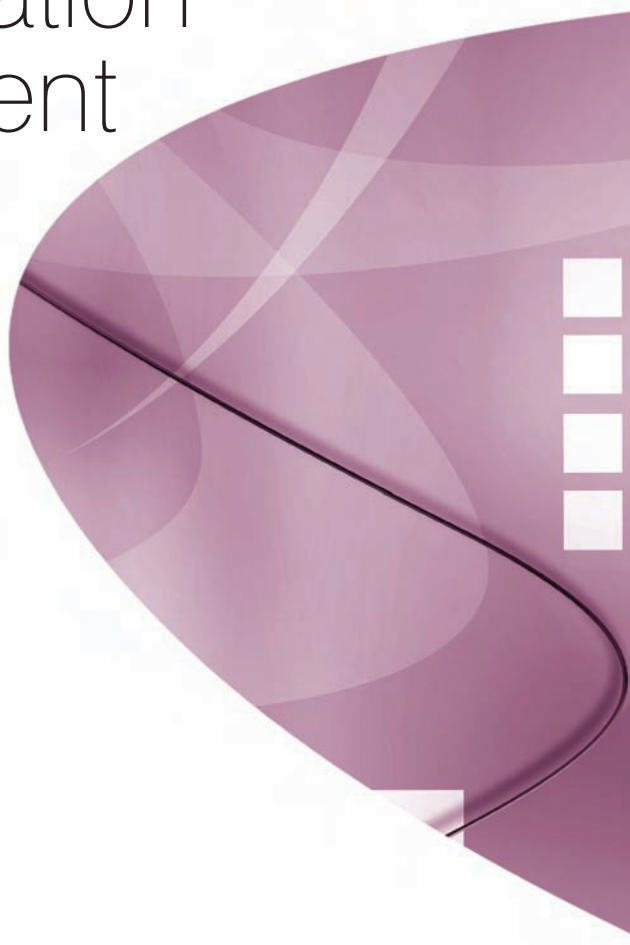
ISSN 1477-7266
Volume **21** Number **4/5** 2007

Journal of

Health Organization and Management

Power and people

Guest Editors: Louise Fitzgerald, Annabelle Mark and Lorna McKee



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ISSN 1477-7266

Volume 21
Number 4/5
2007

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Introduction

This special edition of the journal looks at different aspects of power and how it affects and is affected by the people involved in health care organisation. The papers are drawn from the 5th Organization Behaviour in Health Care (OBHC) Conference held at University of Aberdeen in April 2006.

There were many excellent papers submitted for our consideration and in our selection for this special edition, we were keen to create a platform for new and young researchers and we include in this issue, papers which were chosen as award winners by the Conference participants (Anton, Bridges, Harris). This focus on the new generation of researchers is consistent with the objectives of our academic society (The Society for the Study of Organizing in Health Care), which aims to nurture and develop rising researchers.

While all the papers include in the edition met our quality criteria, we have also included papers for their collective story. There are many ways in which they could have been sequenced and a convincing narrative told, but the rationale of the selection is set out below to aid readers.

The first paper by Braithwaite *et al.*, focuses on an examination of concepts underpinning trust and communication especially when health care encounters go wrong. Their approach is innovative and they explore whether insights from evolutionary psychology can help to explain major organisational failures leading to external inquiries. Evolutionary psychology was also identified as important in the first OBHC Conference in 1998 (Mark and Dopson, 1999). Braithwaite *et al.*, argue that when individuals are stressed through an adverse event, many of their behaviours reveal the genetic roots of survival. By positing this theoretical view, Braitewaite *et al.*, challenge the naivety and limitation of many adverse event models and interventions. Their powerful case helps shed light on the inclination to both tribal and political behaviour so evident in healthcare organisation and the not infrequent uses and abuse of power and trust. The paper is both novel and compelling in the way the analysis unites inquiry data from both the UK and Australia through this theoretical lens.

The second paper by Lapsley also engages with a theoretical perspective that of accountingization to explore understandings of adverse medical outcomes. The thesis that Lapsely addresses is how far accounting controls, such as clinical budgeting have affected the behaviours and rationales of doctors. Dissecting a number of medical cases with adverse outcomes, he interrogates the role of financial limits and discovers very few instants where the power of budgets has had a direct effect. His analysis illustrates the role of human frailty and suggests that the weak impact of accounting practices on medical practice is in part due to the inability of clinical budgeting to catch the imagination of doctors and the continued failure to represent financial data in a meaningful way to clinicians. Both studies suggest that management attempts to harness and direct the behaviour of clinicians either through adverse event reporting (Braithwaite et al) or accounting procedures (Lapsley) have been largely ineffectual or constrained.

In the third paper, Bridges *at al.*, turn attention to the adequacy of traditional research methodologies by offering a longitudinal study of micro level innovation in a

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
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hospital setting. Their emphasis is on using an action learning approach to research. Action research is people focussed and acknowledges that such research cannot make assumptions about stasis and control – indeed the research results demonstrate that innovation processes are longer term and more continuous than previously conceptualised and that end descriptors are just chosen snapshots in time with which to describe this dynamic world. The focus of Bridges *et al.*'s study is on the novel role of inter-professional care co-ordinators and they found inattention to governance and the complexity of the innovation made this role shift difficult. Again the theme is one of unshifting power blocs and habits.

Over the past decade, the OBHC Conferences have addressed a number of continuous themes and the issue of managing innovation was central to the 2004 OBHC Conference (Casebeer *et al.*, 2006). Picking this up again in the fifth meeting, Addicott and Ferlie have set out a very coherent explanation of their interpretation of power in reviewing the emergence of new organisational types in healthcare which are network, rather than structurally based. Their analysis suggests that even in the political priority area of cancer and with facilitation, the dominant managerialist culture cannot be adapted to accommodate potentially more expedient ways of communication and knowledge sharing. This latter point is further explored in the work of Currie *et al.* who look at the barriers to knowledge sharing in one of the most exciting areas of development, genetics. Their paper explores the apparent negative behaviours which, in fact, have their roots in political behaviours associated with issues of trust and uncertainty between the political, professional and managerial domains. As Lukes (2005) reminds us, the exercise of power does not require being intelligent and intentional, even though the capacity to understand it will enhance its use for good or ill. In concluding, Currie *et al.*, look at some strategies to ameliorate these dysfunctions including incentivising behavioural change (which returns us to Lapsley's theme); promoting new career paths and organisational development to engender the formation of trusting relationships. They conclude that behavioural change to increase collegiality depends upon a context where there is a sensitive leadership approach.

Following the themes relating to power and people, we offer a group of papers, which explore novel dimensions of HRM and HRD in health care. Again we would suggest that these aspects of organization behaviour in health care have, until recently, been relatively neglected fields of research. It is evident that the issues relating to the management of human resources are especially critical within a human service organization, such as health care and that we need to expand our understanding of the ways in which HRM/HRD can facilitate better performance (Kinnie *et al.* 2006). Within this group of papers, Sambrook explores the role of HRD in the NHS, using discourse analysis. This represents an illuminating and insightful approach showing how different discourses impact on professional identities. One particularly problematic transition is described, that of moving from being a nurse to becoming a manager. The different discourses that Sambrook describes are complicated by the multiple frameworks and perceptual complexity. Compounding this complexity are the ambiguities inherent in the notion of defining HRD activities and shared purposes across professional and organisational boundaries.

The next paper by Miller explores another major aspect of power inequality, this time in a Scottish context, by reviewing gender inequality in healthcare. Although the vast

majority of staff employed are female, she argues that there is still a marked gender imbalance in management and a pervasive, masculine organisational culture, which she suggests rests upon the dominant power networks from which many women are excluded. The experience of Scotland does how ever differ from that of England where progress may be seen as better in terms of equality but where significant barriers still exist. In a wider UK context, it is notable that there is increasing divergence of structure and organisation in UK healthcare following the devolution of political power.

The last paper in this grouping directly addresses the theme of HRM and performance and provides a very timely review of the extant literature. There is an emerging debate in the literature on the role of Human Resource Management as a strategic player in the organisation, deriving from the work of David Ulrich (Ulrich and Brockbank, 2005). These ideas and the associated debates propose that the HR function needs to be strategic in its approach, adopt the role of business partner and provide justification for its contribution. These ideas are at the heart of the study by Harris *et al.* to link HR strategies and policies to outcomes in health care. The ground is complex and the links may be tenuous or context specific, resting as they do on methods which cannot confirm direct causal relationships, but can only infer patterns of relationships. However, there is clearly a basis for arguing that our understanding may be enhanced by utilising qualitative methods which display and explain the variety of context specific interconnections (Dopson and Fitzgerald, 2005) and also employing quantitative methods, which seek to identify uniform patterns (West *et al.*, 2002).

The last pair of papers analyse and illustrate the influence of the professional bodies and finally, and by no means the least of patients and the public! Academic analysis of the perceptions, power and role of both of these, very different constituencies has been limited. The paper by Baker offers an illuminating and unique insider view of the work of a medical professional body in the UK. Baker describes the attempts to involve patients and patient representatives in the decision-making processes within a professional body. The analysis highlights that the history of prior decision making methods, coupled with accountability to their members create barriers and limits to both perception and action. The paper illustrates the struggle of the professionals to come to terms with the adoption of a more patient centred or consumerist model in healthcare. She argues that the profession of medicine has an underdeveloped understanding of its role in shaping the service and has biased its power toward a model of patient involvement that is unthreatening to professional values.

The final paper by Anton *et al.*, focuses on the core issue of public involvement. It develops an exploration of the difficulties in involving the public, and more importantly the challenges involved in developing assessment and evaluative measures of public involvement. In Scotland, all Health Boards are having to assess their performance in relation to public involvement. This study argues that public involvement is difficult to conceptualise and is contested. The paper demonstrates the problems of identifying who should be involved, issues of representation and relevant stages for involvement. As indicated by their symbolic placement in this special edition, patients are often disempowered and placed last in the queue of those who can exercise power in health care.

This special issue provides different offerings in a number of ways. We offer novel theoretical perspectives on the exercise of power in health care and explore our themes through varied and underutilised methodologies.

A continuously reiterated finding across many of the papers is the titanic problem of shifting power across the professional and organizational boundaries. We see this expressed at the individual level, in role change and at the organizational/inter organizational levels in structural changes to networks and in professional responses to adverse events.

Another underpinning theme is the challenge of working in new ways, sharing knowledge more willingly, developing new roles, and involving professional organizations, patients and the public. We identify the crucial role which can be played by support functions in particular, HRM and HRD and emphasise the need to develop these functions into more strategic roles and activities. Many of our papers are empirically based and in offering additive new data they take up the challenge of researching these core topics relating to power and its interrelationship with people in health care.

Louise Fitzgerald
De Montfort University, Leicester, UK
Annabelle Mark
Middlesex University, London, UK, and
Lorna McKee
University of Aberdeen, Aberdeen, UK

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Trust, communication, theory of mind and the social brain hypothesis

Deep explanations for what goes wrong in health care

Jeffrey Braithwaite
University of New South Wales, Kensington, Australia
Rick A. Iedema
University of Technology, Sydney, Australia, and
Christine Jorm
University of New South Wales, Kensington, Australia

Abstract

Purpose – The purpose of the paper is to examine the deep conceptual underpinnings of trust and communication breakdowns via selected health inquiries into things that go wrong using evolutionary psychology.

Design/methodology/approach – This paper explains how this is carried out, and explores some of the adverse consequences for patient care. Evolutionary psychology provides a means of explaining important mental capacities and constructs including theory of mind and the social brain hypothesis. To have a theory of mind is to be able to read others' behaviours, linguistic and non-verbal cues, and analyse their intentions. To have a social (or Machiavellian) brain means being able to assess, compete with and, where necessary, outwit others. In the tough and complex environment of the contemporary health setting, not too different from the Pleistocene, humans display a well-developed theory of mind and social brains and, using mental attributes and behavioural repertoires evolved for the deep past in hunter-gatherer bands, survive and thrive in difficult circumstances.

Findings – The paper finds that, while such behaviours cannot be justified, armed with an evolutionary approach one can predict survival mechanisms such as turf protection, competitive strategies, sending transgressors and whistleblowers to Coventry, self-interest, and politics and tribal behaviours.

Originality/value – The paper shows that few studies examine contemporary health sector behaviours through an evolutionary psychology lens or via such deep accounts of human nature.

Keywords Culture, Trust, Communication, Politics

Paper type Research paper

Introduction

The organisational and social aspects of contemporary health care problems are customarily investigated via extant theories and modern research tools. While most social scientists and theoreticians would agree that history is an important determinant of today's problems, and can offer a contextualised explanation for them, few studies mobilise historical explanations. The reasons are varied, including lack of time and resources to incorporate a historical component in a study. Even fewer social scientists and theorists have had recourse to the deep past in order to illuminate contemporary

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 353-367
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778899

human behaviour. The deep past is the province of prehistory, and the scholars in this mode are archaeologists, primatologists, evolutionary biologists, palaeoanthropologists and palaeontologists. The social sciences and sciences have long been divided (Snow, 1959; Wilson, 1998), and few investigators traverse the two domains.

This paper attempts to mobilise an explanation based on scientifically grounded prehistory in order to offer an alternative elucidation of behaviours and attitudes in contemporary health care settings. In order to do this, the paper is organised in a logical flow, as follows. The paper opens with a recurring problem. Things go wrong, and adverse events and iatrogenic harm are prevalent in all health systems (Kable *et al.*, 2002; Vincent *et al.*, 2001). The scale and scope of these have been exposed via multiple health inquiries into organisational failure (Watt, 2002; Douglas *et al.*, 2001; Health and Disability Commissioner, 2002; Health Services Commissioner, 2002; Sinclair, 2000; Slovenian Ministry of Health, 2003; Walker, 2004; Department of Health, 2001; Hindle *et al.*, 2005a). We review these. We then look at a specific conceptualisation of this problem, which can be stated thus: when organisational failure looms, trust and communication are compromised. The normal approach to examining such an issue is to attempt to understand, in contemporary terms, how trust breaks down and communication patterns fall short, and how they might be addressed. An alternative account is presented. We assess how trust and communication patterns become compromised from the perspective of evolutionary psychology (EP). Following this is a discussion in which we focus on the question, what does an evolutionary explanation add, and what are the consequences of it? Finally, we reach a conclusion and consider the implications of the analysis. Armed with the paper's conceptual schema, we move to the task of explicating it.

The scene: multiple health inquiries of acute sector failure

It is almost always the case that the internal and external systems established to identify error or harm do not initiate major external inquiries, even when such inquiries are needed. Typically, there are common patterns leading to a major inquiry (Hindle *et al.*, 2005b). There are initial, often sporadic complaints, which turn into multiple allegations of poor clinical practices and outcomes. The prevailing management and clinical systems, in place to detect error and improve safety and quality, do not work effectively to uncover the problems, or, if they do, they are ignored by many clinicians and managers. These internal groups are habitually, and perhaps understandably concerned with their reputations, and do not want an externally constituted, formal inquiry.

The external agencies established to protect patients from harm have also in the past been loath to institute any external scrutiny beyond themselves. Medical, nursing and allied health professional associations are seen largely to act to protect the interests of clinical members rather than patients. They, too, do not raise issues such that they cause an inquiry to be instituted. In fact, internal staff with responsibility for existing detection and warning systems, and external formal agencies and associations, can often operate concertedly to constrain or deter inquiries from coming into being.

Instead, inquiries are often forced on health services through the persistence of whistleblowers (relatively isolated insiders who decide to take on what they see as poor care or practices, and raise their concerns against organisational, clinical and social

resistance) or parents, relatives and friends (often grieving outsiders who continue to raise complaints beyond ordinary levels). Providers who are the subject of complaints, and local managers who get involved as complaints escalate, often prove reluctant to acknowledge and deal with the substance of the concerns.

Invariably practitioners who are the subject of an inquiry are found to have been working in deficient systems and neither positive nor negative lessons are readily learnt (for a discussion, see Walshe and Higgins, 2002). The types of shortcoming most frequently mentioned include poor teamwork, disrespect between different clinical professional groups with accompanying professional barriers, low levels of sharing clinical documentation and information, long-standing and unresolved enmities, egos of difficult-to-handle staff, club cultures often manifesting through in-group and out-group tribalism, structurally rigid organisational silos, poor involvement of a wide range of stakeholders in clinical decision-making and the exclusion of patients and relatives from care choices and processes. Inquiries have also found a lack of sympathetic consideration toward some who wish to express concerns. The essential communication and trust needed for multidisciplinary teamwork to be encouraged and to take an inclusive, caring approach has broken down. Clinicians and managers systematically fail to remedy the inadequacies.

Several inquiries have been subject to considerable interest from the media, the public, legal commentators, researchers and health professionals. They can serve as exemplar case studies. These include those from Bristol, England (Bristol Royal Infirmary (Department of Health, 2001)), Perth, Western Australia (King Edward Memorial Hospital (Douglas *et al.*, 2001)) and Manitoba, Canada (Winnipeg Health Sciences Centre (Sinclair, 2000)). Bristol and Winnipeg concerned poor outcomes for paediatric cardiac surgery patients and the King Edward inquiry centred on the treatment of obstetrics and gynaecology patients. In each case the behaviour and attitudes of health professionals and managers were called into question.

The nature of the problem: when organisational failure looms, trust and communication are compromised

That these cases represent a disturbing type of organisational failure has been convincingly argued (Walshe and Shortell, 2004). Walshe and Shortell found five common themes in cases in six countries (see Table I).

Substantial and repetitive harm to customers in any industry or by any organisation would be construed as failure. In the case of organisations, which have been subject to major inquiries, two types of failing can be observed. The first type is those exposed by the inquiries – recurring and inappropriate behavioural routines. Taken-for-granted, sub-standard practices, relationships and values are reported in all inquiries we have examined in our research (Hindle *et al.*, 2005b, c), and these are seen to lead causally to harm rather than effective care or palliation.

The second type of failing is brought on by the inquiries themselves. As complaints accelerate and whistleblowers or relatives and their supporters increase their demands on local providers and their organisations for explanations or apologies, eventually senior policymakers in central agencies and ministerial staff are drawn into the drama. At some point the media is mobilised by someone, often the complainants, and this fans the flames. Later, depending on the seriousness of the issue and other circumstances, there is mounting conviction that an inquiry is needed. During this

Themes	Key descriptors
Long-standing problems	Poor clinical performance and systems can go on for many decades without adequate action
Well-known but not addressed	With hindsight, many people, particularly insiders, knew about these problems at some level or even intimately, yet failed to tackle them
Large-scale harm caused	Many patients can suffer serious harm in a range of these cases
Poor management systems	Detection and management systems are ineffective or ignored, and often managers and clinicians are estranged from each other
Repeated incidents	Failure occurs repeatedly or even constantly, and little is learned or done about how to correct the problems

Table I.
Five common themes and key descriptors of health care failure

Source: Modified from Walshe and Shortell (2004)

process, those inside the organisation who are the subject of the allegations come under ever-increasing scrutiny, and the pressure on them intensifies. Where once they were merely working within poor but hidden care processes and dysfunctional organisational systems, and delivering inappropriate treatments in culturally problematic circumstances, now participants' practices and *modus operandi* are exposed to critical surveillance. This type of pressure, induced by the threat of, or the eventual conduct of an inquiry, strains already fragile internal trust and communication patterns. Greater mistrust, and less sharing of information is apparent as individual stakeholders and groups position themselves to minimise the adverse consequences which eventuate from an open, judicially-oriented inquiry. By now the stakes have been raised to new heights and dirty laundry is being washed in public, usually daily.

Trusting relationships and open communication, the normal social glue that makes well-performing organisations work, already suffering, are now doubly compromised. Once they are commissioned the inquiries do background preparatory work and then begin to call the central players as well as those who are peripherally involved. They take their evidence under oath or assemble other evidence and then, those presiding on inquiries begin the task of understanding what has happened, making findings, formulating recommendations and seeking resolutions to the long-standing and deep-seated issues. To a greater or lesser degree, inquiries are also seeking some atonement from perpetrators on behalf of society. All inquiries face the challenge of getting the balance right between individual culpability and a systems approach. While this question is usually finely poised at its fulcrum, in the past two decades health care inquiries in many countries have increasingly embraced more of a systems rather than a blaming perspective.

The "normal" mode of conceptualising and addressing these problems

The typical social science research response to organisational problems of this kind is to see how investigation, evaluation, theorising or other forms of assessment can help so that light can be shed on the interpersonal dynamics. At its centre, this involves understanding what the inquiries and the clinical evidence on patient safety says, and to develop strategies to repair trust and improve communication between stakeholders.

We characterise trust in terms of relationships between one or more others in which there are honest, benevolent and well-intentioned behaviours. Workplace trust involves reliance on, and confidence in, the integrity of colleagues. When this occurs a sense of shared effort and community are more likely to prevail.

Communication centrally concerns the exchange of information. It involves imparting, receiving and deciphering knowledge. The effective interchange of various signs, signals, information and data, written, verbal and non-verbal discourse connects people together, facilitates collaboration and lays the groundwork for forms of consensus. The reverse is also true.

Clearly both high levels of trust and effective communication in the way we define them here are desirable features of multi-disciplinary care teams and organisations which are required to deliver multi-dimensional health services in technologically and organisationally sophisticated settings to patients with complex conditions. Yet such teams may be the exceptions rather than the rule.

As we have noted, the inquiries have repeatedly seen below standard team performance as being at the heart of what went wrong. They have also commonly agreed that trust and communication were essential causes of the organisational breakdowns, which they were charged to investigate, and therein lay solutions, too. Table II shows the counts of the use of the words trust and communication and their morphological derivatives following a content analysis of three inquiries.

Table II undergirds the claim that trust and communication are seen as crucial elements in the organisational failings of Bristol, King Edward and Winnipeg Health Sciences Centre. Our research suggests similar patterns hold for other inquiries (Hindle *et al.*, 2005b, c).

We can look at three aspects of this phenomenon through the eyes of these selected inquiries: the importance of trust and communication, the dimensions of the trust and communication problem according to the inquiries, and the skills thought to be needed by clinicians and others in order to realise greater levels of trust and communication. First, in regard to importance, at Bristol, for example, the inquiry argued: "the provision of adequate information is an essential prerequisite to the development of trust. It underpins the honesty between professional and patient" (p. 287 of the Final Report). The King Edward Inquiry said: "Latent conditions are those under which people work and which can affect decisions and actions that result in incidents and adverse events. They include inadequate communication, poor planning and scheduling … " (paragraph 11.1.63, volume 4 of the Report). Associate Chief Judge

Inquiry	Trust	Communication
Bristol Royal Infirmary Inquiry, Final Report	36	159
King Edward Memorial Hospital Inquiry, Volumes 1-4	9	150
Manitoba Paediatric Cardiac Surgery Report, Winnipeg Health Sciences Centre, all Chapters	22	130
Total	67	439

Notes: [a]The use of the word "trust" includes trust, entrusting, mistrust and similar derivatives; it excludes use where the word means "health authority", i.e. in the English NHS, and when it refers to a "trustee" or a "trust fund", i.e. a financial account; [b] The use of the word "communication" includes communicate, communicating, miscommunicate and similar derivatives

Table II.
Use of the concepts "trust"[a] and "communication"[b] in three inquiries

Sinclair in his assessment in the Winnipeg Inquiry asserted: "Operations are not performed simply by a collection of individual professionals, but by teams, which require a high degree of trust and strong communication" (p. 131, chapter 6).

Inquiries are under few illusions as to what is at stake, then; and second, neither are they opaque about the compass and dimensions of the problems at issue. The King Edward inquiry indicated: "... we make a broad conclusion that there are unclear lines of communication within medicine, particularly when more than one specialty is involved. This is also a problem between medicine and midwifery or nursing ... " (paragraph 5.19.14, volume 2). Another problem for King Edward was "the need to enhance communication between junior and senior staff regarding the care of patients, particularly after hours" (paragraph 9.3.94, volume 3). Judge Sinclair was even more robust about the early events at the Winnipeg Health Sciences Centre: "Lines of authority were fractured, team members had not had a chance to develop trust or confidence in one another – indeed, difficulty with communication was already emerging as an issue" (p. 136, chapter 6).

Third, one component in a complex solutions set devised by each inquiry, articulated as recommendations for health systems reform, was to argue for the importance of team-building and communication proficiencies and competencies across clinician groups. The Bristol inquiry expressed this requirement in these terms: "We have referred earlier to the need for better education in communication and listening, interpersonal skills, and trust and respect for others. These skills are the essence of good leadership" (p331 of the Final Report). The Perth, Western Australia inquiry panel agreed: "KEMH is to ensure that all staff have the necessary communication skills to be able to develop assessment strategies collaboratively ... (with the patient)" (recommendation 53). The Associate Judge of the Manitoba inquiry was equally clear: "Leadership, teamwork, communication and decision-making are recurring themes in this Report. They are not side issues ... (they must be) ... addressed in a systematic fashion through programs of quality assurance and error and risk management" (p. 492, chapter 10).

What have researchers said in response? Organisational and social scholars who have commented on these inquiries also see trust and communication improvement as bedrock issues, and they have arrived at similar sentiments to those proffered by the inquiries. They have come collectively to see that resolution requires changes to health care culture (Firth-Cozens, 2001; Braithwaite *et al.*, 2005a; Carroll and Quijada, 2004; Westrum, 2004), necessitating a systems-orientation (Kaplan and Fastman, 2003; Burrow and Berardinelli, 2003; Ketring and White, 2002; Braithwaite *et al.*, 2002; Runciman, 2002; Liang, 2002). The Institute of Medicine's reports "To err is human" (Kohn *et al.*, 1999) and "Crossing the quality chasm" (Institute of Medicine, 2001) argue that breaking down cultural barriers, and longstanding clinical boundaries, are core requirements for systems change. Other authoritative reports such as those from Canada (Baker and Norton, 2003), Australia (Runciman and Moller, 2001) and the UK (National Health Service, 2000) agree. Whatever the individual circumstances, a concerted effort involving all stakeholders is required (Reason, 1990, 1997, 2000; Hindle *et al.*, 2005a). A national and international focus, learning from mistakes and positive examples of improvement, raising standards and creating better systems of care are all prerequisites to safer systems of care according to contemporary commentators.

An alternative account: understanding how trust breaks down and communication patterns fall short from the perspective of evolutionary psychology

So it is that the collected wisdom of scholars and inquiries has reached a widely agreed position on what will resolve some of health care's shortcomings: at its broadest level we can characterise this as culture change and systems improvement. The normal mode of assessing these organisational phenomena has led to a conclusion that seems to have been widely accepted. The case we would like to make here, however, is that we may need to look more deeply to gain a greater appreciation of the kinds of behaviours, which have manifested in these cases, how they have emerged, and what can be done about them. EP is a relatively new discipline, which tries to apprehend modern behaviour and mental processes in terms of Darwinian evolutionary biology (Badcock, 2003; Barrett *et al.*, 2001). The core EP concepts are relatively unproblematic, although they can be complex – and, for some, controversial (Barkow, 1992; Cosmides and Tooby, 1992; Dunbar, 1996; Crook and Gartlan, 1966; Ridley, 1993; Pinker, 1997; Dennett, 1995). The human mind, and everyday behaviours, are fashioned by our evolutionary past. They are the product of millions of years of natural selection. Everything we are, think and can do is shaped by these processes. Human nature, our physical apparatus, mental structures and behavioural repertoires have been subject to millennia of selection pressures which influenced *Homo sapiens* and its predecessors all the way back to the early Pleistocene. Human culture matters, too, in determining the modern mind and society, but the biological shaping of contemporary behaviours and practices cannot, for evolutionary psychologists, be wished away. This kind of explanation, for all its importance, is downplayed or simply ignored in modern theories and research explanations.

Think about it this way, through a consideration of the fossil record (Stringer and Andrews, 2005; Tattersal, 2003; Tattersal and Schwartz, 2001; Wong, 2003; Leakey and Walker, 2003). The branch separating our hominid line and that of the great apes was around 10 to 5 million years ago. We evolved from the *Australopithecines*, or a related line, which are found between 4.5 to 2 million years ago. It is controversial how many species of humans there were, depending on whether you are a lumper or splitter. The first identifiable human, *Homo habilis*, is known for early tools. Emerging humans on our line of descent include *H. rudolfensis, H. ergaster* and *H. erectus* and then early *H. sapiens*, through to us, the arrogantly self-named *H. sapiens sapiens*, or very wise human, emerging around 500,000-400,000 years ago. Or perhaps it is not so arrogant: sophisticated cultural innovations such as art, religion and a logico-scientific approach to life arrived with recent humans, dating perhaps from as early as around 100,000 years ago (Mithen, 1996) until the present.

This means that on the basis of fossil hominid and stone tool assemblages, we can claim with confidence that humans evolved over the past 2 million years, and this emergence is conjoined with complex cultural acquisition. More recently we have moved from small hunter-gatherer bands, successfully exploiting the natural environment, to a technologically sophisticated society, which predominantly lives in modern buildings in cities and towns. We subsist and flourish economically by combining skills across intricate socio-political settings, via multifaceted organisations and institutions, which exist to serve various societal purposes. Competition and

collaboration in varying degrees and at different societal inflection points help maintain our way of life.

Despite this modernity, however, our primary role is as hunter-gatherers, adapted for an existence on the African savannah, or, later, in equivalent environments across the world. EP calls this the "environment of evolutionary adaptedness" (EEA) (Bowlby, 1982). In fact, 99 percent of human existence was spent as hunter-gatherers, so any evolved characteristics are bound, logically, to be of value to such an existence. It is only in the most very recent era (the final part of the Pleistocene, known as the Holocene, or the last 10,000 years) that we created agriculture, and began to domesticate plants and animals, which led to settlements and signalled the start of the end of hunter gathering for most humans. By 5,000 years ago farming was widespread (Mithen, 2003). But modernity, if we date it from the beginning of the industrial revolution, is not much more than 200 years old.

If we are evolved for hunter gathering in the Pleistocene, living for the bulk of evolutionary time on the African savannah, various inferences can be drawn. Humans, in common language, have a stone-age mind. We are adapted like any other successful organism to be able to survive by taking on sustenance (in our case, plants, meat and fluid), protecting ourselves from harm (e.g. from predators and lean times) and propagating the next generation. Because our existence was then and is now as a social species we are adapted to exploit the environment in tightly knit bands, occasionally meeting other groups through trading (Douglas, 2004) or larger kinship groups, perhaps at intermittent or annual feasts or festivals. There is survival value in being good at things like detecting danger, forming cooperative alliances with people in our band who can help us, engaging reciprocally with others we trust, working out quickly the costs and benefits of social exchange, and reading social cues rapidly and reacting to them as necessary. We should not be surprised at any of this, as it applies widely, including to some considerable degree to chimpanzees as well as all human societies.

Two aspects of this, which have interested EP, are the development of a theory of mind (Premack and Woodruff, 1978) and Machiavellian intelligence (Byrne and Whiten, 1988). Humans' theory of mind refers to our capacity to speculate, guess or hypothesise (have a theory) about others' intentions. Children display these skills quite early, as every parent knows. On the savannah and in modern settings, humans will benefit from assessing their own mental state against that of others (e.g. what is my friend or enemy thinking or intending to do, how is he or she likely to react to my moves, how am I positioned in relation to one possible reaction or another?).

The second human characteristic to deal with here is known as the social brain hypothesis, or Machiavellian intelligence. An intriguing question is why do we have such big brains and extensive computational power? Our personal answer might be "to think, of course, and figure things out" but EP suggests that, among primates, increased brain size is naturally selected to solve social problems, including to befriend others for our own purposes, manipulate social situations, benefit from social alliances, and to deceive and outwit when necessary; overall, to balance social benefits against costs. In short, primates constantly weigh the advantages and disadvantages of social life, read others' behaviours for positioning purposes, and keep tabs on personal and group relationships. Humans do this best of all primates.

The old political saw says there are two kinds of people in the world: those who are positioning themselves and those who are repositioning themselves. This is a

necessary preoccupation for hunter-gatherers, but also for individuals today who live in "in a global network of nations, alliances, tribes, clubs, friendships, corporations, leagues, unions and secret societies" (Zimmer, 2001). People could not proceed in the savannah or, ultimately, the modern world, without the sophisticated capacity of mind to understand others' behaviours, mental states and intentions, and use this knowledge to advantage. Armed with these skills, they aim to do well for themselves and their kin as well as, more indirectly, their organisational allies and even more distantly, for their institutions.

Our individual and group survival depends on theory of mind and Machiavellian intelligence. These characteristics are hard-wired into all human societies. Not all that different from the Pleistocene, the health sector contains unstable habitats and complex terrains requiring subtle and sophisticated navigational skills. Can the breakdowns in trust and communication observed in modern health care settings using the inquiries as case studies be explained using deep evolutionary accounts such as theory of mind and Machiavellian intelligence?

We believe so. The health system is under pressure, as our three case-study inquiries illustrate. Contradictory, political behaviours emerge in such circumstances. Clinicians and managers position themselves relative to each other, as do the professional tribes of medicine, nursing and allied health (Braithwaite and Westbrook, 2005; Braithwaite *et al.*, 2005b). Wards, units and departments rival each other for resources, attention and prestige.

As we have seen, people are stretched, and then under siege, as inquiries take hold. Even without a looming inquiry to worry about, participants' levels of trust and communication patterns in the cases, pre-inquiry, were strained and compromised, and across-professional teamwork was poorly constituted.

Individuals and groups in the cases indulge in turf protectionism. For example, at Bristol, the inquiry expressed concern about polarised managers and clinicians. The inquiry said: "To protect patients, as they saw it, clinicians fought a rearguard action against what was termed 'management'. Suspicion became the order of the day, particularly among doctors and nurses, a mentality which some feel still pervades these professions: suspicion of government, suspicion of trust managers, suspicion generally born of years of genuine frustration that the NHS was failing to provide them with the tools they needed" (p. 265, Final Report). Add to such an environment a situation in which the professions are trained in different traditions and with levels of competition and structural mistrust between them, and a whistleblower, Dr Stephen Bolsin, who against the odds continued to raise concerns about paediatric cardiac surgery cases, and you have a heady mix of professional instability, social and political complexity and a threatening environment.

So people seek status, power and safety, and cling to known clinical or managerial pecking orders. They shun others who represent a threat. Indeed, when someone becomes a whistleblower, or vociferous complainant, they are ostracised, and it becomes very difficult for them to sustain their concerns as against reciprocal behaviours designed to make them feel extremely uncomfortable or isolated. This too is behaviour well known to EP (Axelrod, 1984): people do "tit-for-tat" for both positive and negative behaviours. With our modern language we call this "repaying kindness" and "retaliation", but it is an ancient response.

Self-interest, in-group survival measures, and falling back on trusted tribal members who collectively see themselves as battling the rest of the world – these represent the hallmarks of social protectionism. Indeed, it is typically the case that most inquiries offer statutory protection to those giving information to them, for legal and procedural reasons.

Such behaviours have survival value. On the savannah and in the modern health service people will turf-protect, become tribal if and when it helps, shield themselves against threats, try to outmanoeuvre others, blame the perpetrators of threatening behaviours toward them and close down trust and communications with anyone who is a dangerous or even merely suspicious "them". Is this surprising? Hardly. These are not justifiable behaviours, but they are predictable (Braithwaite, 2005).

Discussion and conclusion

Pushing our argument to its conclusion

Why, then, did some people's patterns of trust and communication at Bristol Royal Infirmary in the UK, King Edward Memorial Hospital in Perth, Western Australia and Winnipeg Health Sciences Centre in Manitoba, Canada fracture to such an extent? How did the participants whose behaviours were subject to detailed inquiries take-for-granted that their conduct was somehow normal, even acceptable? We have noted that the usual answers given include: lack of teamwork, professional barriers, egos, poor cultural practices and organisational silos. On our argument an alternative answer lies within human prehistory, and is provided at the convergence of evolutionary biology and social psychology. They have been conjoined as EP, a hybrid discipline.

Our EP argument proposes that the genesis for conduct in contemporary organisations lies in the Pleistocene, and Pleistocene-oriented behaviours become especially prominent when stress is experienced. In this deep past, humans in hunter-gatherer bands evolved to solve certain pressing problems of survival – to locate food and water, navigate the treacherous environment, find opportunities to pass on their genes, and recognise rapidly who is friend and foe. Our approach is based on the proposition that, among others, two intellectual capacities evolved in the Pleistocene. The ability to read people's non-verbal cues and utterances (to have a "theory of mind") is crucial for inferring others' intentions. The ability to solve complex social problems including through manipulation and deception (to have a "social brain", or "Machiavellian intelligence") is also a vital capability. These are useful adaptations whether one is traversing in the savannah of the Pleistocene or the health service of the twenty-first century.

It does seem to be the case that we can account for the failures in trust and communication observed in modern health care cases using deep evolutionary explanations. When the health system is under pressure and contradictory behaviours emerge, it is not easy to dismiss arguments to the effect that humans are naturally selected to survive through mechanisms like turf-protection, securing personal rewards as against others, shunning those who represent danger to us, striving purposefully via self-interest, playing the political game and falling back on trusted tribal members when needed.

A discordant note

A deep examination of behaviour in EP context does, then, seem to offer an explanation beyond the existing analyses of safety and quality problems through the evidence of

the inquiries, extant research and scholarly theories. As good as these current-day analyses have been, they can be boiled down to a few principles: we should change cultures and subcultures to be more productive, and health care systems to be safer. And: we ought to increase trust and improve communication. Stated thus, present *modi operandi* seem overly simplistic, even naïve.

Nevertheless, such thinking has spawned a range of strategies and initiatives including root cause analysis, re-engineering care processes, clinical pathways, monitoring adverse events and near misses and taking corrective action, tackling human factors in iatrogenic harm, and training people to use safety improvement tools and techniques. These may yet contribute the package of measures that will enable us to look back one day and claim that people changed practices and relationships and improved health care systems such that care is now delivered much more safely and at higher levels of quality than ever before.

This package of measures is a recent development, and may mean that we are early in an improvement cycle, and progress will accelerate from here. But it is possible to strike a discordant note. The inquiries keep coming (Hindle *et al.*, 2005b). Error rates seem ingrained in health systems (Baker *et al.*, 2004). People find it hard to work in teams. Professionalised tribes rule, and organisational silos proliferate. People can readily shun, or send to Coventry, those who criticise, complain or blow the whistle. In the worst places, as the inquiries relentlessly show, trusting relationships and instances of transparent communication are rare. There, cultures and sub-cultures are Stygian and moribund.

Perhaps a deeper explanation, accounting for entrenched human characteristics, gives us both insights into the magnitude of the problems we face, and a moment's pause for reflection. If humans all the way back to the early Pleistocene are evolved to be tribal, designed to be mistrusting of others, to have a propensity for survival through mechanisms such as outmanoeuvering others and calculating benefits and costs of alliances, at least to some extent on the basis of self-interest, then we have an unacknowledged challenge which is larger and trickier to resolve than many contemporary commentators admit. It is very hard to reject arguments such as this out of hand. They seem compelling to us: and they post a challenge, the magnitude of which we may only now begin to contemplate. Simplistic or downright naïve solutions do not appear to us to factor in human nature sufficiently well into the social equation.

It means we can expect tribal behaviours, and challenges to trust and communication, in every organisation. But poorly led organisations, those with systems deficits, or those which are excessively fragmented, will likely be characterised by even more extensive tribalism and blaming behaviours than is the norm. These latter two may be the ultimate early warning indicators for patient safety. We can also expect even more clearly pronounced tribalism and blaming, and running-for-cover behaviours, if an inquiry looms or is initiated, regardless of the reasons for or the merits of its origin.

We are likely only to be at the beginning of our understanding of what it means to change behaviours, values and attitudes in complex acute care settings, how professional teams work and how cultures and systems can be sustainably improved. At the very least, we should listen to and absorb ideas from EP. If the human mind, and our behaviours and capacities in relating to others in the present are designed through the processes of natural selection for life in the savannah in small tribal bands, then

this adds an important dimension to our understanding. Perhaps it helps profoundly to both explain some of the challenges of present day health systems, and open up new avenues for reflecting on the extent of the problems we face.

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Corresponding author
Jeffrey Braithwaite can be contacted at: j.braithwaite@unsw.edu.au

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Accountingization, trust and medical dilemmas

Irvine Lapsley
University of Edinburgh, Edinburgh, UK

Abstract

Purpose – The purpose of this paper is to investigate the impact of accounting on clinical practices.

Design/methodology/approach – This paper reviews existing studies of clinical budgeting; analyses publicly available data on cost-effectiveness recommendations for the NHS; analyses publicly available data on the influence of accounting in medical dilemmas.

Findings – The paper finds that there is limited evidence of clinical budgeting dominating clinical decisions, but there is some evidence of central agency directions on appropriateness of treatments, but this is on a cost-effectiveness basis. Numerous examples of adverse medical outcomes are cited in this paper – but with limited influence of accounting in these decisions.

Originality/value – The paper shows that the combination of accounting and medical data in a topical matter makes this an original and distinctive study.

Keywords Accounting, Trust, National Health Service

Paper type Research paper

> Until there is a practicable alternative to blind trust in the doctor, the truth about the doctor is so terrible that we dare not face it. In this predicament, most people fall back on the old rule that if you cannot have what you believe in, you must believe in what you have (Bertrand Russell, 1933).

Introduction

This paper explores the significance of accounting in the UK's National Health Service (NHS), particularly as it affects the decision-making of hospital doctors. In common with most health care systems, the NHS has an excess demand for the services, which it offers. This demand is fuelled by the co-morbidities of an ageing population, by the expectations of the public over access to the most recent innovations in health care treatments, and by a health care system in which health care is free at the point of use (Lapsley, 1996). This context for the UK's NHS has prompted many reforms which have intended to improve the efficiency of this organisation, and demonstrate value for money. Many of these initiatives have accounting techniques and technologies in central roles.

Accountingization and trust

This paper explores an issue at the heart of health care: the inter-relationships of accounting (and resourcing) and medical practice, and their influence on trust between

Earlier versions of this paper were presented at a Seminar at Copenhagen Business School, February 2006, and at the 5th International Conference in Organizational Behaviour in Health Care, Aberdeen, April 2006. The author is grateful for the helpful comments of participants at these events.

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 368-380
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1477-7266
DOI 10.1108/14777260710778907

patients and health care providers. The opening quotation by Bertrand Russell (1933) is a reflection on medical practice before the establishment of a National Health Service in the UK in 1947. In this quotation, Russell observes a "blind trust" in the face of a health care system in which doctors received greater financial returns for performing more complex operations or treatments on those who where able and willing to pay, with poorer patients offering the prospect of free care in return for the testing of new treatments. Russell alludes to the possibility that the doctor's fees were more important than medical outcomes. This was a world in which finance had real significance within the medical profession and in which the motives and behaviour of individual doctors may have been distorted by their treatments and procedures.

However, this paper focuses on these inter-relationships within the context of a state health care system and in which the direct link between the fees charged for services provided by doctors no longer exists for the bulk of health care provision. In this context, a different set of circumstances (accountingization) are also alleged to have a deleterious impact on trust and the doctor-patient relationship. In this case, it is alleged that the drive to make the state run health care system more efficient has adverse effects on patient care. However, the disentangling of the multiple dimensions of health care reveals many influences operating in medical outcomes rather than just the intrusion of accounting members on clinical decision-making.

First, we explore what "accountingization" is, or is alleged to be, and how this might impact on trust in medical care. Accountingization refers to the emergence of accounting practice as a dominant component of the New Public Management (Hood, 1991, 1995), with the displacement of the social by an economic or managerial logic, which has affected the organisation, and delivery of health care, just as it has other parts of public services. The expression "accountingization" was coined by Power and Laughlin (1992). They define this as follows:

> ... the technical neutrality of accounting practice is illusory and accounting is a potentially colonising force ... accounting is very much the vehicle for economic reason in practice ... accountingization ... expresses the sense in which accounting as method may eclipse broader questions of accountability ... (Power and Laughlin, 1992, p. 132).

This phenomenon of accountingization has prompted a warning from Power and Laughlin (1992) who highlight the potential of accounting to subvert existing value systems, to redefine the world or social space, which it enters. In this regard, Power and Laughlin (1992) identified health care systems as being at risk from the phenomenon of accountingization. They expressed the manner of this intrusion into the medical domain, as follows:

> ... accounting emerges as a new organisational language which displaces a previously dominant culture ... the colonizing power of accounting consists less in its manifest claims to information-based rationality than in its capacity to capture organisational self-understanding and to reframe it in accounting terms ... (i.e.) the rendering of increasing areas of social life within an economic language (Power and Laughlin, 1992, p. 127).

This language of accounting is therefore depicted as carrying values and placing boundaries on activities. This phenomenon was located within the UK's National Health Service by Power and Laughlin, as the following comment demonstrates:

> A context in which it (accountingization) is particularly evident in the UK at the present time is the public sector in general and the NHS in particular . . . there is evidence to suggest that in the area of health care the sacred (emphasis inserted) domain of clinical action is becoming influenced although not yet comprehensively transformed, by accounting initiatives despite complex forms of resistance . . . as the accounting language of budgeting attempts to occupy clinical discourse it has the potential to control significant definitions of the hospital environment (Power and Laughlin, 1992, p. 127).

However, whether this accountingization has taken place, or has the potential to take place, and the manner in which such a process would be realised, is not straightforward. This critique could be a demonisation of accounting in public sector reforms (Lapsley, 1998). There are contrasting views within the medical profession on whether accountingization may or may not occur. The Parsons (1951) model of the doctor-patient relationship depicted a trusting relationship in which financial interests were not part of the encounter. More recently, one paediatric consultant cites a case of financial interests dominating clinical practice (in McHaffie and Fowlie, 1996, p. 4), in which a child was being treated outside its health authority and the cost of treatment was a repeated concern of the health authority in which the child was treated. However, in a survey of paediatric doctors and nurses only seven doctors (12 percent) and 20 nurses (17 percent) felt that the fact that resources were limited influenced their thinking about when treatment should be withdrawn or withheld (McHaffie and Fowlie, 1996, p. 76). Furthermore, there are eminent members of the medical profession who have challenged the significance of accounting in health care. For example, Hoffenberg (1982) has made the observation that cost, if taken into account, would be regarded as one of many factors.

Similarly, Lomas (1994) identified a range of influences on clinicians' behaviour, including patient characteristics, the doctor's education, the administrative setting and economic factors. Indeed, clinical guidance on the doctor-patient relationship does focus on the process of communicating with patients, the handling of patients' anxieties – but not resourcing issues (see Fletcher and Freeling, 1988). However, the experiments for quasi-markets in health care have raised the possibility that the doctor-patient relationship becomes more of a contractual relationship, with the possibility of a greater role for accounting and finance (Bury, 1997).

At the heart of this challenge to clinical thinking and behaviour is the potential for costing or accounting information to penetrate the clinician's decision-making processes in the doctor-patient relationship. However, the doctor-patient relationship is complicated and it continues to attract the attention of researchers, and indeed, this paper does not seek to resolve this research agenda. However, as Bertrand Russell highlighted in the preamble to this paper, trust is, or should be, a fundamental element of this relationship. More recent commentators affirm the significance of trust in patient-doctor relationships (Clothier, 1987, p. 63; Giddens, 1991, p. 136). In this paper, erosion of this trust by the penetration of accounting language and logic into clinical decision-making processes is taken as evidence of "accountingization". Therefore, on the face of it, the doctor-patient relationship, which is still an active area of research, has some potential to absorb the language of accounting. The next section explains the research design used in this paper to determine a closer examination of whether accountingization has taken place, or not.

Research design

This study explores the phenomenon of accountingization and whether this has taken place in the UK's NHS, or not. Power and Laughlin (1992) emphasise two features of accountingization:

(1) Accounting as an economic language, which colonises by displacing the previously dominant clinical culture.

(2) The sacred nature of clinical practice, which is threatened by the spread of accounting ideas.

Both of these dimensions are studied in this paper. The first dimension is studied in two ways. First, there is an evaluation of studies of clinical budgeting in the NHS. Clinical budgeting was seen as the principal means by which the language of accounting would occupy clinical discourse by Power and Laughlin. The study of previous empirical research in clinical budgeting sheds light on the penetration or otherwise of this form of budgeting within the NHS. However, this approach to the study of accountingization in the NHS does not take account of the longstanding practice of clinical practices being influenced by the costs of drug regimes. This is examined from the perspective of the central government agency, the National Institute of Clinical Excellence (NICE) which was established as part of the Labour Government's modernisation of the NHS (Department of Health (DoH), 1997).

The second dimension – the "sacred" nature of the work of clinicians – is a challenging task to investigate. The investigation of previous empirical research on clinical budgeting and of the activities of the National Institute of Clinical Excellence establishes a prima facie case that clinicians may have been influenced by accounting information as the mechanisms were in place to make this possible. To investigate this second dimension of accountingization, we need evidence of whether patients' trust in doctors has been corroded by undue or disproportionate influence being given to accounting and financial information in clinical decisions.

One challenge is the sheer volume of clinical activity in the NHS. In a typical day in the NHS, the Department of Health estimates the following activity levels: one million people visit their family doctor; 33,000 people are cared for in accident and emergency; 1.5 million prescriptions are dispensed; 25,000 operations are carried out; with 90,000 doctors and 300,000 nurses at work (Department of Health (DoH), 2000, p. 23). The sheer scale of this activity makes it extremely difficult to capture all incidents in which clinical actions have been explicitly constrained by financial considerations. This study therefore uses the concept of "fateful moments" (Giddens, 1991), as instances of medical activity in which clinicians and patients are confronted with dilemmas in which resourcing issues may play a part. Specifically, this paper looks at instances of adverse medical outcomes to determine if there are cases in which financial considerations dominated clinical ones. There is no routine comprehensive data capture of adverse medical outcomes (including fatalities, serious injury and near misses) on patients other than mortality in surgical interventions. Therefore, this paper focuses on particular case studies of medical dilemmas and explores the influence of accounting information on clinical thinking. These case studies capture a range of experiences of hospital doctors in dealing with medical dilemmas with adverse outcomes and shed light on whether there is accountingization in the UK's NHS.

Accountingization and health care

In this section:

- The impact of clinical budgeting on the actions of clinicians is assessed; and then
- The impact of attempts to influence clinical prescription and treatments by national guidance of the National Institute of Clinical Excellence (NICE) is assessed.

In their description of accountingization and its impact on health care, Power and Laughlin (1992) pointed to developments in clinical budgeting, which they saw as a potential colonising force, influencing the thoughts and actions of hospital doctors. In their view, this development would result in an attenuation of the dichotomy between the worlds of hospital management and hospital doctors (Coombs, 1987). Indeed, there have been numerous attempts to implement clinical budgeting systems in hospitals. Before Power and Laughlin (1992) contribution of the concept of "accountingization", there had been attempts at clinical budgeting in the UK. These were management budgeting (Department of Health and Social Security (DHSS), 1985), which was an outcome of the introduction of general management in the UK's NHS (Griffiths, 1983) and resource management (Department of Health and Social Security (DHSS), 1986) which was an immediate attempt at refinement of the 1985 scheme of management budgets. Bourn and Ezzamel (1986) highlighted the difficulties of these clinical budgeting initiatives: they were perceived as limiting clinical freedom and increasing clinician accountability; with problems over the definition and measurement of outcomes and performance; and with technical accounting problems over the treatment of overheads. These problems were discovered in a further study by Bourn and Ezzamel (1987) in which they identified medical opposition to clinical budgeting trials and difficulties over the allocation of budgets to appropriate groups.

Studies by Pollitt *et al.* (1988) and Preston *et al.* (1992) of management budgeting revealed a rejection of this form of budgeting by hospital doctors. Pollitt *et al.* (1988) discovered different priorities of the various groups involved in clinical budgeting leading to conflict. In this study, Pollitt *et al.* (1988) found that the impact of clinical budgeting was restricted by its inability to fit into hospitals because of boundary, position, information and authority constraints. In the Pollitt *et al.* (1988) study, even the proponents of clinical budgeting did not give it a high priority. The Preston *et al.* (1992) study of the implementation of those clinical budgeting systems reported major difficulties of making these systems operational. These uncertainties were resolved by the "fabrication" of budgets. Another investigation of resource management by Packwood *et al.* (1991) reported concerns by hospital doctors over the impact of this form of clinical budgeting on their patients; a lack of operational resource management systems; and little evidence of such budgetary systems influencing clinical actions.

With the introduction of internal markets in health care (Department of Health (DoH), 1989), clinical budgeting was to assume a new significance in the management of hospitals as they sought costed contracts for the provision of health care. However, studies of the impact of accounting on clinical behaviour reveal that hospital doctors regarded this financial information as alien (Jones and Dewing, 1997) and hesitancy and reluctance on the part of clinicians to accept or act on this financial information (Lapsley *et al.*, 1998). An exception to this general finding of rejection of clinical budgeting by hospital doctors is the Lapsley (2001) study of trial sites for management

budgeting and resource management in Scotland. This longitudinal study reveals both of these earlier initiatives failed, but ultimately a version of the earlier initiative on management budgeting took hold.

There have also been numerous studies, which have demonstrated that these initiatives do not function as intended. Indeed, there are clear examples of clinical budgeting not impacting on clinical decisions. Kurunmaki *et al.* (2003), for example, note the case of hospital doctors taking extremely expensive options to treat a patient with significant burns over a large percentage of his body to save the patient's life. This had the desired clinical outcome, but the budget for this group of doctors was depleted, and without any prior reference to the hospital accountant. Indeed, this accountant was labelled an "historian" by Kurunmaki *et al.* (2003), as this role was one of documenting and costing clinical practices after the event. While the Kurunmaki *et al.* (2003) study is an example of rejection of budgetary information in UK hospitals, there are other examples of accounting information being used in a symbolic, rather than an instrumental, fashion. Arnaboldi and Lapsley (2004) report on the adoption of activity based costing by a health care organisation. In this study setting, this new form of costing was not operational. But the management of this organisation portrayed this as being operational. This was part of a strategy to present themselves as businesslike and efficient, as modern and up to date. This legitimating behaviour contrasts directly with the Power and Laughlin (1992) thesis, which presumes such accounting systems are instrumental. Despite the above evidence that clinical budgeting initiatives have not operated, as intended, one of the first actions of the New Labour government elected in 1997 was to reform the NHS and to place clinical budgeting as an essential component of these reforms to promote efficiency (Department of Health (DoH), 1997, para. 6.21). This persistence of approach has been described as a triumph of hope over experience (Brunsson, 2006).

However, there are examples of costing information being presented to, and influencing the behaviour of, clinicians. But this kind of costing information is very narrow – it relates to the costs of drugs. Also, this information emanates from clinicians (pharmacists) and not from finance departments. Furthermore, this kind of cost information has been made available long before clinical budgeting experiments, and before "accountingization" has been speculated on as a phenomenon (Perrin, 1978, p. 109). However, this kind of information was intended to have an enhanced role in the reform of the NHS. Specifically, a new National Institute for Clinical Excellence (NICE) was established to produce clinical guidelines based on relevant evidence of both clinical and cost effectiveness (Department of Health (DoH), 1997). This institute assumed a key role as gatekeeper for the adoption of new drugs and treatments within the NHS.

It is important to note that NICE performs appraisals of new treatments and drugs, which assess both the effectiveness of new treatments and their costs. NICE has developed an evaluation framework (called "technology appraisals") drawing on the work of Eccles and Mason (2001). The Eccles and Mason framework develops profiles of treatment attributes. These cost-effectiveness studies are intended to include consideration of multiple dimensions of evidence (effectiveness, tolerability, harm, quality of life, health service delivery issues, costs) in the creation of "attribute profiles" (Eccles and Mason, 2001).

An analysis of the complete set of technology appraisals undertaken by NICE is shown in Table I. This reveals that the majority of technology appraisals undertaken by NICE recommend the particular treatment of drug under consideration. There may be constraints, such as the use of particular therapies being restricted to different phases of an illness. It is also notable that there are a significant number of these technology appraisals where NICE did not have sufficient information to make a recommendation. These gaps in information include both uncertainties over medical outcomes and a lack of publicly available costing studies. This results from the comprehensive and systematic approach taken to such assessments.

More importantly, of these Technology Appraisals (TAs) in which NICE rejects the treatment or drugs under consideration, this is not simply a matter of costs. In TA089 on the treatment of cartilage injury and TA017 and TA105 on colorectal cancer (for which ordinary surgery was recommended as more cost effective than laparoscopic surgery), for TA081 on the use of topical steroids and TA023 on the use of fermozolomide for brain cancer – all of these rejected treatments were on grounds of not being cost-effective. However, there were also treatments within the rejected group, such as TA030 and TA062, both for breast cancer, where treatments were rejected because there was no evidence of effectiveness. This is some removed from the "accountingization" predicted by Power and Laughlin.

Influences on clinical practices and outcomes

Therefore, given the limited manner in which clinical budgeting has impacted on the actions of hospital doctors, as demonstrated by the majority of the research studies above, it is difficult to see how Power and Laughlin (1992) concept of accountingization could take place in the way which they expected. Next, the potential for the negative impact of accountingization in the "sacred" (Power and Laughlin, 1992, p. 127) activities of hospital doctors is analysed from a different perspective. Medical dilemmas (and adverse outcomes associated with them) are examined to determine if, despite the apparent failure of the mechanism of clinical budgeting, hospital doctors values were undermined by accounting and financial constraints on their actions. In particular, these phenomena are examined to scrutinise whether "accountingization" has adverse effects on trust between doctors and patients in the resolution of medical dilemmas.

In a discussion of trust, dilemmas and the role of expert opinion or judgement, Giddens (1991, p. 142) made the following observation:

	($n = 91$)[a]
Treatment recommended	41
Treatment rejected	14
No recommendation: insufficient evidence	36
	91

Table I.
Analysis of results of NICE appraisals of new drugs and treatments

Note: [a]This includes a technology appraisal, which examined two treatments and (a) recommended one, and (b) had insufficient evidence to make a decision on the other treatment
Source: National Institute of Clinical Excellence (NICE) 2007, available at: www.nice.org.uk

> ... dilemmas become particularly acute, or are experienced with special force, during the fateful moments of an individual's life ... the individual feels at a crossroads ... Fateful moments are phases when people might choose to seek refuge in pre-established beliefs and in familiar modes of activity ... at fateful moments individuals are today likely to encounter expert systems ...

This is an insightful comment by Giddens about the need for trust and particularly in the context of "fateful moments" where expert judgement may come to the fore. In this part of this paper, the concept of accountingization and whether it exists or has influenced clinical practice is discussed. The focus is on cases of breakdown in trust because of failure in medical dilemmas, with scrutiny to determine if "accountingization" has made a significant contribution to these "fateful moments".

Three different elements of evidence are examined here:

(1) High profile cases of adverse clinical outcomes in medical dilemmas.

(2) The experiences of leading experts in the medical profession.

(3) The experiences of less experienced members of the medical profession.

This is not, and cannot be, an exhaustive account of all such cases of adverse medical outcomes. As noted above, the very scale of the NHS inhibits such a scrutiny. However, Gray (2005) has estimated that at least 21,000 patients in Scotland have been injured or killed by medical mistakes over 2003 and 2004. This was based on an incomplete (ten out of 15) response from Health Boards in Scotland to a Freedom of Information query. This study by Gray revealed 9,123 incidents where patients were harmed by medical staff in 2004, with a reported 12,120 such cases in 2003.

There is little indication of what has triggered such a high level of adverse outcomes. However, studies of adverse medical outcomes point to medical error as the principal cause of such outcomes (Merry and McCall Smith, 2001). Also, Ferner and McDowell (2006) study of doctors charged with manslaughter in the course of medical practice over the period 1795-2005 concluded that the majority of cases were classified as mistakes (errors in planning) or slips (errors in executing action). However, Rosenthal (1995) study of medical incompetence found a complex picture – a necessary fallibility on the part of clinicians, given the nature of the job; a norm of non-criticism and an exclusivity of professional judgement on whether incompetence had occurred or not. These studies suggest that, *prima facie*, we should not be surprised by medical error. But what is of particular interest here is the role played by accounting information and financial constraints in these circumstances.

The first category of cases received considerable media attention (see Table II). Within these high profile cases, there are examples of medical outcomes, which appear to have been affected adversely by accounting information and/or resource constraints. This observation could apply to cases 2.1, 2.2, 2.3. However, the case of 2.1 is complex. The medical considerations dominate. The reluctance to operate is indicated by the medical outcome in this case. In 2.2, there were suggestions by the family of the deceased, and in the media, that the operation was not carried out because of the cost of treatment. However, the judge's view was that this decision was based on medical grounds and not financial ones. The case of Mr B. is exceptional. In a situation of apparent scarcity, this man had two liver transplants, despite his lifestyle problems, leading ultimately to his demise.

2.1	In 1995 Child B died of leukaemia. Her treatment was the subject of national debate over cost and effectiveness
2.2	In 1995, Miss X died of liver failure. Both cost and medical grounds were cited for a no-transplant decision
2.3	In 1993, Mr A was refused a coronary by-pass because his hospital refused to treat smokers to ration limited resources
2.4	Mr B suffered liver failure through alcohol abuse and had two operations. He resumed his former lifestyle and died in 2001
2.5	In 2004, Mrs Y, with a pacemaker, had an image scan. She died within minutes
2.6	Mrs Z died in 1999 after the consultant did not diagnose her test results accurately
2.7	Surgeon D was suspended in 1997 for being drunk on duty after four patients in his care died
2.8	In 1997 a child had a heart operation and was left brain-damaged
2.9	In 1997 there was a major investigation of high mortality rates in paediatric heart operations at Bristol Royal Infirmary
2.10	A 15-year old died after receiving repeated overdoses of radiation for a brain tumour

Table II.
High profile cases of adverse outcomes in medical dilemmas

Source: Cases extracted from *The Times* and *Scotsman*, 1993 to 2006

Within Table II, the remaining high profile cases all raised issues over the competence of hospital consultants in looking after their patients, with inadequate attention to detail (cases 2.5 and 2.6), the lifestyle of a surgeon and its impact on medical outcomes (case 2.7) and the competence of heart surgeons (case 2.8 and 2.9) and their manner or arrogance in dealing with patients. Within these high profile cases, the issues of accountingization and resource constraints are not evident. Indeed, these cases concur with Hoffenberg (1982) observation on the manner and effect of accounting (not) influencing doctors' decisions, and with the work of Merry and McCall Smith (2001). These are examples of what Giddens calls "fateful moments" (Giddens, 1991) in which the trust of patients, or the parents of patients, is not corroded by accountingization, but is undermined by the actions or inactions of doctors.

The information presented in Tables III and IV is drawn from a major exercise to make the discussion and scrutiny of medical errors more open and transparent. Table III shows 14 cases of adverse medical outcomes by senior medical professionals. These instances stem from the reflections of senior professionals on their lifetime experiences. Of the 14 cases, there are only two examples (3.6 and 3.8) which appear to have the indications of "accountingization" or resource constraints. However, in the case of 3.6, this is rather weak. The doctor in this case has worked long hours, but this is more an enduring case of the employment conditions of doctors than accountingization. Also, while case 3.8 does have the issue of a lack of intensive care beds, there is a multiplicity of factors influencing this outcome.

The remaining examples in Table IV are the medical dilemmas of younger doctors. The table reveals a number of adverse medical outcomes and medical dilemmas, such as poor communication (case 4.1), inaccurate prescriptions (case 4.2), the mixing up of patients test results (case 4.3), the stretching of competences in intervention (case 4.4),

3.1	Use of wrong syringe
3.2	Faulty diagnosis. Death of patient
3.3	Failure to inspect tests, failure to diagnose tumour
3.4	Emergency adjustments in theatre because of inadequate pre-operation
3.5	Wrong diagnosis – brain haemorrhage missed
3.6	Confused vital aspect of drug prescription
3.7	Fatality. Faulty diagnosis
3.8	Dispute over treatment. Tardy treatment of necrotising fasciitis
3.9	Inaccurate diagnosis of testicular cancer
3.10	Wrong incision in surgical procedure
3.11	Injected patient with overdose of drug
3.12	Sprained ankle diagnosed, but patient had a fracture
3.13	Overdose, by ten times, of prescribed drug. Discovered just before injection
3.14	Fatality. Incorrect diagnosis

Source: National Patient Safety Agency, *Medical Error,* 2005

Table III.
Experiences of leading experts in the medical profession in medical dilemmas

4.1	Patient fatality. Inaccurate amount of drugs recorded
4.2	Drug prescribed on a daily basis, but should have been weekly. Patient ill, but recovered
4.3	Mix-up of biopsy results. Two patients received wrong treatments
4.4	Emergency treatment of baby's breathing difficulties resulted in significant damage
4.5	Right operation, wrong patient
4.6	Patient fatality. Chronic condition overlooked

Source: National Patient Safety Agency, *Medical Error*, 2005

Table IV.
Experiences of junior members of the medical profession in medical dilemmas

the right operation, but the wrong patient (case 4.5) and inadequate scrutiny of medical records (case 4.6).

All of these examples of medical error are indicative of human mistakes rather than accountingization. They are suggestive of the practice of medicine as a craft rather than a science (Merry and McCall Smith, 2001). They also suggest that the notion advanced by Power and Laughlin (1992)) that the activities of the medical profession may be regarded as "sacred" is overstated. The examples of hospital doctors impaired by alcohol, or motivated by private gain, or not paying sufficient detail to patients' records are not "sacred" behaviour.

Conclusion

Human frailty is as likely, or more likely, to undermine trust in medical dilemmas then accountingization. This paper has identified numerous examples of adverse medical outcomes, which are the consequence of inadequate standards of care. Such inadequacies may reflect on the personal weaknesses of medical professionals (alcohol problems), inadequate attention to detail (not reading medical notes, with fatal consequences or inaccurate prescribing), inappropriate treatment (the wrong operation). Within these case studies examined here, there are some limited examples of resource constraints. But overwhelmingly, the adverse medical outcomes are matters of human frailty, as the doctors practise the craft of medicine. These findings run counter to one element of the accountingization theses: that medical professionals indulge in "sacred activity".

Furthermore, the accountingization thesis identified a specific mechanism by which the values of accounting could lead to the colonisation of the medical culture. However, that mechanism – clinical budgeting – has not had the impact that Power and Laughlin expected. Indeed, the majority of empirical studies demonstrate the failure of the various clinical budgeting initiatives to impact on the actions, thoughts and behaviours of medical professionals. There are numerous reasons for this (the over-optimism of the initiators, the inability to transfer budgetary systems from industrial settings to health care, the failure to capture and analyse the kind of information which medical professionals would understand and value).

However, the constructs of the 1980s and 1990s may have been superseded by different forms of accounting. One particular such mechanism is the new structure of national reference costs in the case of the National Institute for Clinical Excellence, which makes recommendations on the acceptability of new treatments in terms of medical efficacy and affordability. A notable example of this is the manner in which not all patients with suspected breast cancer have equal access to drugs such as Femara or Herceptin, which many specialists consider to be more effective than present treatments. This is not what Power and Laughlin envisaged as accountingization, but this impacts on that part of doctor's decision-making practices, which have long been influenced by costs – drug treatments. On the basis of the above analysis, the conclusion must be accountingization has not taken place in the UK's National Health Service.

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Corresponding author
Irvine Lapsley can be contacted at: I.Lapsley@ed.ac.uk

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New workforce roles in health care

Exploring the longer-term journey of organisational innovations

Jackie Bridges
City University, London, UK
Louise Fitzgerald
De Montfort University, Leicester, UK, and
Julienne Meyer
City University, London, UK

Abstract

Purpose – This paper seeks to present findings from a longitudinal action research study aimed at exploring one such innovation. Little is known about the micro-level impact of health service innovations over time.

Design/methodology/approach – The paper shows that action research is a participatory approach ideally suited to monitoring the process and outcomes of change. Over 20 months, an action researcher studied the work of four interprofessional care co-ordinators (IPCCs), whose role was intended to speed patient through-put within a London teaching hospital general medical directorate. The action researcher kept regular participant observation field notes and supplemented these data with a profile of IPCC patients ($n = 407$), in-depth interviews ($n = 37$) and focus groups ($n = 16$) with staff. Throughout the study, findings were regularly fed back to participants to inform practice developments.

Findings – The findings in this paper show that, in spite of the original intention for this role to provide clerical support to the multidisciplinary team, over time the role shifted beyond its implementation into practice to take on more complex work from registered nurses. This raised actual and potential governance issues that were not attended to by service managers. A complex and turbulent context disrupted managers' and practitioners' abilities to reflect on and respond to these longer-term role shifts.

Originality/value – This paper argues that the complex nature of the innovation and the setting in which it operated account for the role shift and the lack of attention to issues of governance. Current innovation literature suggests that implementation into routine practice represents the end-point of an innovation's journey. These findings suggest that certain innovations may in fact continue to shift in nature even after this "end-point". The conclusions drawn are likely to be of global interest to those interested in complex health service innovations.

Keywords Innovation, National Health Service, United Kingdom

Paper type Research paper

Introduction

This paper reports findings from an in-depth study of an innovation, namely a new workforce role in the UK National Health Service (NHS). The role of interprofessional care co-ordinator (IPCC) was introduced to a general (internal) medical directorate

The authors thank Dr Sue Dopson and Professor Trish Greenhalgh for their comments on earlier drafts.

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 381-392
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778916

within a UK inner city teaching hospital to facilitate speedy patient throughput. In spite of the high frequency and wide diversity of recent NHS innovations, theory on the diffusion of innovations is underdeveloped in the health services context (Greenhalgh *et al.*, 2004a). In particular, little is known about what happens to innovations after they have been introduced into mainstream practice. This paper begins by exploring the theoretical, policy and local context for this study. Following this, details of study methods and findings are shared. The implications for policy are then discussed in the light of findings that highlight the need for ongoing scrutiny of innovations beyond the point of implementation into routine practice.

Theoretical context: gap in understanding at point of institutionalisation

Greenhalgh *et al.* (2004a) define an innovation in health service delivery and organisation as "a set of behaviours, routines and ways of working, along with any associated administrative technologies and systems", which are:

- Perceived as new by a proportion of key stakeholders;
- Linked to the provision or support of health care;
- Discontinuous with previous practice;
- Directed at improving health outcomes, administrative efficiency, cost-effectiveness, or the user experience; and
- Implemented by means of planned and co-ordinated action by individuals, teams or organisations' (p. 40).

Greenhalgh *et al.* (2004a) particularly highlight the criterion of "discontinuous with previous practice" to distinguish innovations from other service developments.

Many studies in the field of innovation have focused on the journey, which is taken from the initial idea for an innovation through to its implementation into routine practice (Wolfe, 1994). However, there is a growing recognition that more work is needed to inform understanding of the "end-point" of this journey. Van de Ven *et al.* (1999) claimed that innovations terminate when they are implemented and institutionalised, or when resources run out. Innovation theory in general reflects an end-point at which an innovation is integrated or embedded into routine organisational operations, and the goals and values surrounding the innovation are internalised by the organisation. This end-point however is loosely defined in the literature. Greenhalgh *et al.* (2004b) argue that the most serious gap in the literature on innovations relates to the question "by what processes are particular innovations in health service delivery and organisation implemented and sustained (or not) in particular contexts and settings, and can these processes be enhanced?" (p. 620).

Much of the recent innovation research in health care has focused on the influence of context on the innovation journey. For instance, research to date suggests that health care professionals play an active part in the interpretation, reconstruction and negotiation of new scientific knowledge for local use (Ferlie *et al.*, 2005; Locock *et al.*, 2001). A number of other context-specific variants ranging from government policy through to influences specific to an individual practitioner have been suggested by research to date, but the complexity of the mix and contribution of different variants makes more work in this area of great importance.

In addition to a lack of understanding of the sustainability of health service innovations, and the influence of the context on the journey of innovations, limited attention has been paid to the substance of organisational innovations. Research on innovation in health care has mainly concentrated on clinical and technological innovations and limited work has been done on new workforce roles. Wolfe (1994) review suggests that the differing attributes of innovations influence the journey taken. The action research study of a new workforce role outlined below attempts to throw further light on the two key gaps in knowledge in relating to the "end-point" and substance of innovations.

Policy context: innovation through workforce development

Current NHS policy explicitly challenges the traditional boundaries between occupational groups in the health service and encourages service providers to "shatter the old demarcations which have held back staff and slowed down care" (Department of Health, 2000, p. 83). This has translated into guidance supporting the development of new and "redesigned" workforce roles designed around service needs rather than existing occupational groups. A diverse plethora of new and redesigned roles has subsequently emerged across the NHS. Their widespread introduction is reflected in recent NHS policy developments related to competencies, pay and professional regulation.

Despite this policy thrust, research into the introduction of new workforce roles is rare, and not strongly related to the research on innovation. The project outlined below provides a useful case study of issues that may be relevant to new workforce roles in practice. In addition, it offers an opportunity to evaluate the relevance of innovation theory to role innovation within turbulent contexts, such as the NHS in the UK.

Local context: a new flexible workforce role

This study focuses on the development of an innovation in the general (internal) medical service of a large, inner London acute (tertiary) hospital in the UK. In 1996, service managers had introduced a new role to the workforce, that of IPCC. Four IPCCs were appointed, each having held clerical positions in the hospital previously, but none of who held health or social care qualifications or professional registration. Their prime tasks were to offer clerical support to the interprofessional team in moving patients through their admission as fast as their clinical status would allow and to help remove non-clinical obstacles to patient progress (such as delayed test results). Managers had encouraged the IPCCs to be flexible in the work they took on, so that they could easily respond to individual patient needs and were not constrained by boundaries dictating what they could and could not do. The management of the IPCCs changed a number of times during the study. Sometimes they were managed by the senior nurse for general medicine and at other times by the service manager for general medicine. The post of IPCC was unique to the hospital (and to the UK as far as could be determined) and could therefore be considered an organisational and role innovation.

While the introduction of the IPCC role preceded health service policy on new workforce roles, the IPCCs represent exactly the challenge to traditional workforce boundaries that current UK policy is now aiming to promote.

Methods

The study began in 1998 (two years after the IPCCs took up post) with the objectives of exploring and describing the characteristics, impact, issues and influences on the IPCC role. The study took place over 20 months within the framework of an action research approach. Action research is part of a participatory paradigm in research that emphasises the value of the quality of relationships between inquiry participants in enriching the findings and optimising their utility in informing positive, practical changes (Heron and Reason, 1997). Participatory inquiry blurs the distinction between the researcher and the researched, and in this study the lead investigator worked alongside hospital staff to negotiate appropriate research methods informed by practice and emerging findings, and to use emerging study findings to prompt new reflections and initiate practice changes.

Mainly qualitative data were gathered, an approach consistent with exploring phenomena in-depth. Data were gathered from the following sources: field notes of participant observations over 20 months (including 24 half-day sessions shadowing the IPCCs at work); semi-structured interviews with 37 interprofessional staff from 11 different professional groups (including practitioners and managers); 16 focus groups (unidisciplinary and interprofessional); profile of the characteristics of 409 IPCC patients; and analysis of key documents such as job descriptions and hospital policy.

All qualitative data were initially handled using NUD*IST Version 4, specialist software tool for the management of qualitative data. Following initial coding using NUD*IST, coded data were re-read, reflected on and re-categorised into wider themes. Cross-analyses were also conducted to enable exploration of relationships between variables. Finally, emergent themes were compared against the wider body of knowledge to enable new understandings to emerge.

A number of measures were taken to optimise the trustworthiness and transferability of the data (Gillis and Jackson, 2002; Lincoln and Guba, 1985). For instance, as findings emerged, constant checks were made with the original data to ensure consistency. In addition, negative cases and alternative hypotheses were examined fully (Murphy *et al.*, 1998). An audit trail was kept of research processes and decisions taken, in addition to an explicit account of investigator assumptions and values (Gillis and Jackson, 2002). Whilst direct generalisation from case study research can often be seen as problematic, the depth of analysis in this longitudinal study allows for wider transferability through both theoretical development and enabling the reader to judge for themselves the relevance of findings to their own practice context (Meyer *et al.*, 1999; Murphy *et al.*, 1998; Sharp, 1998).

The following two sections illustrate key findings arising from these activities. The first section shows how the substance and core tasks of the IPCC role shifted over time and the second explores the contextual influences on the role. Findings are reported in greater detail by Bridges (2004).

Findings

Shifts in the substance of the role

The findings reflect that, two years on from the role's introduction to practice, the IPCCs had become an accepted and valued part of routine practice in the general medical service:

> It is just a huge communication point because (the IPCCs) bring the whole team together, so they will often feed things back into the medical team or liaise between social work and occupational therapy (Physiotherapist 1, focus group).

However, the findings also reflect a significant difference between the original IPCC job description and their work in practice. While some clerical co-ordination had been retained as part of the role, the IPCCs had also taken on the lead in planning and actioning the discharges of the most complex patients. This role had previously only been carried out by registered nurses (RNs). Over the two-year period, this task had gradually shifted to the IPCCs without this being questioned seriously, though a number of respondents expressed concerns:

> What has ended up happening is that (the IPCCs) do devote quite a lot of time to discharge. I'm not sure how much time they are able to spend on the front end of the patient's stay (Manager 1, interview).

The role shift then continued in this direction throughout the course of data collection, as noted by the IPCCs during their final focus group in the study:

> I think we're more focused on discharge planning than anything else (since the start of the study). I mean, I suppose we'll always be called care co-ordinators, but to be quite honest with you, I think we should be called discharge co-ordinators, because a lot of the other jobs go out of the window if you haven't got enough time (IPCC 1, focus group).

Although the IPCC role had continued to shift, other findings reflect that the managerial systems to support it had not. The IPCC job description continued to reflect a purely clerical role and hospital policy still named registered nurses as the lead occupational group in discharge planning. The IPCCs had received no training since their initial induction and the regulatory aspects of their move into the core work of registered nurses had not been explored or clarified. The IPCCs also continued to work autonomously and without supervision in spite of developing a significant amount of patient and family contact over time. While the IPCC role was clearly valued by the IPCCs' managers and their clinical colleagues, the field notes highlighted a number of instances in which the quality of IPCC practice could have been improved by further training or improved supervision.

In summary, findings here reflect that a significant role shift into the core work of registered nurses had occurred. The role shift continued in that direction after the IPCC role's institutionalisation into routine practice. Findings also reflect a lack of managerial response to the role shift and a number of instances in which the quality of patient care was potentially adversely affected by the substitution of nursing work by the IPCCs. The next section presents findings that explore the context that defined the response of managers and practitioners to the role shift.

Reflection and learning constrained by complex context

The action research approach to this study included highlighting findings as they emerged to managers and practitioners with the aim of prompting reflection and positive developments in practice. However, while some changes were made (for example, changing the organisation of medical teams to a ward-based system), no changes were made in the way that IPCCs worked or that clarified any of the issues around their training, regulation and supervision. Some changes in this regard were

started but never completed. An exploration of this lack of response with the managers and practitioners threw light on a number of contextual attributes that served to constrain reflection and learning by managers and practitioners.

Other managerial duties distracted from learning

Service managers described a context for their work that was complex and demanding, often requiring instant responses to unanticipated situations, or complying with externally set deadlines. A key pressure consistently identified by the managers and evident throughout the field notes was the need to ensure, as far as possible, that hospital beds were only occupied by people who were acutely ill and not, for example, occupied by people well enough to leave hospital but whose discharge had been delayed for non-clinical reasons. This was in line with central government priorities and described by service managers as a hospital board priority:

> Our drive, if you look back, although we maybe had a vision about what we wanted to do and what we wanted to achieve, our drive was that the board stated that, our length of stay was unacceptable, it was too high. So we had a very tangible target that was very managerially set out (Manager 3, interview).

This demand was often what focused staff's attention, and, although the service staff felt they were managing as effectively and efficiently as they could, pressures remained high. The shift of the IPCC role to discharge planning was attributed to the need for efficiency with resources:

> So I think that emphasis (of IPCC work on the whole inpatient stay) has gone and I think that is an emphasis which has probably come to us just the way the health service is running at the moment, that you need the beds and the only way to have empty beds is to make sure that you are discharging people timely and effectively (Manager 2, interview).

It is perhaps unsurprising that managers were reluctant to interfere with a role that was seen to successfully contribute to achieving this. This reluctance to look more proactively at the role is reflected in the views of the IPCCs' manager on encouraging the IPCCs to undertake further formal training or gain accreditation of some kind for the skills they had:

> They've got no interest in doing it. Perhaps a couple of them think they do it already, they are a bit too old and people don't want to do it . . . if there had been complaints or somebody was under-performing then I would have turned round and said you have to do this course (Manager 2, interview).

Findings reflect a sense from managers and practitioners that, once the IPCC role had become established into everyday practice, it was difficult to build up the momentum to initiate change, in spite of the fact that the role shift had raised new issues and that participants had agreed on the need to address these issues:

> I think what the action research has done is taken something that had a real danger of stagnating and getting very complacent and a bit stale and made it take a fresh look at itself. I think [the IPCCs] are a very good example of the way things operate in that we have lots of ideas, we get these things started, we're really interested in them to start with and then we move on to something else, and we leave these people to sort themselves out and get on with it (Manager 4, interview).

This quote draws attention to a key difference between introducing and sustaining an innovation, and this continues to be a neglected topic.

A further factor was also identified in relation to managerial attention to the role. In the four years between the role being introduced and the action research study ending, the IPCCs had five different managers. This lack of continuity impacted on the organizational capacity to take a long-term view of role development and is consistent with other findings (not detailed here) which illustrate that the most successful changes achieved during the study were led by managers who had been in post for relatively long periods of time. A picture is described here of an organisational context in which change was common and was often perceived to be outside the control of participants. Other matters, particularly the need to ensure efficient use of hospital beds, distracted managerial attention from reflecting on and learning from the IPCC role shifts.

Perceived lack of control by RNs

In addition to a lack of managerial attention, it is clear that health care professionals, particularly RNs, did not perceive that they had any responsibility for or involvement in sorting out the issues of IPCC governance. This is clearly illustrated by exchanges between nursing ward managers in a focus group on the IPCC role. While the ward managers did not complain about their lack of control over the role or raise it as an issue, findings illustrate that the decision-making about the role was perceived to lie elsewhere:

> The question I'd like to ask is somewhere along the way the hospital is now going to have to accept what (the IPCCs) are doing and give you the responsibility or they are going to have to accept that they are asking the nurse to take responsibility and therefore let us do it, and I don't mind which way they do it but I just don't want to be caught in between where I'm being asked to be responsible for something I'm not actually doing (Ward manager 1, focus group).

Despite their positions, the ward managers exhibited a passive response to the IPCC issues even when the way the IPCCs worked clearly inconvenienced them. Even when the IPCCs were being directly managed by the senior nurse, RNs acted as though they had no influence over how IPCC roles worked. The tasks of the IPCC role lay in an area of overlap with RNs, but the latter did not perceive that they had influence or a responsibility for the quality of the input to patients. Thus managers did not receive input from practitioners about the IPCC role and its attendant issues, and this may also have reduced managers' imperative to act.

In summary, findings in this section have illustrated key contextual influences present during the study. While there was agreement that issues of training, regulation and supervision needed addressing given the shift of the role into the core work of registered nurses, a number of key factors were identified that influenced the role and its management. Managers were distracted by other priorities, particularly the need to ensure efficient use of hospital beds, this efficiency being aided by the IPCC focus on discharge planning. RNs did not perceive that they had control over the work of the IPCCs, although the IPCCs were carrying out work that was formerly the territory of RNs. The final section explores the implications of these findings for theory and practice.

Discussion

Theoretical and conceptual contribution

These findings raise a number of implications for theory on the diffusion of innovations and for the management of innovations. Unusually, this research tracks the processes of the innovation journey over time and is able to demonstrate the length of the innovation journey. In addition, the participatory and in-depth approach taken with data collection enabled key practical issues associated with the role and its context to emerge. As noted earlier, much innovation theory implies the notion of an end-point to an innovation once it has become an accepted part of routine practice. However, these findings challenge the assumption that this is indeed the end-point of the journey. The role boundaries and practices of the IPCC role continued to shift well after the role had been accepted and embedded into routine practice in the service.

It may be helpful here to distinguish between the existence of a role and its boundaries and practices. The IPCC role had been implemented into routine practice, accepted and utilised by interprofessional colleagues. However, the persistence of the emergent nature of its practices, discontinuous with previous practices (Greenhalgh *et al.*, 2004a), merits a continuing label of innovation. The marked contrast between the formal role (evidenced through the job description and hospital policy) and its informal practices (often hidden) highlight the importance of furthering understanding in this area. The findings point to two key layers of influence that help account for the complex picture reflected here: innovation attributes and contextual attributes.

Innovation attributes

This innovation's attributes may have increased the likelihood of continuing role shifts. It is possible that the nature of the innovation as a new role rather than, say, the introduction of a concrete, new piece of technology or a drug, impacted on the journey taken by this innovation and increased the likelihood of it having a complex journey. In addition, the IPCCs were charged with doing whatever was required to move patients through the system as fast as clinically possible. This flexibility justified the absorption of new work, in line with the changing demands of organisational targets and individual patient needs, and may also have given implicit authority to the role shifts that occurred. The fact that the IPCC roles were each held by individuals with a range of personal characteristics added a further layer of complexity to the innovation journey. The substance of organisational change is a relatively unexplored area (Buchanan *et al.*, 2006) and these findings further our understanding by reflecting that inherent complexity adds to the likelihood of a non-linear journey and accounts, at least in part, for the dynamic nature of this role's practices.

Contextual attributes

This study's findings add to our understanding of the influence of health service context on the journey of innovations, particularly new roles, and lend empirical weight to claims that context influences the journey of an innovation. Findings have highlighted a number of contextual attributes that constrained managers' ability to reflect on the role beyond its initial introduction and act in response to identified needs.

In particular, top-down government targets for efficient use of acute beds sanctioned the IPCC role shifts, creating a context in which reflecting on and developing alternative modes of managing acute efficiency was difficult. The existence

of a top-down agenda that drives priorities echoes theory on the new managerialism that identifies the "command and control" influence that the current Labour government in particular has achieved (Klein, 2001; Lapsley, 2001). The findings also raise questions concerning the dysfunctional side effects when attention is focused solely on one or two indicators of quality and management do not feel able to adopt a balanced approach. This echoes elements of Weick and Sutcliffe (2003), in their analysis, which describes hospitals as "cultures of entrapment" in which individuals become set in patterns of behaviour.

The organisational change literature also highlights the importance of managerial stability in the effective management of strategic change. Pettigrew *et al.* (1992), point out that the unplanned movement of key personnel results in draining of energy, purpose, commitment and action from a change programme, and that the change programme "goes into a period of regression leaving the newcomer manager to start again but now possibly in a soured and non-receptive context for change" (p. 278). Other studies also show that high levels of turnover, particularly amongst senior managers, have a negative impact on the progression of service improvements (Fitzgerald *et al.*, 2005; Griffiths and Wilson-Barnett, 2000). These findings lend support to the idea that there is often a loss of momentum in a change programme in the face of managerial turnover.

The findings here throw new light on the role played by practitioners in the journey of an innovation. While much previous research has indicated that health care practitioners can play an active part in customising innovations for their local utility (Ferlie *et al.*, 2005; Locock *et al.*, 2001), these findings suggest a passive role can instead be taken. RNs in this study deferred responsibility for how the IPCC role was shaped to more senior managers and to the IPCCs themselves. This more passive response may be accounted for by the fact that much of the previous research has focussed on the part played by medical staff, a traditionally dominant group, or by multidisciplinary teams, while the present study has examined the part played by nurses, a group that has traditionally been more influenced by state and/or organisational needs (Allen, 2001; Davies, 1995).

Recent research in health care moves the analysis of the role of context a stage further to suggest that within complex organisations, context is not merely the backcloth to change but that actors and features of the context interact, as here, and form a part of the change process (Dopson and Fitzgerald, 2005; Fitzgerald *et al.*, 2002).

In summary, this study makes a key contribution to innovation theory through its identification that a work role innovation can become institutionalised while its boundaries and practices remain emergent and innovatory. These dynamic features are related to attributes of both the innovation and its context.

Implications for policy and management

The findings indicate that managers and practitioners were operating with an assumption that managerial and professional attention was required as an innovation is introduced and accepted, but not once the role was part of routine practice and working effectively in helping to achieve acute efficiency. The data demonstrate that emergent and innovatory practices continue, in ways that are complex to define and measure. This raises questions about how long an innovation may need to be monitored. If roles are left deliberately flexible and unconstrained by traditional

occupational boundaries, then role shifts and the consequent cumulative effect of unintended consequences may well occur over long periods of time, incurring new governance requirements. However, if organisational energy is by this time focused on other things, these requirements may be ignored at the cost of patient safety and quality of care. These findings might lead one to suggest that institutionalising and embedding an innovation appropriately into an organisation, and making decisions about its ongoing scrutiny, require as much energy and skill as the initiation and adoption stages.

These research findings raise important issues and questions for the formation and execution of health care policy in three key areas. The new and redesigned roles promoted in UK policy, particularly those that challenge current occupational boundaries, represent a major challenge to the status quo in professionalised settings, where roles are subject to professional regulation managed through traditional groupings. Prior research (Hinings *et al.*, 2003; McNulty and Ferlie, 2002; Pettigrew *et al.*, 1992) has clearly indicated that the intentions of such radical changes are frequently "diverted" and produce unintended consequences. This case study draws attention to the risks and the potential issues involved in developing new roles – and the absence of clear arrangements for regulating and monitoring the emergence of these new roles.

Second, our data highlight that practices in the role continued to develop over a prolonged period and resulted in alterations to role boundaries. The additional tasks performed by the IPCCs included tasks previously within a professional role. Despite these issues being raised with the action research project, they were not addressed by either management or nursing professionals. Clearly, these data focus attention on issues of managerial control and professional governance. At the broadest level within the institution, one might question who is managing and monitoring the extension of the IPCC's role. Significantly, our results suggest that this was seen as neither a management nor a professional responsibility, with potentially negative implications for the quality of care.

Third and finally, there are strong indications here that the managers and senior staff did not have any depth of knowledge or understanding of innovation and change processes. Thus they were not alerted, in advance, to potential dangers or attentive to unintended consequences. Given the similarity of the challenges facing health systems internationally, the type of change described in this case example may well be extended throughout the health care sector with role developments and role experimentation becoming widespread. If this is to occur, then there is a clear need to develop the capacity for change management and for supporting and monitoring role change.

While these findings originate from one case study, they have current and wider relevance. The participatory nature of this action research study enabled a rich picture of change over time to emerge that offers more useful guidance for policy and practice than the commonly used "snap-shot" evaluations of NHS innovations. Findings suggest that it is possible for complex innovations such as new workforce roles operating in complex contexts, such as the public services to merit a different kind of attention than is currently assumed. Current UK public workforce policy reflects the assumption in conventional innovation theory that, once an innovation has become institutionalised into practice, its nature and output remain stable. As this study

illustrates, use of this assumption in practice raises concerns of governance. These findings suggest that policies are urgently needed that acknowledge longer-term workforce role shifts and that promote a reflective and empowered culture which encourages debate between managers and practitioners in the public services.

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Corresponding author
Jackie Bridges can be contacted at: j.m.bridges@city.ac.uk

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Understanding power relationships in health care networks

Rachael Addicott and Ewan Ferlie
University of London, Egham, UK

Abstract

Purpose – The purpose of this paper is to show that networks are emerging as a new, innovative organisational form in the UK public sector. The emergence of more network-based modes of organisation is apparent across many public services in the UK but has been particularly evident in the health sector or NHS. Cancer services represent an important and early example, where managed clinical networks (MCNs) for cancer have been established by the UK National Health Service (NHS) as a means of streamlining patient pathways and fostering the flow of knowledge and good practice between the many different professions and organisations involved in care. There is very little understanding of the role of power in public sector networks, and in particular MCNs. This paper aims to explore and theorise the nature of power relations within a network model of governance.

Design/methodology/approach – The paper discusses evidence from five case studies of MCNs for cancer in London.

Findings – The findings in this paper demonstrate that a model of bounded pluralism can be used to understand power relations within London MCNs. However, power over the development of policy and strategic direction is instead exerted in a top-down manner by the government (e.g. Department of Health) and its associated national bodies.

Practical implications – The paper supports the argument that the introduction of rhetoric of a more collaborative approach to the management of public services has not been enough to destabilise the embedded managerialist framework.

Originality/value – This paper uses empirical data from five case studies of managed clinical networks to theorise the nature of power relations in the development and implementation of network reform in cancer services. Also, there is limited understanding of the nature of power relations in network relationships, particularly in relation to the public sector.

Keywords National Health Service, United Kingdom, Cancer

Paper type Research paper

Networks are emerging as a new, innovative organisational form in the UK public sector (Pettigrew and Fenton, 2000). The emergence of more network-based modes of organisation is apparent across many public services but has been particularly evident in the health sector. Cancer services represent an important and early example. Managed clinical networks (MCNs) for cancer have been established by the UK National Health Service (NHS) as a means of streamlining patient pathways and fostering the flow of knowledge and good practice between the many different professions and organisations involved in care. There is very little understanding of the role of power in the structuring of public sector networks, and in particular MCNs (Ferlie and Pettigrew, 1996). There is considerable literature that focuses on the dominance of professionals in health care, and the ability of the medical profession to govern their own practice and the organisation of institutional services, however MCNs

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 393-405
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778925

offer an alternative organisational and governance structure where managers potentially have a greater role in decision-making.

The paper will discuss evidence from five case studies of MCNs for cancer in London. The findings demonstrate that a model of bounded pluralism can be used to understand power relations within London MCNs. However, this discussion deals solely with the demonstration of localised power through the enactment and implementation of policy and strategic direction. Power over the development of policy and strategic direction is instead exerted in a top-down manner by the government (e.g. Department of Health) and its associated national bodies. Using a public management perspective, this paper further suggests that, despite rhetoric of localised innovation and knowledge sharing in the NHS, the reality is that the dominant New Public Management (NPM) framework – and its centralised administration – has proven to be too powerful for clinical networking to survive in a meaningful way. The strengthened vertical lines of the NPM model that developed during the internal market era made it more difficult for networks to develop. This supports the argument of McNulty and Ferlie (2002) that the introduction of rhetoric of a more collaborative approach to the management of public services has not been enough to destabilise the embedded NPM framework.

Introduction

This paper describes a research study that explored the impact of a potentially novel mode of service delivery in the United Kingdom (UK) National Health Service (NHS) – managed clinical networks (MCNs). The MCN model was initially developed as an attempt to transform the delivery of cancer services, as survival rates for many cancers in the UK have historically been poorer than in the rest of Europe and there have been significant variations in the quality of, and access to, treatment and care across the country (National Health Service, 2000).

The MCN model, as developed within cancer services, has been defined as "linked groups of health professionals and organisations from primary, secondary and tertiary care working together in a coordinated manner, unconstrained by existing professional (and organisational) boundaries to ensure equitable provision of high quality effective services" (Edwards, 2002, p. 63). These networks were developed initially as a means of streamlining patient care and fostering the flow of knowledge between professionals and organisations.

Note, however that these new networks evolved to be managed rather than taking their traditional informal and tacit form. They were to employ management teams and be responsible for meeting the key targets outlined in the NHS Cancer Plan (2000). In this politically sensitive sector there have been central targets imposed (e.g. reducing waiting times) that networks have been expected to deliver and which have been monitored through performance management. There has also been a strong policy focus on organisational restructuring, with centralisation of services in centres of excellence.

According to MCN policy (Calman and Hine, 1995; National Health Service, 2000), cancer centres were to be acute institutions that carried expertise in the management of all cancers and would offer specialist diagnostic and therapeutic techniques. The units, however, would be based in district hospitals, with their function being to focus on routine treatment of common cancers. It is evident that the MCN model is established on the basis that specialisation and centralisation of cancer services will improve outcomes.

There is a considerable body of academic literature that examines the network model in practice, however much of this has failed to consider the impact of power or accountability relations (Thompson *et al.*, 1991; Huxham and Beech, 2002). Analyses of networks typically consider the model to be based on internal developed forms of collaboration and consensus between network stakeholders, however the MCNs presented here reflect a managed network model, which is subject to considerable government regulation and a multiplicity of divergent stakeholders with somewhat competing purposes.

Utilising a political science and public management perspective, this study attempts to extend the existing knowledge of interorganisational and interprofessional power relations within public sector networks, specifically the population of five MCNs for cancer in London. It is envisaged that the "forced" nature of the relationships and subsequent communication within these networks may have presented different power relations and conflicts than have been exposed in private sector networks. This study will utilise three different political science theories from pluralist, structuralist and post-structuralist approaches as a guide for understanding how power operates within MCNs for cancer. This section of the paper will outline each of these theoretical approaches, as operationalised by a particular scholar. It will also use the public management literature to consider the steering role of the Department of Health.

Theories of power

Dahl's pluralist approach to power

Dahl (1958, 1961, 1986) pluralist approach assumes that power only exists when it is being exercised through action and response. Pluralist approaches are based on a consensus (rather than conflict) approach which holds that common interests and values ensure that cooperation, rather than conflict, is experienced most of the time as actors strive for agreement. Dahl proposes that if an issue does not reach the political agenda, it may indicate that there is no discontent. While pluralists generally view the state as referee, Dahl considers the state to be merely one player in the decision-making process (Ham and Hill, 1993). Dahl chose the political issues for consideration in his 1961 study of decision-making on the criteria of there being disagreement between two or more individuals, therefore the study only focused on open conflict (thus ignoring unexpressed conflicts). Pluralist democracy is reliant upon the existence of bargaining between groups as a means of resolving conflicts.

A common criticism of Dahl (1957, 1961, 1986) pluralist approach is that the assumptions presuppose the conclusions. By emphasising overt conflict and direct decision-making, the approach is restricted and could not identify any explanation other than a pluralist one. Although Dahl's pluralist conceptions initially arose from a critique of elite theories, more recent theorists have attempted to integrate some of the key principles of both pluralism and elitism.

The "plural elite" model proposes that a plurality of elites exist that interact for the purposes of consensus building. Interaction between elite groups is infrequent, however elites do interact on specific issues where power is centralised in a core group at the top of each of the involved organisations. Power is dispersed – but also contained within a finite number of multiple elites. Within these multiple elites, there are no dominant groups and each remains relatively autonomous (Hazan, 2001).

Alford's structuralist approach to power

Structuralism argues that pluralism is simplistic in its thesis that power can be observed, measured and negotiated through overt conflict (Hancock, 1999). Alternatively, the key feature of structuralism is that dominant groups may control agendas to promote or protect their dominance, even if not responding to a direct challenge – the powerful remain so without having to act (Harrison *et al.*, 1992).

Alford (1975), p. xiv) conducted a comprehensive and widely cited structuralist analysis of power relations in the formation of health policy in the US. Alford argued that one of the primary barriers to reform is the power of strategically structured interest groups. Through this analysis, Alford identified three major structural interest groups: "…'professional monopolists' controlling the major health resources, 'corporate rationalists' challenging their power, and the community population seeking better health care via the actions of the 'equal-health advocates'".

Ham (1981) applied Alford (1975) structural interest approach to a study of policy development and decision-making at a UK regional hospital. Ham found that the distribution of power weighed heavily in favour of the professional monopolists (medical professionals). Corporate rationalists (hospital administration and management) won some challenges at a Board level, however they typically did not attempt to challenge the professional monopolists on service delivery. Powerful professional interests at an operational level were the main obstacle in implementing policy, however power within the medical profession was unevenly distributed in favour of senior staff in acute specialties.

Fairclough's post-structuralist approach to power

More recent research (Ham, 1981; Harrison, 2001) implies that structuralist approaches are becoming increasingly irrelevant as the health care system becomes more complex and heterogeneous. There is an emerging body of literature, which suggests that possession of knowledge and specialist discourse are particularly relevant to the distribution of power. Such post-structuralist approaches hold that the world is constructed and maintained through shared language, and that it is actually through theory, ideas and language that issues of power and domination are played out and resolved (Mizen, 1998; Hassard, 1999).

Fairclough (1989, 1992) post-structuralist perspective proposes that the use of language is related to unequal power relations. Ideological assumptions are implicit in social conventions and legitimise existing social relations and differences in power. Disparate power relations are created not only through what is said, but also through who has access to different discourses and who has power to impose and enforce constraints on access. Discursive practices are socially controlled and constrained – what can be said by whom in particular situations, boundaries between disciplines and social constraints on access to particular discourses, all reflect and maintain existing power relations.

The bio-medical discourse has historically been dominant in health care (Fairclough, 1992). This alienates other health care stakeholders, including patients and managers (Maynard, 1991). However, Ferlie and Fitzgerald (2001) suggest that there has been a dramatic and sustained rise of management functions, knowledge, authority and also discourse in the UK. Managerial concepts and language (e.g.

management of change; service improvements) have been adopted within policy, and managerial control and language could replace professional control and language.

As each body of literature briefly presented above developed through a critique of other understandings of power, they utilised increasingly complex conceptualisations to explain the distribution of power. Pluralist perspectives appear to be insufficient and naïve in their explanations of power, too reliant on an assumption of consensus – or at most bargaining – through individual decision-making. Structuralist considerations, through their critique of pluralism, instead place too great an emphasis on structural forces and homogenised categories, while dismissing human agency. Post-structuralist perspectives move away from the agency-structure debate altogether, and instead propose that all power relations are based on the way that discourse functions to create a collective and exclusive identity.

There is very little understanding of the role of power in public sector networks, and in particular MCNs (Ferlie and Pettigrew, 1996). There is considerable literature that focuses on the dominance of professionals in health care, and the ability of the medical profession to govern their own practice and the organisation of institutional services, however MCNs offer an alternative organisational and governance structure where managers potentially have a greater role in decision-making. As such, this paper will consider how the three different theories of power apply to interorganisational and interprofessional relationships in managed clinical networks for cancer.

Methodology

Comparative case studies of the five MCNs for cancer across London were utilised to provide an in-depth understanding of the relationships between the organisations and professional groups involved. These London networks are comprised of multiple teaching and local district hospitals, as well as service commissioners and health authorities – contained within a relatively small geographical area. This complexity is not evident to the same degree in the cancer networks in other parts of England and Wales, therefore the selection of these five cases is also considered to represent more complex cancer networks.

This study examined three specific issues (or "tracers") in order to gain some insight into power relationships in the newly formed MCNs for cancer. These tracers were:

(1) Centralisation of specialist services;

(2) Budget/resource allocation, and;

(3) Education and training activities.

Case studies – triangulation

Three methods were combined to gather data – semi-structured interviews, document analysis and observation at meetings. Multiple data sources were used to address a wide range of issues, and provide a more convincing and robust contextual account. A total of 117 semi-structured interviews were conducted with representatives from a range of organisations and key professional groups involved with the London cancer networks. Table I outlines the range of professional groups to which these interviewees belong[1].

Key organisational documents were also analysed to provide a historical narrative of the development of the cancer networks and a textual indication of communication

	Network A	Network B	Network C	Network D	Network E	Total
Medical	2	7	9	9	10	37
Nursing	3	4	4	3	5	19
Managerial	1	4	3	3	0	11
Network Management	5	6	4	5	5	25
Strategic Health Authority	1	1	2	2	1	7
Primary Care	2	0	0	1	1	4
Palliative Care	1	1	1	2	0	5
Commissioners	1	1	3	2	2	9
Total	16	24	26	27	24	117

Table I.
Interviewees by network and professional group

Note: Networks are anonymised and referred to as "Network A", "Network B", etcetera

and accountability arrangements between the organisations and groups within the networks. Network meetings were also attended to observe and gain further insight into how the groups relate in a professional environment.

Data analysis

First, some consideration needs to be given to the operationalisation of the three previously identified theories of power, or more simply – how to identify these theories in action. On the basis of the core principles of each specific theory that was considered, power relations were identified through:

(1) *Pluralism*: evidence of cooperative bargaining between different coalitions of stakeholders across different issues;

(2) *Structuralism*: evidence of professional dominance in agenda-setting; and

(3) *Post-structuralism*: evidence of the use of language to manipulate network activities.

Interviews were tape-recorded and transcribed verbatim. Interview transcripts, documents and meeting notes were examined and coded using QSR NVivo software, to organise and manage the resulting data. Codes were developed to provide a basis for categorising and analysing data and the coding structure was then checked and validated by another researcher. The data was then scanned for specific cases that illustrated and provided evidence for the themes.

Case study findings: dominant elites and limited local control

Due to the necessity to follow the national policy agenda, each of the five networks were structured in similar ways and power relations followed a similar pattern across the case studies. As such, this section presents an amalgamated narrative of the case study findings, with vignettes from particular networks as appropriate.

Each of the five studied MCNs for cancer was managed by a network management team (NMT), which was typically comprised of four core staff – a manager, lead clinician, lead nurse and (more recently) a service improvement lead. The role of the NMT was to facilitate communication between the professional groups and organisations that comprised the network. However, their function was frequently disputed by network members. As mentioned previously, one of the predominant

initiatives of these newly formed MCNs was to designate the segregation of specialist cancer services into centres and units. Adhering to these guidelines has become a key priority for MCNs in London and is an example of the top-down autocratic approach to the structural configuration of these networks.

Power relations could be seen to be operating on two levels – development of the policy and strategic direction of the MCN model, and then the enactment of this policy and strategic direction. Although the Department of Health (DOH) were ultimately responsible for developing the MCN agenda, they were considerably removed from actual enactment. NMTs were the localised appointees of the DOH to steer and facilitate policy enactment. However, with this role came no statutory influence or performance management mechanism, and NMTs were instead reliant on their interpersonal skills to influence cooperation. In many instances, the NMT did not have resources or these interpersonal skills to generate any meaningful changes or control the delivery of services. In such situations, control and power tended to default to the medical profession – most typically to a dominant sub-group of medical professionals from prestigious and powerful major London teaching hospitals.

Medical dominance in the enactment of policy

Centralisation of specialist services and subsequent distribution of resources were the key areas where power relations between network stakeholders could be analysed. The requirement for centralisation was determined on a national level (by the DOH through the National Institute for Clinical Excellence), however the localised configuration decision was dominated by the medical profession in all of the five networks.

Medical professionals from acute teaching Trusts dominated decision-making ("losing" clinicians in Network C referred to this as "flaunting") to achieve the ultimate objective of their organisation becoming a cancer centre. Medical dominance was most evident in Network B where powerful clinicians from a specialist Cancer Trust acquired control of enacting policy and distributing resources, due to an under-resourced and ineffective NMT and an inattentive Strategic Health Authority. In this case in particular, a sub-group of medical professionals exerted their influence over other stakeholders – especially cancer unit clinicians – to acquire resources and ultimately the coveted designation of cancer centre status.

Network E could be presented as an anomaly – the NMT were able to exert greater influence over decision-making processes and the majority of medical professionals had very little control over the distribution of resources. However, on closer inspection, Network E could also be viewed as professionally dominated. The NMT as a whole were not considered to be powerful by network members, rather it was the singular influence of the NMT's Director of Services (also a medical professional at the cancer centre) that generated the anomalous authoritative structure of Network E. Although on one hand, Network E could be considered as uncharacteristically dominated by the NMT, this case instead represents the most medically dominated MCN considered.

While a sub-group of medical professionals from the cancer centres exhibited the greatest explicit influence over localised decision-making, there was considerable – and largely covert – resistance from medical professionals from the cancer units.

Medical resistance in the enactment of policy

Resistance from medical professionals at the units was exhibited in different ways at two stages – during localised decision-making and during implementation of policy. Firstly, unit clinicians attempted to block decision-making by arguing against the evidence presented. A urology tumour group meeting in Network E saw clinicians disputing survival rates as a means of discrediting the reconfiguration arrangement that was presented. This example demonstrates medical resistance to localised decision-making, whereby less dominant medical professionals (or professionals from less dominant organisations) presented barriers to attempt to exert influence.

During stages of implementation, these less dominant medical professionals – who had been ultimately designated as the "losers" in the decision-making process – again covertly resisted structural reforms through non-compliance. Clinicians from some networks reported that the MCN would have to wait until they retired before they would comply with the structural reconfiguration. There were no formalised mechanisms available to the network for ensuring that unit clinicians complied with the guidance, and as such many simply did not adhere. Progress in Network A has stalled because of this resistance, while the NMT and cancer centre in Network E have continued to progress regardless of this resistance.

The London MCNs considered represent a narrow and closed approach to networking, contravening pluralist approaches to power, which suggest that a range of stakeholders participate in decision-making, each with roughly equal influence over time as different issues emerge. Evidently, on a local MCN level, decision-making was dominated by a sub-group of medical professionals from the cancer centre(s). On many occasions, this was resisted by another sub-group of less powerful medical professionals.

Discussion: power relations in the enactment of health policy

Much literature regarding professional dominance in health care indicates that medical control and autonomy may be in decline in the UK with the rise of greater managerial authority and bureaucratic accountability (Barker, 1996; Harrison and Ahmad, 2000; Harrison and Dowswell, 2002). The findings presented here, however, indicate that (within networks at least) a sub-group of medical professionals continued to exert control over the conditions of their work, including at a strategic level, such as in reconfiguration decision-making – with minimal managerial intervention.

Professional dominance literature frequently fails to consider intraprofessional power relations. However, some notable exceptions (Ham, 1981; Abbott, 1988; Freidson, 1994) identify that there are differential degrees of power held by individuals or sub-groups within a professional group. The findings presented here demonstrate that there was considerable variation in the degree of power demonstrated by medical professionals in the cancer centre and units. In this case, the medical profession does not represent a homogenised professional group, but rather a fragmented group in constant conflict over resource distribution.

These case studies could in some ways be considered to represent an example of structuralist relations of power. However, the conceptualisation of MCNs and their ultimate implementation represent a move towards a more heterogeneous professional power structure than has been exemplified elsewhere. These cases instead demonstrate that the medical profession were internally divided, with active power and influence

unevenly distributed in favour of those in the cancer centre while less powerful medical professionals were then forced into defensive mode to resist decisions that had been made. Further, these cases indicate that the medical profession does not have control over what reaches the policy agenda. Structuralist approaches focuses heavily on agenda-setting and propose that some conflicts never arise because structural interest groups subversely prevent an issue from reaching the pre-decision stage through manipulating the desires and values of those involved (Bachrach and Baratz, 1962, 1963). These findings instead propose that the medical profession is split into several heterogeneous coalitions with differing degrees of power over localised decision-making and agenda setting. However, these cases demonstrate that the medical profession has limited control over agenda setting and policy development, which was instead dominated by the DOH and its representative bodies.

These findings do indicate some evidence of greater governmental control over the structure of clinical care – that is, where it is delivered – and judgments of the quality of care – through peer review and audit commissions. However, there was no indication that any aspect of this policy agenda was driven by the medical profession. Rather, the DOH and its representative bodies were solely responsible for setting the agenda for the delivery of cancer services through MCNs in London.

Although not fully representing a structuralist model of power relations, even less so do the five cases illustrate an example of pluralist (Dahl, 1958, 1961, 1986) or post-structuralist (Fairclough, 1989, 1992, 1995) models of power. It is clear from the findings that considerable conflict arose in the development and implementation of MCN activities and as such, that there was only limited evidence to support a pluralist model of power. There was also only very limited evidence to support a post-structuralist theory of power. There was no indication that *all* power relations could be reduced to discursive interactions. For example, the medical profession shares a technical discourse, however they were internally divided along organisational (structural) lines. Further, despite an emphasis on restructuring the delivery of cancer services, there was no indication that managerial discourses were significantly dominant within organisations or networks. Post-structuralism also does not account for the example of arguably the most powerful individual within the considered networks – the Director of Services at Network E, who was successfully able to combine managerial and medical discourses.

To summarise, none of the three identified theories correspond unequivocally with the empirical findings presented. However, the findings here provide evidence for some aspects of both structuralist (Alford, 1975) and pluralist (Dahl, 1958, 1961, 1986) notions of power and this will now be explored.

Bounded pluralism?

The finding that both structural and pluralist illustrations of power were evident in relationships within London MCNs could be reconceptualised as representing an example of something similar to the earlier discussed, plural-elite model – or what will be termed here more accurately as "bounded pluralism".

The findings presented here indicate that the plural-elite model of power is too simplistic to account for the power relations between stakeholders in London MCNs. First, the plural-elite model (from its pluralist roots) proposes that motivation for interaction is predominantly based on overriding consensus between a number of elite

groups. However, these findings instead suggest that there were dominant elite groups that were not interested in achieving consensus or cooperating with other groups, but instead intended to dominate decision-making. Second, the plural-elite model of power supposes that these elite groups retain their autonomy in social relations and decision-making. The findings here instead suggest that dominant coalitions of elites bargained and negotiated amongst themselves to share resources, and in some cases "joined forces" to override the interests of less dominant stakeholders. Each network combined two or more acute hospitals to form a cancer centre, and in many cases it was their collective dominance that allowed them to influence units to comply with their intended direction.

On the basis of these discrepancies between the principles of the plural-elite model and the findings presented here, a model of "bounded pluralism" is instead suggested for understanding power relations between stakeholders within London MCNs. The findings demonstrate that resources and power were predominantly only shared amongst a bounded group of elite medical professionals (not senior managers) from large teaching hospitals, while the interests of smaller district hospitals were seemingly ignored. There were boundaries within these networks, where only some (elite) groups were permitted to dominate the distribution of resources and power.

A dominant coalition of medical professionals from the cancer centres battled – rather than cooperated – to enact organisational change in their favour. To a large extent, bargaining and negotiation were evident within this dominant coalition to ensure that their interests were being met. As mentioned previously, unit medical professionals – who did not form part of the dominant coalition of professionals from the teaching Trusts – exerted power in a different way, through resisting the enactment of policy. However, in some cases the dominant coalition was able to indirectly exert their influence to overcome this resistance.

The above discussion explains and justifies why the three initially presented theories of power have been (at least partially) rejected, and a model of bounded pluralism has instead been theorised to understand power relations within London MCNs. The findings presented here contribute to a theory of power within networks and suggest that the distribution of power within London MCNs is narrowly concentrated within a dominant coalition of medical professionals, who bargain together to enact organisational change in their favour.

Conclusions and policy implications

It is proposed that, within these networks, a bounded pluralist model of power relations has prevailed over time, whereby an elite coalition of medical professionals from acute teaching hospitals have continued to dominate decision-making and have benefited in the distribution of resources. This reflects historical power relationships within the health service, a model dominated by the medical profession.

The influence of this bounded pluralist model was restricted by an overriding centralised accountability framework, based on audit and performance management. MCNs were initially thought to represent a move away from the prevailing New Public Management ideology – based on managerialisation and marketisation – towards a softer governance approach.

When the Labour government was elected in the UK in 1997, following many years of Conservative rule, "modernisation" became the narrative for the package of

proposed reforms. The elected government was labelled New Labour, to reflect their recognition of a globalised economy, whilst also appreciating the value of social cohesion (Newman, 2001). Previous Conservative governments had emphasised marketisation and privatisation, while New Labour attempted to shift the focus towards greater collaboration between providers and towards holistic governance, partnership and networking (Newman, 2001; Hamilton and Redman, 2003). Theoretically, such networking should encourage a plurality of actors to engage in a more reflexive process of dialogue and information exchange.

However, the "joined up government" rhetoric of New Labour does not represent a seamless transformation in the organisation of public services, but instead characterises an uncertain strategy, legitimising a set of conflicting reforms.

Distrust of professional self-regulation and the responding emphasis on managerialisation have emerged as underlying (but prominent) considerations in policy development in the UK. Continual attempts to break the old NHS culture have largely failed to penetrate the dominance of an elite sub-group of the medical profession within a given context. However, the prevailing focus on structural reconfiguration and centralisation of specialist services that is presented here has generated a competitive environment that has damaged many long-standing clinical relationships and their attempts at knowledge sharing and collaboration.

As such, future policy development should take more care to appreciate and work with the existing NHS culture, rather than attempt to dissolve it. Heavy-handed attempts at structural reform increase the divide between local providers and policy makers. An effort should be made by policy makers to actually put into practice the espoused rhetoric of decentralised decision-making.

Future research may also wish to consider whether MCNs in some way represent a special empirical case that might not reflect the wider health service. MCNs represent a formal, managerialised approach to networking in an acute care context that may not have been evident in other clinical areas. As such, the specific empirical findings may not be generalisable to other clinical areas and professional relationships. For instance, although GPs were marginalised in MCNs, other research indicates that some GPs (for example those on PCT Boards) have a greater influence in wider health service planning (Buchanan *et al.*, 2005). Although these findings can be theoretically generalised into a broader understanding of power, governance and sedimented change in the public sector, future research could usefully empirically consider whether it is the specialised nature of cancer care that allows doctors in acute teaching Trusts to dominate.

Note

1. Networks are anonymised and referred to as "Network A", "Network B", etc.

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Corresponding author
Rachael Addicott can be contacted at: rachael.addicott@rhul.ac.uk

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Spanning boundaries in pursuit of effective knowledge sharing within networks in the NHS

Graeme Currie
Nottingham University Business School, Nottingham, UK, and
Rachael Finn and Graham Martin
University of Nottingham, Nottingham, UK

Abstract

Purpose – The purpose of this paper is to examine power asymmetries in the delivery of genetics healthcare that inhibit knowledge sharing across sector, organisational and professional boundaries.

Design/methodology/approach – The paper is a longitudinal comparative case study approach, which encompasses semi-structured interviews and observation.

Findings – The paper finds politics to be significant in its influence on knowledge sharing across sector, organisational and professional boundaries, but this can be mediated by attending to human and social aspects of the context in which knowledge sharing was expected to take place.

Research limitations/implications – The paper encourages research that evaluates the effect of increased emphasis on human and social aspects of organisational change in pursuit of the "dream" of spanning boundaries and improving knowledge sharing within the NHS.

Practical implications – The paper shows that structural change appears to be of limited effect in promoting knowledge sharing. Organisational and individual development, career management and performance systems are worthy of attention for the purpose of managing knowledge.

Originality/value – The paper exposes this assumption as managerialist. Policy-makers assume that professionals are willing and able to share knowledge when delivering healthcare through networks.

Keywords Knowledge management, National Health Service, Genetics

Paper type Research paper

Introduction

Our paper examines power asymmetries within health care systems that inhibit knowledge sharing. We focus upon the NHS in England, where policy-makers expect knowledge sharing to flourish following a number of initiatives designed to encourage this. Our paper explores boundaries that inhibit innovation in a service development initiative, funded by the Department of Health (DoH), which aims to "mainstream" genetics knowledge. The central requirement of the DoH funded initiative is that knowledge needs to be shared more effectively across sector, organisational and professional boundaries and, in particular, that the balance of power needs to shift from clinical specialists located in hospitals to GPs, nurses and genetic counsellors in primary care.

Our study responds to a call for research to inform policy and practice regarding the development and implementation of more effective arrangements for knowledge sharing across sector, organisational and professional boundaries encouraged by policy-makers. Analysis of our findings exposes expectations of policy-makers as

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 406-417
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778934

managerialist and unreflexive. Policy makers assume that sectors of health care, organisations and professions are both willing and able to openly share knowledge in pursuit of improved public services. However, political problems considerably stymie knowledge sharing. Following this, we consider how knowledge sharing problems might be mediated through attending to human and social aspects of organisation.

Power, politics and knowledge sharing

On the one hand, political problems that inhibit knowledge sharing are similar to those noted in generic organisation and management literature. There exists a political problem with knowledge and power inextricably intertwined in relations between capital and labour. As a consequence individuals and groups hoard, rather than share, knowledge in pursuit of self-interest (Contu and Willmott, 2003; Pritchard *et al.*, 2000). On the other hand, political problems are more acute in health care systems with power differentials that make up the healthcare field impacting adversely upon the ability and willingness of individuals, groups and organisations to share knowledge across boundaries.

First, hospital doctors enjoy positional power within the UK healthcare system that, in the main, comes from the professional institutions to which they belong, associated with which is their clinical autonomy (Harrison *et al.*, 1992). Their privileged position in the UK healthcare system was reinforced during the inception of the NHS (Klein, 2001). Allied to this, specialists, particularly hospital surgeons and hospital physicians, enjoy higher status than other doctors outside hospitals, such as GPs and public health consultants (Currie and Suhomlinova, 2006). Any aspiration that knowledge is freely shared across organisational and professional boundaries needs to be synchronised with existing power arrangements. A professional logic of specialisation and hierarchy is dominant, which remains essentially paternalistic and authoritarian (Bate, 2000). This renders the following knowledge sharing interactions difficult: doctor to nurse; doctor to manager; hospital doctor to GP or public health consultant located in a primary care organisation.

Second, political interference from government has an adverse effect upon the willingness and ability of organisations to share knowledge across boundaries. Government-set performance indicators may cause the activity of organisations within the health service to diverge and this effect is reinforced by policy moves to encourage efficiency through competitive pressures: for example, publicly available league tables of hospital performance, the inception of foundation hospitals, private contractors delivering health care, patient choice. In short, tension exists between the performance-orientated economic facet of policy and that facet of policy that encourages the breaking down of segment boundaries in pursuit of public services improvement (Currie *et al.*, 2005; Currie, 2006; Newman, 2001). As a consequence, vertical "command and control" structures may be difficult to supplant with partnership, networking and lateral modes of organising so that knowledge is shared more effectively (Ferlie *et al.*, 2003; Hood *et al.*, 2000; McNulty and Ferlie, 2002).

Yet, such difficulties seem ignored by policy-makers in the UK, who pursue a "dream" that health care organisations transform themselves into "learning organisations", with individuals, groups and organisations sharing knowledge across institutionalised boundaries (HEFCE, 1999a, b; Nuffield Trust, 2000; SGUMDER (Steering Group on Undergraduate Medical and Dental Education

Report), 1990) and the NHS officially encouraged to create an "open and participative culture in which knowledge sharing flourishes" (NHS Executive, 1999, p. 5). In short, the expectation of policy-makers that knowledge sharing flourishes in the public services domain appears rather managerialist and unreflexive. Policy makers assume that organisations and professions are both willing and able to openly share knowledge in pursuit of improved public services. Recognition of political problems of knowledge sharing, which are emphasised in generic organisation and management literature, appears relatively absent in the public services domain.

Addressing this research gap, our study responds to a call for research to inform policy and practice regarding the development and implementation of more effective arrangements for knowledge sharing across sector, organisational and professional boundaries (Bate and Robert, 2002; Currie and Suhomlinova, 2006; Ferlie and McGivern, 2003; Gabbay and Le May, 2004; Hartley and Allison, 2002; Rashman and Hartley, 2002). To aid our analysis, empirically we draw upon comparative case studies from a Department of Health (England and Wales) (DoH) funded study to evaluate service development pilots that seek to "mainstream genetics" into healthcare. Central to the initiative is the requirement that knowledge needs to be shared more effectively across organisational and professional boundaries and, in particular, that the balance of power needs to shift from clinical specialists located in hospitals to general practitioners (GPs) and nurses and genetic counsellors in primary care.

Mainstreaming genetics: policy context

Investment in specialised genetic services has been increasing for a number of years. It has, however, become apparent that the major challenge for the NHS is to "mainstream" the use of genetic testing and genetically informed or genetically based therapies so that specialist services can be focused on those rarer or more intractable problems that justify the use of tertiary referral centres. The White Paper, Our Inheritance, Our Future (DoH (Department of Health), 2003: para. 1.38) sets two goals relevant to this project. First, the White Paper desires that genetics permeate all branches of medicine by supporting new initiatives in genetics-based care in key diseases areas, in secondary and primary care, and through national screening programmes. Second, the White paper seeks to empower frontline staff and commissioners in the NHS through investment in education and training, information systems and developing the evidence base.

As part of the Government's drive to improve the nation's health through advances in genetics the Department of Health commissioned a number of pilot projects to develop and deliver genetics services. Commissioned projects included the following: 12 GPs with a special interest (GPwSI) in genetics to develop an expertise in genetics, following which they will educate others, build networks and provide specialist clinical input; seven familial cancer service development projects to redistribute risk assessment and counselling between specialist genetic centres, cancer services and primary care; ten service development projects encompassing hospital-led and primary care developments, which are distributed across various disease categories. The latter typically use nurses or other health staff to advise on family history and to co-ordinate care pathways, new joint clinics, possibly using telemedicine, to unite expertise from different specialties, and different specialties collaborating to redesign referral and care pathways.

Research design

We used a comparative case approach. This allowed individual cases to be analysed for corroboration of specific propositions, with cross-case analysis allowing patterns to be perceived more easily and chance associations eliminated. By piecing together the individual patterns, a more complete and robust theoretical picture can be developed (Eisenhardt, 1989, 1991; Yin, 1994).

The initial stage of our work, focused on support for the pilots' internal evaluation work, involved a series of face-to-face meetings with key stakeholders in the projects, alongside national evaluation events convened for all pilots and examination of documentary materials produced, such as original bids for funding to the Department of Health. In the course of this work, we met with representatives of each of the pilots to discuss their plans and approaches to evaluation, and attended steering group meetings in some of the sites. The primary purpose here was to provide guidance and support for internal-evaluation work, but in the course of the meetings, wider issues were discussed, such as progress with developing services, challenges faced, and issues around involving stakeholders across organizational boundaries. The issues discussed at these meetings were then analysed thematically and formed a basis for developing interview schedules for the in-depth qualitative research that followed in 11 of the sites. Drawing upon factors identified within our review of the literature, cases were carefully chosen to serve a specific purpose within the overall scope of inquiry so that a theoretical sampling logic was followed. Interviews were carried out in these 11 case-study sites (four cancer-genetics projects, three service-development projects and four GPwSI projects) with 90 stakeholders (identified by the project lead as significantly engaged in the network), alongside analysis of documentary materials produced by the sites and of notes taken at project and steering group meetings in the case-study sites.

In this paper we draw upon both our initial, scoping analysis of themes emerging from early meetings with project stakeholders, and our subsequent case-study work in the 11 selected sites. In analysing both sets of data, a number of iterations were undertaken by the authors in the development of key themes. The themes we generated reflected practitioners' perceptions of knowledge sharing problems and solutions within their pilot project. Rather than coding the interviews through software, so that data remained contextualised we treated the material holistically as narratives. The project stakeholders were telling stories relating to their experiences, typically time sequenced, that chronicled the emergence of knowledge sharing problems and solutions to these over the course of changes to the delivery of health care through the pilot projects (Riessman, 1993). Each of the three authors had engaged in fieldwork, following which all three engaged in independent analysis before reconvening to discuss the themes identified. Finally, the analysis agreed across the authorial team for each case was considered against the over-arching research questions.

Empirical findings

Our work revealed politics to be significant in its influence upon knowledge sharing across sector, organisational and professional boundaries, but that this could be mediated to some extent, by attending to human and social aspects of the context in which knowledge sharing was expected to take place. First, we outline political problems revealed within our study. Second, we examine attempts "on the ground" to solve political problems.

The political problem of knowledge sharing

The political problem has two dimensions. The first dimension is a jurisdictional one. Professional boundaries inhibit collaboration across boundaries. The implementation of information technology in the projects exemplifies this. We also see that professional boundaries institutionalise career paths, which render the recruitment of staff to hybrid, boundary-spanning roles difficult. The second dimension is politics associated with central government imposition of divergent performance frameworks upon organisations and stakeholders that are expected to collaborate.

Taking the first of these, a key idea that underpins the DoH's rationale for funding mainstreaming genetics pilots is modification of traditional structures, which inhibit knowledge sharing across boundaries, in particular the boundary between secondary or tertiary care located in hospitals and primary care. For example, GPwSI are seen as intermediaries between primary care and secondary care, between generalist and specialist orientations, and between professions. Meanwhile, familial cancer projects emphasise integrated working between sectors, particularly between primary, secondary and tertiary care, and also of course between professions. However, a number of problems rendered the new structures less effective conduits for knowledge sharing than expected by policy-makers.

The effect of jurisdictional issues was visibly evident around the implementation of IT to support knowledge sharing across sector, organisational and professional boundaries. The value added by IT was the subject of some debate, in particular the use of software packages for conducting risk assessments of those susceptible to genetic conditions. Whilst some advocate these packages as a means of aiding, standardising and recording risk assessment, others question this as the best/most accurate way to proceed, pointing in particular to the importance of clinical expertise and judgement in interpreting information, overriding outcomes and considering other variables in the risk assessment process. Different software packages were able to record differing degrees of supplementary information that might impact upon risk assessment; some conditions required greater amounts of clinical judgement than others. A common approach was to use risk-assessment software as a means of verifying longhand risk assessment, without relying on the outcome of a software algorithm unable to incorporate the more nuanced and subjective aspects of clinical judgement into its calculations.

Associated then with assumptions that IT is a tool that aids collection, interpretation and use of information are issues around professional roles and who can conduct such activities effectively. This relationship between IT systems, professional roles and expertise is a generic NHS-wide theme (Brown, 1995). We also note concerns regarding how far decisions about referral pathways can be legitimately devolved to non-medical staff. Triaging decisions about whether family histories justified further genetic investigation were among those commonly delegated to lower-grade staff, having previously been undertaken by specialist nurses, genetic counsellors or even medical consultants. Whilst this was seen as an appropriate shifting of less clinically complex responsibilities to sufficiently trained staff, it did nevertheless require close liaison between these staff and their supervisors, both through normal clinical-governance arrangements and frequently also through close collaborative working, sometimes across organizational boundaries. These staff tended to be strongly guideline-driven in their clinical decision making, relying heavily

on written protocols (and to a lesser extent on risk assessment software), and in doubtful or complex cases deferring clinical judgement to their supervisors rather than attempting to give a definitive assessment of risk themselves. Through time, close collaborative working with more experienced and expert practitioners reduced these margins of doubt, but protocol-driven practice remained the norm, with clinical judgement in borderline cases left to supervisors.

The jurisdictional influence of professional associations also created difficulties in recruiting personnel for new boundary-spanning roles. The new boundary spanning roles brought together distinctive knowledge domains. That knowledge domains were brought together in this way was deemed crucial to the delivery of service. Yet cognisance of two knowledge domains was not regarded as adding value to career.

There was evidence that where individuals sought to bring together two knowledge domains, this was an issue of personal motivation rather than ambition for career advancement. Within one primary care led project, specialist nurses were able to draw upon existing links within the regional genetics service to identify what components of training were required to supplement their knowledge to carry out risk assessments within their disease area. The nurses however stated that this was not something that would be formally recognised, but rather they were motivated by a desire to be able to "do their jobs better".

Similarly, this point was emphasised by a nurse specialist within a secondary care led project. Her role within the project necessitated that she supplemented her specialist knowledge around a particular disease area with genetic knowledge, to enable her to carry out risk assessments. However, there was no formal process of training, accreditation or incentives available for undertaking this professional development to extend her role. The nurse actively sought out the training she needed herself, with support from the lead clinicians, but saw this as an issue of personal motivation and ambition for learning, rather than for any formal recognition or career advancement. The clinical leads for this project indeed recognised that it was entirely due to the personal attributes and motivations of the particular nurse involved that the role had been developed successfully to meet the needs of the service development.

For other service development projects, this lack of formal support for boundary spanning roles created more difficulties, particularly around recruitment to nurse and genetic counselling posts. One project had particular difficulties recruiting a genetic counsellor at the required level of experience. Individuals who had inquired stated that they found the nature of the post unattractive in taking them too "far away" from their profession, in so far as there would be little time available for clinical contact with patients and they would "miss out" on developments within the profession. Similarly, genetic counsellors recruited to another project working within primary care expressed this concern and stated that this was something they had to actively manage themselves through maintaining links with their clinical genetics departments.

Overall, this can be thought of as reflecting a lack of institutionalised career paths offered by the pilot project posts. These include concerns about job insecurity due to the nature of posts offered (secondment or temporary, often without support from current employer), but also fears about moving too far away from one's own profession (for example, genetics counsellors can be seen as hybrid role, which combines nursing and counselling without the professional status ascribed to either). Potential applicants were concerned about lack of opportunity for professional development and

accreditation, unclear career paths, incentives and progression opportunities within these new hybrid roles.

Examining the second dimension of the political problem, we highlight any incentive for collaboration as relatively absent, particularly with respect to GPs. Project leaders faced the challenge of gaining access to or engaging with other health care professionals, specialities and health care sectors for project development and implementation (for example, in implementing new referral guidelines, managing patients through a new care pathway). A key challenge has been engagement of primary care and GPs, with relative lack of interest for genetics among GPs and the overburden of work/guidelines relating to other conditions for GPs with which genetics has to "compete". The new GP contract, with its clear priorities and incentives attached to particular areas, meant that for many GPs, genetics was well down the agenda. Consequently they were less willing to engage in knowledge-sharing interactions through educational events or other fora.

At another level, tension exists between individual projects and their host primary care trusts (PCT), which may be reluctant to engage in mainstreaming genetics. Exemplifying the fragmented nature of the health care system, some projects appear particularly decoupled from their local PCTs. All projects face the challenge of securing future funding, with the exception of a minority who have already managed to secure this/have projects built into future plans. Gaining knowledge of the complexity of the commissioning process and future PCT commissioning priorities coupled with forthcoming changing arrangements is a source of concern for many and there is realisation of the importance of building a good business case and the role of robust evaluation evidence to support this, both of which project stakeholders feel they lack knowledge. Yet PCTs' engagement with projects to address the knowledge gap is slow or even absent. For the PCT, genetics is low priority compared to other disease categories, which are subject to more prescriptive government targets. Reinforcing their lack of concern for the future of genetics, PCT commissioners are concerned for their own futures in the face of another restructuring exercise with PCTs merging.

Such effects were a product of, but also reinforced by, what project stakeholders described as the culture of the wider healthcare system. For those working as "boundary spanners" between sectors, such as GPwSI or outreach workers from specialist centres, the difference between the focus of specialisation and the broader interests of the wider healthcare system were starkly apparent. Those whose remit involved the delivery of a specific service often questioned how far such a minor component, such as genetics, could significantly affect the culture of a wider healthcare economy, which privileged traditional treatments of disease delivered through hospital-based care with others parts of the health care system relatively de-coupled from hospital activity. Those in genetics projects complained that other, non-genetics professionals "just don't think genetics" and that they were inclined to view genetics as the mere provision of genetics tests for rare conditions. Consequently the relevance of genetics to mainstream care was not appreciated by others, who remained reluctant to engage in knowledge sharing around genetics knowledge.

The above illustrations of political and associated cultural problems in sharing knowledge around genetics alerts us to the influence of human and social aspects of health care systems, which policy makers should attend to alongside structural change. We now turn to this.

Mediating political problems

Political problems associated with structural change appear mediated by attention to human and social aspects of organisational change. Specifically, our study revealed the interventions in the following area as promising: incentivising behavioural change; promoting new career paths; organisational development to engender the formation of trusting relationships, voluntary networks and shared perspectives upon problems; training and development, in particular to facilitate context sensitive leadership approaches.

Taking the first of these, many projects found that GPs needed a clear reason to give up their time for training and information events, which in some projects meant payments to practices to cover locum time, and in others meant the prioritisation of certain conditions which were more prevalent or more likely to be of concern to the public to ensure GP "buy-in", at the expense of conditions rarely encountered in primary care. Some other projects sought to create their own incentive structures for GPs, for example by liaising with PCTs to offer payments for genetics training as part of enhanced local service provision contracts. Some hospital-based projects found that primary care nurses were less bound by rigid performance frameworks than GPs, and therefore more inclined to become involved with service provision if they felt their patients would benefit. The work of these genetics pilots was also likely to tie in more closely to their day-to-day work, such as providing Well Person check-ups and taking family histories of new patients to their practice.

Second, overcoming recruitment difficulties, some projects redefined job requirements to fit in with institutionalised specifications for professional work of nursing or counselling. Others allowed job sharing or created new role categories, involving novel skill mixes and levels of responsibility, such as genetic risk assessors. By relaxing the level of qualification and competencies required for these posts – for example, by opening them to applicants with non-clinical backgrounds or by replacing the need for prior knowledge of genetics with the offer of on-the-job training in family history taking – projects were able to increase the level of interest in these posts. In the process, they were also able to ensure that those skills which were genuinely indispensable to service provision and less amenable to development through formal training – for example, communicative and empathetic abilities – were already possessed by the successful applicants. In some cases, though, it took projects more than one round of recruitment to reach this stage, and to tailor job and person specifications in this way.

Third, we suggest some potential for organisational development to contribute to more effective knowledge sharing by engendering the formation of voluntary networks and shared perspectives upon problems. We note the prevalence of existing networks / relationships impacted upon knowledge sharing. The degree to which these are already well established, or have to be developed from scratch by projects was variable. Where established, networks had a positive effect upon knowledge sharing since they provided project stakeholders support, access to information, resources and knowledge, insights into how things work (for example, giving primary care professionals insight into secondary care and vice versa), and "spreading the word" about projects across sector boundaries. These cross-boundary relationships also served in some pilots to negotiate and reinforce boundaries between the roles of professions and sectors, but in ways which were amenable to all concerned parties and

which avoided confusion at a later date. Thus specialists and others could be clear about where responsibility lay and about exactly which areas of clinical practice could legitimately be transferred from one to the other and which could not, whether for reasons of clinical governance, funding or professional identity. Even within sectors, being a "well known face" had tangible advantages for some of the GPwSI, many of whom had acted previously as informal contacts when their colleagues had questions about unusual patients with possible genetic conditions. Their formal induction as GPwSI was welcomed by their colleagues, whereas others who felt less tied in to local networks often felt that their new status and ambitions for service provision were met with scepticism.

More specifically, facilitating development of a shared perspective across boundaries, collaboration in some sites between the genetics service and the secondary care hospital ward has seen nurses seconded from the ward to the service and provided with extra training, knowledge which they will then take back with them to their normal practice, with benefits for both.

Another interesting example of the form organisational development might take is a third-party organisation acting as a conduit through which projects cohering around a disease category or population come together and share knowledge. Within the mainstreaming genetics programme, the charity, Macmillan Cancer Relief, acted as a programme lead for and mediator between the DoH and service development projects concerned with familial cancer. In contrast, other service development projects did not "enjoy" programme leadership, reporting directly to the DoH. In line with its organisational remit, Macmillan has been keen to inseminate a culture of mutual learning and sharing of experiences between its pilots, holding events at which pilots have presented their work to each other and at which key questions of common interest, such as post-pilot funding arrangements, have been addressed. These have had mixed success: initially projects guarded their approaches carefully, and although some opening up and sharing of knowledge has occurred, there is still a sense that pilots see themselves as in competition with one another, having been through a competitive tendering process and expecting to be compared to each other and evaluated in search of "best practice".

Finally, individual leadership of projects also appears important. We do not promote leadership as the panacea for the ills of knowledge sharing (Currie *et al.*, 2005), but we note its significance and a need for individual development in the area of leadership of service development, as well as clinical leadership. Key issues in the realm of leadership included what form leadership takes within projects (for example, dispersed or centralised), the significance of key individuals or local champions to project success (carrying implications for the transferability of service development models elsewhere) and the importance of wider organisational support (for example, of PCT to GPs). Many of the projects relied on the drive of a few key individuals, who had born witness to the difficulties associated with existing ways of doing things and who had applied for pilot funding to pursue alternative approaches to care pathways and the balance of work between sectors. By their nature, these projects tended to rely on collaborative leadership between sectors, organisations and professions, which drew on divergent clinical expertises and contextual knowledge. However, without the existence of leading champions, and the existence of key collaborative relationships in the first place, it is likely that many of the pilots would not have got off the ground.

This point is exemplified by one service development project, whereby two lead clinicians (a secondary care consultant and a consultant geneticist) collaborated in bringing the project about. Significantly, both these clinical leads recognised the importance of their prior working relationship as crucial to getting the project off the ground. They had both engaged in research as a product of their shared interest in a particular inherited disease, and this had given them the opportunity to exchange ideas, discuss and develop the idea for the service development project. The specialist nurse working within the project identified this "driving force" and clear leadership essential to the support and guidance she had received in the development of her role.

Conversely, leadership was more problematic for other projects. For one GPwSI, the challenge was that the disease area around which the project focussed involved a complex network of stakeholders that crossed professional, organizational and sectoral boundaries. This resulted in a lack of clarity around who should be leading the project, coupled with a lack of ownership and unwillingness to take on the responsibility for leadership. As a consequence, the GP concerned took on leadership responsibilities, but found this very difficult to enact due to her position as an "outsider" and lack of existing contacts or working relationships to facilitate this.

Discussion

Political problems around knowledge sharing revealed in our study of "mainstreaming genetics" reflect those evident in literature. First, issues of jurisdiction between different professions inhibit knowledge sharing. Second, and most visibly, performance frameworks imposed by central government inhibit knowledge sharing.

When considering how political problems associated with knowledge sharing might be mediated, the "mainstreaming genetics" initiative reveals that human and social aspects of organisation require attention. There are lessons here for policy-makers.

The policy emphasis upon structural change emphasises that traditional organisational structures inhibit sharing learning between different functions. It suggests that organisations adopt lateral structures, such as project groups, or develop networks to ensure effective knowledge sharing (Mohrman and Cohen, 1995; Starkey, 1996). However, even with structural change the same set of institutionalised boundaries adversely impact upon knowledge sharing. That structural change appears of limited effect in promoting knowledge sharing is unsurprising given the history of NHS reform that almost exclusively has relied upon such recipes for change but which have failed to shift the balance of power. Within our study we also note that IT intervention results in knowledge sharing, which also reflects institutionalised political boundaries (Currie and Kerrin, 2004; McDermott, 1999). In short, human and social aspects of organisational life require attention for "knowledge management" initiatives to succeed.

Consistent with generic organisation and management literature, organisational and individual development, career management and performance systems are worthy of attention for the purpose of managing knowledge (Currie and Kerrin, 2003; Scarbrough and Carter, 2000). Until recently, this has been absent. We note the emergence of diverse, local, organisational level interventions within our study (e.g. incentives, job redesign) that might mediate knowledge sharing problems. Consequently, we encourage research that evaluates the effect of increased emphasis upon human and social aspects of organisational change in pursuit of the "dream" of spanning boundaries and improving knowledge sharing within the NHS.

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Corresponding author
Graeme Currie can be contacted at: graeme.currie@nottingham.ac.uk

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Exploring HRD in two Welsh NHS Trusts

Analysing the discursive resources used by senior managers

Sally Sambrook
Bangor Business School, University of Wales, Bangor, UK

Abstract

Purpose – The purpose of this paper is to examine human resource development (HRD) in the UK National Health Service (NHS), and particularly in two Welsh NHS Trusts, to help illuminate the various ways in which learning, training and development are talked about. The NHS is a complex organisation, not least with its recent devolution and separation into the four distinct countries of the UK. Within this, there are multiple and often conflicting approaches to human resource development associated with the various forms of employee, professional (nursing, medical etc.), managerial and organisational development. How people are developed is crucial to developing a modern health service, and yet, with the diverse range of health workers, HRD is a complex process, and one which receives little attention. Managers have a key role and their perceptions of HRD can be analysed through the discursive resources they employ.

Design/methodology/approach – From an interpretivist stance, the paper employs semi-structured interviews with seven Directorate-General Managers, and adopts discourse analysis to explore how HRD is talked about in two Welsh NHS Trusts.

Findings – The paper finds some of the different discourses used by different managers, including those with a nursing background and those without. It examines how they talk about HRD, and also explores their own (management) development and the impact this has had on their sense of identity.

Originality/value – The paper highlights some of the tensions associated with HRD in the NHS, including ambiguities between professional and managerial development, the functional and physical fragmentation of HRD, conflict between a focus on performance/service delivery and the need to learn, discursive dissonance between the use of the terms training and learning, a delicate balance between "going on courses" and informal, work-related learning, inequities regarding "protected time" and discourses shifting between competition and cooperation. These tensions are exposed to help develop a shared understanding of the complexities of HRD within the NHS. The paper concludes with a summary of the different discursive resources employed by senior managers to articulate and accomplish HRD. These are "surfaced" to enable managers and HRD practitioners, amongst others, to construct common repertoires and shared meaning.

Keywords Management development, Learning, National Health Service

Paper type Research paper

Introduction

This paper examines human resource development (HRD) in the British National Health Service (NHS). The NHS is a complex organisation (Smith and Walshe, 2006), not least with its recent devolution and separation into the four distinct countries of the UK. The NHS is one the largest employer organisations in the world, and thus the role of HRD is critical. How people are developed is crucial to developing a modern health service, and yet, with the diverse range of health workers, HRD is a complex process, and one, which receives little attention. There are multiple and often conflicting

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 418-431
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778943

approaches to human resource development associated with the various forms of employee, professional, managerial and organisational development, giving rises to diverse "development" discourses, and there is growing interest in the role of discourses in health organisations (Iedema, 2007). How people are developed impacts on their sense of identity, as they attempt to make sense of their developing professional/managerial roles. This sensemaking (Weick, 1995, 2001; Parry, 2003) can be expressed through their various discourses, and examining these can reveal discursive (power) struggles.

The NHS comprises a complex range of stakeholders (Garavan, 1995) with an interest in developing the workforce. It is argued that these stakeholders have varying needs of HRD and talk of HRD in varying ways, thus giving rise to multiple discourses of HRD (Sambrook, 2000, 2001, 2004). One important stakeholder is the manager, who has both a role in, and a need for, management development. This paper explores some of the different discourses used by different managers, particularly those with a nursing background and those without. Indeed, Gilbert (2005, p. 455) talks of "managerialism as a distinct set of discourses and practices that shape both the operation and our experience of healthcare and welfare services".

Human resource (or workforce) development within the NHS has only recently acquired a strategic position – to help bring about the modernisation of the service where "Workforce development underpins the modernisation agenda" (DH, 2002, p. 4). Little is written about HRD in this context, although more has been written about management development (Thompson, 1994), and specifically for clinicians (Allen and Hughes, 2002, Ashburner, 1996; Burchill and Casey, 1996; Dopson, 1996; Dowding and Barr, 2002; Leopold *et al.*, 1996, Traynor, 1999), and to some extent organisation development (Stewart, 1993, Iles and Sutherland, 2001, Davidson and Peck, 2006). Yet, little explores how managers themselves articulate and accomplish HRD.

This paper draws upon recent research conducted in two Welsh Trust hospitals, identifying stakeholder perspectives and their associated discourses of HRD. The paper focuses on the language used by a key group of (relatively powerful) stakeholders – Directorate General Managers – and how this helps shape and maintain their identities (Potter and Wetherell, 1987) and social constructions of reality (Berger and Luckmann, 1967). I suggest (Sambrook, 2004) that how we talk about the practices associated with developing people attempts to describe and influence how we think about and go about HRD. This also influences how HRD is perceived by other organisational and societal stakeholders. Here, I focus on how HRD is articulated and accomplished by one group of powerful stakeholders – senior managers.

It is important to acknowledge the context of this research. Wales is a distinct part of the UK with a separate national identity and behaviour, which is being emphasized by the process of devolution. Discourse analysis has additional meaning in a country in which two languages are in use, and this creates further power struggles. Although this research was conducted entirely in English, I am mindful that language shapes perceptions, and the perceptions in Wales may be more complex as a result of dual languages used by some of the participants. This may have something important to reveal as a consequence, and further research is required in this area.

The paper introduces the concept of discourses of HRD, and then briefly reviews HRD within the NHS. The methodological approach is discussed, followed by the presentation of findings from in-depth semi-structured interviews with seven

Directorate General Managers (DGMs) from two Welsh NHS Trusts. These highlight some of the tensions associated with HRD in this specific context, including evidence of multiple discourses of HRD. Finally, some conclusions are offered to help develop a shared understanding of HRD from senior managers' perspectives as they struggle to develop themselves and their own staff and retain their sense of professional identity. Having introduced the paper, the next section focuses on discourses of HRD.

Discourses of HRD

There are ontological problems of how "HRD" exists, (unlike natural phenomena dominant in medical/health research) and this impacts on how we might research this phenomenon. To address this, HRD can be conceptualised as a discursive and social construction (Sambrook, 1998, 2000, 2001). This suggests HRD is a socially constructed phenomenon, created and accomplished through talk. For example, doing HRD involves talk, and formulating HRD strategies involves talk.

Thus, HRD can be conceptualised as discursive action, where words do and achieve something.

Social phenomena, such as HRD and New Public Management, are created through language, symbols and words, of which discourses are a part. We discourse to describe a particular way of talking about something expressed through our choice of discursive resources (words), for example, "health" or "illness", "patient" or "client." Additionally, a discourse is more than a collection of items of vocabulary – it is a rational and legitimate way of talking about and engaging in practices, such as "patient" (dependency) or "client" or "customer" care (consumerism?). Here, the focus is on practices associated with learning and development (L&D – another discourse to replace or enhance HRD?).

Meanings are derived from social interactions, between doctors, nurses and managers for example, and are created through developing shared understandings. Within a Welsh context, meanings may not easily translate from one language into another. Although all the interviews were conducted in English, I cannot be sure if some participants were actively "translating" from Welsh and thus some "original" meaning might be "lost". Meanings can be learned, for example, by using and sharing new language. The "new" language of HRD incorporates discursive resources from the notions of culture, strategy and economics, for example, which are from the "business" language used by managers, referred to as intertextuality. In the NHS context, we also borrow discursive resources used by other (powerful?) stakeholders, such as clinicians (protected time) and policy makers (modernisation). However, whilst we may adopt new discourses, Clarke and Newman (1997, pp. 102-103) note that "Older discourses and the subject positions and identities associated with them have not gone away – they linger on not just of nostalgia, but because specific practices continue to require them". Additionally, within the now devolved NHS, there may be distinct and competing discourses between the four countries of the UK. So, how do senior managers in two Welsh Trusts – including professional nurses and allied health professionals – talk about HRD? Is this influenced by a "traditional" business and/or health professional background, and what impact does this have?

HRD and management development in the NHS

Managing learning and development in the health service is a complex process (Burchill and Casey, 1996, p. 124). The responsibility for co-ordinating this rests with HR practitioners, yet very little literature examines this complex role.

Much HRD in the NHS appears to occur in professional silos, for nurses, clinicians and allied health professionals (Sambrook, 1998). As Dopson and Fitzgerald (2006, p. 46) note, "social boundaries are created between professions and occupations by the systems of training and postexperience learning that are largely uniprofessional". This is particularly the case for management development, which can be exclusively for clinicians, for nurses, and for managers. Seldom is there integration, perhaps for political reasons. Dopson and Fitzgerald (2006) suggest, "the medical profession maintains a dominant position and ... the problems are simply due to inertia or an historical unwillingness to share power" (p. 46) and that "strong social boundaries exist which are derived from defined professional roles and identities and reinforced by traditional work practices" (p. 47). As Winyard (2003) notes, the introduction of general management in 1984 created fault-lines between doctors and managers, highlighting the incompatibility of managerially determined targets with the essence of professional practice, and leading to the development of a management agenda disconnected from healthcare. This "separateness" can reinforce professional boundaries and can lead to separate discourses, which lack shared understanding and meaning. Gilbert (2005, p. 454) notes that "managerial discourses are critical of health care professions and the way they operate" and through discourse analysis identifies "the politics of care" and the way professional and managerial discourses articulate to produce complementary and contradictory positions'. Yet, the modernisation agenda calls for "joined-up" development based on evidence-based practice, management, and HRD, and thus the need for joined-up discourses:

> "Modernisation" may be a new discourse, and creates a huge organisational development (OD) agenda. The NHS Plan refers to the NHS being a "1940s operating system in a twenty-first century world" and "The NHS is too much the product of the era in which it was born. In its buildings, its ways of working, its very culture, the NHS bears too many of the hallmarks of the 1940s. The rest of society has moved on" (DH, 2000, p. 29). To address this, and within the Agenda for Change, a key purpose of the Knowledge and Skills Framework is to: "facilitate the development of services so that they better meet the needs of users and the public through investing in the development of all members of staff" (DH, 2007). This suggests HRD is central to modernisation, and associated with the modernisation discourse are other discourses, including "new public management" and "evidence-based practice and management" (Walshe, 2006).

Evidence-based practice is deemed central to the modernisation of health care in current UK policy. Yet, Dopson and Fitzgerald (2006) found that general managers have relatively little influence in evidence-based health care compared with clinicians. Perhaps to alleviate this (Hamlin, 2002, 2005; Hamlin and Cooper, 2007) supports the development of evidence-based management and his research within a UK NHS Trust Hospital suggests the notion of the "universally effective manager". Hamlin *et al.* (2006) also identify common aspects of managing and coaching across various contexts. However, Hewison and Griffiths (2004) also examines evidence-based management in the NHS and doubts whether it is possible, suggesting an alternative approach based on the notion of "craft". This, perhaps, takes into account the contingencies of diverse managerial contexts where contested terrains require constant negotiation and re-construction of the

managerial role, and perhaps the specific discourses available to achieve this and affirm managerial (professional) identity. It would be interesting to compare current managerial discourses and activities across the four, now separate, NHS regions of the UK.

Although HRD is not explicitly mentioned, learning is considered central to modernising the NHS. A key role of managers is to provide opportunities for learning (Hamlin *et al.*, 2006), and perhaps help create organisational learning. However, as Nutley and Davies (2001) note, whilst continuing professional development (CPD) has an important role to play in improving learning, there is also a need to pay more attention to collective (organizational) learning. Uniprofessional CPD might reinforce professional separation and identities, and disparities between professions can create conflict (for example, over "protected" time for doctors).

Developing health professionals (particularly nurses, who are predominantly female) into managers is fraught with issues of power and identity. Miller *et al.* (2002) critically examine gender in relation to the "professionalization" of management in the NHS, focusing on the Master of Business Administration (MBA) qualification and the role this plays in professional development of managers and clinicians. They highlight the implications of gender for the NHS and suggest ways in which management education might incorporate gender into the curriculum. However, HRD professionals also need to consider the hidden and informal curricula within these and other forms of management development, such as in-house programmes and other informal learning opportunities. Having identified the limited research exploring HRD within the NHS, the next section explains how the current research was conducted to address this problem.

Methodology

This paper draws upon ongoing research investigating HRD in the NHS. This research began in 2001 and involves case study research in two Welsh Trusts, building on earlier ethnographic case study research conducted within two English Trusts in the Trent Region. Primary research data were collected from tape-recorded in-depth interviews (lasting 30 minutes to two hours) with more than 25 participants (stakeholders) involved in HRD, including Directors of HR, Training Managers, Nurse Developers, Medical Educators, Directorate General Managers (DGMs), Nurse Managers, Business Managers and other Allied Health Professionals.

This paper focuses on HRD from the perspective of senior managers, and draws upon interviews from the seven DGMs. Table I provides brief biographical details of the participants. The interviews, all conducted in English, were transcribed and

Table I.
Brief biographical details of the participants

Trust A DGM role and background	Gender	Trust B DGM role and background	Gender
A3 – community/head of nursing, nursing background	Female	B3 – community, nursing background	Male
A4 – acute, graduate general management trainee	Female	B5 – acute, finance background	Female
A7 – acute, nursing background	Male	B7 – acute and community, nursing background	Female
		B12 – acute, non-nursing	Male

thematic analysis was employed to explore emerging patterns and themes in relation to HRD. Transcripts were read, re-read and initial coding took place. Discourse analysis was used to explore connections between the participants, their professional identities, their discursive resources and what these attempted to achieve.

Discussion

Three key themes emerge: the ways senior managers talk about:

(1) HRD within their particular Trust;

(2) Their views on learning, their own roles in HRD activities and management development; and

(3) Their own management development.

These are each discussed in detail in the following.

Senior managers talking about HRD within their particular Trust

Activities associated with learning and development in the health service is very diverse and seldom labelled HRD:

> Well, in this Trust we have our own, we use the term training and development ... We have our own department, and we have two aspects of training and development. We have organisational managerial training and development, we also have professional training and development, and, for our purposes, we more or less use the training and development department for managerial and organisational development (A3).

However, although a widely used (if not uncontentious) academic term, perhaps HRD is not appropriate in the NHS and workforce development might be a preferred term. This quotation recognises HRD is split between managerial/organisational training and development, which is the responsibility of the training department, and professional development, which is "done" elsewhere. This mirrors the separation in earlier research (Sambrook, 1998) and can reinforce separate identities. As in many Trusts which have accommodation problems, in Trust A the Training and Development department was located "off-site" which was considered "not deliberate, but symbolic":

> There is a training and development department ... and they do seem to get involved in a lot of training, particularly management type training, management type development ... Our (training) department's in (place). I mean it's not exactly the hub ... I don't know that it was deliberate but it is symbolic, isn't it ... "The training department's for like admin and clerical, management, I think people are quite clear about it" (A4).

Both the functional and physical dislocation suggests a lack of horizontal integration or internal coherence of HRD activities. Not being at "the hub" may also suggest a lack of power. This DGM continues "T&D is fragmented, not high enough profile". A colleague also states that:

> The main problem is that it's offsite (A7).

HRD appears to be fragmented functionally and physically, which is problematic for some, as their discursive resources suggest. However, some do not think of T&D as separate. "I don't see them as two separate things it's just that we organise them as two separate things, because our training department doesn't concern itself with

continuing professional development" (A3). And yet there appears to be ambiguity or confusion here, trying to hold contradictory positions.

In Trust B, the T&D department is also off-site, and this might cause different problems:

> I'd say it was crap, some people rave about it. Anybody that has had some training as well before won't think it's very good … (it's a) nice setting … you get pampered … have coffee breaks … they (staff) wouldn't say it's crap in case it gets stopped (B5).

It's off-site, but this is considered a good thing – away from the sheer busyness of the ward. Here, the discourse suggests HRD is a treat, or a relief from health care work. On a more positive note, another DGM explains:

> the big thing is now that the library here is going to be an education centre … it's hugely symbolic, it's trying to say education is for everybody … it's a huge leap forward but it had to be done for clinical governance it's just a shame it didn't happen before (B7).

This suggests an explicit attempt to move away from silos of professional development and the fault line between doctors and managers (Winyard, 2003), towards more shared collective, organisational learning (Nutley and Davies, 2001).

Despite the physical and functional fragmentation, this did not necessarily impact negatively on HRD practices. In general, in Trust A, the HRD team were considered proactive in organisational and managerial development. Also, there appears to be support by senior management:

> I think this Trust has a very positive attitude towards uh, learning, which comes from the top (the Chief Executive?) Yes, and the Board. We have on our Board (a Professor) who … champions the cause of training … also there is, I think there's just an acceptance that you can't, you can't move forward unless you're training, and unless you're willing to learn (A3).

This suggests, at least, some connection (vertical integration) between HRD and strategic goals ("move forward"), through organisation development. However, there is a discursive tension between the terms learning and training. These discursive resources appear to be used synonymously, but do they mean the same thing? In Trust B, senior support appears to come directly from the HR Director, who was talked about as being "the training innovator", whilst "the Training Manager is the doer, does training" (B5). The DGM also talks of how staff have a positive attitude towards learning. "Staff want to learn, that's half the battle, it's when you've got to force people to doing things that is no use to anybody, (there's a) culture of wanting and we encourage learning. We rarely turn people down" (B3). Again, this illustrates a melange in the use of the terms learning and training – but is there consistency of meaning?

There are some difficulties and time is repeatedly identified as the biggest issue, mentioned by all participants in both Trusts. Often, it is not lack of budget that inhibits learning and development but service pressures. "The big tensions are resources, there's very little elasticity left … having quite a lot of money but no time to spend it … the different things that compete, the service is under so much pressure" (A7). The word elasticity suggests things are stretched to the limit. In Trust A, one DGM (A3) comments, "Releasing staff from the service is problematic", as "everybody's absolutely swamped with work". Similarly in Trust B, another DGM (B3) explains, "It's finding time, releasing staff, finding cover, there's none available, staff are already

busy". The discourse here is of being stretched, swamped, due to the sheer busyness of health care. It is difficult to manage to find time, but is this particularly for training (off-site) or learning (possibly work-related?). The problem appears largely to be associated with "going on courses" which takes people away from the workplace.

The theme about (protected) time emerges again and again, closely associated with the different "rules" for professional development between (powerful) doctors and nurses.There's an issue about protected time, junior doctors by and large get the protected time because of the law and because of the regulations that they're working out of. Medical staff have formally protected time for teaching, education, training. If you're a nurse working on a ward that's permanently hammered, if you're a ward sister, the ward is permanently hammered. Their difficulty is ensuring they can release staff (A4). Again, here are examples of discursive resources ("hammered") expressing the sheer workload of professionals (particularly nurses), creating logistical difficulties in "releasing" staff. The managers are also adopting resources from the dominant medical discourse (protected time). Having explored their perceptions of HRD within their own Trusts, the next theme focuses on the senior managers' views on learning and their own roles in HRD, and management development.

Senior managers talking about learning, their own roles in HRD activities and management development

Managers have an important role in HRD – providing opportunities for learning, approving training, and acting as coaches and role models. There is also a growing literature associated with the distinction between formal and informal learning, and increasingly workplace learning (Sambrook, 2005). Some of these senior managers are involved in formal courses and "chat to students about management and structure within the organisation" (B12). They also talk about informal opportunities for learning:

> My personal philosophy is providing opportunities for staff where they feel valued, learning doesn't have to necessarily take place in a classroom, identifying one new thing or doing one new thing each day is active learning, it's not just putting a list of courses up . . . there are lots of ways to learn, it's not just sitting in front of somebody who chalks and talks (A7).

This manager talks of active learning within the work context, suggesting workplace learning. Another DGM, a nurse and senior manager (A3), gives talks about the conflict of being a manager:

> I used to train a lot more than I do, I don't do as much now because I'm just so busy, it's impossible, (she) asks me to go and talk on management courses, she asked me to talk not so long ago about the conflict in the role, it was the hardest thing I've ever had to do, I went in and said to them I hope you're not expecting any answers because I haven't got them.

Just as learners are often too busy to attend courses, so too are managers to contribute to such courses. Given the pressures staff and the service are under, informal workplace learning might be one way of overcoming some of the barriers associated with going on courses, discussed earlier. Another DGM agrees that it is about:

> trying to teach people or encourage people that it's not only courses that they can learn from, it can be anything, sitting with somebody or going to a different, if anybody wants to go on a visit we'll fund all of that, if somebody wants to be seconded somewhere we'll make that happen (B7).

Secondments are useful but there is a danger that they disrupt services. In Trust B, another DGM talks about the new general management development programme that has been introduced based largely on secondments, but notes:

> The Trust will not accept a dip in any performance ... that is our concern, people that are going to be involved in this programme are critical to the success of the organisations, they do much of the work ... so we need to be careful that we're not going to disrupt our organisation by taking them out of the system or moving them around the system ...There's a mixture of things, in-house and external training but I think towards the end then it's a lot of moving around ... for myself, it's no good (B3).

These DGMs all appear to agree that learning is not just about going on courses and do their best to facilitate more informal ways of learning. They also appear to get involved in HRD, particularly management development.

On the issue of nurses becoming managers, one DGM explains:

> A lot of our ward sisters are having to take on extra management duties, and to do that we've made some very subtle changes. We've actually changed the title to ward manager from ward sister ... (A3).

This suggests the use of discursive resources to reshape the role and possible identity. To develop nurses into this new role:

> We've ... given them the opportunity to act up as the hospital manager, or to attend meetings, to do shadowing, sending some of them on a ... management course ... (A3).

This illustrates the range of formal and informal management development opportunities available:

> I'm head of nursing as well so obviously as far as the professional side of it is concerned then my role is to make sure that everybody has sufficient training to do the job. And the same with managerially as well, you can't put people, nurses particularly, into a management job just because they're good nurses (A3).

This suggests that being a nurse with good clinical skills and expertise does not necessarily equip you to become a good manager. As a nurse and senior manager, this DGM talks about the conflict between being a nurse and being a manager. "There is a conflict and a lot of people manage to cope with it but sometimes they can't" (A3). There is also reference to professional identity (Traynor, 1999), "because you're a nurse first and, before you become a manager you're a nurse" (A3).

This theme emerged in my earlier research, where a nurse who was involved in managing a management development programme was "a nurse and not a manager" This may also reflect colonisation of professional activity by managerial discourse (Gilbert, 2005, p. 461), and its resistance by nurses. Another DGM (B7, a nurse) states that: "there's a stereotype of nurses, if you're a nurse you're not very good at business, which I don't believe". She also quotes a (male) consultant as saying: "don't worry your pretty little head, you're a nurse". This reinforces gender issues and professional stereotypes which is unhelpful if the NHS is to develop and modernise.

One DGM who doesn't have a health professional background explains:

> I think one of the problems with the Health Service is that we all go down the professional route for training ... There's a lot of emphasis on clinicians now, we're on about management development and opportunities for that, it doesn't work the other way round (A4).

This DGM is concerned that managers do not get the same development opportunities, whereas clinical staff, "you must do continuing professional development". She explains further, "There's an emphasis on everybody to do CPD isn't there … Continuous Professional Development, which a lot of people still see as going off on a course, and that's not necessarily the best way to learn is it. Things like secondment, special projects, things like that I would say, just my view … I mean as individuals I think we are conditioned to a certain extent to say training and development is going on a course, reading a book or sitting an exam, we're not conditioned to think training and development means any kind of opportunity which encourages you to learn something new". This reinforces the earlier views of senior managers' on learning, and Nutley and Davies (2001) concerns regarding the focus on CPD.

Having considered their involvement in management development, the final theme focuses on senior managers' own management development.

Senior managers talking about their own management development

One DGM explained:

> I joined the health service as a general management trainee, graduate trainee … there's five general managers in this Trust and I'm the only one who's not a nurse … so I'm the oddball! (A4).

As a female, she talks about the "Glass ceiling" and the attempts within the NHS ten to 15 years ago to try to address this, yet, Miller *et al.* (2002) still consider gender issues are problematic in formal MBA programmes. The DGM also explained that it was felt that there was little middle level management development, so the managers set up their own group, holding monthly seminars and providing mentorship, and this was also talked about as a "learning network". This identifies an interesting and important "gap" in the middle, which these managers sought to fill themselves. This also illustrates a discursive shift to learning and informal processes such as mentoring and networks. This manager commented that lots of senior managers had MBAs, had been off on management training courses and were encouraged to engage in action learning sets, but "this didn't work because we're encouraged to be competitive". However, she then identifies the "Tangible shift from competition towards co-operation, sharing, learning from each other … Learning from experience, mistakes, learn from colleagues" (A4). This resounds with the move towards more shared collective, organisational learning in the NHS (Nutley and Davies, 2001), and perhaps mirrors the shift in governmental discourse from training and competition to learning and collaboration. This would suggest a joined-up approach to learning, not only across professional and functional silos but also possibly across Trusts.

Another DGM (B5), with a finance background, talks about her recent promotion to the post:

> My predecessor wasn't overly keen on finance … there was a lot of political fury over my appointment … I had a month with her which was horrible, I was shadowing her. Thinking about it now it was hilarious because I was going to meetings as her shadow and she wouldn't turn up, I'd get into cars with her and she wouldn't let me out, so that in theory was training wasn't it, but I didn't really learn much because I don't think she wanted to give me any clues.

Having survived the secondment, it was opportune that the senior management development programme started in the Trust:

> The only thing that coincided with it quite nicely was the senior management development programme, it's two days out and we're all together and it's nice teambuilding . . . as a Trust we are encouraged to be very competitive . . . in the climate we're now in it's becoming a bit destructive, because we're all fairly stressed out . . . this action learning set and this OD is trying to break down barriers, we're starting to think why are we wasting this energy, why don't we just be open . . . funding is limited and you're badgered by your department to get more money, you're not going to bend over backwards to help another directorate to sort their problems out . . . I don't think any of us are winning in any great scale, whether it will be able to sustain itself, the more of us that try . . . learning from your colleagues and learning from other Trusts, if they're far enough away (there's) a lot of competition (things are) top secret (B5).

Here, too, is an explicit shift to a learning discourse, but recognition of the "stressed" and "competitive" context of Trusts within Wales. Managers, as well as being coaches and providing opportunities for learning, also have their own devolved HRD budgets to draw upon, in which there are other opportunities for management development, as one DGM explains:

> I spend some of it on myself (law degree). I went to the Chief Exec, saying everybody's doing MBAs, I'm not really into theory . . . I'm a pragmatic, you know, the organiser that gets things done, I'm not a great visionary, that's why I'm not into MBAs is a lot of strategic models and theory, that's why I've gone for something which I think is a bit more interesting and practical because obviously the NHS its becoming more and more litigious, everybody's dealing with complaints (B3).

This confirms the apparent extent to which NHS managers engage in formal management education through MBAs (Miller *et al.*, 2002), although there is perhaps a message that getting an MBA is a fad and might not necessarily equip managers with knowledge and skills required in the contemporary NHS.

Conclusions

Having identified the range of discursive resources employed by these senior managers, it is interesting to examine who uses these and how these might shape or be shaped by their professional identities. A particularly interesting dimension is the transition from being a nurse to becoming a manager (Watson and Harris, 1999) and the ways in which different individuals cope, as articulated in their language use. This paper highlights some of the discursive struggles to maintain one's professional (nursing) identify when promoted to managerial positions (Watson, 1994, 2003). One of the DGMs (A3) argues that "you can't put people, nurses particularly, into a management job just because they're good nurses", whilst another (B7) comments that "there's a stereotype of nurses, if you're a nurse you're not very good at business, which I don't believe". Both of these are nurses themselves and appear to have made that transition, and have adopted the new managerial discourse without apparent difficulty of changed identity. The paper also presents material from NHS managers who have no nursing background to enable further comparative analysis of the relationships between identity and discourse. One DGM (A4) notices how not being a nurse in such a senior managerial role is "oddball" and she is the manager who describes herself as

"gobby" and uses the most "streetwise" language, such as "crap", "shitty", "hammered", and "slaughtered".

To summarise, the paper has presented evidence of some of the tensions associated with HRD: the functional and physical fragmentation of professional and managerial development, conflict between a focus on performance/service delivery and the need to learn, discursive dissonance between the use of the terms training and learning, a delicate balance between "going on courses" and informal, work-related learning, inequities regarding "protected time" and discourses shifting between competition and cooperation. All the senior managers are aware of the politics and competition ("top secret") but talk of the tangible shift towards co-operation and sharing as learning. Managers are generally supportive of learning and development, and have an important, if sometimes difficult, role to play.

Various and varying discourses and associated discursive resources have been identified, illustrating the diversity of talk about HRD within the NHS. As one DGM commented, "I think we're using the same words but it means something completely different, (B5)". Not one senior manager used the term HRD – it was always "training and development" or "professional development" or "managerial and organisational development" and sometimes "learning". Nor was there much use of the government's preferred term "workforce development". Whilst it was recognised by our senior managers that their roles included a responsibility for HRD – through managing training budgets, approving study leave and providing learning opportunities – there were mixed feelings about the training and development functions within their Trusts. Yet, this is a difficult role in the NHS where HRD is separated into "professional" and "other": "nursing gets the big money" or "the emphasis is always on clinicians" while training and development is "only" about managerial and organisational development. Further research is needed to compare HRD activities and discourses across other professional boundaries, across Wales and across the four countries of the UK. To borrow from Dopson and Fitzgerald (2006, p. 50), "if the quality of health care delivery is to be improved, we need to understand the complex historically and contextually informed interaction between different professional groups and to design (learning) strategies that acknowledge this complexity". Understanding this can help inform and enhance HRD practice in this complex, dynamic context. This paper makes a small contribution, providing evidence of the multiple ways in which HRD is articulated and accomplished by senior managers in two Welsh Trusts, to help to construct common repertoires and shared meaning.

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Corresponding author

Sally Sambrook can be contacted at: sally.Sambrook@bangor.ac.uk

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Policy and organizational implications of gender imbalance in the NHS

Karen Miller
Glasgow Caledonian University, Glasgow, UK

Abstract

Purpose – The purpose of the paper is to examine the policy and organizational implications of gender imbalance in management, which research suggests exists in the NHS.

Design/methodology/approach – The research in this paper involved a qualitative approach with an analysis of élite interviews conducted with a non-random sample of officials involved in health policy and interviews with a random sample of senior managers in NHS Scotland. The research formed part of a larger study, which explored the enablers and inhibitors to female career progression in various Scottish sectors.

Findings – The paper finds that gender imbalance in management exists in the NHS. This is manifested in a masculine organizational context, leadership and policy decision-making process, which have implications for female career advancement opportunities and subsequently access to macro policy decisions.

Research limitations/implications – The paper involved a sample (30 percent) of senior managers and examined policy processes in NHS Scotland. To improve the external validity of the findings further research should be conducted in NHS organizations in England and Wales.

Practical implications – The findings in the paper suggest that gender imbalance in management and a masculine organizational context and leadership style within the NHS create a less than conducive environment for female employees. This has practical implications in terms of levels of part-time employment, career progression and attrition rates.

Originality/value – The paper adds to the debate of gender and organizational studies by examining the health sector, which has high levels of female employment but low levels of female representation at senior management levels. The paper therefore adds to an often-neglected area of study, women in leadership and senior managerial positions. The paper is original in its approach by examining the micro and meso organizational dimensions which impact on women's ability to influence macro health policy.

Keywords National Health Service, Gender, Leadership, Social capital, Scotland

Paper type Research paper

Introduction

The NHS has made a commitment to promote equality of opportunities through policies such as *Opportunity 2000* and *Fairness for All* (2004). In Scotland the NHS for example intends to "... place at the heart of policy making the promotion of equal opportunity for all in a just and inclusive Scotland" (NHS Scottish Partnership Forum, n.d.) and to this regard introduced strategies such as *Scottish Executive Equality Strategy* and *Human Resources Strategy for NHS in Scotland Staff*. However, despite these efforts there still exists a gender imbalance within the NHS. For example in NHS Scotland women account for approximately 80 percent of the workforce (Scottish Executive, 2003a), but despite this high proportion of women, most women are concentrated at lower grades and levels of the workforce. In a ten-year period (1993 to 2003) there had only been approximately a

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 432-447
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778952

12 percent increase of women to management levels within NHS Scotland (Scottish Executive, 2004), and currently there are only two female NHS Health Board Chief Executives in Scotland. The low level of descriptive representation of women at senior management levels within NHS Scotland has implications for the management and implementation of the equal employment agenda, and for health policy formulation and implementation. Similar findings were made by Dixon (1996) with her research into career paths and progression of women in NHS England.

Scholars of public policy argue that access to networks provides access to power and ability to influence policy (see Heclo, 1978; Jordan and Richardson, 1979). Female access to power, policy networks, and thereby the contribution that they can make to policy in terms of macro access, and the contribution they can make to the organization in terms of micro and meso access are inhibited by the low level of descriptive representation of women at senior managerial levels in the NHS. Policy networks are dependent on actors participating in a social system in which they impact upon one another's decisions (Parsons, 1995). Research has shown that although women and men contribute similar levels of human capital (education, skills, experience, etc.) when entering an organization, success and career advancement is not determined by human capital alone (Timberlake, 2005). Social capital plays an important role in networks and access to power in organizations and ability to influence policy (Kanter, 1977; Brass, 1985; Fukuyama, 1995; Kathlene, 1995; Barr, 1998; Timberlake, 2005).

Social capital refers to the norms, social relations and connections within a social structure that enables actors to achieve desired goals (Cohen, 2001; Putman, 1995). Social capital creates collaboration, information sharing and trust, which enhances participation and leads to greater effectiveness for an organization (Timberlake, 2005). Women are in part disadvantaged in career advancement due to their frustrated access to social capital; an important source of knowledge, resources, networks and power that are essential for career development (Brass, 1985; Fukuyama, 1995; Kathlene, 1995; Barr, 1998; Burt *et al.*, 2000; Timberlake, 2005). Thus, the inability to access micro and meso level social capital within an organization inhibits female career advancement and contributes to a gender imbalance at senior leadership and managerial levels. Moreover, the inability to access social capital has implications for macro access to networks, power and policy.

The paper intends to explore the micro and meso inhibitors to female career advancement by discussing women's frustrated access to social capital in the NHS. The policy and organizational implications for this will be explored by examining the gender imbalance, which exits in the NHS with a case study of NHS Scotland. Furthermore the paper will address the question of what are the contributing factors, at the micro and meso level of the NHS organization, which inhibit female career advancement and limit their contribution to macro policy networks.

In order to answer this question, researchers from Glasgow Caledonian University in partnership with the Scottish Leadership Foundation and funded by the European Social Fund embarked on a study of a number of organizations in various sectors of Scotland with the aim of investigating the inhibitors and enablers to female career progression in these sectors. The NHS was selected as a sector for research since it has one of the highest employment rates for women. The paper is partly based on this research by analysing the qualitative research conducted with a sample ($n = 31$) of randomly selected senior managers throughout NHS Scotland. The sample consisted of

13 men and 18 females constituting a sample of approximately 30 percent of senior managers in NHS Scotland. The senior managers where interviewed according to a semi-structured questionnaire and were asked to respond to questions relating to equal employment opportunity policies, national and organizational policy processes, organizational development, career development and progression, and gender issues. The research also included elite interviews ($n = 5$) with officials involved in health policy formulation. All the interviews complied with ethical standards and interviewees were assured anonymity and confidentiality.

NHS and gender imbalance in management

The NHS is the largest employer in Western Europe with approximately 1.3 million personnel (Department of Health, 2004). The NHS consists of highly qualified personnel (high level of human capital) and a high proportion of female employment; for England, Scotland and Wales women constitute on average 78 percent of the workforce (Department of Health, 2002; ISD Scotland, 2005; Welsh Assembly, 2005). Almost half of the workforce consists of nurses, most of whom are female with many employed on a part-time basis (Department of Health, 2004). The capacity of the NHS is dependent mostly on a female workforce, but despite the high proportion of female employment in the NHS relatively few women have reached senior leadership and managerial levels in the NHS. In Scotland for example women constitute 33 percent of senior management at Health Board level (all figures accessed from Health Board web sites: www.show.scot.nhs.uk/organizations/orgindex.htm), while in England the representation of women is slightly better with 43 percent of executive directors of NHS Trusts being women (Department of Health, 2004). However, given that there is a high proportion of female employment in the NHS, it would be expected that the representation of women at senior leadership and managerial levels would be higher, but there is approximately a 30 to 40 percent gender gap in leadership and managerial positions (Miller *et al.*, 2006). Moreover, given that there are 535 NHS Trusts in England, thereby presenting more career opportunities, as opposed to Scotland's 14 regional Health Boards, it would also be expected that there would be a higher proportion of women at leaderhip levels in the NHS Engalnd (ibid). Dixon (1996) found a disproportionately high number of men at all senior management levels and among nurses, with women disproportionately represented at lower levels of the NHS in England. She also found evidence of horzontal gender segregation in NHS England with women more likely to reach senior positions in community health organizations (ibid). In Scotland there is similarly a low porportion of female leadership and senior management (clinical and non-clinical) of Health Boards. Even more concerning is recent evidence to suggest that the representation of women at senior levels in the public sector is declining (Bawden, 2007). The low level of female representation at senior levels, in particular within the NHS, and thereby the lack of inclusion of women in strategic decision making has implications for macro policy formulation.

Gender imbalance in policy: the case of NHS Scotland

Scotland presents an interesting case study as it has the same workforce issues as England and Wales, i.e. high proportion of female employment, shortages in health care professionals, high proportion of nurses on part-time employment and low levels of female representation at senior leadership and managerial positions (Miller *et al.*,

2006). Scotland has a high incidence of ill-health with health indices poor in comparison to other European countries despite high public expenditure levels (approximately 8 percent of GDP) (Ham, 2005). Scotland is reforming its health care system and improving human resource capacity in order to address the high levels of ill-health. It has initiated a number of policies to restructure the NHS, and adopted human resource and equal opportunity policies such as "Fairness for All" (2004) and the host of Partnership Information Network guidelines such as family friendly policies in order to improve human resource relations and workforce capacity.

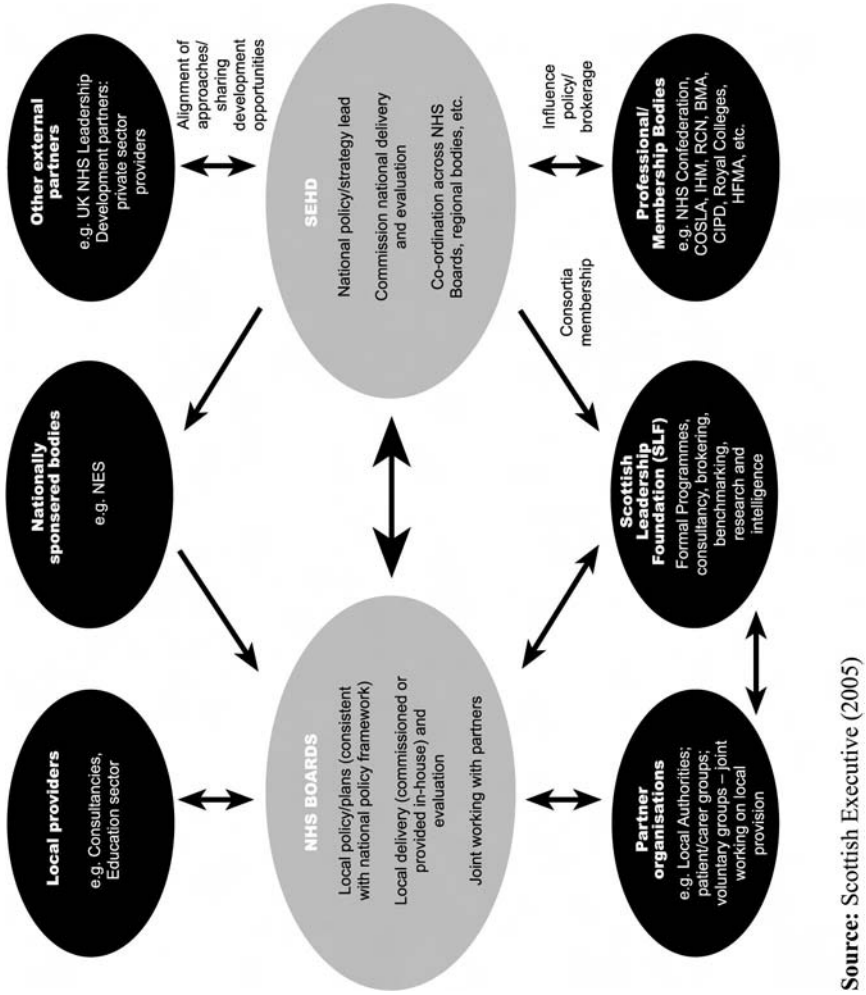
NHS Scotland reforms

The Scottish Executive introduced the White Paper, "Partnership for Care" in 2003, which set the strategic framework for improving health and introduced the unified, single system of health care delivery and thereby dissolved Trusts. This is an effort to modernize the health care system and meet political priorities such as health improvement; the reduction of health inequalities; the provision of high standards of healthcare and improved access; focussing on youth, the workplace and communities; involving patients and partners in health care; and devolving decision making to frontline staff (Scottish Executive, 2003b). Most of NHS Scotland is in a process of restructuring and reforming to a single system of working. All of NHS Trusts have now merged to form single unified NHS Health Boards in Scotland. Thus, previously separate organizational entities are amalgamating into larger organizations with consequent alignment of systems, processes, personnel, financial and physical arrangements, services as well as the attempted integration of organizational cultures (Miller *et al.*, 2006).

Policy process in NHS Scotland

The Management Executive in the Scottish Executive Health Department (SEHD) is primarily concerned with policy formulation and direction (Scottish Executive, 1997). Through policy guidance it provides NHS Scotland with health delivery priorities and strategic direction (ibid). Scotland has 14 regional Health Boards and a number of special Health Boards, which are responsible for implementing the policy direction provided by SEHD, but are also involved in the formulation of policy. Figure 1 provides a framework for understanding the role of Health Board leadership in relation to SEHD and other stakeholders. Senior management within this framework provide strategic leadership and ensure operational performance of the local Health Board (Scottish Executive, 2003b). This is achieved through working in cooperation with SEHD in the formulation of policy and with other partners in the implementation of local policy and plans (Scottish Executive, 2005).

Health Boards consist of non-executive and executive members who provide strategic leadership and ensure performance for the local area in terms of health care delivery (Scottish Executive, 2003b). Non-executive members are usually laypersons, publicly appointed by the Minister for Health and Community Care. Non-executive members provide strategic leadership as well as ensure health care delivery by holding senior management of Health Boards accountable for performance (Scottish Executive, 2000, 2003b). Executive members (clinical and non-clinical) of Health Boards ensure corporate functioning and optimal performance of operating divisions, provide strategic direction, and constitute the senior management team or corporate leadership of the Health Board (ibid). Senior management in Health Boards are therefore responsible for operational and



Source: Scottish Executive (2005)

Figure 1.
Framework of leadership in NHS Scotland policy process

strategic issues such as planning for and ensuring health care delivery at local level. Thus, they play a pivotal role in Scotland's health policy process through their input into policy and planning as well as delivering health care through policy implementation. They are held accountable for delivery on policy objectives through performance assessment frameworks (Scottish Executive, 2000). The senior management's engagement in the policy process is therefore at a meso and macro policy level.

Employment profile

NHS Scotland has the highest employment rates for women with nurses, 90 percent of whom are female, constituting the largest proportion its workforce (43 percent) (Scottish Executive, 2004; ISD Scotland, 2005). In total, 50 percent of female nurses and midwives are employed on a part-time basis (ISD Scotland, 2005). The headcount total of administrative/managerial positions is 4,109 with males constituting 1,787 (43 percent) and females 2,322 (57 percent) (ibid). This figure reflects a gender balance of managerial positions in the NHS, but given the high proportion of women in the NHS one would expect to have a higher representation of females in administrative/managerial positions. The grouped statistic skews the representation of women in managerial positions given that it includes administration and clerical grades (Miller *et al.*, 2006). There is a high proportion of women in clerical grades, but less so for senior management grades which reflects vertical gender segregation. The grouped statistic therefore ameliorates the gender imbalance for senior management in the NHS (ibid). Most of the senior management positions in the NHS are occupied by men. The headcount total for senior management, i.e. executive membership of Health Boards, is 111 of which males constitute 63 percent and females 33 percent (all figures accessed from Health Board web sites: www.show.scot.nhs.uk/organizations/orgindex.htm). There is a further gender segregation of managerial positions with females concentrated in occupations such as Human Resource Management and Nursing (Miller, 2005). The non-executive membership of Health Boards has a disproportionate number of male members (67 percent) with only two female chairs of the 14 regional Health Boards (all figures accessed from Health Board web sites: www.show.scot.nhs.uk/organizations/orgindex.htm). Thus, in NHS Scotland there is a gender imbalance with a high proportion of female employment, but low levels of representation at senior leadership levels. Even at the most strategic policymaking level, the Management Executive of SEHD there are two female and six male Directors, and 20 male and eight female senior managers. Why are there low levels of female representation at senior managerial and leadership positions in SEHD and NHS Scotland, and what are the implications for micro and meso levels of the organization and for macro health policy?

Gendered access to power, social capital and policy networks

Policy networks and power

Much has been written about policy networks by various scholars (Atkinson and Coleman, 1992; Heclo, 1978; Rhodes, 1981, 1988, 1997; Jordan and Richardson, 1979, 1987; Richardson, 1982; Smith, 1990). The basic premise argued by these scholars is that there exists formal groups of actors, whether within and/or among government and social organizations, who attempt to influence the formulation of policy. According to Rhodes (1988, 1997) policy networks are a function of stability of membership, restrictiveness of membership, degree of insulation from other networks, and the distribution or control of

resources by the network. Rhodes (1997) further atriculated the idea of policy networks as based on three central premises. First, interdependence of organizations and exchange of resources, in other words the existence of networks is dependent on an exchange between organizations in order to achieve goals, although membership to the organization is restricted (ibid). Second, there are game-like interactions which are competitive strategies among members in order to achieve goals (ibid). Third, networks are autonomous as there is no internal or external authority with most networks being self-organising, although power relations exist among networks (ibid). The basic assumption therefore is that there are select members of an organization who interact with others, in the context of public policy within and/or among government, in order to exert influence on public policy decisions for some resource extraction. The underlying behaviour of the actors is competition (Rhodes, 1997), politicking or the exercise of power. Moreover, dependent on the availability of resources, networks offer members access to power and the opportunity to influence policy.

Policy networks and social capital

The concept of social capital is dependent on the disciplinary prespectives of sociology, psychology, economics, political science, management studies etc. by various scholars such as Baker (2000), Bourdieu (1986), Coleman (1990), Portes (1998) Putman (1995) and Akdere (2005). According to Portes (1998), for example, social capital is the ability of actors to secure benefits due to membership of social networks. Similarly, Coleman (1990) defines social capital as any aspect of a social structure that enables value for members of that social structure. Lin (2001) also conceptualises social capital as value derived membership of a social structure and defines it as an investment in social relations by an individual with an expected return in the market place. Putman (1995) describes social capital as aspects of organizations such as networks, norms and social trust that facilitate cooperation for mutual benefit. The social network of actors is durable and is an institutionalised relationship of mutual acquaintance (Bourdieu, 1986 as cited in Akdere, 2005). The membership of a network is dependent on trust, mutual understanding, and shared values and behaviours that bonds actors to form a cohesive network (Akdere, 2005). Thus, social capital requires the inclusion of an actor within an institutional or formal network of actors with the inclusion resulting in some benefit for the actor at a micro level and some added value for the network of actors at meso and macro level.

The value or benefit for the individual actor, dependent on the context of the network, is career progression (sometimes accelerated), desired employment or positions, increased remuneration, etc. (ibid). At a micro level social capital refers to the individual's ability to mobilise resources within an organization in order to gain some benefit (ibid). In an employment context it would involve an individual using his/her human capital (skills, knowledge and innate ability) to gain some benefit from the network or organization whether it be recognition, career advancement, increased pay, etc. At a meso level social capital refers to the processes that govern interactions among networks and can viewed from a structural perspective in terms of the way in which resources move through networks (ibid). Social capital at this level is concerned with social identity and belonging, the inclusion of members and exclusion of outsiders (Coleman, 1990 as cited in Akdere, 2005). Thus, at a micro level a potential member is attempting to be included in order to gain some benefit by using human capital, or an existing member of a network is using human capital to extract some benefit from the

network. The manner or process in which individuals of a network relate to each other, how benefits are distributed, and who is included or excluded is the concern of social capital at a meso level. It could be argued that micro and meso level social capital are interdependent. In other words the network at a meso level requires micro social capital to exist, but it is at a meso level that it is decided who can be included and derive a benefit from the network. The macro level of social capital is concerned with the impact networks have on policies at a national level. At a macro level social capital includes institutions such as government and political parties (Grootaert, 1999 as cited in Akdere) and is critical in determining how government functions (Putman, 1995).

The restrictive nature of meso social capital and policy networks (Rhodes, 1988; 1997) makes for exclusive membership for those who do not share smiliar values and attitudes. Moreover, it could be argued that a policy network is based on homogeneity, which may exclude diverse groups and perspectives. According to Tulloch (as cited in Parsons, 1995, p. 184):

> As the feminist movement gathered momentum during the seventies, it was realised that men had always used the old boys' network to get ahead, and there was no reason why women should not do the same … By the late eighties networking was recognized as an important way of advancing all kinds of interests.

The idea of networks therefore offers the opportunity to take advantage of contacts (Parsons, 1995) or to gain social capital. But the restrictive nature of networks may exclude some from the opportunity to gain social capital and influence macro policy. Hallberg and Lund (2005) in their paper, "The Business of Apocalypse: Robert Putnam and Diversity" criticise Putnam's argument that diversity undermines the social capital of groups. Thus, when is it suggested that an "old boys' network" exists, this implies that the network is gendered to the disadvantage of women. The result is that women do not gain an advantage from being included in a network, or more precisely they are excluded from opportunities to build social capital, and influence policy at a macro level.

Micro and meso inhibitors to female career advancement in the NHS

Work-life conflict

The NHS encompasses highly qualified staff, including women with high human capital, but this is often not translated into social capital at micro and meso levels. In other words, women are frustrated in using their human capital to gain social capital or mobilise resources. At the meso level, women do not benefit from social capital because they are excluded from networks.

The obvious explanation for this exclusion is discrimiation (direct or indirect) which limits women's ability to utilise their human capital and are excluded from social capital due to the gendered nature of a network. When participants in the research were asked whether gender discrimination exists in the NHS, 87 percent responded that discrimination did not exist in the NHS. However, all participants qualified their statements with the issue that women's reproductive and domestic role may inhibit their career progression. Participants did not view this as discrimination, but as societal norms which impact upon the organization. In other words the demands of domestic work, which many women face creates a work-life conflict (Hakim, 2000, 2004). Nonetheless the notion that women have reproductive and domestic roles which is perceived to be in conflict with traditional notions of full-time employment creates a

gender bias of women in relation to their capacity to undertake various roles in the NHS organization.

Women still bear the burden of domestic responsibilities in society and this dometic work is often viewed by organizations and networks as less commitment by women to work and careers (Hakim, 2000, 2004; Lane, 2004). In the NHS the high proportion of part-time female employment not only reflects their domestic work (see Dixon, 1996), but is negatively perceived by organizations and networks. Furthermore, part-time employment limits the opportunity to engage in the organization in order to build social capital. Part-time employment and the lack of social capital inevitably limit opportunities for career advancement. Becker (1991) argues that women are making a rational choice between full-time employment and domestic work, while Hakim (2004) argues that women are making choices between three lifestyles; combining work and family, focusing on work, and life centred around the home. However, research within NHS Scotland proved that the issue of part-time employment is much more complex.

Women do not necessarily "choose" between lifestyles as argued by Becker (1991) and Hakim (2004) rather they function within a micro and meso organizational context. According to Lane (2004), p. 269) women's careers do not simply reflect the relationship between work and domestic trajectories of the self, but are inextricably linked with the organizational context of opportunities and constraints within which women carve their careers. Organizations accept, reward and value an "ideal" employee who demonstrates commitment to the organization and work. The "ideal" employee is usually in full-time employment and does not adapt work for non-occupational life, but prioritizes paid work and often displays stereotypical male attributes such as aggressive go-getting characteristics (Gamble *et al.*, 2006, p. 46). Acker (1998) similarly argues that jobs are structured on the assumption that the ordinary worker is a man, an abstract person who has few obligations outside work that could distract him from the centrality of work, which creates a gendered dimension to organizations. Dixon (1996) research with managers in the NHS showed most women regarded family commitments and the lack of flexible working as barriers to career progression. Thus, a further explanation of micro and meso inhibitors of female career progression to leadership positions is the masculine leadership and organizational context of the NHS. In other words, the organizational context and leadership style in the NHS creates a less than conducive environment to balance work and non-occupational life; invariably to the disadvantage of women.

Gendered leadership in the NHS

Leadership and management are often associated and socially constructed with masculine behaviours (see Mavin *et al.*, 2004). Furthermore, most studies of leadership focus on men since "although methodologies and models have changed during these phases of leadership research, one factor has held constant. This is, the virtual absence of women in such studies. Is it surprising, therefore, that women are still largely excluded from power and influence in organizations . . . " (Alimo-Metcalfe, 2002, p. 2).

A few studies have explored the gendered nature and construction of leadership (Alimo-Metcalfe, 1995, 2002, 2005; Eagly and Johannesen-Schmidt, 2001; Fletcher, 2004; Mavin *et al.*, 2004; Rosener, 1990; Sparrow and Rigg, 1993). Research in this area revealed that women generally adopted and identified with transformation styles of leadership (Rosener, 1990; Sparrow and Rigg, 1993; Alimo-Metcalfe, 2002; Bass and Riggio, 2006). Transformational leaders are respected and trusted by followers, they motivate

followers, encourage followers to be innovative, and develop the potential of followers (Bass, 1998; Bass and Riggio, 2006). This is often contrasted with the transactional style of leadership. Transactional leaders reward or sanction the actions of followers, they monitor the performance of followers, take corrective action when needed and are therefore more directive (Bass, 1998; Bass and Riggio, 2006). Transformational styles of leadership are generally regarded as more effective and satisfying than the transactional style alone (Alimo-Metcalfe, 1999, 2002; Eagly and Johannesen-Schmidt, 2001; Bass and Riggio, 2006). Eagly and Johannesen-Schmidt (2001, p. 793) research found that men exceed women on transactional scales of leadership while women had higher scores on transformational leadership scales. They argue that an explanation for this is that transformational leadership requires a repertoire of social and interpersonal skills such as being attentive, considerate and nurturing towards followers, which are consistent with the stereotyped female gender role (Eagly and Johannesen-Schmidt, 2001). Alimo-Metcalfe (1999) in fact argues that the NHS requires transformational leadership in order to effectively manage employees, deal with organizational change and deliver services. This then begs the question; if transformational leadership is more effective than transactional leadership, if women are associated with transformational leadership, and given that there is high proportion of women employed in the NHS – why are there so few women in leadership positions in the NHS?

The answer may lie in the organizational rewards for transactional leadership styles and displays of masculine behaviour (Eagly and Johannesen-Schmidt, 2001; Fletcher, 2004). A transactional leadership style is reflected in stereotyped masculine or agentic behaviours (Eagly and Johannesen-Schmidt, 2001). Agentic leadership styles are those behaviours associated with aggression, assertiveness, control, ambition, dominance, forcefulness, independence, being daring, self-confidence, and competitiveness (Eagly and Johannesen-Schmidt, 2001). In an employment context agentic behaviours may include speaking assertively, competing for attention, influencing others, initiating activity directed to completing tasks, and making problem-solving suggestions (p. 783). In contrast communal leadership styles are primarily concerned with the welfare of others (ibid). These behaviours involve affection, helpfulness, kindness, sympathy, interpersonal sensitivity, nurturing and gentleness (ibid). In an employment context communal behaviour may involve supporting others, interpersonal skills and contributing to solutions (ibid). Thus, these communal behaviours, associated with transformational leadership, are often not rewarded by organizations with male leaders. According to Martin and Collinson (1998 as cited in Fletcher, 2004, pp. 652-653) stereotypical masculine attributes such as assertiveness are associated with leadership since "... men have dominated spheres of influence in the work world for so long, doing masculinity and doing work have gotten conflated such that everyone experience subtle pressure to do masculinity at work in order to be perceived as competent ... " Furthermore, women who enact communal behaviours are likely to be seen in a stereotypical manner as being selfless, helping others and expect nothing in return (Fletcher, 2004). Recently, this has become known as the female advantage in organizations – albeit based on stereotypical assumptions (Bass and Riggio, 2006). However, because communal behaviour is stereotypically associated with femininity, women who display transformational styles of leadership are not seen as exceptional nor are they rewarded (Eagly and Johannesen-Schmidt, 2001; Fletcher, 2004). Thus, the dominance of men in leadership positions in the NHS neither values nor rewards the

potential contribution women can make and as suggested by Alimo-Metcalfe (1999; 2005) selection, promotion, performance review and development activities need to be reviewed. However, the overriding problem is the negative attitudes and commitment by senior leaders because they were likely to have been promoted and selected on the basis of displaying agentic and transactional leadership behaviours (Alimo-Metcalfe, 2005, pp. 22-23). Thus, at the micro level women's contribution is not valued and they are therefore excluded from networks and meso level activities in the organization since the criteria for access is based on masculine constructions of leadership.

Organizational context of the NHS

The organizational context also mitigates the value of women to the leadership and policy processes of the NHS at a macro level. Acker (1998) argues that organizations are gendered in structure, practices and policies that perpetuate unequal power, rewards and opportunities, and interpersonal relations, which reinforce and recreate gendered patterns of behaviour and processes. It could be argued that the organizational context is a gendered phenomenon with values, patterns of behaviour and roles ascribed to certain sexes being rewarded (see discussion above). Thus, organizations, which have a disproportionate representation of men, especially at leadership levels, and rewards stereotypical masculine behaviours, create a context, which is less than conducive to women and thereby alienates women. Studies have shown reward systems and work processes which privilege masculine traits and male working patterns reinforce organizational masculinity to the disadvantage of women (Sheridan, 2004; Maier, 1999).

The evidence suggests that the NHS has a masculine organizational context and style despite the high proportion of female employment. This masculinity is reflected in the disproportionate representation of men at leadership and management levels in the NHS. Moreover, the policies and decisions, which are made by the male leadership and management, are not conducive to women. On indicators of masculine organizational culture 78 percent of participants' responses reflected a masculine organizational culture. The following responses from participants reflect this argument:

> Bureaucracy is systematic. You get things from the Scottish Executive and think what a lot of nonsense, but if you are told to comply by the Chief Executive then you have to ... There is a blame culture; you have to justify work because you have to meet performance targets ... (male manager).

> It should be a "no blame" culture but the ... Chief Executives can explode mainly because things are not followed through ... it can be quite stressed at times (female manager).

> The biggest pressure is public perceptions or expectations. The public wants promises delivered. Politicians promise but clinicians and management has to deliver. The thumbscrews get turned that we cannot meet expectations. All for targets but as a health service these can be unrealistic. Decisions are made nationally that are out of our control (male manager).

> Female staff are particularly under pressure as there is very high expectations of the manager's here – meeting targets, balancing resources, the closures ... (female manager).

> It's very much command and control ... " (male manager).

> When jobs or promotion do come up people now consider do they really want it, do they really want to go there! Is it worth the extra hours, money or work? There are too many targets, we

> are not in control of workload, we are driven by national policy initiatives … (female manager).

The quotes illustrate the existance of a masculine organizational context and transactional leadership style. The research also revealed the existance of command-control behaviour, increased job demands, pressures placed upon employees and a long-hours working culture. The majority of managers (68 percent) interviewed for this research work long hours of 50 to 60 hours per working week with some working on weekends. Similar findings were reported by Dixon (1996) with her research into the the career paths and working patterns of NHS managers. Managers work these long hours in order to meet the increased job demands associated with the increase in performance assessment frameworks and policies emanating from the Scottish Executive. As discussed above the policy formulation process at the Scottish Executive level, and at the non-executive and executive Health Board level is disproportionately representative of men. These performance frameworks and policies are formulated from a masculine perspective with the resultant increase in job demands which is more conducive to traditional notions of full-time career paths and employment.

These policies therefore alienate women as these increased job demands create a work-life conflict. Furthermore, their part-time employment is not valued and not seen as a commitment to job and organizational demands. Women, particularly those in part-time employment, are therefore not viewed in a favourable light for career advancement opportunities. Thus at a macro policy level, in other words the strategic leadership level, decisions are being made which do not create a conducive organizational context at a micro and meso level for female career advancement. Moreover, the process becomes somewhat of a cycle with female career advancement to senior levels being inhibited, and thereby their access to policy networks and social capital being inhibited. The result is the lack of female representation and engagement in macro policy decisions with health policy formulated from a masculine perspective with implications for women at the micro and meso level of the organization.

Conclusion: implications NHS policy and organization

The masculine organizational context and leadership style does not provide women with a "choice" between work and family, but rather creates a work environment which is less than conducive to a work-life balance. This may explain the high rate of part-time employment among women in the NHS. The reality is that for women (and increasingly men) work and domestic life is inextricably linked and that the "… dichotomous relationship of the two spheres of work life and domestic life is more a myth … " (Fletcher, 2004). However, it is the "ideal" employee who prioritizes work that is valued by the organization. The masculine organizational context and leadership therefore frustrates women at the micro level of the organization, and thereby inhibits female career progression and access to meso social capital. The implication is that with inhibited career advancement fewer females reach the macro levels of policy decision-making. This creates a cyclical pattern, which perpetuates a masculine organizational context and is re-enforced through masculine strategic policy decisions and restricted social capital to the disadvantage of women. However, this disadvantages the organization as well. According to Alimo-Metcalfe (2005, p. 22) social capital, that is the resources inherent within networks of alliances and

relationships within an organization contributes to identity, morale, motivation, commitment and ultimately performance.

The implications of a masculine organizational context, macro policy network and processes is that policy decisions are not inclusive of the greater proportion of employees in the NHS, that is women. This restricted policy network and process may in fact affect the quality of policy decisions. The exclusion of women in policy networks creates a less than conducive organizational environment for women. This may explain the relatively high incidence of part-time employment, turnover and attrition (Lane, 2004) and thereby the shortages of staff in the NHS. There was approximately a 7 percent turnover of staff for the period 2003/2004 (ISD Scotland, 2005). Furthermore, research showed that one in ten women left the NHS due to personal and family circumstances, compared to one in a hundred for men (Dixon, 1996). An example of the implications of a gendered organizational environment is the increasing shortages of clinical staff in acute medical specialisms. This is partly explained by the gender segregation of clinical careers within the medical profession. There is evidence to suggest that women prefer a general practice career in primary care as opposed to specialist acute careers (Miller, 2005). This may be due to direct discrimination, but also the lack of flexible work practices and notions of traditional career paths, which do not accommodate a balance between work and family (ibid). Thus, the general practice career provides more of a conducive environment for women because as independent contractors they do not necessarily have to comply with a masculine organizational culture. In the foreseeable future, with increasing female medical graduates (Federation of Royal Colleges of Physicians, 2001) there may be a shortage of specialist medical practitioners in acute services. For nurses the opportunity to leave the employ of the NHS (for example most nurses can now retire at the age of 55) becomes more attractive with increased job demands and the lack of a work-life balance. The NHS faces competition for skilled employees, but decisions at the macro policy level create less than a conducive environment for the majority of its employees; women. Thus, rigidity in career and working patterns limits those NHS employees with family and other domestic commitments (Dixon, 1996, p. 27). Moreover, traditional managerial career paths in the NHS are out of tune with the current and future needs of NHS organizations and of many potential and future NHS managers (ibid).

Current policy and structural reforms within NHS Scotland have also limited the opportunities for career progression, as senior positions are now limited to 14 regional Health Boards and a few special Health Boards. Previously, within a local area there may have been a number of Chief Executive positions, but it is limited to one position per geographic area. Those who seek career advancement in NHS Scotland may find a limited number of senior positions available and may seek career trajectories elsewhere.

The research found that a gender imbalance in management exists in NHS Scotland with macro policy decisions being made mostly by men and few opportunities for women to engage in these policy networks. Moreover, these macro policy decisions inhibit women at a micro and meso level in terms of social capital and opportunities for career advancement. This is somewhat unsustainable as it affects policy in formulation, the capacity of the NHS to implement health policies and to deliver health care.

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Corresponding author
Karen Miller can be contacted at: K.Miller@gcal.ac.uk

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Human resource management and performance in healthcare organisations

Claire Harris, Penny Cortvriend and Paula Hyde
University of Manchester, Manchester, UK

Abstract

Purpose – The purpose of this paper is to compare the evidence from a range of reviews concerned with the links between human resource management (HRM) and performance. The aim of the paper is to review this diverse literature, and to derive human resource (HR) implications for healthcare researchers, policy makers and managers.

Design/methodology/approach – Recent reviews of the human resource management and performance literature are examined, in addition to the inclusion of a previously unpublished review. Their methods, HRM focus, findings and recommendations are contrasted in order to produce this review.

Findings – The paper finds that relationships have been found between a range of HRM practices, policies systems and performance. Despite being an important concern for HR professionals, there is little research exploring the link between HRM and performance in the health sector.

Research limitations/implications – The paper sees that recent studies have found HRM practices to be associated with patient outcomes such as mortality, yet they yield little information regarding the processes through which HRM affects individual performance and its consequent impact on patient care. The use of approaches that seek to gain an understanding of workers' interpretations of their experience, i.e. the psychological process through which HRM can affect individual performance, may shed some light on how these processes work in practice.

Practical implications – The paper shows that increasing autonomy for healthcare organisations in the UK, i.e. Foundation Trusts, may offer increased opportunity for locally tailored HR systems and practices.

Originality/value – The paper presents findings drawn from a review of previous research on a subject of increasing relevance to HR researchers and practitioners in healthcare organisations. The paper indicates alternative approaches to research and practice in light of extant research.

Keywords Human resource management, National Health Service, Performance management

Paper type Research paper

Over the last decade a great deal of attention has been devoted to examining the links between Human Resource Management (HRM) and organisational performance (Wright *et al.*, 2005). Despite this plethora of research, few studies have been conducted in the UK health sector with a small number of exceptions (see, for example, Borrill *et al.*, 2000; Guest and Conway, 2004; Purcell *et al.*, 2003; West *et al.*, 2002; West *et al.*, 2006). This is curious, both because of recent attention to performance outcomes in health care organisations and because HR seeks a strategic role. As a result, it has become increasingly important for HR to establish hard evidence linking HRM to performance outcomes. Along with other sectors, health organisations are concerned

This research has been supported by the Department of Health, the Chartered Institute of Personnel and Development and the Healthcare People Management Association.

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 448-459
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778961

with enhancing performance through HRM practices, systems and policies (e.g. Department of Health (DH), 2006, 2005).

Recent trends in the UK have moved away from restructuring and reorganising health services and towards modernising working practices (Hyde *et al.*, 2005; DH, 2002a, b). In 2000 the Government launched its strategy for the English NHS – The NHS Plan (2000). This set ambitious targets for increasing staff numbers and modernising the health service in England. To support implementation, the HR in the NHS Plan (2002a) was launched. This pushed HRM to the forefront of the modernisation agenda. Drawing on evidence from "magnet hospitals" in the USA (McClure *et al.*, 1983), which showed that progressive HR practices are associated with better patient outcomes, HRM became a key driver for enhancing patient care. In this paper we outline the research evidence that links HRM and performance and discuss its applicability to the health sector.

Reviews of HRM performance link

Several recent reviews have considered which HR practices or systems of HR practices are linked to individual and organisational performance (e.g. Boselie *et al.*, 2005; Combs *et al.*, 2006; Hyde *et al.*, 2006; Wall and Wood, 2005). Table I shows a summary of the HRM focus and findings of the three reviews and one meta-analysis.

The reviews included studies from 1994 onwards and the meta-analysis included studies from 1990 onwards. The reviews and meta-analysis used different criteria for selection of studies to be included depending on the reason for conducting the review. This resulted in variable numbers of studies included in each review ranging from 25 (Wall and Wood, 2005) to 104 (Boselie *et al.*, 2005). It is interesting to see the range of HRM practices, policies and systems that have been included in the reviews. Boselie *et al.* (2005) included 26 types of HRM practice and policy, Hyde *et al.* (2006) included ten types of HRM practice, and Combs *et al.* (2006) included 13 types of HRM practice. Wall and Wood (2005) focused on bundles of HRM policies and practices, finding a range of terminology including high performance work practice, high involvement HRM, technical and human capital enhancing HRM. This highlights the confusing picture in the HRM performance literature regarding which practices, policies and or systems are linked to performance. The type of performance outcomes explored also varies widely in the reviews, for example Wall and Wood (2005) focused on economic outcomes, Boselie *et al.* (2005) focused on a range of outcomes including HRM outcomes such as commitment and Hyde *et al.* (2006) focused on a range of outcomes but specifically searched for studies that included patient outcomes. Combs *et al.* (2006) focused on operational and financial performance. So a whole range of HRM practices, policies and systems and performance outcomes have been included in these reviews. This makes it difficult to compare the reviews and even the studies within the reviews.

We explored the extent to which the reviews included health sector research studies. Boselie *et al.* (2005) and Hyde *et al.* (2006) reviews uncovered only a handful of studies conducted in the health sector (e.g. Brown *et al.*, 2003; Meyer and Collier, 2001; West *et al.*, 2002). This might be a reflection of the inclusion criteria used in the reviews or might simply reflect the dearth of research studies that have been conducted in the health sector. We believe the latter reflects the state of the research, although we are aware of non-published studies and some published studies that have been conducted

Author, date, detail	HRM focus	Summary of findings
Wall and Wood (2005) Twenty-five studies 1994-2003 Example criteria – refereed journals, 1994 onwards, multiple HR practices, economic performance, highly cited studies	Control v. commitment Skills and structures v. motivation Work system v. HRM policies HR planning v. hiring v. development index and composite index of HR sophistication Administrative HR v. human capital-enhancing HR Four types ranging from Innovative HRM – traditional HRM Four types ranging from high to low/high commitment Five types ranging from cost, quality, flexibility and time HRM + generic scale High involvement HRM index Strategic HRM practices Skill level v. HR incentives + composite index High performance work practices Several combinations of HR practices Strategic HRM v. technical HRM	Fifteen out of 25 studies report statistically significant positive relationships between HRM practices and performance No compelling evidence of synergy within HRM systems or of any systematic strategic fit effects Reliance on cross-sectional evidence could overestimate the relationships between HRM and performance Inadequate measurement of HRM and poor measures of performance could underestimate the strength of the relationship between HRM and performance It is premature to assume that HRM initiatives will inevitably result in performance gains either in all situations or even where deemed appropriate by contingency arguments (p. 454)
Boselie *et al.* (2005) 104 studies, 1994-2003 Example criteria – refereed journals, 1994 onwards	Training Contingent pay and rewards Performance management Recruitment Team working Direct participation Good wages Communication Internal promotion Job design Autonomy Employment security Benefits Formal procedures HR planning Financial participation Symbolic egalitarianism Attitude survey Indirect participation Diversity and equal opportunities Job analysis Socialisation Family-friendly policies Exit management	General assumptions are made in the literature surrounding causality and the HRM performance process. Generally research indicates that organisational strategy links to HR strategy, which links to HR practices, which links to HRM outcomes, which links to internal performance which links to financial performance Empirical studies focus attention on broad areas of policy including careful investment in recruitment and selection, provision of training, flexible job design and performance management There is a disparity of research designs The big three theories: contingency; Abilities, Motivation, Opportunity (AMO); and resource-based views (RBV) offer complementary frameworks

(*continued*)

Table I.
Main findings from reviews and meta-analysis

Author, date, detail	HRM focus	Summary of findings
	Effectiveness of HR function Social responsibility practices	A steady body of empirical evidence has been accumulated since the pioneering studies of the 1990s, yet it remains the case that no consistent picture exists on what HRM is or even what it is supposed to do (p. 81)
Hyde *et al.* (2006) 97 studies 1994-2004 Example criteria – refereed journals, 1994 onwards	Training Pay Involvement Selection Team working Performance appraisal Job security Job design Equal opportunities Career development	Most explored practices are training, pay and involvement, overall studies show positive associations between training and pay and performance and involvement on average was non-significant Bundles of practices had on average more positive associations with performance than single practices Most studies do not state their theoretical perspective used Context in which HR system/practices are implemented matters . . . there is insufficient evidence to suggest that any one element of HRM may be superior to another in terms of its impact on performance (p. 45)
Combs *et al.* (2006) 92 studies, 1990-2005 Example criteria – report bivariate measures, HPWP had to have been used broadly not restricted to management, measure of HPWP had to reflect use of practice not value of practice	Incentive compensation Training Compensation level Participation Selectivity Internal promotion HR planning Flexible work Performance appraisal Grievance procedures Teams Information sharing Employment security	HPWP have stronger effects than individual practices The relationship is invariant to the choice of organisation's performance measures HPWP have stronger effects among manufacturers than service organisations HPWP impact organisational performance through knowledge skills abilities; empowerment, motivation and social structure and performance can lead to investment in HPWPs (feedback loop) Organisations can increase performance by 0.20 of a standardised unit for each increase in HPWP use (p. 524)

Table I.

in the health sector which may not have been picked up in the reviews (see Michie and West, 2004). The health sector studies will be discussed in the next section.

The reviews appear to draw very similar conclusions, for example Wall and Wood (2005) indicate that "it is premature to assume that HRM initiatives will inevitably result in performance gains" (p. 454); Boselie *et al.* (2005) indicate that "... it remains the case that no consistent picture exists on what HRM is or even what it is supposed to do" (p. 81); and Hyde *et al.* (2006) indicate that "there is insufficient evidence to suggest that any one element of HRM may be superior to another in terms of its impact on performance" (p. 45). The reviews all mention difficulties in, identifying the theoretical perspective taken in each study, measuring HRM and performance consistently and drawing causal conclusions about the HRM performance link due to the predominately cross sectional nature of the research designs.

The meta-analysis paints a more positive picture and the authors attribute this to the methods used to estimate the strength of the relationship between HRM and performance. Combs *et al.* (2006) concluded that "by using meta-analysis to reduce the effects of sampling and measurement error, our results lay to rest any doubts about the existence of a relationship ... we estimate that organisations can increase their performance by 0.20 of a standardized unit for each unit increase in HPWP used" (p. 524). Combs *et al.* (2006) also considered the strength of the relationship in manufacturing and service sector organisations and reported that the relationship may be stronger for manufacturing because of the routine, standardised nature of the work "our results suggest that it might take different HPWPs to bring out the performance potential of service employees due to the unique characteristics of service work, such as low task interdependence, high work flow uncertainty and the role of the customer in the process" (p. 521). Health sector work has similar characteristics to the service sector in terms of workflow uncertainty and the role of the patient. This coupled with other unique characteristics of the health sector such as types of HR practices used, performance measured and process by which HRM is implemented in organisations may mean that the most effective HRM systems are those that are tailored to specific health settings.

HRM and performance measurement in the NHS

HRM in healthcare organisations has unique characteristics (Buchan, 2004). In England, NHS Trusts are given suggested guidance from DH about HR practices that can improve trust performance. In 2005, the general HR strategy for all NHS Trusts (HR in the NHS) was superseded by a framework to guide HR Directors in the NHS and Social Care "A National Framework to Support Local Workforce Strategy Development" (2005). The framework highlighted, amongst other things, ten high impact HR changes that can "improve organisational efficiency and improve quality and the patient experience" (pp. 50-51). With the support of David Ulrich, the "National Framework to Support Local Workforce Strategy Development" (2005) suggested to HR Directors how human resources add value. This advisory framework allows Trust managers the autonomy to develop their own HR systems to fit their local environment, thus, moving policy away from standardised HRM and towards locally tailored approaches (Marchington and Grugulis, 2000). However all NHS Trusts are required to provide updates to the DH on several performance outcomes related to HR systems.

Performance measurement in health care organisations is not without its difficulties, and the application of systems designed for the private sector have been criticised (Arah *et al.*, 2003). Until 2005, the system used to measure NHS performance was the "star rating system" using a set of key indicators and a balanced scorecard to set targets for Trusts. The key indicators centred on waiting times, financial management and cleanliness. However, HRM indicators were included, for example; improving working lives accreditation, sickness absence rate, junior doctors hours, health, safety and injuries, views about appraisal, personal development plans, access to training and team-working and staff attitudes toward their job and their intentions to leave. So, in effect, Trusts had to implement at least some HRM practices in order to achieve their star ratings (although they still retain discretion regarding the techniques they use to implement each practice).

In March 2005 the performance management system in the NHS was superseded by the "Annual Health Check" which comprised core standards and developmental standards. Both standards consider HRM indicators. For example, within the core standards Trusts are measured on the extent to which they support and recognise their staff contribution via personal development plans, appropriate recruitment, mandatory training and further professional development. The developmental standards also cover HRM issues, one is quite explicit about the role that HR should play in improving patient care "health care organisations work to enhance patient care through adopting best practice in human resource management and continually improving staff satisfaction". The "Standards for Better Health" (2005) performance management system and the "Framework to Support Local Workforce Strategy Development" (2005) both assume a clear link between HRM and patient care, and provide a blue print for some of the HRM practices that Trusts should adopt in their HRM system. This system incorporates some of the HPWPs found to have had a positive effect on performance in other sectors (Combs *et al.*, 2006).

Aside from the regulation and advice NHS Trusts get from DH, the health sector has other unique characteristics. For example, the workforce is large, diverse and comprises many different occupations, some having sector specific skills (e.g. doctors and nurses). Some professions in the NHS are regulated by other professional bodies (e.g. General Medical Council) and have specific requirements for training and ways of working. There are also many stakeholders in the NHS for example funders (tax payers), the government, health professionals, management, media, private and voluntary sector, regulators, researchers and users, all wanting different kind of performance information. As Buchan (2004) states the irony is that the "health" business is probably one of the most research based sectors with the use of sophisticated methods such as randomised controlled trials etc, yet HRM in health is under-researched (p. 4). Studies of HRM and performance in the NHS are presented in the following.

Selective studies of HRM and performance in the NHS

A handful of studies have been conducted in the NHS on the HRM performance link, some of these will be reviewed here. West *et al.* (2002) examined the relationship between sophistication of appraisal, sophistication of training and percentage of staff working in teams and patient mortality in 61 acute hospitals in England. By asking HR Directors within the hospitals to complete a survey they were able to establish hospital

policy with respect to these key variables. Analysis revealed that sophistication of appraisal had the strongest negative relationship with patient mortality, but that percentage of staff working in teams and sophistication of training also had significant negative relationships with patient mortality. This was the first study to establish relationships between HRM practices and performance in acute trusts in the NHS (West *et al.*, 2002, p. 1307). The authors acknowledge several limitations, including small sample size, cross sectional research design and use of HR Directors as respondents.

West *et al.* (2006) examined the relationship between the HRM system and patient mortality in 52 acute hospitals in England. By asking HR Directors within the hospitals to complete a survey, they were able to establish hospital policy with respect to training, performance management, participation, decentralisation, involvement, use of teams, employment security and investor in people (Iip) status. They also collected data on staffing and compensation but did not include these HRM policies in the analysis because they found little variation in use of staffing practice and pay due to clear directives from the DH with regard to these policies. They conclude that people management systems that emphasize a complementary set of "high involvement" HRM policies may be successful in contributing to high quality healthcare (p. 994). The authors acknowledge some limitations including a less comprehensive measure of HRM practices than previous research, small sample size, no consideration of mediators in the HRM performance relationship and no evidence of causality. Both these studies highlight that HR practices and systems are associated with patient outcomes in health settings.

Purcell *et al.* (2003) examined the impact of people management on organisational performance, focusing on how and why the relationship exists. They identified 11 practices in their model, arguing that they encourage discretionary effort from workers and this improves their performance. Their findings are drawn from case study organisations, one being a clinical department in an NHS Acute Trust. They emphasised the importance of the line manager in "bringing policies to life". Within the health case study they found marked changes in employee attitudes in response to changes in people management practices and policies. Across the cases they also argued that some HR policies and practices were shown to be important in terms of influencing outcomes such as commitment, satisfaction and motivation and these were those concerned with career opportunities, job influence, job challenge, training, performance appraisal, teamworking, involvement in decision making, work life balance and having managers who are good at leadership and who show respect (p. x). This case study goes some way in explaining some of the important aspects of HRM implementation and hence highlights "how" HRM policy is translated into practice for workers.

Guest and Conway (2004) conducted a survey of the employment relationship using telephone interviews with British workers across a range of sectors including the NHS (8 percent). They reported that those respondents in the NHS were more likely to report higher levels flexibility than respondents from other sectors. NHS respondents also reported that their employer made more promises and commitments to them than other sectors and they reported higher levels of commitment, work satisfaction, loyalty to clients or customers and stress. More generally they reported a cluster of practices associated with the concept of being a "good employer" and these were presence of

progressive HR practices, flexible family friendly practices, effective supervisory leadership and delivery of promises leading to perceptions of fairness of treatment and high trust. A composite measure of "good employer" was associated with higher levels of worker satisfaction, commitment, excitement, motivation and lower intention to leave. This study highlights some of the characteristics associated with being a good employer and various outcomes, but also highlights some of the unique characteristics of working in the NHS. However this study only included a small percentage of health sector workers and it would be interesting to see if any differences emerge within different health sector structures. Other notable studies are Borrill *et al.* (2000) who explored the links between team working and effectiveness in health care teams.

In general these studies highlight the potential links between HRM practices and systems of HRM practices and various patient outcomes in the health sector (West *et al.*, 2002, 2006). They also highlight the importance of the process by which HRM is implemented in organisations (Purcell *et al.*, 2003) and the unique characteristics of working within the NHS (Guest and Conway, 2004). In order to advance our understanding of the links between HRM practices and important outcomes in the health sector, additional research aimed at understanding the psychological processes through which HRM can effect individual performance may help to illustrate how HR practices translate through the individual to lead to the patient and other performance outcomes.

Future research and recommendations

Each of the reviews presented earlier in the paper made recommendations for future research. Table II shows the recommendations that the reviewers make about how to study the links between HRM and performance in the future.

The reviewers generally conclude that; longitudinal research designs are required to explore the HR performance link empirically; workers rather than HR Directors should be asked about their experience of HRM; researchers should account for the context of the relationship and type of worker; it is important to consider "how" HRM is linked to performance; distinctions should be made between HRM policy and HRM practice; its important to consider different performance measures that are applicable to the research setting; not all HR practices are equal and techniques of performance management or training may change the nature of the relationship between HRM and performance; reverse causality needs to be explored (i.e. does HRM result in improved performance or does improved performance result in improved HRM?); it is important to explore different moderators and mediators of the HRM performance link.

While empirical attention on the HRM performance link continues to increase, researchers have criticised the theoretical underpinnings of the existing research and called for more specific theoretical models of the process through which HR practices impact performance. Wright and Haggerty (2005) call for more multilevel research to explain variance at multiple levels of analysis (e.g. individual, group and organisation). They also argue that other additional theoretical contributions can be made from cross level theories that explain smaller aspects of the linkage between HRM and performance such as theories on cognitive processes and mental models. These may help us to better explain the individual processes and performance outcomes that are triggered by organisation level HRM practices.

Author and date	Some recommendations from the reviews
Wall and Wood (2005)	Use big science and longitudinal designs to move forward research and practice; small-scale funding currently available to researchers will not lead to new learning HRM assessments require measurement of practices from more than one person, in different contexts, who are ignorant of the performance of the organisation (thus reducing error, and increasing reliability). Use independent audits of HR practices Test hypotheses in different contexts, e.g. private v. public sector, manufacturing v. finance
Boselie *et al.* (2005)	Use employee, customer and trade union experiences of HRM to examine the HRM-performance link; look at "black box" concepts such as the psychological contract and climate Researchers need to ensure that they do not confuse policies (intentions) with practices (actual, observable activities) Examine whether different HR practices need to be implemented for different employee types (e.g. core, peripheral, etc.)
Hyde *et al.* (2006)	Local and wider external contextual factors need to be taken into account when doing research of this nature (particularly in the NHS) Performance measures may differ according to sector and more research is required that focuses on different sectors and takes these differences into account It is important to focus some research on the individuals that experience HR practices
Combs *et al.* (2006)	Not all high performance work practices are equal. For some practices such as incentive compensation, the specific version of the practice such as group versus individual bonus might matter less than other practices such as developmental versus control-oriented performance appraisal. More research is needed that directly compares alternative versions of specific practices (Delery, 1998) as well as conditions under which implementation effectiveness is critical More research is needed that examines the feedback effects of implementing high performance work practices on performance – is it that HR practices enhance financial performance or does greater financial performance result in more investment in high performance work practices? The best set of HPWPs in a given organisation depends on the type of work being conducted – more research is needed which investigates HPWP systems developed specifically for services Explore other moderators of the relationship (in addition to type of organisation) Explore other mediators such as knowledge, skills and abilities, empowerment, motivation, internal social structure

Table II.
Recommendations made by extant reviews

Understanding how HRM practices can contribute to performance by motivating employees to adopt desired attitudes and behaviors that in the collective can help enhance organisational performance is also important. Drawing on recent theoretical papers by Bowen and Ostroff (2004) and Rousseau (2001) we argue that HRM systems influence employee attitudes and behaviors as well as organisational outcomes such as

patient care through employee mental models. Mental models are conceptually related elements, representing prototypical extractions of complex concepts (Stein, 1992). They develop from experience and guide the way new information is organised in memory. When people enter organisations they will hold pre-employment mental models, acquired through socialisation, professional norms and ideologies. These will contain information about past experiences in organisations and help individuals understand what behaviours are expected of them. Over time, as people become socialised into an organisation their mental models integrate more information and become more stable. They represent "the way things are". HRM systems can send out messages to workers with regard to what they can expect from their organisation and what the organisation expects back from them. They therefore help to form the implicit psychological contract between employers and employees (Rousseau, 2001). These mental models may develop over time and guide individual behaviors. People are motivated to discern patterns, create meaning that enables interpretation of current experiences to provide basis for predicting future events and guide their subsequent behavior (Welch Larson, 1994). When HRM systems send out messages about the goals of the organisation and the practices within the system complement one another, both employer and worker can make accurate predictions about what is expected and be able to identify appropriate behavior to fulfill and maintain commitment to one another (and hence achieve organisational objectives whilst maintaining a healthy psychological contract). Therefore understanding workers mental models of the HRM system that they experience in relation to their own psychological contract with their employers is an important step in understanding "how" HRM is linked to performance.

Conclusions

This review of extant research linking HRM to performance has illustrated the difficulty of establishing unequivocal links between single or multiple practices and performance outcomes. In fact, the difficulties of separating out HR effects from the wider context remain problematic. A recent meta-analysis indicates that HPWPs can increase performance by 20 percent per unit (Combs *et al.*, 2006). This finding is important, given the suggested links between HRM and mortality (West *et al.* 2002). It is important to establish how HR operates through individual performance in order to illustrate how patients may be affected. Borrill *et al.* (2000) illustrated how this might work in primary care through psychological constructs such as: commitment and satisfaction.

The majority of findings, however, remain equivocal and it is arguable whether this is a limitation of methodology or an oversimplification of a complex process. Boselie *et al.* (2005) question the smooth sequential process between HR practices and HR outcomes implying that HR techniques (the means of implementation and local tailoring of HR practices) may have an effect on performance outcomes and this would be important for healthcare organisations. Increasing autonomy for NHS Foundation Trusts may allow for increasing tailoring of HR practices to suit local circumstances. The equivocal nature of findings linking HR practices directly to performance outcomes might suggest that it is not enough to have particular HR practices in place: the potential impact of any HR practice or set of practices on performance may be mediated by the effect of the implementation process on mental models of individuals and thus on HR outcomes such as motivation, commitment and satisfaction. Further

research into how such process work with individuals in healthcare organisations could illustrate how HR practices and HPWPs affect individual performance and therefore how HR systems in healthcare organisations may be locally tailored to maximum effect in terms of both organisational performance and improved patient care.

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Corresponding author
Claire Harris can be contacted at: claire.harris@mbs.ac.uk

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Patient involvement in a professional body: reflections and commentary

Alison Baker
Chiswick, London, UK

Abstract

Purpose – The purpose of this paper is to consider the issues which emerge when an autonomous, professional, member-led organisation attempts to demonstrate its accountability to patients through lay involvement in its standard-setting processes.

Design/methodology/approach – The paper reports a project, which is still in progress and could be described as action research. Data were collected through participant observation in a series of discussions and working groups. A limited literature search was carried out at the start of the initiative but found little which relates to lay involvement in professional bodies.

Findings – The paper finds that patient involvement in a professional body is unlikely by itself to be a useful mechanism for delivering greater professional accountability.

Research limitations/implications – The paper is a single case study and can only suggest hypotheses for further research.

Practical implications – The paper shows that professional bodies of various types are increasingly being asked to demonstrate public involvement in their decision making. It is important to identify the most effective mechanisms for this and the limitations inherent in the structures of organisations, which are accountable primarily to their members.

Originality/value – The paper shows that individual doctors are held to account through a number of mechanisms, but little attention has been given to how medical professional bodies can be made more accountable for the collective power they hold. Patient involvement is interpreted within a consumerist model, which focuses on the doctor-patient relationship and ignores the considerable strategic influence which medical royal colleges exercise within the health service.

Keywords Primary Care, National Health Service, Doctors

Paper type Research paper

Introduction

The primary stated objective of most medical royal colleges is to set the standards of practice for doctors (Chisholm and Askham, 2006). However, they also exert considerable influence over the structure of the National Health Service, and affect the way in which services are developed and delivered and how resources are allocated. They set the standards for training young doctors and they are responsible for nurturing the professional culture within which their members operate (Askham and Chisholm, 2006). They shape the medical workforce and in so doing they necessarily have a considerable impact on other health professions. The colleges are also formidable players in the arena of health service policy, with privileged access to politicians and senior civil servants.

In the past there has been a tacit understanding that the medical profession assures the interests of patients simply by promoting good quality care. However, there has been a steady shift in the health service to requiring greater accountability from the

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 460-469
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778970

medical profession (O'Neill, 2002). As they exert a significant influence over a major area of public spending, and their members benefit from employment in public service, there is an important question of how medical professional bodies are governed and how they deliver their accountability to patients and the wider public. Given their powerful position it is surprising how little analysis there has been of their organisational structures.

The work reported here describes the initial thinking behind an initiative in one of the medical royal colleges, referred to here as "the College", to establish greater and more effective patient and public involvement in standard setting and quality assurance. The majority of the members of the College provide services in primary care settings. This paper sets out the issues, which have been encountered, in early attempts at increasing patient involvement in the College. It suggests that the way in which patient involvement is currently structured contributes to the development of patient-centred care delivered by members of the College, but is much less effective in enhancing the accountability of the profession as a corporate body.

The initiative to improve patient and public involvement in the College was instigated by the author, one of the senior managers in the College. The material for this paper comes from a series of discussions between the author and the College members who had responsibility for setting and implementing professional standards. The College, like most professional bodies, carries out much of its work through committees and task groups. These discussions, therefore, were for the most part in the context of the six committees, which oversee what are known as the College quality programmes. The committees were composed of about a dozen members, mostly doctors. Some committees involved a single patient representative and one or two also included a nurse or a primary care manager.

The topic of improving patient and public involvement was discussed briefly with the chair of each committee, to secure agreement to it appearing on the agenda. The author prepared a paper, which was discussed with a small group of managers working on the College quality programmes. The paper was then discussed at each of the committees, in some cases more than once. The author was a participant observer at the committee meetings, and facilitated the discussions on this subject. Informal interviews were also held with a small group of patients who had already been invited to bring a lay voice to specific college projects and who sat as individual lay members of the committees. A meeting of patient representatives was also used to elicit more views about how the College could best involve patients and public. A limited literature search was carried out at the start of the initiative but found little which relates to lay involvement in professional bodies. Patient involvement is generally seen in the literature as a matter of the quality of healthcare; its implications for professional accountability have received less attention.

Professional bodies, which are funded through membership subscriptions, experience a tension between accountability to their members and accountability to the public and to patients (Kennerly, 1992). The College, in common with other medical professional bodies, states its aim as protecting patients by ensuring high standards of practice. Its claims for influence over health service policy and its role in the training of young doctors are based on this premise. However, the organisation is dependent for income, and for influence and standing, on the support of its members, and its organisational structures and culture are defined by this. On the other hand, as the

health service has become more concerned with patient and public involvement, the College has recognised that it must be able to demonstrate how it involves patients in its work. This is necessary to secure the credibility and acceptability of its standards, and to enhance its influence in the political environment.

Background

The government's thinking about patient involvement in the health service has encompassed both a consumerist approach and an approach led by concepts of governance and accountability (Lewis *et al.*, 2006). Patient involvement, particularly through greater choice of healthcare provider, is seen as a driver for quality. Less explicitly, there seems to be an assumption that patient involvement is one of the mechanisms through which the health service can be made more accountable to its users (Coulter and Elwyn, 2002). Although the concept of patient and public engagement as an aspect of accountability has found some expression through foundation trusts and patient forums, doctors are more aware of the agenda around individual patient choice, complaints, providing information to patients and patient satisfaction (Department of Health, 2004).

The College has tended to define patient involvement through two main themes. One is usually described in terms of "patient-centeredness". This refers to a style of consultation, which emphasises being alert to the agenda, which the patient brings to the consultation, which may or may not be explicit, and to sharing decision making with patients. The College has developed sophisticated standards for patient-centred consultations which form part of the assessments leading to membership and which have become influential in the training of doctors (Siriwardena *et al.*, 2006). The second aspect of patient involvement, which has figured strongly in College thinking, is the level of patient satisfaction, particularly as measured through questionnaires to individual patients.

The College has, thus, largely defined patient involvement in terms of individual relationships and patient satisfaction. The patient is seen as an individual "consumer" of services. The College has been much more cautious about advocating engaging with the collective voice of service users or exploring wider issues of public accountability. This is not to suggest that the College explicitly embraces a consumerist model of quality in health. Many of its members have considerable concern about the erosion of trust between patient and doctor, and the change in relationships between doctor and patient, which the more general ethos of consumerism may bring (Fugelli, 2001). Some of these tensions are apparent in the professional response to public concerns about out of hours provision. The response calls for better patient information, and support for patients to make appropriate choices between services. The involvement of patients in the governance of services is not addressed (Royal College of General Practitioners, 2007).

Members of the College have not generally been closely involved in the performance review structures, which the government has introduced, such as those of the Health Commission and local scrutiny committees. Issues of accountability in primary care are also complicated because the majority of doctors work in independent partnerships, which are not formally part of the NHS. There is no required role for patients or the public in the governance of practice partnerships in the way in which lay non-executives are involved in the governance of NHS trusts. Although practices may

set up patient groups to advise on the way the practice is run, their role is determined by the partners. Members of the College, therefore, have little collective experience of developing or working with organisational structures of patient or public involvement.

The purposes of patient and public involvement in a professional body

The initiative to improve patient and public involvement in the work of the College started by exploring the rationale for this process. Some ambiguity and confusion in views emerged immediately. Medical members of the committees were vague about what constituted a patient perspective. They agreed that patient involvement would bring a non-medical, user perspective and that it would ground professional standards in the patient experience. However, they couched the discussion in terms of aspects of services, which they thought were the terrain of patients, e.g. patient leaflets or the waiting area. It proved almost impossible to tease out a more detailed definition of the patient perspective (Van Wersch and Eccles, 2001). It was difficult to find ways of expressing the different types of knowledge and understanding of health care, which derive from the experience of being a patient, or the different values, and priorities, which might arise from, lay involvement (Florin and Dixon, 2004). Doctors seemed to hold a tacit belief that patients perceived interaction between doctor and patient differently from doctors, and they assumed that this could be negotiated with sufficient skill on the part of the doctor. The lack of evidence about the impact on health or health services from patient involvement (Crawford *et al.*, 2002), makes it more difficult for managers to define a clear aim for patient involvement in the work of the College.

In trying to clarify the purposes of patient involvement in the College it became apparent that patients themselves tended to define their involvement in limited terms. Interviews with a small group of patient representatives who had contributed to standard setting or assessment yielded only specific examples from their own experience where they felt that patient needs had not been understood. Even when talking about doctor-patient interaction, the patients' ideas of what standards might be developed were quite constrained by the existing college model and did not extend to, for example, how patients are supported to handle risk or to make decisions about their care. It is possible that the patients who are involved in college work have had little experience of other roles where involvement might have a broader purpose, yet even those patients who had wider experience of involvement roles in the health service did not articulate ideas of accountability or talk about influencing the development of services.

It was interesting to note what did not figure in the committee discussions. There was no reference, from either doctors or patients, to the College taking a leadership role in enhancing patient and public involvement in primary care. The concept of patient involvement as an organisational issue for the College was notably absent from debates. Nor was there any sense that patient involvement would increase the openness and transparency of the process of formulating professional standards. There was no mention of patients driving improvements in service delivery.

Patient involvement as a means of enhancing the accountability of the profession did not figure in the College paradigm of patient involvement in its work. It was not that this concept was rejected, but rather that the consumerist model of patient engagement dominated the discussion. A similar approach is evident in a recent report on medical professionalism from the Royal College of Physicians (2005). However, a

report on the "new professionalism" (Rosen and Dewar, 2004), begins to explore how medical professions might develop a compact with government, the public and other stakeholders in improving health services in a collaborative way.

Patient involvement in the development of professional standards

A key role of medical royal colleges is setting standards for their professional specialty. This is done in various ways, including developing training curricula, setting entry exams, drawing up clinical guidelines, formulating standards for specific areas of primary care and working with health service policy makers. A patient representative has been involved on many of the committees concerned with standard setting, but their impact so far has been limited. It became apparent that medical members of committees were unclear about the role of patient representatives on committees, although they normally saw it as good for the College to have these representatives. Managers in the College had hoped that these representatives would ask challenging questions about how the standards contribute to patient care, how they might enhance the patient experience and how they would improve patient/public participation in general practice. It had also been expected that patient representatives would prioritise among the standards and bring ideas about good practice and innovation in ensuring a patient focus. This has not happened to any real extent.

One problem is that a single patient voice cannot easily challenge assumptions or question priorities. The culture of the College committees encourages decisions, which emerge by consensus. It is difficult for one person to introduce new perspectives unless they have exceptionally good skills of persuasion and are well respected in the profession. This is made more problematic by the fact that medical members of the committees have been selected because they have an expertise in quality and standards in primary care. Patient representatives are invited onto committees because they are service users, not because they also have expertise in the subjects addressed by the committee. From time to time doctors have queried the "representativeness" of the patients, and their views were sometimes dismissed as "not typical". The power imbalance between the committee members who are, in effect, guests, invited to comment as one of an ill-defined group of "patients", and a group of professionals whose views are legitimated by their specific experience or credibility within the discipline, is stark, and is well understood by the patients who talked about their reluctance to "rock the boat".

The professional standards, which are developed through the committee process, reflect a limited view of patient involvement. They give a good deal of attention to patient-centred consultations but say virtually nothing about support for patient decision-making or involvement of patients in service development. Where patient-related standards are formally set out in college programmes they form a separate section covering, e.g. patient leaflets, patient satisfaction or disabled access to the premises. There is no patient focus embedded across the standards, and little that encourages the involvement of patients or the public in the design of services or the development the organisations, which deliver them.

A shift away from committees with single patient representatives towards more innovative and inclusive structures would allow for a wider and more diverse group of patients to be involved and enable patient views to be developed through group interaction (National Council for Voluntary Organisations, 2004). Greater clarity about,

and recognition of, the type of expertise which patients bring to the standard setting process would also enhance their contribution. (National Consumer Council, 2002). The patient representatives might make more impact if they were allowed to widen their role from commenting on proposals developed by the College to initiating proposals and to making recommendations about how the College might consult with wider networks of patients and the public. There was one occasion during the project when this happened. The College wished to influence a proposal from the Department of Health, which had made it clear that the views of patients would carry significant weight in the final policy. A wide range of patients, were invited to attend a meeting, albeit facilitated by college members. The importance of a credible patient input to the strength of the College policy response led to a more inclusive patient consultation.

As the initiative to improve patient and public involvement developed in the College, it was decided to hand over the recruitment of additional patients to join its working groups to the current group of patients, with support from college managers. This was presented to, and accepted by, the doctors as an appropriate way of managing patient involvement. The result was that a group of patients with wider external networks and more experience of presenting arguments was brought into college committees, although still as single representatives on any one committee. It has also created pressure from the patient representatives to form a more coherent group within the College and to receive more regular updating about college policy. This approach to selecting and supporting patients who work with the College may enhance the patient-centeredness of professional standards. However, it unlikely by itself to deliver greater accountability of the professional body to the public without a change in college organisational structures to give patients a stronger foothold on decision making and a status as partners not guests. Nor will it deliver a wider accountability of the profession within the health service unless ways are found of introducing a broader concept of patient involvement onto the agenda.

Like other professional bodies, the College structures have been designed on the one hand for accountability to autonomous professional members, and on the other hand, for managing the external, political faces of the organisation. It is in many ways a very democratic organisation with processes of election or open selection for key roles. However, the constituency for the democratic processes is the members of the College. There are no obvious mechanisms through which other stakeholders, such as patient or public representatives, can achieve influence except through participating in debates and discussions where the agenda has been set by members of the College and where the terms of debate are largely determined by the senior officers of the College. This is not to say that the professional body does not hear the non-medical voice – it does. But the processes through which the patient voice is heard, the issues to which patients can contribute and the extent to which they have an influence is all determined by the members of the professional body, who are operating within a framework of accountability to their professional colleagues. A genuine dialogue requires all voices to have equal value (Anderson *et al.*, 2002).

Patient involvement has been added on to a professional organisational structure and culture without any wider changes in the organisation. If the government is looking to increase the accountability of professions through requiring lay involvement in their organisations it may need to foster more systemic changes in the way these bodies operate, and to require a more open and extensive model of

engaging with patients and the public. The greater clinical engagement in radical change in the health system, which the government seeks, is unlikely to be assisted while professional bodies maintain structures, which have no real accountability to patients and public.

There have been initiatives to involve patients not only in the development of college standards but in their implementation through systems of assessment. Some assessment programmes involve a visit to the doctor in their work setting and some teams of assessors have involved a patient. Reports on these visits, given in the form of papers to committees, have indicated that both doctors and patients have found the experience to be positive. Doctors say the patient assessors are stimulating, and their involvement has contributed to the formative, developmental aspect of assessment. Doctors also say that they find patient assessors less threatening than medical assessors: this may be because patient assessors are not seen by candidates as critical to the assessment process. The most frequent concern about patient assessors expressed by doctors has been that patients have set unreasonably high standards. There may be a number of explanations for this and it requires further exploration. It may be that patients compensate for being assigned to assess rather narrow areas of practice organisation by being particularly challenging over a specific topic; it may be that medical assessors have a shared understanding of standards which has not been agreed with patients (Rughani and Warren, 1999).

Conclusions

There is considerable ambiguity about why a professional body should involve patients in its activities and some confusion between the consumerist aims of increasing patient choice and patient satisfaction, which figure prominently in health service policy, and the aims of increasing the accountability of the profession as a standard setting and educational body. This ambiguity is a feature of much discussion within the health service, but the structure and culture of primary care make it particularly difficult to develop a model of corporate professional accountability.

The initiative described here has highlighted some of the issues, which emerge when considering ways to enhance patient and public involvement in a medical professional body. Two themes in particular are possible subjects for further research and management intervention. One is the way in which the purposes of patient and public involvement are conceptualised by both patients and doctors. The agenda was set within the professional body and in this example became defined in a way, which fitted well with existing professional values. This was not challenged by the patients who had been invited to sit on committees of the professional body.

The second theme raises the question of what organisational structures would deliver the public accountability of a professional body. As the initiative progressed it became apparent that, by working within the existing patient involvement structures of the College, the managerial project was flawed. Instead of addressing organisational structures at a corporate level, the project attempted to lever change through empowering patient representatives in the existing committee system. Patient and public involvement in a professional body requires a review of its organisational structures so that patients and the public can become one of the constituencies of the democratic processes through which agendas are formed and decisions are made.

The organisational structures of a professional body have not been designed for public accountability. Although the concept of public responsibility is very much engrained in English professionalism, the mechanisms to achieve this have been implicit, and are based around the idea of trust between individual professional and client. Most professional bodies rely heavily on committee structures to engage their members in a democratic way. A body such as the College requires elected members, in their trustee capacity, to take responsibility for initiatives. They approach their projects with the agenda on which they were elected. Committees are pervaded by a culture of decision-making through consensus and tacit understanding. Patients and public representatives are invited to become involved in an advisory role and as guests can never have an equal status.

Patient and public involvement, which is an add-on to a system designed for professional purposes, is unlikely to be satisfactory. The development of channels of accountability requires new structures and skills within the organisation (Mills, 2005). Increasing accountability would require involving a wider number of stakeholders in a decision process which is more open and includes wider consultation, outside the organisation, on key policy and education issues, and the promotion of patient involvement in service and organisation development at local level. This does not sit easily with the concept of professionalism, which has grown up in medicine, where the relationship between individual doctor and patient is the locus of accountability.

There is a well-worked set of models of community, deriving from nineteenth century sociology (Nisbet, 1966) which offer some insight into the tensions created by patient involvement in a professional body. The professional community still relies on shared understandings and peer support in handling the complex responsibilities and risks, which the practice of medicine involves. The pressures for patient involvement derive in large part from an organisational model, which assumes a more explicit contractual relationship between doctor and patient, and a more pluralistic concept of accountability. The initial response from the professional body described here has been to define patient involvement in terms of patient-centred care, a concept which is well accepted and understood, and which enhances, rather than challenges professional values. The professional body has set up structures, which enable the professional body to receive comment and input on those aspects of its standards, which pertain to the relationship between doctor and patient. It has not addressed the issue of how it might become more accountable as a profession for the way in which it shapes the health service and the delivery of care.

A model developed by anthropologist Jane Jacobs (1993) is also useful in understanding these tensions. She describes a "guardian" syndrome and a "commercial" syndrome. The former is a set of behaviours, which derive from values of tradition, hierarchy and authority, which operate in strongly bounded communities where symbolism and reputation are important. The commercial syndrome is a set of behaviours predicated on collaboration and contracts, initiative and enterprise. Although Jacobs argues that the syndromes should be kept separate, professionals working in primary care draw from both. As independent practitioners they are well used to operating within a commercial paradigm. As members of a professional body striving for a status equivalent to that of the old established medical royal bodies (known as "the ancients"), they understand the importance of maintaining boundaries, adopting the symbols of professions and creating a hierarchy within the

profession. The new requirements for public accountability have been interpreted within a commercial syndrome, drawing on concepts of responsiveness to the individual patient as consumer. Wider issues of accountability, relating to the responsibility of the professional body in shaping the structures of health care, challenge the boundaries and rights of the profession defined within the guardian syndrome, and are much more difficult for a professional body to address.

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Corresponding author
Alison Baker can be contacted at: abaker@rcgp.org.uk

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Involving the public in NHS service planning

Silvia Anton and Lorna McKee
University of Aberdeen, Aberdeen, UK
Stephen Harrison
University of Manchester, Manchester, UK
Shelley Farrar
University of Aberdeen, Aberdeen, UK

Abstract

Purpose – The purpose of this paper is to report the findings of a study that examined the development of an assessment framework for public involvement.

Design/methodology/approach – The paper has adopted a multi-method approach that includes: a focused review of literature relating to tools that might be used to provide valid and reliable assessments of public involvement; key informant interviews with people with experience from various perspectives of efforts to involve the public in the planning and development of health services; and a detailed study of a specific public involvement initiative involving a range of "stakeholder" interviews.

Findings – The paper finds that there are uncertainty and a lack of consensus about how assessment of public involvement should be undertaken. The findings emphasise the need to recognise the diverse nature of public involvement, which may require assessment to be employed flexibly at each individual NHS Board level.

Research limitations/implications – The paper is a small-scale study, in which it was only possible to probe a limited number of stakeholders' views due to practical and time restrictions.

Originality/value – The paper adds value to the discussions taking place at Scottish Government level as to the best approach in assessing public involvement in health service decision making.

Keywords Scotland, National Health Service, National Standards

Paper type Research paper

Introduction

There is a clear commitment in Scotland reflected in the "Patient Focus and Public Involvement" (PFPI) policy initiative to involve the public in health service planning (Scottish Executive, 2001, 2004). It is now a statutory requirement for NHS Boards to directly involve patients and the public at "all levels of their ongoing work – from individual care planning to major service redesign" (Scotland Bill, 2004). The Scottish Health Council (SHC) was established in April 2005 and together with Quality Improvement Scotland (QIS) is now charged with assessing NHS Boards against PFPI performance standards. All NHS Boards in Scotland (including Special Health Boards) are required to complete an annual PFPI self-assessment framework (Scottish Health Council Workplan, 2006).

"Public involvement" basically refers to attempts on the parts of organisations such as Health Boards to include a range of (often unspecified) individuals and community groups and organisations, and the "public at large", in their activities. The SHC regards the National Standards for Community Engagement (Communities Scotland, 2005a) as

Journal of Health Organization and Management
Vol. 21 No. 4/5, 2007
pp. 470-483
© Emerald Group Publishing Limited
1477-7266
DOI 10.1108/14777260710778989

applicable to Health Boards that serve a whole region of potential and actual users of health services (Scottish Health Council Workplan, 2006).

Public involvement policy

Despite, or perhaps because of the current prominence of policies promoting public involvement, a number of tensions and ambiguities relating to this policy have not been well explored. Discussion of public policy is increasingly characterised by references to "governance", a concept that is employed both descriptively and normatively (Pierre and Peters, 2000). Descriptively, "governance" is opposed to "government"; it signifies the recognition that traditional assumptions about top-down government from Whitehall or Edinburgh are empirically inaccurate. Policy outcomes are rather the result of a wide range of interactions between a much wider range of actors, including organisations, pressure groups, and elite networks. Normatively, governance may be the subject either of disapproval, on the grounds that it can bypass the accountability arrangements of representative democracy (Rhodes, 1997) or (more frequently) of approval as signifying more direct or participative democracy (Held, 1996). Contemporary statements of formal government policy frequently take the positive stance, and the Scottish NHS is no exception: "To develop options for change *with* people not *for* them, starting from the patient experience and engaging the public early on to develop solutions rather than have them respond to predetermined plans conceived by professionals" (Scottish Executive, 2005c)

Yet there are obvious policy tensions that imply that these policy aspirations cannot simply be taken at face value. First, the NHS constitutes a system of "third party payment" (Harrison and Moran, 2000) in which neither patients nor health professionals have any immediate incentive to restrict the services that are provided. Rather it is the third party payer (central government in the case of the NHS) that faces this incentive, implying that policy cannot simply consist of "giving people what they want". Second, such "consumer moral hazard" is likely to be compounded by the sort of demand-side factors such as demographic shifts (though there is a debate about whether an ageing population necessarily implies rising demands), technological development, the tendency to "medicalise" more human and social problems (Moynihan and Smith, 2002), the phenomenon of conservative preferences relating to service provision (Hundley and Ryan, 2004) and perhaps also generally rising expectations. Third, involvement policy is in tension with another major plank of health policy: evidence-based health care. Crudely, what people want may not be what the research says is effective (Harrison *et al.*, 2002). One high-profile example of this is the case of Interferon Beta for relapsing-remitting multiple sclerosis, where there was no consensus about the implications of the cost effectiveness evidence of the drug reviewed by the National Institute for Clinical Effectiveness (ref needed).

Public involvement policy in Scotland

There are five key policy changes that set the scene for public involvement policy in Scotland:

(1) Raising the PFPI profile: the Scottish Parliament has placed a legal duty on NHS Boards to involve and consult the public and promote/encourage equal opportunities.

(2) Local Health Councils (LHCs), which used to serve as "the voice of the public" were abolished in 2005.

(3) Substantial health service changes have been proposed in recent SE policy documents.

(4) The policy emphasis in relation to public involvement is now placed firmly on "Early involvement" in the identification of problems and development of possible solutions, as opposed to "End-stage involvement" in the acceptance of a particular change.

(5) The establishment of Community Health Partnerships and their developing Public Partnership Forums. Public Partnership Forums will be a key vehicle for Community Health Partnerships and NHS Boards to engage with their wider communities.

It is impossible to appreciate the implementation issues concerning PFPI without paying some attention to the broader pressures and dynamics in the Scottish health care system. For example, there have been proposals for significant changes in the way services are delivered, including shifting the balance of care away from hospitals to community care. There has been substantial public reaction to some of these, particularly in relation to hospital or service closure (Scottish Executive, 2005a, b).

Performance measurement and public involvement policy in Scotland

NHS Boards' PFPI activity has been assessed since 2002/2003. During this time and prior to the existence of the SHC, the assessment of NHS Boards' public involvement activities was undertaken by Scottish Executive Health Department's "Involving People" Team, which included a self-assessment by NHS Boards and latterly a report from the former Local Health Councils. As an organisation at arms-length from the SEHD, the SHC will fulfil its assessment function by reviewing the annual self-assessments that NHS Boards provide of their achievements on PFPI against a set of performance assessment quality indicators, and by using national guidance and standards, such as the draft guidance on Informing, Engaging and Consulting the public (Scottish Executive Health Department, 2004) and the National Standards for Community Engagement (Communities Scotland, 2005b). The quality indicators for PFPI at the start of this project were set in the context of a broader Performance Assessment Framework (PAF). This framework has now been replaced by Health, Efficiency, Access and Treatment (HEAT) that captures planned performance against these 32 key performance measures which relate to an agreed core set of 28 key targets (Chief Executive Report, 2006).

Study objectives, design and methods

The overall aim of the present study was to inform discussions about the development of a framework of assessing public involvement in NHS Scotland.

More specific project objectives were to:

- Identify potential criteria and methods for assessing public involvement in the planning and delivery of health services; and

- Consider the suitability of the identified criteria and methods for assessing public involvement for the particular case of Health Boards' efforts to involve their publics in decisions about the planning and delivery of services

Study design and rationale

There are three main components to address these aims and objectives:

(1) A series of key stakeholder interviews to gather key issues; and identify potential assessment criteria and concerns about their application.

(2) A focused literature review of existing tools for assessing public involvement.

(3) A focused "case study" of health service redesign in the Scottish context with the view to considering further how public involvement can appropriately be assessed.

This paper reports on numbers 1 and 3.

Interview methods

An initial literature search of published policy documentation on public involvement in the UK provided us with a starting point for identifying our key stakeholders in the Scottish policymaking community as well as the broader research community. From this list, we identified individuals by considering who were "actively engaged" and "close to central debates", and could therefore provide us with rich insights relating to criteria and methods for the assessment of public involvement. We conducted 14 interviews: ten informants were Scottish NHS policymakers, planners, voluntary sector and consumer representatives who had been involved in either informing, designing or using previous assessment frameworks; and four were academic experts with a close knowledge of public involvement issues. The interviews aimed to explore a challenging set of key issues including the desirability of public involvement assessment in the absence of clear, measurable criteria; weaknesses and strengths of existing criteria and methods for Public involvement; the larger constraints posed by specific features of the policy context; organisational processes, structures and resources in the Scottish context; and a sense of "direction" for a Scottish assessment framework.

The interview schedule was informed on the basis of a wider understanding of the literature and from discussions with colleagues familiar with the policy context of the NHS in Scotland.

Given informants' time constraints, the interview schedule was used flexibly and tailored to suit the individuals' roles and responsibilities.

Background to case study

This "case study" is set in the context of a series of public involvement activities relating to proposed changes to re-organise health services in a "remote and rural" part of Scotland. The time period covers 2002-2005 and makes reference to two landmark events: the commissioning of the West Highland Project and following from this, the formation of a Solutions Group. Both events were born out of a recognised need for health service change and therefore officially initiated a number of Public involvement activities. However, latterly, public involvement took place as part of a reaction against the emerging outcomes of these events.

The issue at large, also expressed in the literature as a historical issue for rural and remote areas of Scotland is the sustainability of services (see RARARI in the following section). Although some informants disputed that the origins prior to 2002 were founded in this context, for the purposes of our period of examination, we found the related issue was:

How to sustain 24-hour consultant emergency cover in the face of pressures from within the health care system (e.g. recruitment and retention of consultant staff), and from outside the health care system (e.g. European Working Time Directive (EWTD)).

The following discussion reports mainly on our stakeholder interviews and our focused case study, and sensitises the reader to the policy context by probing the views of a range of stakeholders who have been involved in either informing, designing or using previous assessment frameworks; and those with a close knowledge of public involvement issues. During the lifetime of this study, we took advice from Scottish policymakers and representatives of key institutions through workshop discussions and individual interviews. This advice was used to identify our key stakeholders for the initial interviews, and focus on an appropriate "case" study of health service redesign.

Methods

Case study method

Our case study reports on an attempt to develop and re-design health services in rural Scotland, and particularly a debate about emergency cover. It considers the opinions of diverse stakeholders about the characteristics of public involvement (PI), and further how PI can be appropriately assessed.

This particular case of service redesign was chosen following a discussion led by the steering committee on this study. A nominated coordinator from the region identified ten informants who predominantly served as "public representatives" on the selected "Solutions Group" committee, including three members that were closely involved in the work of this committee. These represented a mixture of: Health, Regional and Community Council members, Primary and Secondary Health professional staff from the area and Health Management representatives. However, due to the small case study context, we did not assign professional labels to quotations featuring in this report.

The study team designed an interview schedule partly based on the emerging issues, but aimed to use it flexibly to account for peoples' preferences in discussing their concerns about the good and bad features specific public involvement activities in relation to this "case", and the assessment of public involvement.

All interviews were conducted face-to-face or via telephone, audio recorded and transcribed. Through iterative, thematic comparative analysis, we identified in the informants' accounts, some broad views on whether assessment is valued and what types of criteria might be favoured.

Through iterative, thematic comparative analysis, we identified themes about what mattered to our stakeholders in valuing public involvement, and how public involvement might be assessed. it is important to mention that most of our informants struggled in viewing our list as criteria, but rather preferred to view them as guiding principles. Thus, this gave us a clear further indication of the difficulty of any attempt in proposing specific criteria.

Interview findings

Our stakeholders generally embraced the idea of assessing public involvement, but they held varying opinions as to why it was important. Many shared the view that it was crucial to demonstrate NHS Boards' accountability to the public and evidence of impact of public involvement; the majority of stakeholders believed that the public's views, when taken into account, could create better health services in the long-term.

Views on the role of public involvement assessment

Despite the inherent complexities of judging the success of PFPI, all those interviewed were in support of the attempt to develop an assessment framework for Scotland. This is an important endorsement of the current priority given to PFPI performance management. One of our informants expresses this sentiment well and suggests that the lack of evidence concerning the impact of PFPI should not deter the search for evidence:

> Public involvement can improve planning, but we have not got the evidence yet that it (public involvement) is the right thing to do; also we don't know exactly how it does it. We need to demonstrate what impact it (public involvement) has ("Policymaker").

One informant was especially keen to establish how PFPI linked to "hard" data and wished to be able to demonstrate a concrete link to service performance: for example, improved waiting times. This focus on the need for measurable, quantitative evidence on impact of PFPI was not commonly shared: the majority of informants emphasised instead that an assessment framework would be useful in facilitating discussion among all relevant stakeholders, as well as for initiating organisational learning and a cultural shift towards defining and reaching common goals in health service development.

This reveals a significant difference in ambition: one that points towards the gathering of qualitative material that is evidence for such discussions taking place in the first instance; and secondly, the valuing of PFPI activity as a trigger to engendering a "common spirit" in which discussions take place.

Among our informants, there was no consensual view on what criteria could be broadly applied to Scotland's NHS Boards, nor any agreement on how objective data could be collected to evidence any one of the many perceived "successes" of PFPI. One informant was keen to point out that there is a need to encourage all stakeholders, including patients and the public, to be involved in a dialogue in order to arrive at a shared understanding of common definitions for the development of an assessment framework. They expressed the view that such common definitions may, following a lengthy process of discussions, translate into "objective indicators".

Our discussions showed that all interviewees found it difficult to discuss criteria in terms of specific indicators and seemed much more comfortable discussing general principles in relation to these criteria. The reluctance by informants to use the language of "indicators" may point to the general problem in measuring the "inputs" of public involvement against clearly defined output metrics.

Nature of involvement, legitimate voices and assessment approaches

Having analysed and interpreted the data, we have identified three tensions that emerge from the extensive discussions with our informants. These tensions highlight the complexity of policy implementation with respect to the formal inclusion of the

public and patients' "voices" in health service planning in Scotland. We have categorised the tensions as follows and will discuss each in turn:

(1) Informing versus consulting.

(2) The legitimacy of "representative" and "direct voices".

(3) Prescriptive versus flexible assessment processes.

"Informing" versus "consulting" the public

The informants' views about the nature and meaning of involvement seemed somewhat polarised between what was mostly referred to as "informing" and "consulting": some regarded it as sufficient to inform members of the public about service developments; others thought that a more active consultation was required. Their divergence of opinion in the conception of public involvement shows that they were either happy to "passively" inform, or "actively" consult the public.

This difference in opinion show "involvement" may be viewed as either a one-way or two-way process in decision-making. While the former is usually associated with indirect action (e.g. receiving information through community newsletters), and the latter usually with the "direct action" of inviting members of the public and patients to meetings, the terms are used to describe the sentiment in which our informants referred to the stake which members of the public and patients were able to assume in the decision-making processes: i.e. "informing" was directed towards a passive recipient, "consulting" was seen in a positive light as moving towards partnership. Apart from one informant, none of the informants mentioned "partnership". This highlights the intractable tension that is well expressed in Arnstein's "ladder of participation" discussed earlier, that defines a spectrum of public involvement, ranging from professionals giving information to the public to a genuine hand over of power and decision making to the public (Arnstein, 1969).

One distinct view represented by some informants referred to members of the public and/or patients as either largely uninformed or disinterested about current policy changes and planning issues. Often, "involvement" was interpreted as merely passing on information in order to educate; however, it precluded any form of discussion that implied recognition of patient or public "expertise".

The nature of involvement to one of our informants encompassed the notion of "re-focusing" for the benefit of policymakers. They described this as "convening around the table" with decision-makers and letting professionals and the public remind them of the important issues that may have been overlooked. A significant impact on the decision-making process, however, was not considered useful:

> To be honest (if you're doing something like that), an individual person round the table can be of use in the board room discussion, but "change of service" I don't think. The role of the individual is to bring you back to that issue, it's so easy when you're in to day-to-day management of the service or whatever you are, you know you've got so many focuses, that you've got so many things on the go, you can't always think of them all at the same time ("Policymaker").

In contrast to the former position, some interviewees recommended that patients and members of the public take a strong interest in health planning issues; and while recognising that there may possibly be little understanding of the importance and reasons for large policy changes, they should be "engaged intelligently" in the issues,

and encouraged to enter into a "collaborative" relationship. One informant reinforced this point stating that:

> I think you need a more intelligent engagement of people and an explanation of this hugely complex organisation. I mean, as a shareholder of a company, I would expect that company well run, to talk to me about its problems, to tell me if there were any financial problems and this is where I think the NHS finds it very difficult to "let go of the reins" and to keep abreast of what's going on in something which I have a stake . . . ("Patient and public representative").

Our discussions also reflected the impact of the structural changes taking place within the Scottish health management structure, which has implications for what will be considered the "legitimate" voices in public involvement activities. Previously, the Local Health Councils (LHCs) were considered the "representative voices" of patients and the public. Their recent dissolution had required NHS Boards to identify and involve members of the public and patients "directly" through other mechanisms.

The legitimacy of "representative" and "direct voices"

Following the dissolution of the LHCs, it has become statutory for NHS Boards to directly involve patients and the public at "all levels of their ongoing work – from individual care planning to major service redesign" (Scottish Executive, 2004). This new legislation presents a tension between "legitimate" views of public "representatives", who may be "called-upon" by Health Boards, for instance, to participate in consultation exercises, and the "direct" views of any members of the public "at large".

This tension raises important questions, ones that have naturally emerged from our discussions with stakeholders. In sum, there is a recognition that the public needs to be directly "involved" in as much as public members have a need to be "informed" and "consulted" of major changes. One informant stressed the need to receive invitations to NHS Board meetings and feel part of their decision-making processes, at least, when an issue as important as redesign of services is concerned. Difficulties arise, however, from the "duty" to directly engage when the general public (including patients) may not be willing and able to be involved. For example, "lack of confidence" was identified by one of our informants as one reason for not wanting to be involved. For the purposes of confidently representing certain views, public representatives have an important role to play, although there are difficulties in defining the "best" candidates for public representative given a limited pool of individuals (the so-called "usual suspects") and giving them legitimate status (e.g. skills that public representatives should acquire in order to make them fit for the job, and being recognised by the public as their representative, most importantly "being trustworthy").

This issue is therefore concerned with the tension that arises in defining "legitimate voices" on behalf of members of the public and patients and finding a suitable mechanism to capture public and patient representation, and offering opportunities for the public "at large" to be "informed" and "consulted". Informants voiced a number of concerns, such as that the public:

- Do not necessarily want to be involved in health service planning activities;
- Should not always be involved (depending on the issue at hand, and associated resource implications);

- May not be "organised" yet to be involved (which may lead to an under-representation of their "voices"); and
- Require advocates "to make certain voices heard".

In recognition of these constraints, what seemed important to our interviewees was the need to allow for a cultural change to represent peoples' "direct voices", which is underway. As one informant commented:

> It's (the NHS) a different animal farm to what has gone before we had very much moved over the last two or three years towards supporting people with their own voice rather than speaking for this is something that we're very keen on doing, which really kind of leads into what is happening now ("Patient and public representative").

At the same time, informants stressed that there is a very practical issue for policymakers to be able to recruit people to represent the public for example on decision-making committees. The interpretation of a number of informants' statements shows "lay members" are recruited to take part in discussions by virtue of their position (e.g. director of a charity or consumer organisation); and thus gain legitimacy by speaking on behalf of a group of patients and/or the public. As one informant put it, sometimes it is unclear "who" exactly they are supposed to represent. They may also become part of a list of "representatives" that are regularly called upon for involvement purposes, which may exclude a pool of potential representatives from the wider public, which in turn may lead to narrow representation and fail in terms of capturing diversity of interests.

Prescriptive versus flexible assessment processes

A third tension evident in the informant data is created between what informants refer to as a "prescriptive assessment process" as opposed to a flexible approach that stresses the need for success criteria to be determined locally and together with participants. Most of our informants recognised that prior assessment indicators were used like a "tick-box" and therefore, may have deterred NHS Boards from focusing on the underlying purpose of public involvement. Flexible assessment frameworks and guidelines, therefore, may be more appropriate in helping to depict which aspects of involvement and properties particular exercises focused on and why. Moreover, a framework that focuses on individual argumentations and evidence for raising the quality of public involvement may be more conducive to expressing existing cultural practice.

The absence of a clear link between any identified public involvement assessment criteria and output metrics supports the view that the assessment of involvement should be implemented in a flexible fashion, with success criteria defined collaboratively and by consensus. Importantly, informants overall found it much easier to articulate and concur on the process elements of involvement and there was remarkable consistency in the elements identified.

Case study findings

In line with our findings from the first series of stakeholder interviews, our case study informants predominantly argued in terms of what they saw as a "good" and "necessary" process- and desirable outcome features or principles. Informants did not

unanimously argue that good process features could ensure a desirable outcome, although two informants suggested that there was a causal link. One informant stated:

> The West Highland research group exercise before the Solutions Group was probably consultation at its best. It involved people, but the Solutions Group came about because of the furore that arose from the decisions that were made.

The final decision, when accepted by the public is what most of our informants saw as crucial to measuring a successful outcome of public involvement:

> People want to see that they have been listened to.

Definition of criteria

The following section is our analysis of informants' narratives and specific references to the meaning of our list of criteria when prompted. As mentioned in earlier sections, often "criteria" were viewed as "guiding principles" and therefore, there is a reluctance to attribute any "measures" in discussing these terms. The headings in the following sections show that some terms were discussed in relation to each other, and have therefore been clustered as "emerging themes".

Leadership, trust and public representatives

There was a consensus view that leadership, trust and the notion of a public representative are closely related: "good" leadership skills are carried by those interested in public involvement, who are "charismatic"; "have knowledge and experience in local community matters"; they are "trustworthy" and "confident at discussing and presenting difficult issues". The role of public representative was considered a difficult one, one that requires training and skills, and one, as suggested by one informant, that may be remunerated. In addition, none could suggest how public representatives would be recognised, one informant suggested the role may be assumed by somebody who is proven credible through their commitment and experience in general community matters; three others suggested that sometimes they require using language in a way that most of the public can understand it. It became evident in the course of discussions, mostly because of the politically sensitive nature of health service planning, the particular challenge with respect to the choice of person is that they should not already be represented as part of a stakeholder group that would be expected to have a clear political agenda. At the same time it was necessary they should understand the issues and "facts" about the proposed health service change in a particular context.

The controversy with the local action group as public representatives was that there was no clear distinction between people's professional and public roles. This meant that medical staff became vital actors in leading the public opposition to the development of proposed change. Although they were accepted leaders by the public, their political stake in this debate meant there was a conflict of interest that some of our informants sensed was misleading the public:

> It's my opinion that probably the way it (the issue) was being sold wasn't quite right ... the stuff they had written in the paper it was they were getting rid of either (rural hospital A or rural hospital B), now that is very emotive to people. And there was support for ... there was a group of medics, and they got huge support for the things that they were offering or wanted to keep (the hospital).

Transparency, feedback and open meetings

Transparency was suggested by most of our informants as a continuous process of involvement through a range of mechanisms that need not be "prescribed" in advance. Importantly, for those who wanted to be informed there should be minutes of meetings made publicly available, for those who wanted to be more directly involved there should be invitations to official meetings. Most importantly, however, three of our informants stated that regular and formal feedback should present evidence of how the views of people had been taken on board in the decision-making process. This is important given the recognition that not all views can be incorporated in the final decision:

> According to one informant, in particular, transparency was evident through large public meetings where "everybody was there" and "everybody got the opportunity to be listened to". They added: "... everybody felt the outcome was good because there was a high turnout, and the process ensured that everybody could be there".

Summary and Conclusion

We have not identified any objective criteria for measuring public involvement, and have not found it was possible to conceive of a universally applicable approach to measuring the "success" of public involvement from the data collected in this research. Although there is support among key stakeholders for the assessment of NHS Boards' public involvement activities, there is no consensus and significant uncertainty about how this assessment should be undertaken. This reflects a lack of clarity among the respondents about both the purpose of the assessment and, more fundamentally, about the purpose of public involvement and what matters about it.

The purpose of assessment

Assessment may be undertaken for a variety of reasons, and may be intended to facilitate improvement more or less directly via a variety of mechanisms. Assessment approaches may need to be tailored to achieve particular purposes. For example, if it is important that those who monitor NHS Boards' performance to be able to show whether all Boards have achieved a satisfactory level of performance in relation to public involvement, and/or to rank Boards in order of achievement, then they will need a standardised metric that can capture what matters about involvement.

If it is more important that those who monitor NHS Boards' performance can be reassured that those Boards are working continuously to improve their performance in relation to public involvement, then a qualitative check to ensure that more flexible (and participatory) self-assessment processes are taking place may be more appropriate.

The findings from our stakeholder interviews highlighted a tension between a prescriptive and standardised assessment process as opposed to a flexible approach that could facilitate participatory approaches and that stress the need for success criteria to be determined locally. Most of our informants recognised that prior assessment indicators were used like a "tick-box" and therefore, may have deterred NHS Boards from focusing on the underlying purpose of public involvement.

The purpose of involvement and what matters about it

Any assessment of involvement will reflect a socially constructed notion of what matters about involvement. Both our key informant interviews and our case study tended to confirm that there is a diversity of opinion about this if we focus on specific processes or features of involvement.

However, there is a broad consensus that it is not acceptable for NHS Boards to pay lip service to consultation and facilitate only tokenistic involvement. Rather, they should aspire to "genuine and meaningful" involvement of the public in service planning decisions. Genuine and meaningful involvement is difficult to characterise, but it seems to incorporate both process-quality and outcome considerations. It requires, for example that people are informed and engaged in a meaningful dialogue and listened to. It should also aim to achieve public understanding and acceptance of decisions that are made about service design.

Our case study showed that in the absence of certain process features such as "listening" and "early involvement". There was also an assumption that "being listened to" and "creating a meaningful dialogue" are constituent parts of a "good outcome". However, it is not clear what could be considered sufficient evidence for "listening".

Levels of public influence

Any assessment framework also relies on a clear notion of the level of influence the public should have. It is useful to consider Arnstein's ladder of participation (Arnstein, 1969), which illustrates the different levels of influence the "public at large" may have on decisions regarding health service planning. If decision-makers seek an "active" partnership with the public at large, there needs to be a discussion around a common understanding of partnership, and the "effective" mechanisms for this to happen.

In consideration of the overwhelming positive response from our informants as to the desirability of public involvement assessment, the publics' views must be a clear feature of future decisions. In the absence of objective criteria, improving public involvement quality is currently promoted through a self-assessment model. This approach may be preferable to an external assessment model that would seek a formulaic measure for public involvement performance, but not support NHS Boards in keeping the goal of "genuine involvement" in focus. In fact, genuine involvement may only be achieved if Boards themselves are able to take ownership of the Public involvement assessment process through greater reliance of self-assessment and culturally determined Public involvement assessment criteria.

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Corresponding author
Lorna McKee can be contacted at: l.mckee@abdn.ac.uk

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