Herman). Relatedness was an important part of the identity of GGZ Connections, as it was through networking and (fictive) kin relations that people found jobs. By looking at the characteristics of two sets of key relationships on which the clinic was built, I have argued that Monica and Rob, as well Herman and Marloes were related and that this had its effect on the culture of the clinic.

The culture of GGZ Connections resulted in some advantage for those staff members who were close to Monica and Herman. Some people, like Gerard and Kees were not only offered key positions in the organisation of the clinic, they were also paid excessively for their positions, while most therapists and other supporting staff, such as the secretaries, were paid according to CAO, the collective labour agreements. This asymmetry was the result of the way Monica managed the clinic and led to a division in roughly two groups at the clinic, although the lines were not always clearly visible. The practices of the inner group, people close to Monica and Herman, were not known among the rest of staff, and normally this division would not be clear among staff, except in times of disagreement, conflict or when there was a lot of pressure on the clinic. Then the division became more visible in the form of the different perspectives that each group had. Although towards the outside, at difficult times, the clinic seemed to perform as one unified group, as Goffman's frontstage/backstage theory (1990 [1959]) suggests, at the same time there were a lot of disagreements between people. These disagreements were the result of how much information each group had about some of the problems. Often sensitive information was withheld from people in the outside circle by people from the inside group, which increased the distance, as people in the outside circle felt excluded, distrusted and not taken serious.

## **6.6 THE NEOLIBERAL FRAMEWORK IN PRACTICE**

The migrant patient group was also the target group for the clinic as a business and both Herman and Rob were drawing on their networks to get as many patients as possible. Rather than seeing the clinic as a place to heal patients, the clinic was seen as a place for commercial activities, that is selling treatments. Both Herman and Rob were successful as business men, on the premise that they were approaching patients as potential customers and advertising the advantages of specific treatments, which would usually take place abroad, either in Turkey or Spain, both well-known holiday destinations. In the neoliberal spirit, healthcare is seen as nothing more than a commodity to be sold or bartered and I have shown how neoliberalism has influenced the Dutch healthcare system.

Caglar (1997) for instance argued that commodities have a cultural value, which allows us to look at how these commodities have influenced culture. From her point of view, healthcare can be seen as a commodity that is negotiated within a certain cultural context. Apart from a huge need for mental healthcare, this can now also be seen as an opportunity to make a profit. As every Dutch resident has health insurance, there is a possibility to utilise the insurance towards fraudulent behaviour, something that the clinic was accused of and the reason for their trouble. In this thesis I have also described the powerful position healthcare insurers are in, and the process of how a

clinic might get a contract. These contracts are often limiting the healthcare professionals and the treatments they can provide for their clients and are a subject of resentment among the healthcare community.

On another level, productive engagement with patients had become more and more important. Clinics make money by providing treatments to their clients, and they can make more money if they spend more time with patients. However, one problem is that the clinic could only send the declaration of these treatments after the treatment was finished, which could take up to one year. This meant that the clinic had to pay the costs of treatment (personnel, software, rent, etc.) upfront and it was hoping to get these costs back afterwards. However, I explained that GGZ Connections found a way around this. The clinic was trying to provide very short, but intensive treatments, that could be closed off quickly, after which the clinic could send its declaration soon afterwards. The neoliberal framework in which care is provided has changed the healthcare system into a system where profit is allowed. Although GGZ Connections was a non-profit foundation, there was an incentive to provide more care in order to receive more money. Although technically this profit was only intended for the foundation, and was expected to be invested to improve the quality of care, the clinic was working on ways to maximise profits and to ensure that a select group of people in Monica's network would take advantage of this. As noted above, kin relations were an important part of the organisation of the clinic, in which (fictive) kin were assigned to important roles.

This resulted in an implicit division between staff members, whereby one group consisted mostly of therapists, while another group consisted of people who mostly had managerial or admin positions. Although the division was usually not visible, it became more pronounced in times of conflict, whereby people in the peripheral group usually were not involved in the politics of the conflict and would mostly receive information through the gossip channels. To maximise profits, managers were pushing staff to increase production and high intensive therapies were introduced to increase the cash flow of the clinic. One of the ways in which they sought to maximise production was to ensure that staff were productive and efficient. To prove they were working hard, most therapists had to fill in a form, whereby attention was paid to contact points and time spent with patients on a form, which was then checked by me or Gerard. Ironically, filling in the form also cost valuable time, sometimes 30 minutes per day, but the point was that people felt the pressure to work hard and document everything. People really felt Monica's power and authority as a board member by this kind of micro-management, which is a kind of rhetorical edge, as Carrithers (2009) would put it, and has the same value and intent as words.

To be able to put things into context, I have also described the political situation and the debates and rhetoric about migration in the Netherlands, particularly towards Muslims, in which right wing politicians often make statements that are divisive, lack nuance and are totally bereft of context. These debates critiquing the integration and assimilation policies have led to further alienation of the migrant population. The shared experiences of discrimination had an added benefit, as it was

easier for the therapists to empathise with their patients. But such experience had also led to an increased stigma around having a different ethnic identity. When it came to the fraud allegations, this stigma was accentuated more in the media. Fraud was a wider problem in healthcare in the Netherlands, but the level of coverage of non-migrant clinics and hospitals was less than the level of coverage of some migrant clinics. Migrant clinics seemed to receive more scrutiny, which increased the level of pressure of the clinic to come across as a quality clinic, towards the public, but also towards the insurance companies and the state. This pressure was one of the main reasons for GGZ Connections to obtain a HKZ Quality certificate.

## **6.7 BUREAUCRACY AND AUDIT CULTURE**

One of the most used techniques to “measure” the quality of the clinic was the audit, a technique that originated in the economic and accounting sector. Although the audit was adapted for the purposes to measure quality of care, I conclude that audits do in fact not contribute to quality of care itself. The main problem of an audit is that it is more concerned with how the clinic performs, and whether the appropriate language is used. But the audit does not really check whether this is backed up by any evidence. The ethnography I carried out at the clinic suggests that the clinic should not have received the quality certificate by its own standards. As such, I argue that the audit lacks the depth and insight to be able to give a fair representation of the quality of care. Instead of providing insight into how the clinic operates, the audit is in fact the cause of what Bourdieu calls ‘symbolic violence’ (Bourdieu 1977), leading to stress, panic and anxiety among staff. As I have shown, this symbolic violence by means of the audit was experienced as real violence by staff. People became genuinely nervous and even panicked when being confronted by an unannounced visit by inspectors. Another issue I showed was that the audit is a technique that is comparable to Bentham’s Panopticon, as described by Foucault (1991). The audit as panoptic technique is a way for the state and insurance companies, as proxy for the state, to ensure self-regulation by internalising the gaze of the state. Particularly the internal audit is meant as a tool to ensure that clinics are critically evaluating themselves, without state intervention, as the HKZ scheme is considered to be “voluntary”.

The pressure I described to sign up for the HKZ scheme is a factor that is often not identified. Without this quality statute, insurers have the right to deny payments. In order to obtain the quality certificate, the clinic had to go through a series of internal and external audits. As a preparation for these audits, the clinic was advised by consultants, in which they provided assistance with writing the HKZ quality handbook, the legal aspects of quality control and how to prepare for “the real thing”. For GGZ Connections, this service was invaluable, as they were able to obtain and retain the HKZ certificate without problems. Neither the auditor nor the consultants were able to see that the organisation of the clinic was problematic, not transparent and that the culture of the clinic was based on fear rather than professionalism.

## **6.8 FINAL REMARKS**

All in all, I have aimed to show the complexities of this particular clinic, with the intention of looking critically at the system in which this clinic operated, how it was open to abuse and fraud, and also the ways in which my informants were facing the challenges. As I have argued, organisational studies could benefit from engaging with theories of rhetorical culture, and rather than focus on changing policies to influence behaviour, it should consider the words, intentions and actions that are the building blocks of the culture of a clinic. My aim was to show the weaknesses of the quality system, the power and influence of insurers and the state, and how culture influenced and was influenced by events, actions and words. At GGZ Connections, the environment to create and maintain a competent, well-functioning quality system was undermined by its culture. This was exacerbated by external forces, such as the insurers' suspicion and the inspectors' interventions, but also by the sometimes excessive reactions of Monica to particular situations.

Although anthropologists are generally not judgmental about what is a "good" or a "bad" culture (with a few exceptions), it seems preferable to create a culture where strong social relations, accountability and responsibility towards the patients and fellow colleagues, structure and transparency are inherent in the organisation. Although I am not pleading for audits to be abolished, I am arguing that for audits to be more effective as measurement for the quality of care, it needs to be drastically reviewed and adjusted. It requires more in-depth analysis for an auditor to get an accurate picture of whether a clinic is running the way it says it does. The best way to achieve this is by combining an audit with ethnographic elements to get a more in depth idea about the culture of the clinic. Furthermore, it would be advantageous to decrease the power disparity between insurers, the state and healthcare providers and to allow healthcare professionals and their patients to determine which treatment would best suit for any particular illness or problem. The neoliberal framework in which the healthcare system operates perhaps works to the advantage of minority groups, as it is left to the entrepreneurs to provide healthcare that meets their specific needs, but the system is open to abuse. More research is needed to look at how other clinics operate in a neoliberal setting. Healthcare can certainly benefit from a culture that promotes transparency, responsibility and efficiency, but there need to be adequate conditions, where different stakeholders have equal influence. Furthermore, the state should be working together with entrepreneurs in the healthcare sector and insurance companies, rather than taking a distance, to ensure cooperation between different stakeholders and to create a fairer system.

# Appendix 1

## LIST OF INFORMANTS

Monica	—	Member of the board of directors
Herman	—	Psychiatrist
Rob	—	Communications advisor
Maria	—	Psychologist
Sophie	—	Social worker
Joke	—	SPH <sup>45</sup> (Social Pedagogue)
Agatha	—	SPH
Marijke	—	Secretary
Alain	—	Herman's ex-patient, Marijke's husband, was temporary board member
Wendy	—	Child psychologist
Kees	—	Intern, administrator
Gerard	—	General director
Robin	—	HR manager
Roger	—	Psychiatrist
Cornelis	—	Psychiatrist
Sanne	—	Social worker
Marloes	—	Secretary, was also board member
Leontien	—	Psychologist
Floortje	—	Intern, psychologist
Willeke	—	Psychologist
Thea	—	Friend of Monica, was helping out with administration at times
Louis	—	IT Specialist
Theresa	—	Patient of Herman and temporary board member
Carolien	—	Medical Secretary
Remco	—	Administrator, brother of Robin
Michel	—	Husband of Thea, worked as driver for a while
Gerben	—	Intern SPH, brother of Gerard
Ineke	—	Community worker
Heleen	—	Secretary
Lydie	—	Secretary
Liesbeth	—	Secretary
Elsemieke	—	Intern, psychologist
Kasper	—	Intern, administration
Dineke	—	Psychologist

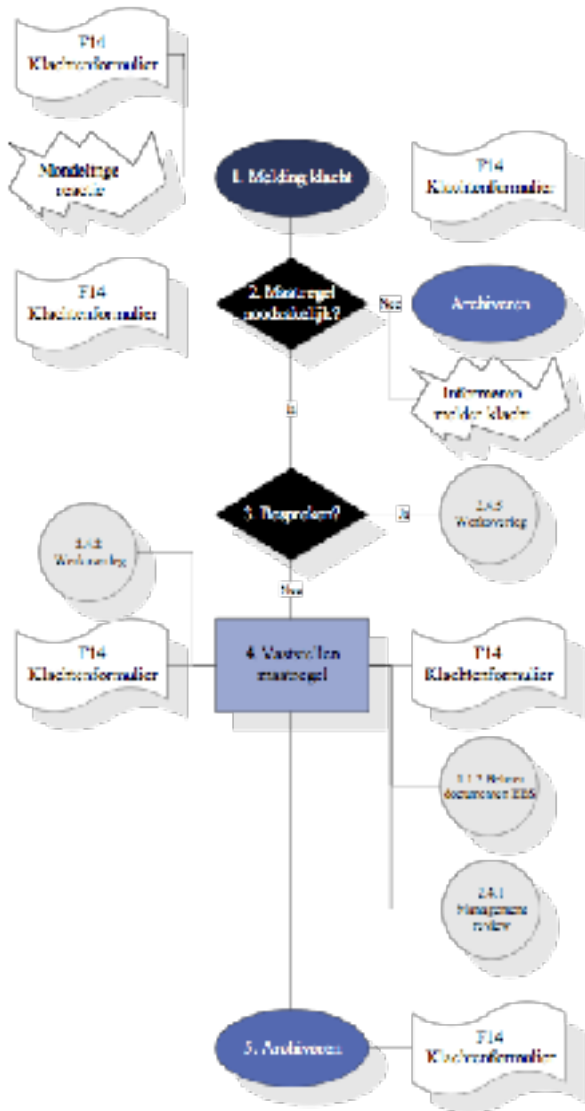
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<sup>45</sup> A kind of Social Worker

Willeke	—	SPH
Sarah	—	Psychologist
Emiel	—	Manager, father of Gerard
Noor	—	Psychologist
Vera	—	Psychiatrist
Iris	—	Legal advisor
Hanna	—	Legal advisor
Donna	—	Patient of Herman
Barend	—	Ex-husband of Monica
Gilbert	—	Auditor
Emma	—	Psychiatrist



## APPENDIX 2



### 1. Medewerk(st)er

- Ontvangt een mondelinge of schriftelijke klacht van een cliënt, medewerk(st)er of andere betrokken personen of partijen.
- Hoort de klacht aan en neemt indien mogelijk en noodzakelijk direct maatregelen.
- Legt de melding vast op F14 klachtenformulier en verstrekt deze aan de klachtenfunctionaris. Geeft de eventuele direct genomen maatregelen aan op het formulier.
- Informeert bij dringende zaken direct de klachtenfunctionaris over de klacht.

### 2. Klachtenfunctionaris

- Beoordeelt of de procedure goed gevolgd is. Mocht dit niet het geval zijn dan wordt de klacht teruggelegd.
- Draagt er zorg voor dat de klager een schriftelijke bevestiging ontvangt van de ingediende klacht.
- Beoordeelt de aanleiding inhoudelijk, hoort hierbij binnen 2 dagen alle betrokkenen.
- Binnen 4 weken wordt vastgesteld of er maatregelen getroffen moeten worden en legt dit vast op het formulier.
- Betrokkenen worden uiterlijk het einde van de 4 weken op de hoogte gesteld van de beslissing. Zowel als er wel als dat er geen maatregelen worden genomen naar aanleiding van de klacht
- Wanneer geen maatregelen noodzakelijk zijn, wordt de klacht gearhiveerd en worden de betrokkenen op de hoogte gesteld van deze beslissing.

### 3. Klachtenfunctionaris

- Stelt vast of de melding besproken moet worden in het werkoverleg

### 4. Klachtenfunctionaris

- Stelt, eventueel op basis van het gehouden overleg, vast welke maatregelen genomen moeten worden.
- Draagt er zorg voor dat de maatregelen worden uitgevoerd. De genomen maatregelen worden jaarlijks geëvalueerd in de Management review.
- Stelt vast of het doorvoeren van wijzigingen in het bedrijfsbeheerssysteem noodzakelijk is.
- Brengt de betrokkenen binnen 4 weken op de hoogte van de afhandeling van de melding.
- Werkt het klachtenformulier bij.

### 5. Raad van Bestuur

- Archiveert het klachtenformulier.

Indien de indiener niet tevreden is over de klachtenafhandeling, kan deze contact opnemen met de onafhankelijke klachtencommissie van GGZ Connections (zie procedure 1.1.4 Corrigerende en preventieve maatregelen). Klachten m.b.t. tot de Raad van Bestuur worden afgehandeld door de Raad van Toezicht.

## Translation of the complaints procedure<sup>46</sup>

### 1. *Employee*

- Receives verbal or written complaint from client, co-worker or any other stakeholder
- Listens to the complaint and, if possible and necessary, takes immediate steps
- Records the statement on F14 complaints form and hands it over to the complaints officer. Indicates which steps have been taken on the form
- Informs, in case of urgent matters, the complaints officer immediately

### 2. *Complaints Officer*

- Assesses whether the proper procedure has been followed. If this is not the case, the complaints will be referred back
- Ensures that the complainant receives a written confirmation of the complaint filed
- Assesses the substance of the complaint and hears out all parties involved within 2 days
- Determines within 4 weeks whether any measures need to be taken and records this on the form
- Involved parties will be informed at the end of 4 weeks at the latest about the decision. Both in case of any measure taken or not as a result of the complaint
- If no measures have been taken, the complaints officer files the complaint and informs the involved parties of the decision

### 3. *Complaints Officer*

- Determines whether the announcement needs to be discussed in the weekly staff meeting

### 4. *Complaints Officer*

- Determines whether, on the basis of the results of the staff meeting, any measures need to be taken
- Ensures that the measures taken are executed. Any taken measures are to be evaluated in the yearly Management Review
- Determines if it necessary to make changes in the business management system
- Informs involved parties within 4 weeks of the conclusion of the announcement
- Adjusts the complaints form

### 5. *Board of Directors*

- Files the complaint form

If the complainant is not satisfied with the handling of the claim, he can contact the independent complaints commission of the clinic (see procedure 1.1.4 Correcting and preventive measures). Complaints about the Board of Directors will be dealt with by the Supervisory Board

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<sup>46</sup> Translation entirely my own

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