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Reich, A. **Selling our Souls: The Commodification of US Hospital Care** 2014 Princeton University Press 248 pp £32.95 (Hardback)

Every page of Adam Reich's *Selling our Souls: The Commodification of US Hospital Care* is a testimony to the author's craft, his ethnographic skill, his talent for weaving the necessarily messy interview and ethnographic data into a coherent narrative, his disarming ability to simplify the description without dumbing down the analysis. How does one write so effortlessly, with so much clarity, about such a complicated topic – I just don't know. How does one construct a sophisticated and balanced account that melds economic and moral considerations without shortchanging either – I find it impressive.

Selling our Souls is about how people experience and negotiate the practical contradiction between morality and economy in their everyday lives. More specifically, the study centres on the distinctive ways in which three hospital organizations – all located in a large city on the West Coast of the United States, Las Lomas – have sought to reconcile the need to make money and the mission to provide care. The public hospital, labelled here PubliCare, brings us back to nineteenth-century charity organizations, and the framing of medical care as a social right that should be accessible to the poor. As an organization, PubliCare is no longer 'public' in any sort of recognizable way (it was leased to a private, not-for-profit group in the 1990s), but it continues to retain the spirit of the almshouse for the local constituencies that it serves and that serve it, as well as the inefficiencies that were the mark of its older, under-resourced self (and which prompted its privatization by the county). The next hospital, which Reich calls HolyCare, bears the mark of its institutional roots in a mid-century Catholic voluntarism aimed at a wealthier clientele. The nuns no longer walk its corridors but the place is suffused with a highly codified discourse about emotion and vocation, which doctors and staff now brazenly deploy as a marketing tool. Finally, the most recent organization, called GroupCare, represents healthcare for the working masses. Unlike HolyCare, it is soulless. Unlike PubliCare, it is efficient – ruthlessly so, in fact. The threats there revolve around the standardization of care and the invisibility of individual patients. To counter these effects, the organization encourages its members to be actively engaged in the management of their own health.

Each hospital struggles with its own contradictions, with the ghosts from its better past and, in the case of GroupCare, the ever-present spectre of a fully disenchanting future. Hampered by its historical social mission and by its practical disorganization, PubliCare lives in a permanent struggle to make money. But it knows where its heart is. HolyCare does not, or not anymore. HolyCare struggles, instead, to be what it claims to be: its compassion, in fact, feels more artificial than real, and it owes its appeal more to its luxurious accommodations and unneeded procedures than to its superior ethics. Finally, everything in GroupCare's mode of operation pushes it toward standardizing and rationing care – at the expense, perhaps, of individual needs and doctors' discretion, and sometimes at the risk of under-treatment.

Selling our Souls is a brilliant machine that runs 200 smooth pages. The analytical design is mathematically precise, neat and orderly: three parts, one for each hospital, and three parallel chapters in each part: one chapter looks at the organization's history and understanding of its mission; the next one investigates the structure of work relations; and the final one explores the delivery of care and patient-staff relations. Comparison runs both across chapters and within them, so it is impossible to lose sight, when reading about one particular organization, of how different it is elsewhere. What is the purpose of this design, and what bigger story does it tell?

Selling Our Souls offers an eminently convincing demonstration of how organizations reliably structure people's labouring lives. Not simply their schedules, but also their feelings,

their relations to one another, and in some way their entire personalities. The overextended and multitasking nurses and doctors at PubliCare contrast with their counterparts at HolyCare, who wear their compassion on their sleeves, and with the matter-of-factness of the species-being of the GroupCare staff. But the organizations – and this is in my view an even more innovative point – also imperceptibly structure the *patients'* personalities. Not only does each hospital serve different kinds of patients (that is, patients who come from different social milieus and have different needs), it also *elicits* different qualities and demands in those patients as objects of medical intervention. Hence the patients at PubliCare are encouraged to be attuned to the necessity for mutual respect and understanding; those at HolyCare, to express their problems (even if they have none); those at GroupCare, to step up and take charge.

To be perfectly honest, this is in part me extrapolating from Reich's exhaustive fieldwork among hospital staff. Reich (who did not interview any patients) is more guarded. But – as limited as his evidence on this point is – it suggests some powerful theoretical implications. Even for the fleeting moment of their hospital stay, each institution structures and helps (re)-produce patients' personalities: the accepting poor, the responsible middle classes, the pampered and indulged upper classes. In other words, the class habitus, as Pierre Bourdieu would have it, is also acted on and acted out in a place as anonymous and functional as a hospital.

As will become clear below, my first inclination has been to reread Reich's book through a Bourdieusian lens, in a half-ludic, half-serious way. Doing so offers some interesting analytical mileage and perhaps helps draw out more forcefully (if a bit crudely) a complex and conflicted story. As we try to understand *why* the three organizations are so different, and *why* the people in them *feel* so different, a useful move, perhaps, is to step back and look at these three hospitals from the point of view of their respective structural positions in the broader hospital *field*. In other words, we must pay attention to the objective features that organize these subjective differences and produce 'the spontaneous orchestration of practices' and the 'homologies' that Reich observes between patients, place and staff (Bourdieu 2005: 73).

Economic capital is the first organizing principle of this field. As it turns out, material incentives – the public mandate and murkiness of financial accountability at PubliCare, the fee for service system at HolyCare, and the membership-based financial formula at GroupCare – loom large in Reich's story, even though he fights against that explanation all along. Economic pressures express themselves everywhere, but they do so with different intensities, and through different channels – different economic technologies. Along the volume of capital dimension, PubliCare stands opposite to HolyCare. At PubliCare, people make virtue out of necessity, they develop a taste for multitasking and making do with little (just like the working class often does: tending gardens, sharing services, etc.).

GroupCare shows a great medical goodwill, but it remains powerfully framed by economic constraint – so it embraces a disciplined culture of getting the best bang for the buck. And HolyCare cultivates a sense of distinction, the notion that it is unlike any other place, and that it retains the true spirit of medical ethics – the same way that Bourdieu's bourgeois claim to have an innate, effortless sense of art.

Like economic capital, authority and status is distributed differently across organizations. In other words, there are homologies of structure between the position of each organization in the field of hospitals and the relative positions of different constituencies vis-à-vis one another within hospitals. Social hierarchies and differences (between staff, doctors and patients) are most salient in the private hospital (where everything is done in the service of the patient), and flattest in the former public hospital, where the place 'feels like home' for patients and staff alike. Other types of capital could have been seen as structuring this space

further, and complicating the story, for instance the barely touched-upon involvement or proximity of each organization to medical research (a form of cultural capital).

At each institution, people moralize their activity in a way that is consonant with their own hospital's position in the field of hospitals (and with their own social position within that field). There is no real dilemma between making money and having a soul (Livne 2014): Everyone is selling more than a medical service. A moral ideal is always embedded within that service. This is the best demonstration, in fact, that economic institutions are always and everywhere moral projects, as Reich puts it in the introduction. Not because institutions explicitly demand compliance toward a particular ethics, but because different kinds of economic models and economic incentives structure what will be seen as valuable and good, which in turn helps shape the moral personalities and discourses that will carry out this good. GroupCare locates virtue in scarcity and the efficiency of population management, PubliCare in the service of the indigent, and HolyCare in the quality and wholesomeness of service, whatever that means. Reich often suggests that some of these ethics are more genuine than others, and he clearly feels more sympathy toward PubliCare's admirable struggle than toward HolyCare's hollow rhetoric, but what does authenticity mean in this context? Ultimately, the material shows how intensely felt these logics are, and how strongly people identify with them. They have become, for all practical purposes, deeply embodied 'systems of dispositions'. (Only those staff members who have experience across organizations, in fact, seem to be able to distance themselves from them.)

And so perhaps it is not so surprising that when push came to shove it is also my own 'system of dispositions' – or my *habitus*, powerfully structured by my own social trajectory – that silently guided my choice. I, like the author, ended up deciding in favour of GroupCare (or an equivalent) – the system that, in the end, seemed to be 'made for me'.

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Baiocchi, G. and Ganuza, E. **Popular Democracy: The Paradox of Participation** 2017 Stanford University Press 224 pp. \$24.95 (Paperback)

Participation is no longer an obscure topic discussed only by marginal radical left parties and grassroots social movements. As Gianpaolo Baiocchi and Ernesto Ganuza note in their excellent book, *Popular Democracy* (PD), participation has gone fully 'mainstream' with the World Bank spending \$85 billion to promote participation in the last decade, and Hillary Clinton declaring the current era the 'Participation Age'. This has sparked a major debate, one not limited to scholars. On the one side are those who celebrate participation, as a way to give voice to the voiceless, empower marginalized communities, and make governments more accountable, responsive and democratic. On the other are critics, who contend that participation has not only failed to generate more democracy, but worse, it is a sham that is hiding the increasingly unequal and undemocratic societies most people live in today.