Learning from failure: exploring the psychodynamics of work in a clinical simulation centre

We analyze an intervention in a UK teaching hospital designed to enable 'learning from failure', using concepts from the Dejourian school of the psychodynamics of work. Whilst much of the English-language literature about and by Dejours focuses on his theoretical elaboration of Freud's concepts of frustration and suffering in the context of contemporary conditions of work, this article attends to Dejours' method of action research in workplaces. Our purpose is to consider how speech about the failures of work might be considered a basis for democratic intervention, especially in the context of simulation-based learning for professional development in healthcare.

Psychodynamics of work; failure; clinical education; simulation; subjectivity; workplaces; education.

This paper is about our attempt to talk with clinicians about failure in clinical work. It draws on our research and practice in a UK teaching hospital's simulation centre, set up a few years ago – alongside many others across the UK - to enable clinicians learn from 'error' by identifying this under simulated conditions and then drawing the relevant lessons for subsequent application (CMO, 2008). This rationale for simulation – notably high-tech, 'immersive' simulation in which a clinical situation is simulated, such as a patient having a cardiac arrest – frames it as an 'ethical imperative' (Ziv et al. 2003): the lessons of inadequate care must be learned to protect future patients. However, in practice, this imperative has proved difficult to abide by.

Several studies have explored how and why. Rudolph *et al*. (2007, p.369), for example, reflect on their early teaching experiences with simulation, and state: 'we were saying that mistakes were discussable and a source of learning, yet we found that we tended to cover them up or shy away from discussing them'. They attribute this to the desire of 'avoiding negative emotions and defensiveness, preserving social face, and maintaining trust and psychological safety'. In their observational study, Dieckmann *et al.* (2012, p.641-2) identify similar desires, manifest in the 'energy [that] goes into creating, nurturing, and maintaining a positive atmosphere' to ensure that 'everyone enjoys the experience', a pedagogic strategy that is said to pre-empt the discussion of 'frustrations, doubts, and unpleasant emotions'; a strategy necessary, however, to secure positive participant feedback (crucial for winning competitive training contracts). Our own previous research (REFS) also suggests that, in observed practice across multiple simulation centres, failure is rarely named; when it is, conversational difficulties ensue, which

we interpret in terms of the dangers generated from the identification of failure for professional authority and identity.

Although some clinical simulation literature is now beginning to acknowledge the difficulties of straightforwardly 'learning from failure', the implications drawn relate primarily to the need to improve educators' approach (e.g. Rudolph *et al.*, 2007). The hope remains that educators should be able to identify failure without causing negative emotions; rationally, with no defensiveness, by identifying deficits in 'mental models' and 'cognitive frames'. Yet empirical studies on how clinicians and healthcare institutions learn from clinical error more widely, beyond simulation centres, emphasise the importance of acknowledging its subjective, subjectifying and affective dimensions (Iedema et al, 2009; Waring, 2009; Hollnagel, 2014). They suggest that a purely cognitive approach to defining failure neglects the way failure is implicated in a collective and also embodied experience of professional selfhood, which by necessity will be defended against perceived attacks. If failure is understood in this way, what are the implications for a simulation-based pedagogy for learning from failure?

To consider these, we draw in this paper on the body of research called the psychodynamics of work. Developed in France since the 1970s, it is associated in particular with the psychoanalyst, and current president of the Laplanche Institute, Christophe Dejours (published by Karnac, 2015). Dejours posits failure as central to the experience of work. Defensiveness in the face of failure is thus understood as constitutive of rationality at work, rather than its aberrant other. Dejours draws on psychoanalytic conceptualisations of frustration to theorize failure as that which compels the development of thought and bodily capacity. In other words, working as an ongoing, concrete practice is an encounter with the breakdown of activity, what Dejours terms the 'real' of work: anomalies, incidents, unpredicted and unpredictable events that frustrate

control, resist procedure, and thwart know-how. Working means finding ways round this resistance. This is what makes work subjectifying: "for the clinician, work is defined as what the subject must add to the orders so as to reach the object assigned to them, or alternatively, what they must add of themselves in order to deal with what does not function when they limit themselves to a scrupulous execution of orders" (Dejours, 2007, p.72). It is this subjectifying dimension to failure which makes its symbolization difficult: failure here is not on objective, quantifiable deficiency in expert practice which can be systematically monitored (as in clinical definitions of 'error'), but rather an endemic, painful experience of the limit of (self) control and capacity. The affective experience of this limit – termed 'suffering' - compels the development of capacity, or, alternatively, overwhelms and destroys this. Speech about failure is thus inevitably defensive, insofar as one's capacity, and by extension thereafter, one's being, are at stake.

Dejours (2016) presents his work as a form of action research, designed to generate accounts of psychopathologies in the workplace and methodological resources for addressing these; for learning from / through these. Yet although his books are gaining increasing recognition in English-language secondary literature, emphasis to date has been placed on the exploration of his concepts, rather than his method of intervention. Dejours' argument about democracy and work has attracted most analytic commentary. Deranty (2010, 2013), for example, explores Dejours' concepts of recognition, cooperation and emancipation as major developments in post-Hegelian thought, which point to the subjective significance of working, by contrast to more instrumental accounts of productive economic activity. Dashtipour (2014) and Dashtipour and Vidaillet (2017) situate Dejours within psychosocial and psychoanalytic theories of organizations, recruiting his concept of recognition to re-imagine what freedom could look like in the workplace, figuring this as a kind of collective endeavour to overcome

resistances, by contrast to accounts in organization studies which theorise work primarily as a matter of waged labour, and thus inherently exploitative. Tweedie and Holley (2016) position Dejours' ideas within a tradition of craft theories in the field of human relations which understand the work activity as enabling workers to develop capacities in the wake of frustration, rather than primarily a form of domination. They argue that such ideas have critical consequences for theories of management, in demanding recognition of the efforts mobilized to accomplish tasks and the vulnerabilities confronted in doing so. Petersen and Willig (2013) use Dejours' concept of suffering to critique the consequences of performance management in the neoliberal workplace and the need to re-enfranchise professionals in the evaluation of working conditions. This rich literature provides an in-depth account of Dejours' concepts, and situates them in relation to more familiar literature in English-language research, including Kleinian, Lacanian and 'critical' accounts of organizations. However, little attention has been paid to date to Dejours' method of intervention in workplaces. This means that the existing secondary literature has relatively little to say about the experience of failure in concrete work situations, and how Dejours' concepts can be deployed to analyse suffering, and the experience of failure, in practice.

We are using this paper, therefore, to do two related things: consider how Dejours' concept of failure sustained an intervention in a simulation centre; and how the intervention itself helps to understand Dejours' conceptual apparatus as a form of practice / analysis, as action research rather than theoretical account only. This work is experimental: it is an attempt to make sense of Dejours' concepts in relation to a specific situation. In the first instance, we will explore how we made sense of Dejours' ideas in our situation, and then present an analysis of one event. We conclude by reviewing the productivity of Dejours' research to address our situation, and its wider implications.

Making sense of the psychodynamics of work in a clinical simulation centre

Dejours (2016) states that his method has developed through interventions into situations in which working is felt to have become too risky and dangerous, and in which concrete difficulties are not adequately addressed because they are unknown: they cannot be thought (Dejours, 2008; Cru *et al*., 2012). Dejours' team is reported to intervene so as to make such difficulties describable, through efforts of elaboration oriented to developing opinions about the best way of arbitrating contradictions and settling problems. Interventions are reported to have taken place in the nuclear and chemical industry (Dejours, 2008, 2012), nursing homes (Molinier, 2006), telephone exchanges, abattoirs and social services (Cru *et al.*, 2012), and most recently, a regional development agency (Dejours, 2015a).

Yet accounts of the method of work are somewhat ambiguous. Usually described at the end of Dejours' books (e.g. Dejours and Gernet, 2016), it is not clear whether the reported method is a summary of what is/was done in a workplace, or a proposal derived subsequent to an intervention (e.g. Dejours, 2012). Principles and sequential steps are described, but rarely contextualized in relation to a specific investigation (e.g. Dejours 2015b). A recent book (Dejours, 2015a) goes into more detail about one intervention, but primarily with a view to illustrating the concepts defined at the outset, rather than to consider how researchers generated concepts and/as a practice. The relationship between the interventions and the conceptual or theoretical claims therefore remains obscure.

This is problematic because it means that concepts are difficult to grasp in terms of their empirical manifestation. For example, Dejours defines suffering in relation to Freud's account of what the subject experiences in discovering the limits of its mastery over matter, including

the body. But how this suffering manifests analytically, in speech about working, is not shown. Similarly, how recognition and cooperation manifest empirically, as productive responses to such suffering, remains unclear. Dejours (2012) states that he aims to contribute to a research community, including through the presentation of case studies, and *not* do proprietary organizational consultancy. Yet how other researchers are meant to work through his concepts analytically, in relation to a practice and casework, remains a little vague.

This vagueness can perhaps be understood in the light of Dejours' claim that his interventions are always experimental responses: they are an attempt to answer a situated, unique demand to make a situation intelligible (Dejours 2008; 2012; 2015a). We will therefore say a little more about the situation we were in, as we experienced it, and then how we interpreted Dejours' claims in the light of this.

The authors of this paper were brought together by the centre manager of the simulation centre at a large district general teaching hospital in east London, UK. She felt that her and her colleagues – clinicians working as clinical educators - were experiencing difficulties with the prescription, assigned to the centre, to ensure that clinical trainees learned from their mistakes, as performed in the simulation centre. The nature of these difficulties repeats those described above in reference to studies of simulation-based teaching: failure was difficult to talk about, and avoided as a topic of discussion. This raised questions, for the centre manager, about the value of simulation, and how to account for this.

Such questions and difficulties were openly acknowledged in the centre, and its educators sought some kind of solution. One option was to draw on the claims of an emerging field of ergonomics, called resilience engineering, which is increasingly influential in the clinical

management literature (Hollnagel, 2015; Hollnagel *et al.*, 2013). In our centre, educators attended courses on its principles, and its implications for teaching. These implications were in contrast to how the centre approached teaching at the time. Resilience engineering offered prospects of an alternative approach, insofar as Hollnagel argued there was usually little to be learned from failure. This is because resilience engineering understands failure as occasional and contingent: the result of exceptional circumstances. Rather than endeavouring to learn from failure – i.e. things going wrong – resilience engineering implies that practitioners should instead learn to understand better how 'acceptable outcomes' are achieved routinely (Hollnagel et al, 2013). In other words, rather than seeking to learn from an absence – the absence of safe work – clinicians should learn more about the conditions under which work is done well routinely.

The implications of resilience engineering for simulation are extensive, not least re-imagining its purpose beyond the identification and remedy of mental, 'human' deficits; as a school of thought, resilience engineering can be understood as a counter to the 'human factors' and 'human error' version of safety associated with cognitive psychology, predominant in healthcare and influential in arguments about the value of simulation. By making a case for focusing on how clinicians obtain 'acceptable outcomes' under varying conditions, rather than deviate from protocol, resilience engineering is suggestive of how simulation might be deployed to understand how clinicians negotiate incommensurable risks, rather than only increase risk by introducing factors posited as external to work (stress, fatigue, etc – i.e. the varying kinds of 'human factors').

However, the resilience engineering literature raises questions to which the centre educators, and ourselves as researchers based in the centre, found difficult to answer. First, how is the

difference between acceptable and unacceptable outcomes established, and maintained or not, notably in talk about work? How are differences of opinion, or contradictions across time, resolved? The literature seems to treat the difference between the acceptable and the unacceptable as given: transparent, stable and subject to consensus. This neglects the ways in which the meaning of work is subject to disagreement and contradiction – as was visible on the centre's courses, notably over what constituted a failure and a frustration. Second, how do clinicians adapt and invent solutions to risky situations, including living with 'unacceptable' outcomes'? How do they defend against the unacceptable to achieve the acceptable? These questions pertain to how clinicians identify the difference between the acceptable and unacceptable over time; how they make sense of their work on an ongoing basis. It was precisely these questions that clinical educators wrestled with in discussions with trainees. Yet the resilience engineering literature does not speak to this. Reflecting perhaps its intended audience, it is concerned with managers' needs to understand how work gets done, rather than how clinicians wrestle with the frustrations of practice.

It was in the light of this that we turned to the work of Dejours; Dejours' and Hollnagel's view of work also has many points of convergence. This is a consequence of Dejours' effort to combine ergonomics and psychoanalysis. So both writers start from the premise that there is a gap between the prescription of tasks – their symbolization and articulation, including in protocols – and the lived experience of 'real' work. It is within this gap that risk (Hollnagel), or danger (Dejours), arises. Both agree that this is best minimized by workers creatively inventing ways round such obstacles/resistances, by contrast to policing obedience to prescription. However, for Hollnagel, obstacles are theoretically insignificant, precisely because safety – or 'acceptable outcomes' – is treated as the norm, and thus beyond questions of justice, ethics, or indeed workplace politics (Hollnagel, 2014). By contrast, for Dejours, the

lived experience of frustration is what drives the development of practice. 'Outcomes' cannot therefore be determined without taking into account the failures and dangers encountered. The question of how best to respond to failure, individually but also, and crucially, collectively, is what brings work into the realm of politics, imposing questions about workplace democracy.

So whilst resilience engineering seeks to produce, and effect obedience to, better (more authoritative, 'evidence-based') norms by observing actual practice, Dejours attends to workers' speech about their work, to explore the ways in which they cannot make sense of it; how they live it as a kind of painful injustice. This concern with subjective/subjectifying speech, by contrast to a supposed objectivity of representation, is designed to enable the work collective find ways of symbolizing their experience more justly, including naming divergences in what constitutes 'acceptable' work. Hence the analogy Dejours often draws between the workplace and the city: he sees the workplace as a space of collective deliberation, in which the question of how to recognize and reconcile individual contributions to a collective living is what makes working more or less dangerous, and the driver of subjective development and collective practice, inextricably.

Our situation in the centre was not as extreme as some of the ones portrayed in Dejours' accounts of interventions: educators and trainee clinicians were not, to our knowledge, made ill by their work. There was however a sense of frustration, disappointment, irritation, and a degree of disengagement with the prescription to 'learn from failure', precisely because of the gap between this and the lived experience of teaching. This is how we contextualised Dejours' concept of suffering: educators had been charged with an important/impossible responsibility they felt they were not realizing. They did not know how to make sense of this, with resilience engineering proving of some, but limited, use. This suffering arose because of educators'

involvement with another group of workers: attending trainees. Trainees had not complained about the centre's courses but educators felt they were not doing what they were supposed to be doing with them.

This raised a question for us about how to define who issued the demand for an intervention. In Dejours' work, this has to be the 'work collective', whose conceptual function is identifying the situation in which suffering is experienced as a collective achievement – by contrast to an individual pathology. The 'work collective' is the citizenry of the workplace as city: the unit of analysis which 'play[s] a crucial role in enabling individual workers to transform the challenges they face in their work, from a potentially destabilising factor, to one that can be discussed and worked upon in common, from a potential cause of suffering to a potential resource for strengthening of psychic life' (Deranty, 2010, p.194). It is also the subject of speech about the work situation, through whose articulations the value of work is deliberated upon as well as the principles to which action is referenced to judge what is just or unjust, good or bad. In our case, we wondered whether the 'work collective' should be interpreted as educators only; educators and trainees, who were meant to learn from failure together; or also the line management responsible for judging whether centre 'outcomes' were good. We also wondered about expanding the concept further, to patients, on whose bodies failure was rendered sensible.

We outline these options, as they say something about the meaning of the 'work collective' concept, as well as the complexity of interpreting a collective's demand for an intervention. Dejours' account of the 'work collective' suggests a temporal and spatial stability and co-location which was difficult to determine in an actual workplace, and notably one characterized by transitory teams, project work (if one treats a one-day simulation course as a project),

extended hierarchies (the educators' direct line management extended across the city to various clinical sites), as well as service provision (including 'service users'). The metaphor of the city, and the work it performs in illustrating Dejours' concept of workplace democracy, comes under some strain when migrant trajectories are made sensible, as well as external networks. The destruction of collectivity is a prime target of Dejours' critique of contemporary workplaces, but how does one disentangle an appreciation of the social bonds established through work from a fantasy for homogenous spatial, temporal and technical sensibilities, and notably sensibilities manifesting failure and its embodied form as suffering?

Our response to this was to treat the concept of the work collective as an analytic resource to design a specific intervention, rather than a concept denoting a substantive entity. One implication is that the concept of 'work collective' is made both analytic starting point and also a product of the intervention. This has implications for the ethics and politics of an intervention, since the choice about who to include and exclude were ours, not those imposed by a given work situation.

The demand pertained to making a form of speech possible in the centre, but although we had discussed with educators what they found frustrating about simulation-based teaching, we knew little about what clinical trainees experienced as failure: what they were meant to learn from. In some of Dejours' (2015a; also Cru *et al.*, 2012) accounts, an intervention starts with an initial phase of individual and group discussions, exploring the difficulties experienced in work. Our approach was to meet with one specific trainee group – 'core medical trainees' (CMTs) – who attended the centre's courses, and talk to them about what they found frustrating in their work. The interviews were individual, due to CMTs rota-based work schedules – a

characteristic of the work situation that again highlighted the absence of both collective times and spaces.

In Dejours' accounts, the next stage of an intervention consists of the writing of a report, and/or the discussion of initial interpretations between the research team and the work collective, about how the organization of work provokes suffering and how the collective is prevented from transforming this into pleasure and/as development by inventing responses which are recognized as valid contributions to a collective practice. This reporting and its discussion does not focus on offering responses to failure, but rather bringing out its intelligibility.

Our recontextualisation of this principle involved designing simulation 'scenarios' to sustain the staging and role-playing of situations evoked, in our discussions with CMTs, as illustrative of the frustrations of their work. So, whereas a traditional simulation scenario involves simulating a clinical 'crisis', defined in terms of high level of risk (e.g. cardiac arrest, etc.) we sought to simulate what CMTs experienced as frustrating and painful – in other words, what they experienced subjectively as dangerous. In our discussions with CMTs, these situations never appeared in the form of clinical 'crisis'. Rather, they appeared in stories about conflicts with colleagues and patients, as well as with the consequences of the organization of work, notably the need to prioritize, i.e. treat one patient at the expense of another. These were the occasions on which CMTs expressed doubts and fears about their capacity to respond adequately. It was thus these kinds of situations that we sought to make intelligible, speakable, to explore how CMTs experienced and resisted failure subjectively.

Over one month, we ran three courses based on a different scenario each time, for one hour at lunchtime, when CMTs have their dedicated 'educational' time in the simulation centre. In the

next section, we will focus on the speech generated during one of these courses, to explore how Dejours' concepts can be understood in relation to a specific work situation.

Talking about 'difficult patients' and the failure to care for them

Dejours does not present transcripts of speech about work provoked during an intervention. What matters, he argues (2015b), is how researchers interpret suffering and pleasure intersubjectively with the work collective. Whilst this methodological position has a basis in psychoanalytic practice, it inscribes a dubious, and unnecessary, opposition between 'objective data' and (inter)subjective interpretation. A second implication is that the conversations between workers and researchers are never heard; only the researchers' commentary remains, yet without their own presence within it. Whilst Dejours states he does not assume a position of expert explicator, his accounts leave little trace of interpretative difference or ambivalence. Conclusions appear finite, the implication being that an intervention has not only an empirical but also an analytic end.

Whilst we have some sympathy with the intentions underpinning Dejours' methodological stance, we choose to deviate from it, and below, we include transcript extracts, generated from video recordings. We are not claiming this data as 'objective'; it is an achievement, to serve our interests as researchers. We include our speech in the transcript: there is no pretense that the words pertain to an 'objective' reality independent of the intervention. We also include it to enable readers reach their own interpretations, and possibly on the basis of other psychoanalytic concepts than Dejours' own.

The transcript is from a discussion that followed the performance of a scenario about 'difficult patients'. This was intended to stage a situation, often evoked in our discussions with CMTs,

in which they enter into verbal, sometimes physical, conflict with patients over how, and how much, clinical care is provided. The scenario consisted of a patient – role-played by a centre educator – admitted to the emergency unit after collapsing in the street, who asks to leave without waiting for blood test results. The clinical notes indicate she has a mental health social worker who cannot be reached by phone. As in all our scenarios, this started with the participation of one trainee, with another trainee taking the role over after five minutes. The scenario lasted 10 minutes. The switching of actors was intended to make visible the dynamics of the situation, rather than expose individual (in)competence, as in traditional simulation. Lucy and Katherine, two of the researchers, identified as course facilitators, keeping time and initiating the discussion.

After the scenario was called to a stop by Lucy, the discussion started as follows:

Lucy	What are the thoughts on what you've just seen?
Clare	It's pretty everyday stuff really
Several people	Yeah
Lucy	Say more of what makes it everyday, where do you experience this?
Susan	I suppose like patients with psychiatric issues, patients that are frustrated, patients that don't quite know, or have been told what's going on, don't understand why they're having tests done, why they need particular tests (.) you know when they feel well and they want to go home, they don't understand why they have to stay. Yeah. So it's everyday things. Usually mostly you can, I think, persuade them and (.) make them understand why they do need to stay but there are obviously still a lot of circumstances where patients don't and they're happy to take the risks and you deem that they have the capacity to take the decisions and so that's fine

John	I think the solution or the best way of doing it is to actually end up giving someone quite a lot of time, to go through everything and tell them where it's all coming from. The temptation is sometimes if you don't have that much time at that point is then is to just go with 'well that's your decision, if you want to go, go!'

The discussion illustrates the gap between prescription – the duty to provide care whilst practicing 'shared decision-making' with patients – and the real of work. The latter can be said to be experienced in the effort to care for/about patients that are frustrated, that don't understand why tests need to be carried out. Susan's account is suggestive of the work – affective and discursive - called forth in adjusting to the emergent danger: persuading a patient involves trying to make them understand, adjusting, trying again. In the wake of this resistance to control, another prescription is made relevant: judging capacity. Its appearance in the account ends the narration of the various complexities of trying to convince a patient to be cared for, but this framing means that the simplicity of its statement is undercut by what has been said before it. The tension between a professional, prescribed ethic of justice (respecting patient decisions) and an ethic of care (judging capacity) is evoked, precisely in its denial: 'so that's fine'. John's words corroborate this reading. He invokes the same tension in different terms: between caring for multiple patients and ensuring that each one makes an informed decision. The difficulty of achieving this – ethical and technical, inextricably – is evoked in the sin of ceding to 'temptation'.

The two CMTs point to the complexities and uncertainties of what Dejours terms 'living work'. We can read the uncertainty, or resistance to control, expressed as a discursive manifestation of suffering. Dejours (2009) argues that the desire to alleviate suffering is what provokes the development of bodily 'intelligence', *metis* - tricks of the trade, workarounds, professional

wisdom - to overcome the obstacles that working throws up. This is how professional capacities – more precisely, professionally required capacities - are forged. In Susan's account, this can be read in terms of the rhetorical skills of persuasion she evokes. Similarly, in John's account, allocating time well is evoked as a skill.

In Dejours' account, such capacities are the consequence of subjective investment: they are what the worker puts in of her or himself to achieve a task in the face of resistance. But they also implicate the work collective. This can be seen in John's reference to collective norms: 'I think the solution or the best way of doing it is…' This treats responses to the evoked resistance as not simply a matter of personal opinion. It implicates his listeners, and more generally, those encountering the same situation. It frames each speaker's 'best way' round the problem as a contribution to a collective set of practices, and thereby subject to arbitration on its relative merits. The phrasing thus points to how John's thought/speech ('I think…') emerges in relation to a collective which is constituted deontically - rather than libidinally, as in Freud's (1921) account of organized groups. John's speech might thus be interpreted as illustrative of Dejours' concept of cooperation: it compels arbitration between members of a collective about how to work/live together. The use of the 'you' pronoun in Susan's contribution might be read as carrying the same implication. It lays claim to treating her actions as implicating not just herself but the collective to which she belongs.

The excerpt however can also be read to illustrate the difficulties of arbitrating on ways of achieving multiple work prescriptions, and working around the failure to do so. Susan refers to how a conflict between ethical requirements is meant to be resolved: by judging capacity, which makes the outcome 'fine'. But this judgment is undermined by the representation of patients 'needing' tests. Their refusal is not so much the exercise of a capacity to make a

decision, she implies, but rather indicative of a/her failure to persuade. The over-emphatic use of the term 'happy', in portraying patients 'happy to take the risks', might be read as a way of defending against suffering: it works to stop troubling thoughts / speech about the consequences of failing to persuade. John closes his contribution in a similar way, in reference to the prescription to respect a patient's decision, yet after having described this as symptomatic of a lack of time. Each speaker treats the situation, and the failures it sustains, as problematic because of the actions of participants not included in the discussion (and thus our 'work collective'), and whose contribution to the situation is invalidated. In Susan's case, this is the patient who does not understand. In John's, it is hospital management, as becomes clearer later in the discussion, who are blamed for giving CMTs insufficient time to do their work well.

Neither speaker identifies the situation as inherently fraught (yet see Hoggett, 2006 and Fotaki, 2006 on how such tensions between ethical imperatives can be read as inherent to public services). The tensions between prescriptions are denied, and the failures made personal, treated as irrational or unintelligible. The professional capacities developed in working through such situations are represented as sources of danger, rather than achievements. In other words, what is foregrounded, discursively, is not so much the capacity to enable patients make informed decisions, as the dangers and failure of doing so; not so much the capacity to manage time well between multiple patients, as its impossibility. Arbitration on how to achieve multiple prescriptions, which in any specific situation might be contradictory, is neglected in favour of evoking its lack of necessity: protocols simply have to be followed (capacity needs to be judged), time just needs to be given.

Dejours' (2015a) argument for spaces of deliberation in the workplace is that they can make public, and thus thinkable and recognizable, how contradictions between prescriptions are

worked through. Such spaces allow conflicts which cause suffering at the individual level to be recognized as a collective concern, and solutions as a collective achievement, through arbitration on how they can be judged to be good and effective, sustaining the cooperative production of norms. Tensions between prescriptions within living work can thereby transform into civic debate; unintelligibility transform into rationality, or more precisely, rationalities; temptation, or moral condemnation, turned into choice, reducing the suffering associated with it. Without this public deliberation, professionally-required capacities are effectively hidden, individualized, and their failure blamed on unintelligible, external others. This is arguably what the extract illustrates. In Dejours' account, this leads to isolation and retrenchment, as the individual assumes the risks of work as personal dangers, and the capacities developed through work as extensions of such dangers.

In the light of this, did deliberation on the subjective experience of failure generate any of the benefits evoked by Dejours? To explore this, we present another extract, ten minutes into the discussion. Lucy had asked how the group felt towards patients they experienced as demanding of their time. Responses included being 'really resentful', 'defensive' and then 'feeling like a horrible person' because they have to be 'mean'. This re-direction of aggression towards the self led to the following:

Lucy	You mean a bit like the patients in that respect, you're kind of reflecting that?
Susan	Yeah I suppose because in order to get over it you have to be quite, yeah, just I suppose defensive and then it's hard to move from them to the next person and the next person. When someone is really really nice to you, you just feel kind of -
Clare	You've used all your emotional resources

Katherine It sounds like there is a conflict, you said something about how you want to be and you can't be the person you want to be and your kind of turning into a horrible person if this happens. It does sound like there's a lot of conflict between what you want to do and what you actually can.

Mandeep I remember there was this guy on EAU, I was on EAU this old man, this guy was basically like seriously, he got like poking me in the chest…

John I remember you telling me about this, yeah

Mandeep Yeah, I was in a corner in a side room and it's a long story but essentially I had this kind of 70 year old man, his wife was confused, so she was confused, I said 'look she can't go home she needs further investigation', he said 'she's perfectly fine' and she wasn't, she didn't know where she was and we needed to keep her in for tests, he became so confrontational and he started poking me in the chest, like repetitively, I was backed up against a wall, there was no one else there and I told him to stop doing it but in my head I was thinking I would not let this happen in the street

Susan Yeah you wouldn't!

Mandeep And he kept poking me and was like 'you think you're a big man do you?' or something like this and he kept doing it about 10-11 times and I took some deep breaths obviously didn't react, but it was really like, because I couldn't even side-step him, I was in a corner and so yeah it can be quite tough

Clare That's a difficult thing isn't it? What you'd accept outside and -

Susan Yeah it's like -

Mandeep Yeah I wouldn't punch him in real life, but I would aim to move away

We chose this extract as it figures an image of dangerous isolation. Mandeep, backed into a corner, is subject to a violent attack on his professional and arguably also gendered capacities (we can draw on Bishop *et al.*'s (2009) argument about how violence in service work is

experienced as a threat to masculinity to interpret the repetition of 'poking' as having sexual overtones). A disagreement about treatment thus manifests as a physical conflict over power in which Mandeep is assaulted, physically, sexually. There is also a suggestion, we think, of racially-signified conflict, insofar as this is a figuring of a power struggle in which a non-white clinician, in a largely white medical workforce, is made defenceless.

The issue, analytically, is not whether the violence happened as it is re-told, but how it is symbolized at this point in the discussion. It appears following the naming of a conflict between 'what you want to do and what you actually can'; between desire and doing. The 'justness' of this interpretation is indicated by the elaboration of further material for discussion (Dejours, 2015b). The telling of Mandeep's story transforms an evoked need to defend against patients' demands on work time into a need to defend against their physical violence. The two are thereby made equivalent. The specificity of this violence to the workplace is highlighted in the evocation of a street in which it would be possible to move away. Work is thereby evoked as a place in which workers are prevented from defending themselves against isolating assaults: on their time, and then by association, on their person and capacity to continue working. The failure and suffering symbolized in the story haunts Mandeep's body (he poked repeatedly as he spoke): the incident is not closed, even as it is evoked as having already been told (see John's input).

In Dejours' writing, deliberation is specified, in terms of its qualities, as standing in opposition to violence. Violence is what the subject experiences when they feel completely alone, left to confront the dangers of work individually. Work prescriptions then become the imposition of brute power, with no possibility of contributing to arbitration. The gap between prescription and the real of work becomes impossible to symbolize, with capacities thereby annihilated.

Danger is then overwhelming. To defend against such vulnerability, workers also become aggressive. Dejours' particular concern is with suicides at work, the numbers of which have increased significantly in France. Psychoanalytically, suicide can be read as aggression turned against the self. This extract illustrates a much milder form of such violence. The conflict between prescriptions is lived as patient aggression. It is impossible to symbolize, for instance, in terms of a public service, or the suffering of a relative.

Deliberation on the story does not lead to recognition of the tensions in public healthcare, or to the identification of solutions to the represented failure. However, the failure of symbolisation does start to be redressed. The unintelligibility of the scene is made into a story told and heard – not just informally, as implied by John's input, but within the context of an occasion dedicated to developing professional capacities. The annihilation of professional capacity begins to be repaired: 'being poked' is re-signified as 'accepting being poked' (see Clare's last input); being backed into a corner is re-signified as being 'tough' in the face of violence. Suffering/unintelligibility perhaps begins thereby to be turned into pleasure/meaning: in its recognition by peers, the story transforms from the expression of a breach in the capacity to do work, to the overcoming of a loss of control. Failure is articulated as the failure of a collective situation, with others implicated in its arbitration. It is expressed as a failure in and of work, rather than a failure in and of an individual.

Learning from failure more democratically?

Our action, in this action research project, was an experiment: in trying to find ways of talking about failure in medical work; and appreciating Dejours' research contribution in relation to a specific work situation. The limitations of our project are numerous: this was a very small-scale experimental intervention by which to understand some big concepts, including

workplace democracy and its relation to suffering. We make sense of the significance of this intervention in two ways: first, as a counter to existing practices in clinical simulation, and second, as a contribution to debates on the political significance of psychoanalysis in analyzing the relationship between work and subjectivity.

In terms of clinical simulation: the argument for its deployment has been articulated in terms of an 'ethical imperative' to prevent harm to patients done by trainee clinicians. Arguments about the need to 'democratize' health services and medical culture usually accompany the articulation of this imperative (e.g. Ziv et al, 2003). What this version of democratization has led to, however, is a pedagogy of 'learning from failure' in which subjectivity – understood as self-serving interest – is supposedly removed, with expert educators identifying failure 'objectively', rationally, and with no trace of affectivity, applying the corrective of rational expertise. Yet in practice, this has meant that failure is not spoken on simulation-based courses. Re-figuring failure as intrinsic to working, rather than its aberrant excess, offers a basis for re-imagining the 'democratic' value of simulation, grounded in the indeterminacy of medical work, and the compulsion of its participants to work with and through this. Deliberation is made necessary, as part of membership of a work collective, to find better and worse ways of confronting frustration.

Given the constraints of our intervention, we were not able to develop these deliberative practices very fully, and we have highlighted the difficulties we encountered. But our purpose was also limited: to find ways of making failure speakable as part of the experience of work, by contrast to treating it as insignificant (as in resilience engineering). There is a basis, we think, of developing this into a longer-term simulation-based practice, which fulfills its 'ethical imperative' whilst politicizing such ethics.

In terms of what this intervention contributes to debates on subjectivity, democracy and work: Dejours' figuring of subjectivity comes closest, in English-language literature, to Lacanian traditions for researching work. This tradition is prominent in critical business studies, where it describes how employees assume the desires articulated by the organization as their own, in order to become recognizable to themselves and to others (Cederstrom and Hoedemakers, 2010; Glynos, 2011; Stavrakakis, 2008). This literature is often organized around the concept of fantasy, which is figured as papering over lack in subjectivity. One consequence is that workers' speech is heard primarily as alienation: a re-articulation of discourses performed to give substance to subjectivity, and thus the means by which exploitation is achieved. It follows that work can only ever subjectify as domination. Pleasure at work is inherently perverse.

These arguments are helpful for identifying the limitations of our version of the 'work collective', which sustained a discursive framing of miserly managers and obtuse patients as obstacles to the realization of duties – by contrast, for instance, to antagonism within a public service. However, this Lacanian critique has relatively little to say about work practices themselves. It does not examine lack in the ongoing practice of working, by contrast to subjectivity at work in a more generic, and material sense. It does not pay much attention to what workers do, concretely; the contingency they confront in getting work done, the work practices they invent and capacities they develop in the face of resistance to control and symbolization. It is Dejours' conceptualization of such capacities that opens up the possibility for studying subjectivity at work in terms other than exploitation, in terms of a struggle to develop capacities. Such capacities can, of course, be treated as extensions of subjugation - as identification with exploitative structures of authority. Without excluding this interpretation, Dejours' interventionist practice however creates the possibility to recognise such capacities,

analytically, as contributions to a work collective's body of practices and techniques, compelled by the desire to overcome the challenges of work. It then becomes possible to hear, in workers' speech, not only an incapacity to escape subjugation, but also a capacity to contribute to work as a democratic practice.

On behalf of all authors, the corresponding author states that there is no conflict of interest.

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