At the heart of everything we do
A case study of public/patient participation in hospital governance

Guy James Edwards

St John's College
Department of Sociology

September 2016

This dissertation is submitted for the degree of Doctor of Philosophy

Preface

This dissertation is the result of my own work and includes nothing which is the outcome of work done in collaboration except as declared in the Preface and specified in the text.

It is not substantially the same as any that I have submitted, or, is being concurrently submitted for a degree or diploma or other qualification at the University of Cambridge or any other University or similar institution except as declared in the Preface and specified in the text.

I further state that no substantial part of my dissertation has already been submitted, or, is being concurrently submitted for any such degree, diploma or other qualification at the University of Cambridge or any other University of similar institution except as declared in the Preface and specified in the text.

It does not exceed the limit of 80,000 words as specified by the relevant Degree Committee.

This research involved human subjects. It was reviewed and approved by the National Health Service Health Research Authority Research Ethics Committee.

At the heart of everything we do: A case study of public/patient participation in hospital governance

Guy James Edwards

Abstract

Hospitals are of critical importance to contemporary health systems in developed countries, providing essential medical services and leading the development of increasingly complex interventions. From a public policy perspective, ensuring that hospitals are well-managed and meet the needs of their patients is of indisputable importance, both for patients (particularly under the conditions of universal health coverage) and for policy-makers. That said, the precise mechanisms through which the activities of hospitals are determined can be opaque, particularly to patients and potential patients. The direct involvement of patients and public in hospital governance is one solution to this opacity. In this dissertation, public and patient involvement is examined in the context of elected representatives who are part of the management and governance of large, semi-autonomous publicly funded hospitals in the UK. Specifically, this project examines a tertiary-care research-linked hospital that delivers services funded by and on behalf of the National Health Service England. This project represents a novel contribution to understanding public and patient involvement by using ethnographic observation and direct recordings of closed and hitherto undocumented (in the sense of ethnographic research) governance and management processes in a case-study hospital. This dissertation also demonstrates the relevance of conceptualising the hospital in terms of clinical knowledge and expertise which delineates the medical domain from the non-medical. Through the examination of specific episodes of patient and public representative participation in governance, this dissertation argues firstly that the 'governance' should be understood by and through the actions of participants in such processes, and that examination of the actions of governance actors (including public / patient representatives and hospital management) suggests a novel interpretation of health financing as a common pool resource. This in turn forms the basis for a critique of the imposition of economic and management incentives designed predominantly for profit-seeking firms onto public service providers.

Acknowledgements

Table of Contents

1. Introduction

Hospitals are, for people living in developed countries, practically unavoidable. Almost everyone, at some point in their lives, will need to go to a hospital and seek treatment. For some, it will be infrequent, and these visits will be a blur of impressions that pass by and are overridden by more urgent concerns – am I sick? Will I get better? Can I leave? Others will return, often many times, for chronic conditions or for long and sometimes complex treatment regimes. For these patients, the familiarity of the hospital environment might lead to more speculation, about why the coffee tastes a certain way, or why the nurses wear blue, or why there is a sudden ubiquity of alcohol gel dispensers. Increasingly, as populations in the West age, the elderly will be repeatedly admitted and discharged in a cycle that sees the setting of care follow the health of an individual back and forth across an increasingly indistinct border between hospital and home. Whatever reason brings someone to a hospital, they expect that therein they will find people with the technical skills and knowledge needed to provide the required care, that there will be space available in which that care can be provided, and that there will be the required medicines, devices, and technologies that underpin contemporary medical practice. Such expectations are not unreasonable. They have, in fact, become normative; hospitals have been, and will be, available as and when we need them. Hospitals are simply *there*, when we need them, to provide the medical care that we need. People, we assume, want to be healthy, to be free to do and act as they desire (Venkatapuram, 2011). The availability of services that are needed to support the achievement of health is, transparently, of a great deal of importance. That said, it is unlikely that most people who pass through the doors of a hospital think about who decides what the hospital does, and who determines whether the hospital will provide one service over another.

Within the hospital, health care is delivered not only through the individual efforts of medical and non-medical personnel, but is importantly defined by complex systems and markets which both enable and constrain how people are treated. Modern medical systems involve large numbers of participants, and the actual medical acts performed within such systems are dependent upon complex chains of decisions based on clinical judgement, economic exigencies, private interests and public policy. Medicine is created and performed not simply through the expertise of particular practitioners or the

collection of skills which happen to be present within a hospital, but through the options that are made available by the systemic constraints within which hospitals operate. In addition, hospitals themselves can be large and complex organisations in which there are multiple activities and vast numbers of competing priorities. Within this, the hospital must run itself; it must determine, day to day, week to week, year to year, how to operate and how to act in accordance with its objectives. Hospitals, as we currently understand them to be in a variety of global contexts, need to be managed and governed; in short, someone needs to decide what the hospital should do.

This project takes up this question: Who decides? In this thesis, I consider the specific example of large acute hospitals in the English National Health Service (NHS). For more than a decade prior to when fieldwork for this project was undertaken, these large hospitals have been owned and operated as corporate entities that act in the public interest, guided and led by the activities of both appointed leaders (CEOs, Chairpeople, and senior managers) and elected representatives (governors). In the words of the NHS, this places patients "at the heart of everything the NHS does", from the delivery of care, to the decisions about new pharmaceutical products, to the authorisation of new research programs. This project examines the impact and potential consequences of how members of the public and patients have been embedded within the governance of large, public interest corporation hospitals. Through the study of practices and *in situ* activities within a hospital, this project examines the role of elected representatives in hospital governance. In doing so, this project opens up a relatively un-examined aspect of such hospitals to specific interrogation through qualitative ethnographic research. The perspective that this project takes on the hospital is necessarily broad; patients and public representatives are engaged across contexts and topics that span the activities of the hospital itself, from making decisions about particular treatments, to the future financial performance of the hospital. The intent, in being led by the engagement of participants in particular topics, is to follow the logic of practices within the hospital to illuminate how patient and public representatives are conceptualised and constructed. By doing so, this research will contribute to an understanding of specific practices within the National Health Service which affect the day-to-day lives of people living in England. In addition, this research will contribute to understanding governance and management through the ethnographic analysis of ecologically valid examples and real-world social phenomena.

This research is conducted as a case-study within a specific context, using a qualitative research design and following the methodology discussed in Chapter 3. This research may however be relevant for similar hospitals within England (i.e. for organisations with more-or-less identical governance structures), and for hospitals within other health system contexts. By opening up to examination the practices of the NHS in creating patient-inclusive governance – placing the *users* of a public service within the oversight and management of the service – this research project can illuminate not only specifically medical contexts, but other situations where highly specialised services could be overseen by non-specialist users of those services. Certainly, even within the field of health-care and medicine, increasing user involvement is a known trend with an emerging body of academic literature and study, as I will discuss in the background to this thesis. That said, it is perhaps worthwhile to note that the details of how the NHS operates are necessarily fast-moving; any case study captures an organisation, a system, a context at a particular moment in time. The intention, therefore, is not to create a portrait of the NHS, or the hospital, as it was during the fieldwork in total, but rather to illuminate the means by which the practices of governance are achieved, and how patient and public representatives are constructed by and through those practices. Indeed, in the specific context of the NHS, the future of the large acute hospitals which are studied herein is changing rapidly, as the organisational freedom that was once enjoyed by financially sustainable entities is gradually eroded by the reduction of budgets and the imposition of ever-stricter controls[1].

Aims

The central aim of this research, as given above, is to examine the role of public and patient representatives in the governance of a large, tertiary-care hospital in England. In doing so, the intention of this research is, inherently, to demonstrate that the *approach* taken to examining governance and management through the practices and actions of participants is a useful way to consider governance. In addition, this project will consider

---

[1] See http://www.kingsfund.org.uk/blog/2016/02/foundation-trust-model

how the roles performed by different participants are understood and constructed (by themselves, and by others), and examine if these roles are relevant to the actions that they perform in the governance process. Related to the role of each participant, this research will investigate the use of knowledge and expertise in governance and decision-making processes, considering if and how specific domains of knowledge and expertise are used in governance. Finally, an overarching goal of this project is to understand the objectives and purposes of hospitals (as seen through governance processes), and whether the embedding of patient and public representation into such processes can be seen to be consequential for the hospital.

Specifically, this thesis will consider four key research questions within these broad themes:

1. Are different roles and social categories – including the roles established within a governance and management structure – relevant to decision-making processes?
2. How is expertise and knowledge used by participants in decision-making and governance?
3. How do governance and decision-making practices reveal the goals of participants?
4. How does the participation of non-expert representatives in governance and decision-making processes achieve the goals of 'patient representation'?

This project is explicitly constituted as an inquiry-driven examination of practices within a particular social context. This research focuses explicitly on the participation of particular individual members of a governance process – those who are elected patient and public representatives – and is grounded in both ethnographic observation and video-recordings of meetings. Both the data collection and the methodological approach for this research project are discussed in detail in the Methodology chapter.

Overview

This thesis begins with a background chapter which sets out the relevant theoretical perspectives and contextual research. The following chapter sets out the methodology and

fieldwork that generated the empirical data used in this thesis. Following these chapters, I then turn to the analysis of data and the hospital itself. The list below gives a brief overview of each of the analysis chapters:

- Chapter 4 discusses hospitals in the context of the National Health Service and analyses both national policy and the implementation of governance in the specific fieldwork site.

- Chapter 5 focuses on specific decision-making about pharmaceutical products, identifying ways that social categories are relevant to how medical and clinical decisions are made, focused predominantly on addressing research question 1.

- Chapter 6 examines the contributions made by elected representatives to the monitoring of safety events, a key aspect of hospital governance, focused predominantly on addressing research question 2.

- Chapter 7 presents a broader analysis of the oversight and monitoring role of governance, through a discussion of the practices of performance measurement in the contemporary British public sector, and addresses research question 3.

- Chapter 8 considers the notion of representation and how this is understood locally by participants in governance processes, and focuses on research question 4.

Finally, I present a summative conclusion which provides a summary of the key findings and implications of this research project.

In the background chapter, I commence by considering the foundational approach to the hospital, medicine, and health-care which informs this research project, and discuss relevant literature and key research findings from prior work on management, governance, and the National Health Service.

2. Background

The purpose of this chapter is to situate this thesis within a relevant body of theoretical work which informs the development of key arguments concerning the functioning of governance and the management of institutions. The explication of a number of concepts is therefore necessary to demonstrate the sociological relevance of the project, and in order to contextualise the forthcoming discussion. Three main areas are addressed in the following background. Firstly, I discuss how this thesis is oriented with respect to work which specifically discusses hospital management and governance, including conceptualisations of health and health-care delivery. Secondly, although as outlined in the preceding introduction chapter, this thesis is concerned with a particular type of institution – namely, a hospital – it is also concerned with how such institutions – or indeed, any collective body – are managed and governed. Therefore, the notion of governance will be critically examined and the position of a public hospital with respect to other forms of governance, government and management will be discussed. Thirdly, I will consider the notion of patient and public participation and existing literature which informs this research.

This thesis examines how individuals use social action – achieved through talk and other features of social interaction (including gesture and embodied interactional resources, as well as written communication). However, the implication of focusing on social action within the context of a specific organisational and institutional setting means that the relevant sociological concepts encompass the specific institutional setting (the hospital), a normative understanding of the activity which those actors are engaged in (management and governance), and social action within institutional settings. This background discussion focuses on relevant concepts and literature for understanding firstly the hospital and secondly governance and management. The analytical approach to social action is discussed in detail in the methodology chapter.

Governance and management of hospitals

In this section, I discuss the body of literature which examines the management and governance of hospitals and health-care organisations. In particular, I focus on how these

studies structure the relationship between within-organisation activities (i.e. management) and the apparent or measurable status of the organisation (i.e. performance). My intention within this section is to outline work which considers governance and management within hospitals and health-delivery organisations. This body of research is relevant because this thesis will contribute to knowledge by advancing an understanding of management processes and decision-making within hospitals.

Decision-making and management processes within hospitals and health-care systems includes a broad scope of activities. This includes clinical and treatment-related decisions which might be thought of as specifically health related, and decisions which are part of the administration and organisation of large, complex institutions and business. This thesis focuses on these latter processes; the administrative and managerial side of management and decision-making in hospitals. Management, efficiency, and effectiveness of how hospitals and health-systems are managed and organised has been considered in academic literature at least partially because of the economic and social importance of health spending in modern economies. According to an OECD analysis of health expenditure, the average spending on health had increased from 5% of GDP in the 1970s to 9% of GDP by the end of the 2000s (Organisation for Economic Co-operation and Development, 2009), with substantial variation across the OECD member states. In real terms, actual expenditure on health has increased by nearly 100% over the past 30 to 40 years. This increase is driven not only by increasing utilisation of available services, but also by the increasing cost of each unit of such services. In the words of the OECD, the contemporary state of health policy can be summarised thus:

> OECD countries have made tremendous strides in improving population health over recent decades. Life expectancy at birth has increased, rising on average by ten years between 1960 and 2008. Almost all countries have some form of public or private insurance covering the risk of ill health and high medical costs and access to basic health care has also improved. However, these achievements have not come cheaply – countries have confronted steady increases in the cost of health care spending over recent decades. Looking to the future, OECD countries will continue to face upward pressures on health spending from a number of factors including demographic change, advances in medical care technology and the growing expectations from patients and the electorate at large. What can countries do to get the most value for money while maintaining the goals of quality and access that people have come to expect? (Organisation for Economic Co-operation and Development, 2010, p. 3)

The OECD – as a sample of developed nation policy direction[2] – can be seen to position increased health expenditure as a problem, and the various tools of health system management and policy positioned as an amelioration to both increasing unit cost and increasing unit consumption, which are considered to be two fundamental drivers of an overall upward trend in health expenditure. Again, in the words of the OECD:

> Increases in health spending are inevitable. Health policy makers have to ensure that these increases deliver real value for money. This will not happen automatically; health systems are not a "normal" part of the economy, where market forces can, within reason, be expected to drive innovation, responsiveness, cost efficiency and quality. To ensure that health systems continue to deliver improvements in health outcomes at reasonable cost, governments have to ensure that the basic framework for health care is right… (Organisation for Economic Co-operation and Development, 2010, pp. 18-19)

Health systems are explicitly set apart from the (so-called) normal parts of the economy – the expectation that in the other part of the economy, market forces can be relied upon to create conditions which promote improvements is bluntly stated not to be the case for health systems. There are (at least) two chief observations that can be made concerning the OECD's position; firstly that it demonstrates the construction of health-related activities as being separable from other human collective (and economic) endeavours, and secondly that free market evolution is positioned as being positive and desirable change. In other words, due to some structural factor (unspecified by the OECD), health systems – or rather, the actors operating within such systems – are seen to act in ways which are not consistent with the expected actions that those actors might perform in other economic activities. From the perspective put forward by the OECD, the chief deficiency of health systems is that they do not resemble free markets and by extension we can assume that government interventions in the design of health systems are to promulgate changes which increase the similarity between health systems and this other economic sector. Although it is beyond the scope of this current research to present a comprehensive critique of this position, it is perhaps worth noting that, even according to the OECD's own statistics, the most privatised and therefore competitive health system (i.e. the USA) is also one of the least efficient (if we accept that lower levels of expenditure as a percentage of GDP are equivalent to or at least a reasonable measure of efficiency). This

---

[2] Noting that there are significant variations in not only political philosophy of the governments of the day, but also fundamental health system architectures and available policy tools across the OECD member states.

overarching policy context – i.e. the economic distinction between the health system and other economic sectors – provides the backdrop to both the realpolitik of the implemented policy changes which alter the structure(s) of management, and also the (predominantly applied) literature that offers a description of such practices. In this background chapter, I will concern myself for the most part with this second area (relevant literature concerning management), and will address the implementation of policy, legislation, and management / governance structures in subsequent analysis.

In a quantitative investigation of hospital management, Tsai et al (2015) describe effective management practices under four topics; operations, monitoring, targets and human resources. This study is notable because it seeks to systematically and quantitatively compare and evaluate the relationship between specific management practices and the performance of hospitals. This study is positioned by the authors as being an important contribution because of this quantitative approach, identifying much of the prior work in hospital management as being fundamentally either qualitative or theoretical in orientation[3]. In addition, they describe board activities in terms of attention to quality and effective use of metrics, and then correlate hospital performance (based on calculated metrics of hospital quality) with scores on quantitative survey-derived measures of management and board activity against their taxonomies of management practice. Tsai et al's broad conclusion – that better management and higher board attention is positively related to improved measures of hospital performance – is of some interest to this research, in that it supports that examining management (and governance, as will be discussed in terms of similarity to and difference from management shortly) is useful for understanding differences in how hospitals and health care operate. What is, however, more interesting for this thesis is how the authors apply and define management practices *and* hospital performance, and what this can tell us about health care management. Put simply, Tsai et al straightforwardly and uncritically map what might be considered standard management definitions into the health-care domain, and seek to

---

[3] The authors of this study position quantitative work as being an improvement over qualitative research; to be clear, I do not take this position.

determine what relationship there might be between such practices and institutional performance.

At first glance, this might seem to imply that a distinction between health-care and other economic activities is, in fact, not important. However, Tsai et al demonstrate how such a distinction is made. Whilst their model of management practices imports, in a more or less uncritical and unexamined fashion, a notion of management (or rather, managerialism, in the sense that they define management as a set of activities which are measurable by self-reported performance) *into* the health-care domain, hospital performance (i.e. what is proposed by their model to vary according to either effective or ineffective management) is defined in hospital and health-system specific ways. Hospital performance was defined as:

> …high or low quality … based on two well-validated metrics of hospital quality. For US hospitals, we calculated an overall summary score on nineteen evidence- based practices across three clinical conditions… For English hospitals, hospital quality was determined using the National Health Service's (NHS's) quality rating program… (Tsai, et al., 2015, p. 1305).

Thus, we can see that despite appearing to co-examine a health-care institution through the same lens as other contexts, the authors here define performance in ways which are specific to the health-care domain, and therefore can be seen to accept that there is a distinction between hospitals and other economic activities. Tsai et al's study does, however, show that within this view of hospital performance (accepting the limitations health-specific of selected performance variables and survey-based quantitative measures) there is a relationship between management activities and quality of health-related activities in hospitals.

These findings are echoed by a systematic review of management and hospital performance (Lega, et al., 2013), in which the authors claim that systematic studies demonstrate a (positive) relationship between management characteristics and the performance of hospitals. Specifically, this review found that there is some evidence that clinical performance – defined in terms of some patient or health related outcome and / or aggregate outcome across a number of patients – varies according to the implementation of particular types of what are termed operations management practices.

Operations management in this context refers to (generally quantitative) technical controls that limit variation in practices, establish standardised ways of performing tasks and thereby create ways in which to optimise processes (understood as being equivalent to minimising labor and other costs involved in achieving a standardised and measurable quality outcome from such a process). Less defined – or perhaps less quantifiable and systematically amenable to aggregate reporting – positive relationships between leadership (understood as being a quality of executives that aligns and inspires members of an organisation) and hospital performance (again, relying on clinical indicators of performance). The authors of this review note that there are some serious and systematic limitations to the health management literature, of which most significant can be seen to be an under-specification of what precisely is meant by management. This lack of a clear conceptualisation of management leads to the problems identified by Lega et al – namely that there are studies which lack effective use of empirical data (being either wholly descriptive or theoretical), and/or studies which lack clear causal hypotheses connecting particular management practices with specified endpoints (outcomes). In other words, the lack of a fundamental and generative conceptualisation and theory of management contributes to the awkward and uncritical imposition of management as a generic term into the health-care domain (in the way that it is used in the health management literature reviewed by Lega et al).

Perhaps, therefore, a potential solution to this gap in current understanding of management in health-care is to examine the more qualitative and ethnographic approaches to examining organisational activities in hospital which are described in the more quantitatively-oriented review article and study described above. This body of literature approaches management in terms of the roles taken by participants. Predominantly, this has concerned an emerging understanding of clinician-leaders, clinical managers or doctors as managers (Currie, et al., 2012; Goodall, 2011, Kirkpatrick, et al., 2016; Lega & Satirana, 2016; MacIntosh, et al., 2012; Martin & Learmonth, 2012; Petchey, et al., 2012; Veronesi, et al., 2013; Veronesi, et al., 2014; Zachariadis, et al., 2013). These perspectives draw on some aspects of what is broadly termed medical sociology and (particularly in the case of the articles collected by Currie, et al., 2012, in a special issue of *Social Science & Medicine*) organisational studies. Running throughout these studies is an understanding of management practices as being implicitly connected

to organisationally defined roles (that of the manager) and the emerging hybridity of an organisationally defined role that is an extension of or in addition to the professional role of the clinician / doctor. In this model of the hospital, the institutional / organisational structure is seen as a hierarchical imposition upon the more equal peer-to-peer relationships between co-equal members of the professional category of doctors. The role of manager is therefore defined in terms of required duties, and accountabilities (understood as being hierarchical observation of successful completion of said duties), established by and through the specific operational structure of a particular organisation. In this way, the definition of management is achieved based almost entirely upon the local (and empirically determinable) conditions in which such management practices are performed. Management is understood as those activities which are performed by managers in order to fulfil the expectations of other (more senior) managers; it is easy to see, then, how this model accumulates into the hierarchical and complex structures which are undoubtedly present in the modern hospital. Each member of a manager category is at once monitoring and monitored according to their position within the hierarchy, and the expected behaviours and practices of management can be understood according to both formal (i.e. policy and legislative) requirements and informal expectations (i.e. those actions which a manager performs to fulfil their specific management role within a particular organisational context).

There are some clear advantages to this perspective on health-care management, chief amongst which is the empirical orientation to the performance of management within organisations and to the actions of the participants themselves (particularly, in this case, the proposed emerging hybrid clinician-leader / clinician-manager). In addition, this can be seen to be compatible with a Foucauldian view of hierarchically structured power-relations in which mutual monitoring and observation of behaviour consistent with discursively formed expectations create the conditions under which such management practices emerge (see, for example, discussion in Currie, et al., 2012). Does this, however, give a sufficient explanation for what constitutes management? Certainly, we can take from this work an understanding of the importance of an empirically-grounded approach to the analysis of organisational behaviour, but this approach alone does not necessarily define clearly or conceptualise what constitutes *management* as such. As in, it enables an analytical catalogue of particular behaviours which are carried out by people in

management positions, but it does not give an explanation for why management positions and hierarchies are created within organisations. A further perspective on why management structures exist is useful because it provides a more complete context for the observable behaviour, for the purposes of this thesis. Why these management structures come into being within organisations can be usefully explored through examining the literature on governance, activities which are positioned as superordinate to within-organisation management activities.

The distinction between management and governance arises, importantly, from the emergence of a separation between the *ownership* of large firms (corporate entities, including companies, organisations, institutions, and so forth) and the people who were executing the activity of those firms. For the purposes of understanding *health-care governance* in particular, this brief definition from Chambers and Cornforth is useful:

> …modern systems of corporate governance evolved with the increasing separation of ownership from the control in 'public' companies. As owners became separate from those that managed companies, the shareholders appointed boards to act on their behalf, and wider systems of reporting, regulation and audit were developed to try to ensure corporations were run in their owners' interest and subject to constraints of the law (Chambers & Cornforth, 2010, p. 100)

That is to say, that under the emergence of contemporary capitalist corporate ownership structures it becomes necessary to specify how the owners of capital (and thus the titular owners of a particular collective group, or firm) maintain control over such capital (in the form of control over activities within a firm). In turn, this gives rise to systematic and (in most cases) legislative or at least regulatory requirements to have certain structures in place that control the activities of a firm. The implications of this definition are that governance activities refer to the "structures, systems and processes concerned with ensuring the over-all direction, control and accountability of an organization" (Chambers & Cornforth, 2010, p. 99), noting that such structures vary across organisations (including whether the organisation is for-profit, not-for-profit, state/government owned, privately held or publicly listed), geographies and health system contexts (Jha & Epstein, 2010). Despite this, a general notion for the purposes of the current discussion can be adopted which defines a governance body as a board of directors, with directors being both those executive directors (who are both directors of the firm and managers within the organisation) and non-executive directors (those who are directors only), adapting

terminology from the UK Corporate Governance Code (Financial Reporting Council, 2016). In considering the specific roles played by board members, Bennington (2010) identifies two (in her terms) "sacred cows" of governance – independence and duality – but also notes that, in line with the general lack of consensus and clarity regarding health-care organisational governance, their importance may be limited in the health-care domain. Independence, here, refers to the notion that governance should involve participants (directors) who are "not current or ex- employees, have no business association nor, as some have suggested, any social relationship with the organization or its management" (Bennington, 2010); duality refers to the co-appointment of a single individual as both Chair (of the board) and CEO, i.e. the most hierarchically senior management and governance individual, usually invested by organisation-specific regulation with particular privileges to make (executive / management) decisions and determine governance processes.

There is an emerging literature which considers the role of boards and directors in health-care. Similarly to studies of health-care management, many of these studies seek to establish a relationship between performance, on the one hand, and the activities of governance participants, on the other. Studies such as Botje, et al. (2014), Buchner, et al. (2013), Ford-Eickhoff, et al., (2011), Freeman, et al. (2016), Jha & Epstein (2010), Kane, et al. (2009), Kuhlmann, et al. (2016), Millar, et al. (2013), Petterson, et al., (2012), Saltman, et al. (2011) and Smith, et al., (2012) argue for a clear relationship between governance functions and hospital performance, and identify ways in which both health-specific (i.e. quality of care) and more generic performance measures are engaged with and organisational responses shaped by and through governance processes. The role of boards and governance participants in health-care is argued to be more complex than in the corporate context from which such models arise; the prototypical argument being that corporate governance serves a constrained set of stakeholders with well-defined (financial) goals, whereas the goals and outcomes of health-care stakeholders, particularly in public systems, are more diffuse and difficult to adequately measure (Duran, et al., 2011). This is of course a similar rhetoric to the model of hospital performance discussed above, and to approaches to measuring hospital activity proposed in the health economic literature (see, for example, Grosskopf & Valdermanis, 1987). One aspect of this background literature that is important to note is that, in systematic

reviews of governance literature, such as Bennington (2010) and Millar, et al. (2013), the authors (independently) claim that there is a lack of consensus around how to conceptualise corporate governance for the specific purposes of the health-care domain. Indeed, in the words of Millar, et al., the state of the field is described as "inchoate" and in need of additional empirical support for the current state of understanding. Potentially, this is a problematic of the applied nature of research into a specific aspect of corporate and organisational life. Certainly, this conclusion could be supported by similar studies of corporate governance, in which governance processes (as distinct from corporate performance *per se*) are described as being a "black box" (LeBlanc & Schwartz, 2007; Zona & Zattoni, 2007) and there is an acknowledged need for greater insight into how prescriptive models and requirements for governance are put into practice (McNulty, et al., 2013).

Management theory

In the prior section, I have discussed research which analyses management and governance practices in health-care. This could be taken to suggest that, for the purposes of the current research project, governance and subordinate executive management processes could be understood purely as a matter for empirical investigation. That is, that we take the position that the locally determined practices which define how an organisation structures itself in relation to the constraints placed upon its actions by external regulation (such as legislation or other policy requirements) and its own (self-determined) goals are, *a priori*, the most valid source by which we can answer the question of what constitutes hospital governance and management. In some studies of corporate governance or broadly similar processes, this approach can be seen to make relevant those aspects of board and governance process which are oriented to by the participants themselves as being of greater (or lesser) significance, and can begin to establish how such governance processes are performed within particular organisational contexts. This is seen in commentary by Pye and Pettigrew (2005), and work which takes an explicitly ethnographic approach to corporate governance (Samra-Fredericks, 2000; 2004, see also Potter & Hepburn, 2010, noting a focus on the talk-in-interaction aspects of governance in this study), as well as some examples from the applied management and health-care literature, such as in Freeman, et al. (2016). Certainly, it is possible to see that

such approaches are usefully grounded within an empirical examination of governance and management behaviour, and seek to derive an understanding of such management behaviour through an ethnographic engagement with management *in situ*. That said, even with this empirical and ethnographic orientation, I would argue that for the purposes of the research presented in this thesis, there may be an alternative perspective on the emergence of management and governance which can provide a useful theoretical base from which to consider the practices found within a particular organisational and health system context. I suggest that it is possible to re-contextualise the study of management, in terms of the argument put forward by Bourdieu (2005):

> 'Management theory', a literature produced by business schools for business schools, fulfils a function identical to that of the writings of the European jurists of the sixteenth and seventeenth centuries who, in the guise of describing the state, contributed to building it: being directed at current or potential managers, that theory oscillates continually between the positive and the normative, and depends fundamentally on an overestimation of the degree to which conscious strategies play a role in business, as opposed to the structural constraints upon, and the dispositions of, managers. (Bourdieu, 2005, p. 200)

Bourdieu's argument, here, casts the management literature in a new and more critical light; management theory is explicitly positioned as being complicit in the construction of the field which it purports to interrogate. This is a challenging question to resolve, in that Bourdieu's critique of the management literature would suggest that the findings of studies of management and governance in hospitals are directed at forming a normative set of practices. This can be partially supported through a reading of the literature, which emphasises the *applicability* of findings in management education and practice – both Samra-Fredericks (2000; 2004) and Freeman, et al. (2016) explicitly invoke the potential impact of findings on (respectively) the teaching of strategic management and the practice of corporate governance in hospitals. In both cases, the authors are seeking to elaborate theory which has a direct, practice-based impact on the conscious strategies deployed by managers. This would suggest that Bourdieu's claim that this literature has a normative / positive oscillation is valid.

A possible theoretical framework for understanding governance and management can be adopted from an economic perspective on the hospital as an organisation. An organisation, in this sense, is a "legal fiction … a nexus for a set of contracting relationships between individuals" (Jensen & Meckling, 1976, p. 8). The organisation is

the product of individual relationships being "brought into equilibrium" (Jensen & Meckling, 1976, p. 9). Taking this perspective, an organisation is therefore the outcome of contractually-defined economic relationships between individual economic actors, each of which face their own incentives (and disincentives) in making decisions within the constraints of such contracts. This perspective[4] emphasises that particular contractual relationships arise for different types of organisations, including private companies as a distinct type from other examples (such as hospitals). A potential interpretation is that these contracting or contractual relationships are the basis for Bourdieu's "structural constraints upon managers" (as cited above). This would mean that adopting an economic model for an organisation and a related theoretical framework for governance would address Bourdieu's critique of management theory. To do so, however, would disregard Bourdieu's critique of economic theory as an explanation for social and economic behaviour. Economic behaviour, for Bourdieu, is *habitus*, whereby an individual's actions are recognised by both him / her-self and others as being rational (i.e. consistent with both the economic incentives and the socialised value placed upon such incentives) as a direct result of being socialised into a particular understanding of *how to act* and the meaning(s) of such actions. Not all such actions are consistent with an economic theory or explanation (Bourdieu, 2005). Similarly, Granovetter (1985) argues that economic action is the result of a superposition of socialised structure and individual responses, as part of a critique of new institutional economics. An economic perspective on the organisation may itself be normative, in that it forms part of the understanding into which actors are socialised. This means that understanding a hospital, and consequently management and governance, in terms of collective economic activity is not a complete response to Bourdieu's critique. I argue, however, that this normative influence is precisely why models of governance and management which are informed by an economic and financial understanding of the organisation are relevant to this thesis.

This is supported by the argument put forth by Chambers & Cornforth (2010). Their analysis is principally focused on how public sector organisations are governed (including NHS hospitals in the UK). Chambers & Cornforth (2010) state that governance practices

---

[4] Influenced by new institutional economics and the theory of the firm (Coase, 1937)

and models in the public sector have been, since the 1980s, increasingly informed by models developed in the private sector. For Chambers & Cornforth (2010), therefore, theories of governance which have been primarily developed based on private companies and firms are relevant to organisations, such as hospitals. I suggest that, of the three perspectives discussed by Chambers & Cornforth (2010), principal-agent or agency theory is most relevant to this thesis.

Agency theory is centrally concerned with the relationship between a principal or owner and agents or managers within a firm, and takes the perspective that the owner of an enterprise will have different interest to those who manage it (agents) (Chambers & Cornforth, 2010). Governance is a function of an organisation which emerges to monitor and supervise incentives placed on managers to ensure that they act in line with a principal's interest(s). A difficulty of applying this theory to public sector organisations is the ambiguity of ownership (Chambers & Cornforth 2010); the relevance of agency theory may therefore be lowered by a lack of clarity about which entity or individuals are the principal(s). I argue that despite the challenge of applying agency theory to the public sector in general, the importance of principal / owner and agent / manager interests is relevant to the type of hospital (NHS Foundation Trusts) considered in this thesis. This is because as noted (although not explicitly discussed) by Chambers & Cornforth (2010), NHS Foundation Trusts are a public benefit corporation. This raises questions about which actors, within the governance and management of a hospital, can be said to represent the interests of owners, and the relevance of ownership to this model of a hospital organisation.

Agency theory takes the position that relations between actors within the organisation, when seen as contracts, require governance and monitoring to enforce their conditions against the possibility of defection (Williamson, 2005). Governance is thus an emergent property of such conditions, under which organisations self-create hierarchical structures of monitoring and control (Hoffman & Spitzer, 2011). Governance (rather than management) is positioned as the overarching directional structures of the organisation; it is primarily a solution both to different incentives or interests between owners and managers, as well as the challenge of arms-length or dispersed ownership (such as in

public listed companies, for example). We can see management as being understood as those self-defined roles which are determined by and through structures within a specific organisation. In other words, governance emerges as a property of incentives faced by owners as principals of an enterprise and management is deployed within such structures to ensure the successful and continual monitoring of activities against the expected contractual bounds established within the organisation.

It is governance as a concept which concerns us for this analysis, as in the capacity to direct and control the activities of participants within the organisation, as well as the formal structures and roles which are created within institutions to assign such capacity to particular individuals (as well as between institutions, such as in Ostrom, 2005, and Coase, 1960). This raises an important point; under the theoretical conditions of economic analysis, we can lay out a hypothetical relationship between the owner (or the owner of capital) and those contractually integrated into the firm's structure. The private owner faces a set of incentives in the maximising of profit, and uses price signalling of either internal costs or transaction costs in deciding to expand (i.e. to hire more workers and invest additional capital) or to transact on the open market. In this model, we can see that the marginal gain – the profit – attracts an owner to expand when there is this marginal difference between total costs of production *including* the consideration of options to either expand or (in modern parlance) out-source. The object of the present analysis – the NHS Foundation Trust – cannot be said to have such a simple ownership structure, nor face a straightforward set of economic (or other) incentives. To some extent, these are a set of linked empirical questions; who owns the hospital in which my case study occurs, what are the incentives faced by those who direct its activities, and what is their relationship to the owner? Certainly, I will consider these questions in subsequent analysis, but prior to that point there are some additional points that can be made from the literature on institutional economics and governance.

The problem of governance and ownership-at-arms-length has been an important consideration. Principally, the notion of *agency relationship* that exists between the owner(s) of a firm and an *agent* who acts on his / her / their behalf (Jensen & Meckling, 1976). Under this relationship, from an economic perspective there exists an *agency cost*

to the establishment of a relationship whereby direction and control (normally residual with the owner) is ceded to an agent to act on behalf of the owner, under the assumption that such an agent is both appropriately incentivised and monitored in such a way as to ensure maximum utility is received (ultimately) by the owner. Intuitively, this can be seen to match the contemporary structure of corporate and organisational governance structures, where in large or more complex organisations a board of directors is appointed to act on behalf of the owners in directing and controlling the activities of the organisation (typically, a company). Typically, such a board is required to provide certain information back to the owners, generally in the form of periodic and frequently public reports, and to conform to particular requirements (variable by governmental jurisdiction) to ensure that such directors are competent to act in the interests of the organisation and by extension, owners. Under the ownership structure of contemporary corporations, such boards are largely autonomous from individual owners. This is exemplified by the very common types of publicly listed companies that are owned by stock holding investors, each of whom has a minority and easily traded stake in the company. Thus, in these cases, the expectation of corporate governance (determined by the various policies and legislative instruments that define such roles, as in the UK Financial Reporting Council guidance, 2016) is that directors will act in the best interests of the company *in toto*. Contemporary corporate governance is thus expected to fulfil roles of directing the activities of the organisation, determining the best interests of the organisation and engaging in continuous monitoring of the organisation's activities to ensure that they are being executed in line with direction.

In the case of the hospital, then, I propose that governance and management can be viewed usefully in terms of this logic which (at least in part) contributes to the formation of collective economic activities. Under this model, for the purposes of this analysis, we can therefore see that this definition and perspective on how such organisations are directed (as opposed to managed) is most relevant for understanding how public participation impacts hospitals under specifically codified practices or models (as in, in the case study for this thesis) of governance. Governance as a *theoretical idea* is conceptualised in terms of emergent responses to the problems of the organisation (in terms of managing the agency problems and contractual relationships outlined above).

There are some assumptions about the nature of organisations and markets which are implicit to principal-agent theory. Powell (1990) highlights that the theory of the firm (Coase, 1937) and the related institutional economics perspective assumes that there is a boundary between the firm and the market (or the broader social context). Transaction costs, opportunism and bounded rationality influence whether transactions occur hierarchically within a firm (giving rise to the development of the firm and the need for internal governance and management) or across a market boundary. Opportunism is the pursuit by economic actors of their own advantage; the differences between what actions lead to advantages for principals or owners as compared to managers or agents is what leads to the need for hierarchical controls that curb opportunistic behaviour. Bounded rationality is a broad term for models of decision-making in which economic actors make choices under constraints, in contrast to the global or perfect rationality assumed by neoclassical economics[5]. Under bounded rationality, economic actors may make choices which have lower utility than an optimal choice because of cognitive or environmental limitations – which can include, for example, the processes of searching for and considering alternatives, the specific organisational context of a choice, or the differential value placed by an individual on uncertainty over risk compared to reward. Powell (1990) specifically deploys bounded rationality to refer to the "inability of economic actors to write contracts that cover all possible contingencies" (Powell, 1990, p. 297). This means that internal transactions (e.g. through employment relations within the firm) can be preferred because they do not require future contingencies to be anticipated, whereas a transaction that crosses the boundary of the firm would require a contract that includes such contingencies. Outside the boundaries of the firm are competitors and the market. Powell's (1990) argument is that this dichotomous view of markets and hierarchies "fails to capture the complex realities of exchange … [and] the role played by reciprocity and collaboration as alternative governance mechanisms" (Powell, 1990, p. 299).

---

[5] For further discussion of bounded rationality, see Simon (1959, 1964), Conlisk (1996) and Klaes & Sent (2005).

Network forms of organisation are proposed as an alternative to the market / hierarchy dichotomy. For Powell (1990), a network is a form of resource allocation or economic organisation characterised by long-term or recurrent exchanges between economic actors, relational or social means of communication, and value in an exchange (transaction) related to qualities of an item that may be difficult to measure. Transactions within a network are reciprocal and mutually supportive actions between individual economic actors, in contrast to a discrete exchange (market) or an administrative fiat (hierarchy) (Powell, 1990). The network organisation allows for economic actions which are motivated by durable social relationships and by qualities in transactions which are not directly measurable in terms of economic self-interest. Whilst agency theory assumes that there may be differing interests between principals and agents, a network form allows for cooperation based on mutual interests between economic actors.

The relevance of market, hierarchy, and network forms of organisation in the context of the NHS is considered by Exworthy, Powell & Mohan (1999). The NHS has been historically described as evolving or transitioning through successive dominant organisational forms, from an earlier hierarchical model through to a more recent network model. Exworthy, Powell & Mohan (1999) argue against this chronological paradigm. They propose firstly that the NHS is only a partial or quasi example of the three organisational forms (market, hierarchy, and networks). Secondly, they argue that these three ways in which economic exchanges are organised are co-present and should not be considered mutually exclusive. Aspects of market organisation – such as competition for resources between agencies – exist simultaneously with cooperation and collaboration across networks. Therefore, it is possible that the assumptions made by agency theory are valid in some cases, in that aspects of the NHS may operate in ways which are consistent with a market / hierarchy dichotomy. It is also important to return to the argument made by Chambers & Cornforth (2010). The relevance of agency theory to governance in the NHS is at least in part because of the introduction of private sector governance models into the public sector, rather than necessarily because of how economic exchange is organised within the NHS.

The shift away from a clear distinction between public and private governance and management is generally associated with the rise of New Public Management (Hood, 1991). From the 1980s onwards, particularly in the US, UK, and other English-speaking countries, the implementation of New Public Management was associated with the deliberate introduction of private sector management approaches into the public sector. Although a diffuse term for a general trend, rather than a specific set of proposed models of organisation (such as the conceptualisation of markets, hierarchies, and networks), New Public Management is characterised by changes to how public services, such as the NHS, are delivered and managed. Central to the doctrine of new public management is an emphasis on creating competition between public agencies, and an emphasis on private sector styles of management (Hood, 1991; Dent, 2006). Thematically, this has meant the disaggregation of public services into smaller, corporatised units, the introduction of purchaser / provider distinctions as part of resource allocation through competition, and a greater emphasis on incentivisation for managers (Dunleavy et al, 2006). New Public Management is generally positioned as a change from Progressive Public Administration, in which the main axes of change are in the lowering of rules limiting action by public sector officers and the lessening of distinctions between the public and private sectors in terms of business methods, personnel, and structures (Dunleavy & Hood, 1994). In other words, New Public Management can be conceptualised as a series of reforms in how the public sector operates that seek to impose conditions and ways of working which are similar to private sector organisations. Thus, whilst how economic exchange is organised within the context of the NHS may not align to the assumptions about markets and hierarchies which are strongly associated with agency theory, the governance and management structures which have been implemented as part of New Public Management are inherently derived from competitive, private sector organisations. I argue that this supports the relevance of the principal-agent model for this thesis.

In the health sector, the implementation of New Public Management has been linked to a shift from a "professionally driven service to a managerially driven one" (Dent, 2005, p. 624). The implementation of New Public Management can be conceptualised as an intrusion by the management and direction of new, corporatised organisations into the territory previously dominated by a more autonomous medical profession (Dent et al, 2004). Prior to the 1970s, the NHS was characterised by a compact between the state and

medical professionals which assigned everyday control of medical resources to medical professionals and overall absolute levels of resources to the state (Moran, 2003). Medical professionals were autonomous, both from the state and as individual practitioners from a self-regulating body. Moran (2003) argues that the reforms of the NHS from the 1970s and 1980s onwards were simultaneously expressed as the implementation of neo-liberal and market-oriented disciplines into a command system, but were in practice the implementation of centrally-driven controls. Walshe (2003) makes a similar argument in relation to structural reform of the NHS; that despite the rhetoric of New Public Management-era marketisation, local control, and management authority, the reform agendas of the NHS from 1982 to 2003 have ultimately reflected a need for political and centralised control. The creation of NHS Foundation Trusts may lessen direct political control over provider organisations (Walshe, 2003). But these organisations will still be managed and directed; increasing local autonomy to the level of a hospital or provider organisation is not equivalent to unwinding the struggle between the British state and the medical profession over self-regulation and policy autonomy (Salter, 2006). Instead, New Public Management-era reform and arguably the more recent NHS Foundation Trusts rely on the integration of medical professionals into management (Dent, 2003; Dent, 2006), within the structures created by policy-driven reform.

For the purposes of the case study presented in this thesis, it is necessary to examine how governance practices have been codified, and the ways in which stakeholders and publics are substituted for owners, under the conditions of the National Health Service. It is to this notion – that of public and user participation – that I now turn, to situate the case study within work that considers public and stakeholder roles in hospital and health care governance. In addition, I will discuss potential implications and complications for examining governance within state or public owned institutions.

Participants, patients and publics

In the following section, I examine work which explicitly engages with the role of what are variously termed *lay people*, or *patients*, or in some contexts *service users* in the planning, management and decision-making processes around health services and

systems. Aspects of this discussion will draw upon the conceptualisation of management and governance presented in the prior discussion; in addition to these more economically or corporate-oriented conceptualisations of governance, I will also discuss how service-user involvement in institutions and organisations that are explicitly public (in the sense of state or government funded, owned and/or controlled) introduces a model of governance which is derived from a theory of public and participative political democracy and decision-making. My intention is to locate the discussion of public health care institutions, as exemplified by the National Health Service, within a broad context which considers both how such institutions act as individual firms (i.e. under the conceptualisation of governance outlined in the previous section) and how such institutions can be seen to be similar to *state-forming* or *public* forms of governance (understood, in developed Western contexts, as being more similar to the democratically elected systems of government). Empirically, this will be more closely examined in the analysis chapters of this thesis, particularly in chapters 7 and 8, which will discuss, respectively, the self-definition of governance within the NHS and the ways in which members of governing bodies construct their relationship to the particular general populations on whose behalf they are, at least by formal definition, expected or required to act.

As outlined in the introduction to this thesis, the primary focus of this case study is on public and patient representative participation in the governance processes of a large, tertiary hospital. Given this focus, it is important to locate this current research within the context of other work which has considered the role of the patient in such processes, considering in particular work which also focuses on the British health care system. This is not to say that the UK is the only country in which patient participation in directing health care is a particular priority; indeed, there is a general consensus that such patient and public participation programs are increasing and that their importance is widely recognized (Nilsen, et al., 2006). That said, what is meant by such programs appears to vary widely between contexts, and can include formal consultation processes in the development of clinical research projects or changing health policies, the inclusion of representatives (such as in the UK) in health decision-making, or even changes in medical practice at the level of the individual patient, to include more patient-directed health care. Systematic reviews, such as Nilsen, et al. (2006) and Mitton, et al. (2009), although

limited by the extent to which they survey *literature* rather than *practice*, both note multiple examples of such processes across multiple types of public (i.e. multiple definitions of public or patient) and multiple levels of government, institution and health service. Further, Mitton, et al. (2009) note that there is a lack of evaluative studies, and thus there are, alongside such a lack of evaluation-directed studies, a lack of formal means by which to classify, compare and ultimately quantify (at least in terms of number or scale) such activities. I should note here that I do not necessarily propose that public participation should be quantified or evaluated *per se*, but rather that the lack of such a shared framework demonstrates the fragmentary nature of such activities and the literature which describes them, at least at an internationally comparable level. Crawford and co-authors (Crawford, et al., 2002) in an earlier specifically targeted review examining the "active participation in the planning, monitoring, and development of health services of patients, patient representatives, and wider public as potential patients" (Crawford, et al., 2002, p. 1263) found that there was evidence to support "the notion that involving patients has contributed to changes in the provision of services across a range of different settings" but that there was no evidence that there were "effects on use of services, quality of care, satisfaction, or health of patients" (Crawford, et al., 2002, p. 1263). The impact of these reviews on how to conceptualise and further investigate patient and public involvement, however, is limited, in that they merely establish that there are conflicting findings, uneven definitions and that public involvement can be, and has been, defined in multiple ways within multiple contexts. That said, such reviews establish that such intellectual territory is, in many ways, unclaimed and contestable, in the sense that although there are (as noted in these reviews) multiple guides, best practice handbooks, and indeed studies on such practices (such as Boivin, et al., 2014, who conduct a simulated / trial process for qualitative analysis), there is a limited consensus as to the definitions and structure of what constitutes patient or public involvement. Indeed, I would argue that, following the foundations established at the outset of this background, we should consider such categories as being a matter of contestable and socially constructed concepts, which can therefore be seen to be both subject to such processes of social construction and in addition susceptible to (empirical) social analysis (adapting the argument of Fondacaro & Weinberg, 2002, put forward in relation to concepts of social justice). This notion of the social construction of social roles and categories will be discussed further in the methodology chapter of this thesis.

In the specific context of the UK health system (particularly hospitals within the National Health Service England), there have been a relatively large number of studies which consider the role of patients and public(s) in directing and making decisions about hospitals and health care. This is perhaps unsurprising, as public involvement in health decision making has been increasingly embedded within the architecture of the NHS, including both bodies concerned with service delivery (such as hospitals or primary care organisations) and supporting bodies (such as the National Institute of Clinical Excellence, NICE, and the Health Research Authority, through research ethics evaluation processes). The current ways in which this is implemented for hospitals is naturally of critical relevance for this research; for this reason, this is discussed more fully in the analysis of hospital governance and management structure in the specific case study hospital (see chapter 4 of this thesis). For the current discussion, it is sufficient to note that this movement has been embedded within the UK health system in general since at least 1997 (Mockford, et al., 2012), stemming predominantly from state policy-setting activities by which the role of patients and the public is enshrined variously in policy statements and enabling legislation. As noted by the authors:

> This review indicates that PPI [patient and public involvement] takes many forms within UK NHS health care. This ranges from lay membership of NHS managerial boards such as the former Primary Care Groups, Primary Care Trusts and commissioning boards to patient involvement in condition-specific groups of individuals with a solitary aim (e.g. information distribution as in leaflet design or awareness campaigns). The impacts of PPI on NHS healthcare services were broadly divided into service planning and development, information development and dissemination and changing attitudes of service users and providers. (Mockford, et al., 2012, p. 30)

Similarly to the findings of global / international reviews, the authors note that the impact of patient and public involvement in the NHS is under-specified, in that there are limited systematic studies which clearly identify the impact of public and patient involvement.

This theme deserves some discussion. The aim of the reviews discussed in this section up until this point is to establish an acceptable evidence base. In other words, such reviews are intended to change (by contributing to) a shared and collectively accepted body of knowledge about health and medical care. The authors' invoking of an acceptable evidence base as a concept raises an important aspect of knowledge in health and medical care, which is the credibility of knowledge. Epstein (1995) discusses the notion that a critical dimension of scientific and biomedical knowledge is credibility, in turn linked to

the source and means of production of such knowledge. In Epstein's analysis of lay activism in HIV / AIDS (Epstein, 1996), he argues that knowledge in biomedical and scientific domains is determined through a shared set of rules in which some sources are more valid than others, and that there are correct ways to produce new and credible scientific knowledge, and that the accreditation of such knowledge (as credible) is within the control of the medical and scientific professions. Here, Epstein identifies a contradiction in that the scientific foundations of medicine are accessible to those who are non-credible, in the sense that they are not members of the same category of knowledge-holding individuals which make up the clinical and scientific professions.

In relation to the reviews of patient and public involvement, the notion of the acceptable evidence base suggests the authors aim to achieve through the observation of social behaviour a systematic analysis which meets the *expectations* of a particular audience by which additional knowledge is evaluated and accredited. The conclusions of the reviews can then perhaps be reinterpreted as being that the current knowledge of what occurs in public and patient involvement in health systems is, at best, only partially consistent with how the expert[6] members of the clinical and scientific professions expect such knowledge to be constructed. This perspective speaks both to the specific issue of how to interpret the findings of these reviews for the purposes of this thesis, and also suggests why the economic and organisational literature reaches different conclusions about the role of governance and management. For the first, as suggested in the discussion above, these reviews can be said to be of limited relevance; they establish that such activity occurs and provide some context, but do not fundamentally inform how to orient to or conceptualise patient and public involvement. In addition, as the authors themselves note, these reviews operate within the norms of how to generate clinical or scientific knowledge (including that such knowledge can be usefully considered distinct from other forms or sources of knowledge). They are limited in the extent to which they identify a relationship between the activity of public and patient involvement and specific outcomes.

---

[6] Used here in the sense following Epstein to contrast between lay (non medical / non scientific people, in his analysis activists and members of the HIV/AIDS activism community) and expert (doctors, scientists, and other members of relevant professions)

Findings of these systematic reviews notwithstanding, there are studies which specifically examine public and patient involvement in the governance of the UK health system and seek to characterise both the conditions and mechanisms under which such activities occur, and the (at least potential) effect that such activities can be seen to have. Early research conducted by Davies, Wetherell and Barnett (2006) considered the initial Citizens Council formed to support the (then) National Institute of Clinical Excellence (NICE), a process which commenced in 2001[7]. This account of the formation and practices of the Citizens Council examined public participation in a deliberative health-care decision-making process. It is worth noting, however, that the design of the Citizens Council and its relationship to the work of NICE explicitly limits the impact of the Council; the Council provides NICE with a perspective, rather than forming part of the decision-making process of the body itself (as noted in the initial report) (NICE, 2002).

Martin (2008a; 2008b; 2009a; 2009b; 2011; 2012), along with others (Learmonth, et al., 2009; Martin & Finn, 2011; Sutton, et al., 2015), considers the role of public engagement and involvement in representative functions (i.e. in participatory governance processes), in the contemporary UK health system. In his work, Martin considers the public as being those individual members of a society who are either *users* of a health service (i.e. patients) or those who are *potential users* of a health service. For Martin, the role of public participatory processes in governing health care can be summarised as follows:

> What emerges is a conception of the involved member of the public as filling a mediating role of the kind identified in certain other areas of contemporary social policy in economically developed countries … lay individuals whose disposition and social location provide particularly acute insights to government. Such insights make knowable the vagaries of the wider population which involved individuals articulate through typicality, commonality or communicative skill, and help to ensure the appropriateness and efficacy of public services to that population. They are almost, perhaps, 'experts in laity'. (Martin, 2008a, p. 49)

---

[7] It is worthwhile to note that the current National Institute of Health and Care Excellence, the successor body to the original NICE, maintains a current Citizens Council; see https://www.nice.org.uk/get-involved/citizens-council (Accessed September 2017)

This perspective has a number of implications. Firstly, one of the underlying assumptions in this analysis is that public representation has (as in the excerpt above) a mediating role between the largely unknown public and a *government*. This frame transforms the notion of health care governance from being (as discussed in the previous section) a question of managing or governing a collective entity, to being a question of involvement and engagement in government and the creation of social policy. This in turn can be seen to implicitly construct the notion of the public (as used in Martin's work) as being juxtaposed to the state (or rather, to the government and those organisations which are created by and through the operation of government policy to implement and operationalise policy). This is related to a second major implication of Martin's conceptualisation of health care services, one which is common to much (if not all) research on public participation in the UK NHS. Put simply, this work takes as a largely unquestioned starting point that health care is the purview of a government; that it is a matter for social policy, and that by-and-large the provision of services that are consumed in relation to health or medicine is a government-directed activity. Under this assumption, patient and public involvement is seen as being a kind of citizenry; a goal-directed feature of a liberal democracy which is an unalloyed good; in the words of Contandriopoulos:

> The democratic ideal of government for and by the people, implicit in the principle of public participation, is indisputably desirable. (Contandriopoulos, 2004, p. 326)

This alignment of participation in health-care to the work of government – indeed, to the foundational and democratic ideals of Western state-formation – can be seen to therefore explicitly frame the fundamental questions of patient and public participation in the governance of hospitals in terms of a field of publics, citizenry and rights. Rather obviously, this frame diverges from the conceptualisation of hospitals in terms of the firm, as discussed in the previous section; although beyond the scope of this background discussion to resolve this divergence, these analytical frames can be useful to understand the particular roles of case study participants in this research in terms of representation as elected members of hospital governance.

Within the UK (and, as in the case of Contandriopoulous, cited above, Canada), patienthood and citizenship in relation to health-care is indelibly tied to the actions of government; indeed, as argued by Mold (2010), the UK government has become instrumental in the ongoing construction of the patient as a health consumer (in other

words, in the construction of the notion of patient-hood). Milewa (2004) argues that an increased focus within British public health policy on promoting public engagement can be seen as a quasi-communitarian conceptualisation of the roles and duties expected of a citizenry who are charged with a moral obligation to co-participate in the production of a public good (i.e. in maintaining the good health of a nation). For Milewa, this potentially represents a shift in emphasis for a health system which historically has positioned entitlement to health care as a right of citizenship without condition. Harrison and Mort (1998) put forward the argument that public participation can be seen as a technology of legitimation, whereby (at least part of) the purpose of public participation for the government is to increase the extent to which health policy decisions are seen as legitimate by virtue of such decisions having been made through a public and open process. Callaghan and Wistow (2006a; 2006b) identify specific limits to the implementation of public involvement in the governance of primary care trusts (a type of unitary authority within the UK NHS), specifically that such involvement processes typically rely upon pre-specified topics upon which public representatives are permitted to speak and the exercise of power (through, in Callaghan and Wistow's argument, the possession of *social capital*) by the managerial and medical elite over the public participants. These factors are seen as critical aspects of how organisations (such as, in their study, primary care trusts) limit the extent to which public and patient participation are able to exert a significant influence over the actual activity of delivering health services.

Taken together, then, these studies suggest that public and patient involvement may be deployed specifically by government actors as part of efforts to create and control particular relationships between the users of health care services, the provision of such services through institutions such as hospitals, and the mechanisms by which such services are funded and maintained. Public participation, when viewed as part of the actions of government and the operation of a democratic state, becomes therefore complicit in the creation of the public as a category in which a subject can act, fulfilling a pre-specified and designated role in the orchestration of a governance function. This may contribute to findings of some studies, such as Allen, et al. (2012), Bradshaw (2008) and Wright, et al. (2012), which critique the success of such processes. Notably, Wright and co-authors (including similar collaborators to Allen, et al., cited above) despite

referring to past positive findings related to public involvement in governance and regulation, reject the model of local resident (i.e. public) governance in favor of a direct regulatory role for government in assuring the appropriateness, quality and safety of health care.

The argument that patient and public participation is directed by governments (to perhaps questionable goals or that public and patient participation is a failed experiment does not answer the underlying question of what the driving force behind such processes is. The suggestion in the previous discussion is that public and patient participation is *part of* the operation of a democratic state and the exercise of citizens' rights to be involved and consulted in the provision of public services (leaving aside for the moment the question of what such a service is, and relying on the common-sense definition of a service which is available for any member of a particular society to use – particularly in the UK context, where the NHS is, with few exceptions[8], provided free at the point of care). This argument is partially put forward by Lehoux, Daudelin and Abelson (2012), in an analysis of citizenry in public deliberation in health-care, and Tritter (2009), who explicitly advocates this rights based approach to the conceptualisation of public and patient involvement. Tritter identifies policy and legislative drivers behind such initiatives, particularly cases in UK enabling acts or key regulations wherein rights are assigned (to patients). Whilst Tritter identifies some of the key factors by which the practice(s) of rights-based involvement are created, this study does not explicitly identify *why* public involvement in decision-making for health-care institutions – why public participation in hospital governance – is the direct result of some right, other than the general argument put forward by Contandriopoulos (as quoted above). An explanation can be seen in the argument put forward by Weinberg (2007):

> No longer are citizens quite so content to confine their participation in the political process to procedures for delegating authority to politicians who then take control of the state apparatus and install technical experts in bureaucratic positions of policy formulation and implementation. One increasingly sees both a decentralization and diffusion of work that was once consolidated within the institutions of the state and, conversely, the insinuation of citizen groups into spaces within the state apparatus that were once the exclusive

---

[8] Such as dental care, or the distribution of prescription medicines in retail pharmacy channels.

provinces of politicians and their appointed experts. Thus, putatively expert sources of public policy are increasingly challenged by more thoroughly democratic and consensus-based orientations to public policy making. (Weinberg, 2007, p. 71)

Under this model, the increasing engagement of citizens in the political process of implementing (and forming) policy is part of an ongoing development towards a more deliberative democracy. This, perhaps, echoes and transforms the critique of participatory processes as a technology of legitimation, in that this "more thoroughly democratic" process of public policy making *has* greater legitimacy. The greater involvement of an engaged citizenry in governance of hospitals can be, from this perspective, seen as being part of an evolution towards this more deliberative democratic statehood – noting the limitations that Weinberg points out in his analysis of the presumption of competent communicative participation in such deliberative processes, under the conditions of a Habermasian model of discourse ethics (Habermas, 1996).

It is also necessary to acknowledge that there is a small, emerging literature on the role(s) of lay members of committees, particularly in health and related services within England. This body of research generally falls, methodologically, into two categories – firstly, studies which consider how roles, participation, and processes are defined and constructed within policy, legislation, and guidelines. This body of research includes studies such as Abelson et al (2007), Baggott (2005), Emmerich (2009), Hogg & Williamson (2001), and Wait & Nolte (2006). These papers outline proposed and enacted policies and processes by which patients and lay members of committees are engaged, and offer frameworks for understanding and defining such engagement. Notably, these studies frequently highlight the challenge of adequately defining the roles of lay members in such committees to ensure that their input is used and engaged effectively through such mechanisms. This body of work, however, does not attempt to either empirically investigate or to explicitly develop a theoretical framework for understanding lay committee members. Rather, these studies attempt to advance an in-practice understanding of lay committee participation through the analysis of policy and frameworks produced by and through the health system(s) (in these examples, European and Canadian). A second general body of research considers the experience of lay members and health practitioners (including both doctors and nurses) through empirical research, including data collected from both lay and expert members. Litva et al (2009)

argue that there are a variety of expectations for what involvement means across types of service users, distinguishing between the expectations of users as consumers, users as advocate and user as citizen, with consumers focused on limited self-interest, advocates focused on interests stemming from particular expert knowledge (normally from direct experience with health care), and citizens focused on more general public good. Nathan et al (2010) use a survey approach to assess hospital staff views of legitimacy and roles of community representatives, finding that although there are generally positive orientations to community representation, and support for such activity, hospital staff did not feel that there was agreement between health service staff and community representatives about their respective roles in such committees.

These studies reveal – as do the policy studies – that the role and function of lay members is not clearly and universally agreed; the analysis of policy, frameworks, and models for enabling lay member participation suggests that such concepts are contestable and in a state of ongoing evolution. This research project will aim to complement this discussion, then, by considering how the role and function of lay (understood as patient and public) committee members is performed in practice. As in, capturing the operation of such committee members in action and examining how the policy intentions are carried out, and examining how health service and user perceptions and expectations translate into action within committee processes.

As briefly outlined in the opening to this section, the focus of this research is on one particular aspect of patient and public involvement in the NHS – elected public and patient representatives as governors of Foundation Trusts (the owning bodies of large hospitals). Although such governance processes are discussed in the literature outlined in this section, particularly Wright, et al. (2012) for example, I wish to make a brief comment about the *elected representative* nature of such governors. Put simply, we have, in the empirical case study upon which this thesis is based, a situation in which deliberative participation by the public and patients is performed by elected representative individuals. Whilst noting that, to some extent, the nature of such representation and, indeed, whether we should continue to adopt this deliberative democracy frame for the understanding of hospital governance is an empirical question which will be addressed

within the analysis of this thesis, it is useful to orient at this point to the notion of *representation* in democracies and democratic institutions. Pitkin (1967) discusses the foundational theories of representation, and identifies a critical controversy in the notion of political representation (the mandate-independence controversy). Beginning from a formal definition of legitimacy, Pitkin cites Weber's *Economy and Society* (1978) to define representation as the conditions under which the actions of a member of a group are understood to be ascribed to the rest, and are thus regarded as legitimate and binding upon all members of the group. Developing a conceptual definition of representation, Pitkin proposes a series of categorisations of representational functions, and argues that the most relevant for the practical analysis of liberal democracy is representatives who are acting for their constituents, in that such representatives are empowered to *act on behalf* of citizens, but not necessarily as *bound* delegates. As in, under the conceptualisation of a representative acting for, such a representative is empowered (and indeed, perhaps, expected) to act as he or she thinks best for their constituents, not to act directly according to the wishes of their constituents. This model is intuitively familiar, as it can be said to be the normative model for democratically elected officials, members of parliament, and so forth, in Western liberal democracies (disregarding specific instances where either by law or tradition, this does not apply, such as in the United States Electoral College, for example). The mandate-independence controversy, or rather paradox, arises due to the freedom to act that this model bestows upon such a representative; the representative is *accountable* to a constituency only insofar as the electoral or appointment mechanism enables such accountability, and such mechanisms do not extend to the monitoring of a *delegated* representation of views and interests. Rather, elected representatives are expected to both utilise a degree of discretion in acting in the best interests of their constituents and in a manner consistent with the basis on which they were selected as a representative (i.e. in the case of a political or politicised election, consistent with the stated policies and goals of that representative's electoral platform).

Representation in liberal democracy is, it should be noted, most often considered as being distinct from *participatory* and *deliberative* democracy. This presents an apparent contradiction in considering the role of public and patient involvement in hospital governance. As I outline above, if we conceptualise such processes as being part of the

advancement and development of a deliberative democracy, which refers to the increasing engagement of citizens in decision-making and public policy creation, then public and patient involvement should be open to *any* member of such groups in order to facilitate the broadest possible engagement with an increasingly active and informed citizenry. Under such conditions, deliberative decisions should be made through the participation of whichever citizens are engaged in such participation, with no particular requirement for the appointment or election of representatives. Why, then, are such representatives necessary? In the previous section, I discussed how models of governance which involve *representatives* of owners arise to solve a principle-agent problem under conditions of diffuse ownership (i.e. where there are many shareholders, for example). What, then, is the equivalent for patient and public involvement as participatory democracy? Put simply, I suggest that representation in Foundation Trusts arises for a similar reason to representation in parliamentary democracies; the assumption (or perhaps the unquestioned shared certainty) that representation is effective in achieving the fundamental goals of a liberal democracy (as a simplification, that government should be consistent with the opinions of at least a majority of the citizenry) and that a smaller group of elected decision-makers is more effective at making such decisions than the populace at large.

In this section, I have discussed public and patient participation with a focus on the UK health system. Two key issues arise from this discussion; firstly, that it is possible to conceptualise patient and public involvement as being both driven by and an exemplar of deliberative and participatory democracy. I suggest that this conceptualisation fundamentally relies upon an understanding that the delivery of health-related services is part of the operation of governments, and that governments have a legitimate interest in health / health-care. In other words, that citizens have a right to be involved in the determining of health-care services because such services are part of the institutions and organisations which are implemented through a democratically-appointed public policy development (and ultimately, implementation) process – for the UK, through the election of successive governments who have established the various bodies that are collectively referred to as the NHS. The second key issue which arises from this survey of the literature is that, although attempts have been made to evaluate the involvement of patients and members of the public in health-care decision-making, there appears to be

limited consensus as to whether such involvement has any effect, or how such effects might be measured, or indeed, upon which aspects of health-care such effects might occur. That said, with only limited exceptions, policy and practice-oriented research can be generally said to be in favor of, or report positive orientations towards, public and patient involvement in health, including for individuals, specific health-related activities (including research), institutions / organisations and health policy

Theorising power and knowledge

Hannus & Simola (2010) propose an integration of Foucault and Bourdieu's conceptualisations of power for the purpose of analysing governance in education. The authors argue that Foucault's conceptualisation of power does not provide sufficient analytical tools to consider power in the context of their study. Bourdieu's approach, particularly to the symbolic order, is positioned as a solution to these deficiencies. Hannus & Simola (2010) approach power as having a "basic core … as a relation of influence" (Hannus & Simola, 2010, p. 2). They argue that distinctions between theorists of power can be understood as principally a matter of categorisation and attributes described by a theory of power; Bourdieu and Foucault's respective theoretical approaches are potentially compatible because they are fundamentally describing the same phenomena. Hannus & Simola (2010) take the position that Foucault's general theory of power is focused on the mechanism by which an actor *a* has a power relationship with (power over) actor *b*. Foucault's concept of power is as a "relational network" (Hannus & Simola, 2010, p. 6), in which the use of technologies and forms of knowledge are instrumental in establishing power relations between subjects. Bourdieu's model is similarly presented as relational; power relations exist between individuals on the basis of their position within a symbolic order. The symbolic order is composed of relations between individuals based on divisions between forms of capital, social classes, ethnicities. The production of the field in which this symbolic order is understood is the operation of Bourdieu's symbolic power (Hannus & Simola, 2010).

The authors argue for a number of parallels between Foucault and Bourdieu's conceptualisations of power relations. Firstly, both Foucault and Bourdieu are concerned with the formation of how power relations are understood. For Bourdieu, this is the

operation of linguistic markets and the concept of *doxa*; this is positioned by the authors as similar to Foucault's discourse and discursive formation. Secondly, *habitus* and *ethos* are discussed, in which Bourdieu's model of *habitus* as productive of social practices is similar to Foucault's prevailing policy-driven ethics (*ethos*). Thirdly, both Foucault and Bourdieu theorise difference; the visibility of subjects (for Foucault) and distinction (for Bourdieu). Finally, Bourdieu and Foucault consider means of reproduction and technologies (respectively); central to both conceptualisations of power is the means by which they are disseminated, maintained, and normalised. Hannus & Simola (2010) suggest that whilst there are parallels, a key difference is in the utility of each theorist at different levels of power relations. Foucault is positioned as an effective theorist of the meso- or macro- levels of political and policy formation, whereas Bourdieu's model is positioned as more useful in the context of specific schools (in their study).

A similar argument is advanced by Schlosser (2013). Schlosser argues that it is useful to combine the approaches of Foucault and Bourdieu in conducting a sociology of prisons. The approach of identifying parallels or compatible concepts between Bourdieu and Foucault is similar to Hannus & Simola (2010), although Schlosser links *habitus* and discipline, docile bodies and *ethos*, *doxa* and panopticism, theory of practice and history of the present (respectively). Cronin (1996) is more critical of Foucault. As Cronin argues, both Foucault and Bourdieu's conceptualisations of power are a rejection of a subject-centred theory, in which power is invested in subjects who wield it over others. For both Foucault and Bourdieu, a theory of power is inherently a theory of relationships and mechanisms between actors (Cronin, 1996). The difference between Foucault and Bourdieu is in the conceptualisation of the subject. Cronin argues that Foucault's radical approach to the construction of the body through discursive formation and the subsequent elision of the subject as a source of meaning is a crucial flaw in Foucault's approach to power (Cronin, 1996). In Cronin's analysis, Foucault's conceptualisation of the modern subject as an effect of disciplinary power is flawed because it does not sufficiently allow for resistance (by the subject) to the totalising effects of power and knowledge. Foucault's model of disciplinary power relies on the reproduction of the conditions of a closed institution (such as a prison or asylum) in ways which create a large scale society as a whole, but does not provide an account for the means by which this is achieved (Cronin, 1996). Bourdieu's concept of symbolic power is the result of internalisation by subjects

of cultural and shared schemes of recognition, interpretation, and meaning; symbolic power is the means by which a shared consensus of the social world is created (Bourdieu, 2005; Cronin, 1996).

Both Foucault and Bourdieu's conceptualisations of power contribute to the theoretical background of this thesis. However, there are distinctive contributions made by Foucault and Bourdieu's respective conceptualisations of power. The intent of this discussion is not to propose a complete unification or integration of Foucault and Bourdieu's theories. Instead, I take the position that principally Bourdieu's approach to understanding action in social contexts is the dominant paradigm for this analysis. This is reflected in the Methodology chapter. The implication of this is that Bourdieu's conceptualisation of power constitutes an overarching framework within which specific aspects of Foucault's theory are relevant to the analysis of the case study in question.

The distinctive contribution of Bourdieu's conceptualisation of power is the deliberate attempt to move beyond a dialectic between structuralist and constructivist perspectives in the social sciences (Bourdieu, 1989). In order to do so, Bourdieu proposes a shift to relational thinking about the nature of social life. In this mode of thinking, social life is "an ensemble of invisible relations ... a space of positions external to each other and defined by the proximity to … or distance from each other" (Bourdieu, 1989, p. 16). Bourdieu's argument is that this conceptualisation of social space allows for both the structuralist and constructivist viewpoints. Bourdieu allows for the existence of objective structures of organised social groups and relations which are independent from individuals and are capable of guiding and constraining practice. These co-exist with the constructivist "twofold social genesis" (Bourdieu, 1989, p. 14) of thought / perception and social structures. Under this model, the relative positioning of an agent in social space with respect to other agents are these objective structures; the sense of one's place in a structure of social organisation. Social reality, for Bourdieu, is constructed, but subject to constraints associated with existing social relations, and is importantly a collective, as well as individual, enterprise. *Habitus* implies not only an individual's self-knowledge of place in social space, but the place of others and the means by which relative positions are understood.

Social practice, within Bourdieu's model, are produced by the interaction between *habitus*, capital, and the field. This is generally reproduced as:

$$[\ (\ \text{Habitus} \ ) \ (\ \text{Capital} \ ) \ ] + \text{Field} = \text{Practices}$$

Wacquant (2005) defines *habitus* as the way society becomes deposited in persons; it is developed through socialisation as a means by which an individual both recognises and produces practice (social actions). Capital refers to various forms of (in Bourdieu's 1989 terminology) "power", although it is more often referred to as resources of value; economic, social, cultural, and symbolic. The position of individuals in social space is defined by their possession or accumulation of different forms and amount of capital. Field is an intersection of Bourdieu's concept of power and social practice. The field is:

> … a network, or configuration, of objective relations between positions. These positions are objectively defined, in their existence and in the determinations they impose upon their occupants, agents or institutions, by their present and potential situation (*situs*) in the structure of the distribution of species of power (or capital) whose possession commands access to the specific profits that are at stake in the field, as well as by their objective relation to other positions.
> (Wacquant & Bourdieu, 1992: 97)

This definition explicitly equates capital with power. What is crucial about Bourdieu's conceptualisation of capital (and therefore power) is the notion of *forms* of capital. Although framed in the language of economics, Bourdieu's theory explicitly includes non-monetary capital as having value and hence power. The possession of social and cultural capital is equally as necessary for the production of practice as economic capital. Under this model, power and capital are equivalent or interchangeable because the possession (or not) of capital limits the production of practice, as well as defining the structuring relations between agents in the field.

Symbolic capital and symbolic power require some further discussion. Symbolic power is Bourdieu's response to the concept of performative utterances. That is, symbolic power is the power of constructing reality; of stating the meaning of the (social) world such that the utterance itself is determinative of a shared understanding or perception (Bourdieu, 1992). Symbolic capital is generally understood as prestige or reputation, as well as the

transformation of the other forms of capital when they are perceived and recognised as legitimate. Arguably, the use of symbolic power is a demonstration of how Bourdieu's model of social space is created by and through the actions of agents. The use of symbolic power is the means by which those with power shape what Bourdieu refers to as structuring structures (instruments for knowing the world) and structured structures (means of communication) (Bourdieu, 1992). Symbolic power thus specifically refers to the capacity for those in power to shape shared understanding of the social world, legitimating dominance of one group over another (among other effects). Symbolic power illustrates the necessity of a relation between those who exercise power and those who submit to it; symbolic power must be recognised as legitimate and is defined by the structure of the field in which it is exercised (Bourdieu, 1992).

Within this context, the contribution of Foucault's theorising of power is directly connected to the focus of this analysis on a hospital and hence the practice of clinical medicine. In *The Birth of the Clinic* (Foucault, 1973), Foucault considers the history of medical industry in the 18th and 19th centuries. Central to Foucault's conceptualisation of clinical medicine is the gaze. The medical or clinical gaze is an encounter between the observation of a doctor and the physical body of a patient. This encounter can be conceptualised as the application of a discourse about the nature of the body, the pathophysiology of disease and bio-medicine to the natural history of an individual subject. The medical gaze makes concrete the physical body, but does so through the regulation of the body within the logic of clinical knowledge possessed by the doctor. The gaze is constitutive both of the object being observed and the observer; it is a reflexive analysis whereby the gaze defines the object of knowledge and the subject as knowing (Foucault, 1973, Armstrong, 1994). The body, for Foucault, is understood as constructed by and through discourse and practice (Lupton, 1997); the body exists in the terms dictated by the gaze. In other words, a body "analysed for humours contains humours; a body analysed for organs and tissues is constituted by organs and tissues" (Armstrong, 1994, p. 25). What is pertinent here is the directionality of knowledge about the body; it is imposed upon the patient. What is radical about Foucault's approach to the gaze as medicalisation is the contention that the body does not exist outside medical discourse. The body, in the sense that it is relevant to and brought within the disciplinary

power of clinical medicine, is not only discovered and pierced by the gaze, but created by it (Lupton, 1997).

Contemporary medical practice emerges from the development and codification of bodies of clinical knowledge (Foucault, 1973). Foucault's history makes clear that modern medical knowledge has no "privileged epistemological position" (Armstrong, 1985). Clinical knowledge is, however, privileged in that it operates as part of disciplinary power by which individuals are brought into being as subjects; as doctors and patients (Lupton, 1997). Power relations between doctors and patients are defined by the possession of clinical knowledge – the capacity to utilise the medical gaze to delineate and define disease, illness, and the (medicalised) body. I suggest that this delineation of expert and non-expert – the possession of privileged knowledge – is a useful conceptualisation for the purposes of this thesis. The distinction between a doctor and non-doctor is the capacity to act on the basis of this knowledge; in other words, the medical gaze compared to the lay or non-expert.

Foucault's model of power/knowledge opens up the question of resistance and alternative discourse. Epstein (1995) discusses subjugated knowledges in the creation of scientific knowledge about AIDS treatment. Epstein (1995) shows that a critical dimension to knowledge in the biomedical domain is its credibility, which in turn is linked to the source and means of production of such knowledge. Subjugated knowledges lack credibility, and do not enable resistance to dominant discourses. Again, in Epstein's work (Epstein, 1996), the consequences of this are shown in the evolution of HIV/AIDS treatment in the 1980s and early 1990s. The adoption of expert-like communicative competence by lay people and increasing scientific credibility was used to both disrupt established knowledge, as well as to control the development of new scientific knowledge concerning the operation of the HIV virus and anti-viral treatments, as activists became increasingly expert and knowledgeable themselves. Epstein's analysis demonstrates that the domain of biomedical knowledge and expertise is contestable, and further, that this contest is unequal (see also Jones & Porter 1994; Heritage & Clayman 2010). For the purposes of this thesis, Foucault's concept of the medical gaze and his attention to the relationship

between power and knowledge are adopted within Bourdieu's broader framework for social action.

Summary

This background discussion has presented key concepts and relevant findings from the literature on governance and management of hospitals. Firstly, I have discussed studies which have examined how management and governance is carried out in hospitals and health care settings. I have discussed some of the limitations of the management literature, and proposed that governance of such institutions can be usefully understood in terms of theories of the firm and of solving principal-agent problems in the direction and ownership of firms. Secondly, I have outlined how current research on public and patient involvement in health care necessitates a perspective on participants which invokes notions of citizenship, rights and (due to the elected nature of the case-study participants in this research) representation. The purpose of this summary is to identify some key questions which arise from this survey of existing research which I will address through a case study of a specific NHS hospital.

Existing research on hospital management and governance establishes that there is an accepted distinction between patient or lay representatives and other participants in such processes. As discussed, there have been problematic and unclear findings about the impact or importance of this distinction and the effect that the presence of these representatives may have – in terms of hospital performance, or the outcomes of management and governance processes. This research seeks to contribute to an understanding of how individuals who may be fulfilling specific roles, or occupying specific categories, can be seen to contribute to and participate in management and governance. In turn, this gives rise to a question of whether these roles and social categories are relevant to decision-making processes. These questions will be explored through the analysis of how participants in governance and management decision-making processes make their membership of particular social categories relevant to the process at hand.

There is a distinction made in existing literature between lay or public representatives and expert participants. This distinction can be regarded as predominantly a property of the individuals fulfilling those roles – a matter of an individuals' background. For this thesis, I suggest that the literature shows two important ways in which this distinction is made. The distinction between lay or public members and expert members is both a matter of *representation* – as in, the process by which a member of a governance or management process is selected – and the *knowledge and expertise* possessed by an individual in comparison to other participants in such governance and management processes. This research will engage with these concepts to examine the ways in which processes of representation are relevant to hospital management and governance, and the ways in which knowledge and expertise are deployed by participants in such processes.

I have discussed two main theoretical perspectives which argue for a connection between knowledge and power. Following Bourdieu, knowledge can be understood as a form of capital, and therefore power, which is possessed by actors relative to a field which is itself defined by capital (or power) relations. This suggests that analysing how knowledge and expertise is used by social actors is equivalent to analysing how such actors exercise power (over others). Bourdieu's framework is useful in that it explicitly includes multiple forms or types of capital, and therefore different sources and ways by which power may be visible in social action. Within this framework, the major contribution to this thesis of Foucault's approach to power/knowledge is the argument that medical knowledge is privileged because it is constitutive of subjects and relations between subjects within a clinical or medical context. This places a focus on the use of knowledge in a clinical or medical context, rather than on the epistemological validity or privilege of medical and scientific knowledge.

In the following section, I will discuss the methodology by which these broad questions will be addressed, and outline in detail the specific research questions which are answered in this thesis. The methodology chapter will also set out the data collected to support this analysis, and the limitations of using a case study approach for this research.

3. Methodology

This research project is, at its core, a qualitative investigation into specific activities which occur within a particular hospital. Through a combination of ethnographic observation, formal and informal meetings with hospital staff, and video recordings of patient and public governance in action, a disparate collection of data can be seen to coalesce which can subsequently be viewed as a portrait of a specific hospital, in turn situated within a specific political, economic, cultural, historical and social context. This portrait of the hospital can then be interrogated and interpreted, analysed and examined, within the frame of the conceptual background established as relevant to the goals and aims of this research. As foreshadowed, it is the task of this methodological discussion to address both aspects of this investigation; the process by which the investigation was executed and the data which results from those activities, as well as the orientation and approach to interpretation and analysis of such data. I will also return to the aims and objectives of the research, and set out how the methodological approach will enable me to address those objectives.

This project is a case study, in that it is a single-site analysis of a specific hospital. It is useful to set out at the outset some of the arguments for case study research and the challenges inherent within this approach. As noted by Van Wynsberghe and Khan (2007), the case study has suffered from a challenge of definition, being variously discussed as a methodology, a study design, a set or sets of methods, without a clear understanding that delineates a case study as a particular way of performing research. A case study can be usefully considered not as a particular bounded method or design, but as a heuristic by which the phenomena being examined are delineated and evidence is collected (ibid.). Following Stake, the case study is not a "methodological choice but a choice of what is to be studied" (Stake, 2005). A case study is the conceptually bounded selection of an object of study (the case), within which some phenomena, themes, or issues can be observed and usefully understood. The case is the unique object of study; a bounded system (Stake, 1995) within which a researcher can gather evidence through which the aforementioned phenomena can be examined. Data collection and analysis – although typically qualitative, as in this research – can be mixed in method and methodology; the case study is defined as being the investigation of a unique and delineated bounded

system. The case study enables an empirical enquiry into a contemporary phenomenon within its real-life context, particularly in cases where the boundary between a phenomenon or issue of interest and the context in which that phenomenon occurs is unclear (Yin, 2003). A case study focuses on *how* and *why* phenomena occur, and the relationships that can be observed between such phenomena and the context of the case. Case study research enables an inquiry-led investigation of these *how* and *why* questions; in this thesis, this is an investigation of a particular hospital to examine how public and patient representatives contribute to hospital governance. For Yin, case study research can effectively address these *how* and *why* questions, and can enable effective empirical research into cases over which researchers have limited or no control (unlike, for example, experimental research). Yin further identifies three main challenges for case study research:

1. A lack of rigor in case study research
2. Limited or little basis for scientific generalisation
3. Length of case study and of resulting outputs

Points one and two are clearly important to address in this methodology chapter.

As put forward by Abma and Stake (2014), the case study is a tool that can "unravel" a single "demarcated entity". Specifically, following Stake's approach, a case study demonstrates how a particular set of things worked for a singular, identifiable setting. Abma and Stake argue, in relation to an exemplar analysis of an individual, elderly patient's experience, that the naturalistic case study can enable health researchers to develop a multi-layered, holistic understanding of a particular set of circumstances, individuals, and events (those bounded within the case). The case, understood as a demarcated and bounded set of events or phenomena which are identified by a researcher but, importantly, are not created or constructed for the purpose of that research, is the object of flexible inquiry by the researcher into the emerging issues that arise from within the case itself. By understanding the particularities and complexities of a single case, researchers can understand meaningful connections between context and events, in the specific configurations in which they occur. Although, as discussed above, a case study is necessarily specific and singular, Abma and Stake argue that this approach has value for health researchers in particular who wish to explore strategic, moral, or value laden issues, or where there are unclear or absent cause-effect relationships between the various

phenomena contained within the case. The case is, for Abma and Stake, understood as particular events or people which are the sets of relations or phenomena under examination. In the example discussed in their 2014 paper advocating for the use of case study research in health, the case used is an individual ("Mr Powell"), and the aim of the study was to gain a deeper understanding of identity, values, and relations for older people. Their example used observation in a residential home and in-depth interviews to collect data for the case study, and then deployed narrative analysis (Lieblich, et al., 1998) to analyse and interpret the case. In this example case study, extracts of talk (interviews) and description (from field notes and observations) are presented alongside interpretation and analysis, with the aim of demonstrating how the researchers understand particular phenomena to be occurring, and particular issues arising, from the data gathered for the case study. Abma and Stake acknowledge, in particular, that the conclusions that they reach and the arguments put forward on the basis of this case study are by necessity particular not only to the case itself, but also to the specific interviews that they conducted, the specific days which they observed as researchers, and to the interpretation and understanding that they, as researchers, deploy to understand the contextual meanings and relations present within the case. In this paper, Abma and Stake argue for the value of the naturalisticcase study (as a distinct approach to case study), predominantly as a way of coming to an understanding of a particular configuration of (social) meanings and events in ways that are embedded within the specific context of the case. Abma and Stake highlight, using the example case study of "Mr Powell", that their particular understanding of the case is both limited to and enabled by the multiple perspectives and contextual understanding which their naturalistic approach to the case entails. By using multiple ways to understand the events which they study – through multiple interviews with multiple participants, and direct observation – Abma and Stake deliberately incorporate a diversity of perspectives on the case into their research.

It is important to note, however, that although Abma and Stake's argument for the value of naturalistic case study research in health is clearly relevant to this research project, it is not sufficient to simply claim that this research constitutes a naturalistic case study *per se*, in the sense defined by Abma and Stake. In their discussion of case study, Abma and Stake discuss the application of theory within the case study approach that they advocate; specifically, they state that "applying theory beforehand or inferring theoretical relations inductively is … not a feature of naturalistic case study" (Abma & Stake, 2014, p. 1157).

Stake and Abma's definition for theory, in this sense, appears to be an understanding of theory as the application (or inductive creation) of a limited set of denominators and classifiers by which a reductive understanding is created, by the researcher. This, in their discussion, is contrasted with the nuanced understanding of the particular which is enabled through the naturalistic case study, in which depth of understanding of a particular set of events is preferred to the risk (in their words) of leaving out elements through a reductive set of theoretical denominators. This concern is at least partly addressed by understanding the purpose of the case study as enabling an *interpretative engagement* with the case – the development (by the researcher) of a contextually grounded interpretation of meaning within and specific to the case. The process of case study research, for Stake, is the ongoing interpretation and reflection by the researcher on the "coherence and sequence" (Stake, 2005) within the case. The value of the case study – as illustrated through a particular, naturalistic case study – is the development of an in-depth understanding of the case, and the building of relations between the interpretation of that case and the aims and purpose of the research.

For the purposes of this thesis, there are some critical considerations which must be addressed at the outset in stating that this is a case study.

- Firstly, taking up Stake's approach, the case study requires the identification of the case, and the articulation of how that case is bounded and defined as a demarcated set of events that are examined through the research;
- Secondly, the issue of generalisability and interpretation should be considered, and;
- Thirdly, within the demarcation of the case and considering generalisability, the approach to conducting the case study needs to be articulated.

In this thesis, the case study is, in Stake's terminology, an *instrumental* case study. It is a case selected as an exemplar of a particular object related to the aims of the research. The purpose of an instrumental case study is to use this specific example to develop an understanding of a broader phenomenon. This research project is a single case study of patient and public governors in the University Hospital NHS Foundation Trust. As an instrumental case study, it positions the findings derived from an in-depth understanding

of this particular case as relevant to the broader context of NHS Foundation Trusts (each of which has similar governance and management structures). The case is delimited both organisationally – the single hospital at which data was collected – and temporally – through the data collection period in which observations and recordings were made. By using University Hospital Trust as a single instrumental case study, this research project will focus on the *particular* events and meanings that are specific both to University Hospital Trust and to the combinations of participants, contexts, and events which are captured in the observation and data collection period. Through the interpretive analysis of the data collected in the case study, the aim is to support a set of arguments which are relevant and may be applicable to and inform an understanding of the more general phenomena of patient and public engagement in hospital governance.

As noted by Yin (2003), case study research is, as other qualitative research, vulnerable to challenges of rigor in analysis and bias in the presenting of data. The design of this case study aligns to the objectives outlined above; the identification of both how and why particular phenomena occur. As detailed in this methodology discussion, the phenomena under consideration – i.e. the involvement of public and patient governors in decision-making processes within a hospital – are achieved by and through social processes, enacted by individuals as social actors, through a social interaction (i.e. through participation in meetings). The case study is informed by an 18 month period of combined ethnographic observation and recording of meetings in which participants performed the social processes under consideration (participated in meetings, contributed to discussions, and took part in collective institutional decisions). By examining these phenomena both in terms of how actions are constructed through linguistic and communicative means, and in terms of how such actions can be seen to be understood through the contextual actions of participants themselves, theoretical explanations for how the hospital operates can be supported by analysis of actions in context. The analysis of social process is enabled through both ethnographic analysis and analysis of transcribed recordings of the communicative resources used to perform social processes.

This leads to the question of generalisation, identified as a potential challenge to consider for case study research. It is important here to be clear about what is meant by

generalisation. Case study research cannot enable the estimation of frequencies or support statistical generalisation. The intention of case study research is to enable generalisation to *theoretical propositions*, rather than to specific populations (Yin, 2003). This distinction enables the case study to be understood as a means by which a theory or set of theories can be expanded and explored. From this perspective, case study research enables generalisability through the likely transferability of findings based on the theoretical analysis of factors and context(s) in producing the actions and outcomes observed in the case study (Yin, 2003). The intention of this case study is to use examples drawn from the observed actions of participants in a particular hospital to support the validity of theoretical propositions related to the operation of governance within hospitals in England, and the roles performed by patient and public representatives within such settings.

The third consideration raised above is the approach to conducting the case study itself. There are multiple ways to collect data for a case study; common approaches include interview, ethnography, and recordings, deployed to enable a multifaceted understanding of a complex issue in its real-life context (Crowe, et al., 2011). To approach the case – patient and public governors of University Hospital Trust, it is necessary to consider both what kinds of information and data will be gathered, and how that data will be interpreted and analysed in the research process. This is considered in the following section of the methodology. This section also sets out the ways in which the setting of the case – the actions of public and patient governors (and the question of governance) is understood and deployed for the purposes of this research project.

Approaching the question of governance

For the purposes of establishing a methodological orientation to the operation of hospital governance, two critical observations can be abstracted from the conceptualisations of governance, and of patient involvement, which I have outlined in the prior chapter. Firstly, common and implicit to both models (or sets of concepts) is the notion of *representation* (noting the potential challenges and problematics, as discussed in the background). By this I mean that, under the conditions of understanding the operations

of a board (or other governance process) as solving a particular economic problem *or* as the development of a democratic society, implicit to either understanding is the notion that there exists some smaller group of individuals who have some representative function with respect to a larger group of individuals. Secondly, both models assume that there exists (or arises from the empirical study of) some process by which some actions occur in relation to the object of study. As in, the smaller group (the representatives) are engaged in some way in order to achieve some goal (i.e. to direct the actions of the firm, or to deliberate and reach a democratic decision). Although of course both these observations are abstractions, they highlight that implicit within the notions of governance and participation in such processes which I deploy for this research is the (combined) idea that a relatively small group of individuals will undertake some shared activity. Equally, these observations are hardly novel, nor surprising, as they match exactly a commonsense, intuitive understanding of the operation of such processes; organisational structures (understood, in this instance, as the managerial and governance structures established by regulation or self-imposed corporate practice) are generally pyramidical in nature, with fewer actors in senior or leadership roles. Similarly, the very concept of representation requires a small number to speak on behalf of a much greater number. These observations are, fundamentally, uncontroversial, in the sense that they correspond closely to the everyday reality of the hospital and of contemporary organisations. What is critical here, however, is what they suggest about the *importance* (or at least *potential* importance) and consequentiality of the actions of these smaller groups. Inherent to the models of governance discussed and studied in this research is the privileging of few actors over many – the assignation of capacity to act upon a hospital (and by extension, to act upon the health-care of those who are using the hospital) to a restricted set of individuals. Potentially, this may be overstating the (actual) impact of such actors upon hospitals, or upon any individual patient. The intention is to clearly highlight that the phenomena under consideration in this research (namely, governance and management of hospitals) are in essence the actions of a relatively small number of individuals, and that such actions take place in cooperation and coordination with other individuals.

This suggests an important aspect to the operation of governance, which has, to some degree, been overlooked. Inherently, governance processes, although circumscribed by

the particular organisational (legal, political, historical, and so forth) contexts in which they occur, are fundamentally characterised by the co-participation in such processes of a number of *people*. The common element to any study or conceptualisation of governance is that it is an activity performed or undertaken by a relatively small number of individuals and inherent to this constraint (i.e. the reduction of numbers to this smaller, representative group) is that the number involved must be able to *collaboratively participate*. This leads to a fundamental orientation that underpins the design of this research. Inherently, I take the position that, irrespective of the issues discussed in the background, the operation of governance, management, and representation therein, can be understood as a social process in which actors can be seen to participate through some series of communicative actions. In other words, I take the position that governance is inherently a social action (or, rather, a series of social actions, the definition and orientation to which will be discussed further, below), which in turn can be said to occur within (and as part of the ongoing construction of) a social space. It is a social space because of the fact of the participation of people, who are engaged in a social situatio' (Goffman, 1997a), understood as "an environment of mutual monitoring possibilities" (Goffman, 1997a, p. 231) in which they are able to monitor the (communicative) actions of others and be monitored in return. Although this can be seen to be consistent with an empirical observation of governance practices in hospital, particularly with regard to the participation of public and patient representatives, it is critical in this section to set out clearly that this is *a priori* a theoretical and methodological orientation to the idea of governance as a process by which a small group of individuals jointly perform this shared task.

By understanding that such task(s) must therefore be achieved through communicative means, we can further see that the logic of everyday social process, or what Garfinkel (1967) described as the shared methods of practical reasoning by which action is both produced and recognised, is co-present within the practices of governance alongside specific (institutional) practices which are talked into being (Heritage & Clayman, 2010). The phenomena under consideration within this research project are therefore understood as being produced by and through socially mediated processes – or social interaction – between participants. One of the primary implications of this is to shape the design of this research; by orienting to the importance (although not necessarily primacy) of governance

as being achieved *socially*, it becomes important to directly examine the social situation itself to understand the ongoing constitution and co-construction across participants of such governance processes. For this reason, this research project is informed by direct recordings of the *in situ* social and communicative behaviour of patient and public representatives during governance processes, in order to examine how such processes are constructed by the participants themselves through their participation. These practices, processes and participants are thus primarily understood, for the purposes of analysis, as being achieved by social actors in a socially constructed social space.

The notion of the social space as it will be deployed for the purposes of this thesis requires some additional discussion. At a minimum, we can see that, following Goffman (cited above), the social space is constituted by the situatedness within such a space of communicative action which occurs between the participants in the social space. The social space can be considered therefore not merely to be a literal physical location (although, as will be discussed in relation to actions within the social space, we can usefully conceive of linguistically-mediated face-to-face social interaction as a kind of atomic or most fundamental form of a social space), but to expand outwards to encompass the degree to which participants can be said to be aware of the actions of others (i.e. afforded mutual monitoring) and the ongoing and relative constitution of those actions in relation to the self and to others. In addition, we can position the social space as encompassing the participants, the means by which they participate, and the things which they participate about. Social space, here, is used thus to encompass the observation of the social situatedness of the activity which is examined in this research, and to introduce an orientation to the ongoing constitution of the social for the purposes of this thesis.

I propose that the social space can be further understood using the conceptualisation of the social world and social space proposed by Bourdieu:

> …the social world can be represented in the form of a (multi-dimensional) space constructed on the basis of principles of differentiation or distribution constituted by the set of properties active in the social universe under consideration, that is, able to confer force or power on their possessor in that universe. (Bourdieu, 1992, p. 230)

For Bourdieu, the social space is circumscribed by the differential possession of capital by agents, wherein such agents are engaged in the collaborative determining of each (others's) position relative to others in the social space. According to Bourdieu's model, social reality is defined according to the "ensemble of invisible relations … which constitute a space of positions" (Bourdieu, 1989, p. 16), occupied by agents and activated through the ongoing participation by such agents in the activities of social exchange (understood as being predominantly interactional in nature). The agent, under Bourdieu's model, can be positioned within the social space according to the *capital* he or she possesses, understood as being capital defined according to the various forms proposed by Bourdieu. Principally, these are *economic* (countable and tradeable capital which is reducible to an exchangeable form, such as money), *social* (understood as the sum or aggregate of resources which are the result of possessing a network of institutional relationships by which the agent is recognised by others), *cultural* (understood as the knowledge of distinction, or value, placed upon cultural forms and outputs *and* the possession of such cultural products) and *symbolic* (the capacity to produce and impose upon the world a legitimate description and definition)[9].

The social field for Bourdieu (to adopt the terminology used in *Language and Symbolic Power*) is constituted by and through the distribution of capital in its various forms across agents, and this distribution is thus deterministic of the actual (and potential) power possessed by an agent in a social field. By explicitly positioning this analysis of governance as being an analysis of *social phenomena*, construed and constructed within a *social space*, I explicitly take the position that the actions of agents examined in this research are both the ongoing products and ongoingly productive of the differential distribution of various forms of capital across agents. Starting from the most elemental observation – that governance is a process that engages particular individuals in a mutually agreed system of monitoring – we see that such processes must also be

---

[9] We should note that Bourdieu also proposed additional categories, or types, such as technological, juridical, organizational, and commercial; the form of capital, I would suggest, can thus be seen predominantly as being a product of the field itself in which such capital is seen to be used and relevant to the positioning of subjects. See *Principles of an Economic Anthropology* for further discussion (Bourdieu, 2005).

constituted according to this understanding of social space, by virtue of being created by and through the actions of agents relative to other agents (to adopt Bourdieu's terminology for participants in the social space).

By prioritising an understanding of the phenomena under investigation as occurring within a social space, as defined by Bourdieu, we can see that there are a number of conceptual advantages to this position. First and most important of these is that it enables a methodological orientation to social phenomena which prioritises the actions of individuals in the ongoing construction of such phenomena, whilst allowing for the influence of structure within such phenomena. From a practical and methodological perspective, I orient to the institutionalised and embodied practices that can be observed in ethnographically obtained data (Weinberg, 2005). Secondly, adopting Bourdieu's understanding of the social space enables this study to examine how the specific behaviours of agents in a more or less unique context can be illuminating of the *processes* by which such practices are held to be valid by *similar agents* in other similar contexts. In other words, it is a critical assumption underpinning this thesis that the practices that are uncovered within a particular social space are products of the ways in which that social space is (and can be) structured. Therefore, by examining the locally instantiated practices of the case-study presented in this thesis, we can see how (although the *specific* differential distribution of capital and the consequences of that distribution might vary between similar hospitals) other social spaces which are understood to be similar might also have similar structures, practices, and so forth.

There are then two concepts which must be further explained within the social space; firstly, I wish to elaborate further on the *actions* that take place within the social space, and secondly, to define more precisely the notion of *agents* (also variously termed *participants, subjects, individuals*, and so forth) both to establish clearly a limited terminology for the purposes of analysis but also to establish the conceptualisation of the individuals thus termed. I turn first to actions. Within the context of the social space, outlined above, we can see that agents or actors in such contexts are engaged in certain behaviours, which can, under some circumstance, be seen as being consequential for the ongoing creation of the social space. In other words, we can take as the starting-point for

an understanding of what is relevant as a social act in the behaviour of people in a social space as being those actions which are mutually acknowledged to be social acts. Following Ochs' definition of the social act as "social[ly] recognized goal-directed behaviour" (Ochs, 1996, p. 410), we see that the social action can be seen as being such by the *in situ* use to which it is put (by an agent, in Bourdieu's terminology) and the competent recognition of this usage by others. This recognition is by and large an automatic part of everyday life, by which the logic of how to act is understood implicitly by people performing those actions and by those for whom the actions are intended to be consequential in some way. Such communicative action (Habermas, 2001) is presupposed to be the exercise by a rational agent of the goal of achieving mutual understanding with his or her fellow citizens through the enactment of such communicative acts. The goal of a social action therefore is (at least) dual in purpose; both the goals of the communicative rationality proposed by Habermas (see, for further discussion, Weinberg 2007) *as well as* and *simultaneous to* any other mutually recognisable goal-directed action.. Social actions are co-constituted between participants in interactions – their meaning and force (the extent to which they are recognised as goal-oriented and achieve such goals) is dependent upon the contextualised interpretive activity of social actors in understanding the actions of others, and construing their actions in ways that will be understood (Luckmann, 2008).

The primordial site of such action is talk (Schegloff, 2000), and it is the logic of the turn-by-turn exchange of social interaction which provides perhaps the most straightforward exemplar of how such social actions are performed across agents (i.e. through talk-in-interaction) (Heritage & Clayman, 2010; Goodwin & Heritage, 1990; Peräkylä, 1997; Schegloff, 1999; Drew & Heritage, 1992; Schegloff, 2007). In addition, and importantly in relation to knowledge in the constitution of social acts, we can adopt Heritage's (2012) argument that social actors attend to *knowledge* as a property of the social action, in the sense that they are aware of the distribution of knowledge between participants as part of the understanding of talk as a social action. This is not to give talk primacy in this analysis, but rather to highlight (following the logic of ethnomethodology, Garfinkel, 1967) the multiplicity of achievements which occur within the social encounter. Agents can be said to be simultaneously achieving the goal-directed social actions which are the predominant focus of this analysis (with respect to the ongoing co-construction of the social practices

of governance) and also orienting to the creation of a shared and mutually comprehensible set of contexts and understandings upon which the achievement of social action is dependent. The communicative resources (i.e. talk, embodiment, multimodal communicative practices, and so forth) through which such social actions are achieved are important, and are the ways in which the analyst can orient to the unfolding of social action, but it is the constitution of a communicative and social action, and the consequentiality for such actions for the social space, which are the predominant focus of this thesis. Thus, whilst we locate the analysis within and deploy as the empirical trace of such social action the real-world communicative action and social behaviour of agents, we must be mindful of how such action is in turn constitutive of the shared social space and social life-world (to adopt the terminology of Habermas). It is this aspect of a social action which is most critical for this analysis, and to which I will orient in the examination of empirical data that describes the action, responses and so forth of agents within the hospital.

To turn then to the second concept remaining, it is necessary to set out the nature of (in simple terms) people, for the purposes of this analysis. As might be easily inferred from the discussion to date, this research project is informed by a relatively broad theoretical perspective, and for this reason there have necessarily been multiple conceptualisations (and related terminology) for people mentioned throughout the discussion. This is clearly problematic, as it does not clearly establish a perspective on what might be thought of as a fundamental unit of analysis (the individual person) and leaves significant room for interpretive challenges. To begin with, I take the position that each individual person is understood as a subject who exists socially and culturally, and functions as an actor both socially and culturally through the simultaneous presupposition and reproduction of social practices (Duranti, 1997). This begins to establish the language of analysis; for the purposes of this thesis, I refer to each individual person as a subject, and thereby invoke a specific understanding of the subject in doing so. The subject is a social being formed by and through practice (*habitus*) (Bourdieu, 1990); fundamentally, this is to claim that the subject exists in terms of the social life in which he or she engages and the ways in which he or she has been socialised to engage with it. *Habitus* is the practical knowledge – produced through the mutual exchange of practice with other subjects – of the world and the ways that the subject can act within it (Bourdieu, 1990). Individual subjects,

although formed by practice (*habitus*) still retain the freedom to act in individual ways and are not completely predictable producers of socialised practice. The subject, from this perspective, is construed as existing within cultural practices that exist both as internal representations (*presuppositions*) and external practices (*reproduction*).

Importantly, this means that subjects are not *transcendental* (Foucault, 1989; Habermas, 2001), but are understood as coming into being only through the socially situatedness of human experience. Subjectification, therefore, or the process by which the subject comes into being, is positioned as being an inevitable consequence of being human within a social context. The subject exists as the product of (is subject to) the constraints and social ordering of the society and culture in which he or she can be said to be a subject. This alone, however, is not sufficient to an understanding of the subject, as it falsely presents a view of the non-transcendental subject as wholly the product of a process of gradual socialisation. It is critical to be mindful of Foucault's argument that the subject is *subjectified by* self-knowledge of identity (Foucault, 1982) and that this subjectification is a site of struggle against the operation of differential power-relations within society. Importantly, for the current project, this conceptualisation locates knowledge as a critical part of the formation of the subject. As discussed in the background, we see knowledge and knowing as being contingent and challengeable – an epistemic space which is conditional upon the shared consensual agreement of subjects that such knowledge continues to be valid and relevant. With this in mind, the self-knowledge implicit in the definition of the subject similarly becomes liable to interruption and challenge, with the potential for subjects to struggle against the definitional imposition of subjectifying discourses. That said, this is, to a large degree, an empirical question; the intention here is to highlight that the knowledge through which a subject is made aware of their subjectivity is potentially fungible, rather than to demonstrate (at this stage) that such substitution or replacement occurs.

A subject can be said to have the capacity to act – to perform social actions – within the social space, taking the role of Bourdieu's agent in his model of the social universe. A subject interacts with and in relation to other subjects, and, as outlined above, we can see an emergent localised and locally oriented to understanding of a relevant social space

against which a subject positions the self relative to the differential possession of forms of capital. This is necessarily an abstraction, or a reification, of social behaviour which is implicitly understood and performed by subjects without necessarily an explicit point at which they negotiate that such actions are occurring, or that some capital is being deployed. That said, there is one property of a subject which I contend each individual subject attends to within the particular context of this thesis, namely the *social category* to which that subject can be said to belong. This notion of social category is deployed to cover the locally determined and contextualised roles which subjects occupy as part of their participation in the governance activities that are the focus of this research. To reconcile this notion of an explicitly (to some extent) negotiated and signaled categorical identity, I argue that such social identities are most appropriately understood following the work of Harvey Sacks (1995) and his proposed *membership categorisation*.

Membership categorisation refers to the everyday sociological work done by participants in interaction (by subjects) to apply mutually understood categories (i.e. a social role or category-based identity) to a person who can be understood to be a member of that category through satisfying a set of rules for applying a category to an individual. Rules of application for membership categories are not limited to the discursive construction of others through talk in social interaction; membership categorisation holds that members may be categorised on the basis of category-bound activities, the performance of which is sufficient to constitute the categorisation of the member performing them by others having knowledge of such performance (Sacks, 1995; Schegloff, 2007). Examples of membership categories include professions (such as doctor, lawyer or teacher), or paired and otherwise related categories (such as parent / child, or doctor / patient). Categorisation can involve explicit claims to category membership, as in the following example drawn from Housley & Fitzgerald (2002):

01:	P:	There's a doctor on the line… I don't know if it's a
02:		medical doctor..Doctor Elizabeth Duncan from Peebles..are
03:		you a medical doctor
04:	E:	yes

In this brief extract, the profession of a caller to a talk-back radio programme is introduced by the host (P), and the caller is asked to confirm her membership of a particular professional category. Membership categorisation analysis attends to the use of these

categories in social interaction through sequences of talk (such as this extract) which introduce a relationship between a participant (E) and the membership category. By comparing sequences of category-related talk in terms of how categories are used in relation to the topic or focus of the interaction, Housley & Fitzgerald demonstrate that categories and sequences of talk are mutually constitutive – in their words, realised in a reflexive space. This establishes a relationship between a speakers' identity (in terms of membership category), the sequential organisation of talk, and the topic of the interaction.

This straightforward sequence of talk shows how a membership category is proposed by one speaker and accepted by the next, and demonstrates the use of titles, explicit labels, and professional categories to achieve membership categorisation in everyday conversation. Not all categorisation work is achieved in such an intuitively straightforward manner. Psathas (1999) takes the position that categories are produced and oriented to by participants in interaction through *action* – through acting or being described as acting in ways which are predicatively bound to a particular category. Membership categorisation functions as a means by which participants in an institutional interaction collaboratively work out with each other the matching actions which they can perform to fulfil particular interactional and institutional goals. Psathas' approach is grounded in a study of a ski school and a package delivery service – membership categories allow participants to mobilise into interaction understanding of mutually-held obligations, rights, and actions which enable them to achieve the workof the organisation (a skiing lesson, package delivery, etc). Membership categorisation implies the active deployment by subjects of the social structures by which they organise their shared understanding of themselves and other subjects in terms of social category-based identity. The membership categories into which members are categorised are understood as being locally produced and relevant to the social context in which they are produced, but also, importantly, as enabling the mobilisation of shared macro-social and cultural knowledge into social interactions (Schegloff, 2007). That is to say, that the membership categories are inference-rich (Sacks, 1995); what is knownabout a category (i.e. the speakers' understanding of the category relevant to the particular interaction in which it is deployed) is presumed to be so about the persons thus categorised (Schegloff, 2007). In addition, membership categorisation, and the prioritisation of categorical identity, can be seen to

be deployed by subjects in social situations in order to transform *other* subjects into *category*-first objects, in order to achieve particular social goals (Edwards, 2009).

In summary, the methodological orientation of this thesis is to the ways in which subjects can be seen to engage in social actions, which in turn are constituted relative to a social space. This is of particular importance to note in relation to this thesis' focus on governance and decision-making in an NHS Foundation Trust. As set out in the last chapter, it is possible to conceptualise and understand the behaviour of individual actors in an organisational context through an explicitly management and/or economic lens. There is a difference between these perspectives and a focus on subjects in social space (although noting that there is some overlap in the use of ethnographic research methods in the study of management). In this research, therefore, there is a need to acknowledge this juxtaposition of a theory of management with a theory of socially situated action. This juxtaposition, although perhaps not wholly comfortable, is necessary in order to both acknowledge the existence of and knowledge represented by a body of research on management and governance, and also to insist upon the grounding of this research in an examination of socially situated practice.

Through an analysis of social action, I will seek to provide an answer to the research questions for this thesis which is grounded in an interrogation of empirical data, the details of which are discussed in the following section. The conclusions of this analysis are necessarily limited, in the sense that they are generated from a case-study which will show a set of possible configurations of actions and social spaces in relation to the governance and management of hospitals. That said, the intention is to identify how that set of possible configurations – the specific actions which are captured in the data for this thesis – show the potential scope and affordances for action which are created by and through the shared subjective knowledge of similar structures, held by subjects in similar contexts (i.e. both within the United Kingdom's health system, and in hospitals more broadly).

Fieldwork and data collection

The fieldwork for this research project was conducted in England, through a series of linked activities. The purpose of this section is to give a brief overview of the case-study hospital (bearing in mind that the hospital and its specific context are the subject of the following chapter), and a detailed discussion of the data collection protocol followed for this thesis, and the sources that form the corpus of empirical data. I will conclude this section by setting out the analytical approach which I have taken, within the context of the orientation to social action discussed in the prior section. At the outset, a note should be made about the ethical considerations for this research. The project involved the observation and, subsequently, the recording of subjects as they variously took up volunteer positions within the hospital, or discharged their professional responsibilities. Each participant in this research project gave their individual informed consent to participate in the research, and to have their speech and image recorded. In each case, participants gave limited consent for their speech and images to be reproduced, with a requirement imposed by the organisation and the supervising ethics committee to take due care to reduce the likelihood of any individual participant being specifically identified in publications arising from this research. For this reason, throughout this thesis, all individuals are referred to according to their organisationally-determined role, rather than by name, and the name of the participating hospital has been reduced to "University Hospital".

The participating hospital for this case study, University Hospital, is an institution constituted as a Foundation Trust, which incorporates adult, paediatric, maternity and neonatal medicine. Although a singular entity, particularly from the perspective of the governance and management focus of this research, University Hospital Trust organisationally is divided into two distinct hospital entities, each co-located on a large campus-style site which also hosts affiliated research institutes. During the period of fieldwork for this research, the campus was the subject of significant change and the focus of development, with a number of commercial enterprises, a separate Foundation Trust and a co-financed public / private venture with University Hospital announcing development or planned developments on the site. University Hospital Trust delivers health-care to patients from across the local area, and is one of the largest academic hospitals in Britain. It delivers a full range of medical services, including multi-organ

transplant, emergency and trauma care, complex paediatric medicine, oncology, neurosurgery and maternity / obstetric services (the last being the focus of the second of the two hospitals under the University Hospital Trust). Within the legal framework which determines the structure of the Trusts's governance, the University Hospital Foundation Trust is governed by a Council of Governors, composed of 8 patient governors, 7 public governors, 4 staff governors, a Chair and Deputy Chair, as well as invited 'partner governors' from the partner University with which the Trust conducts research and clinical education activities, and neighboring National Health Service (NHS) organisations.

As a case study of the hospital, this research project is based on an 18-month process of observation and video-recordings conducted from 2012 to 2014, which capture subjects as they go about the activities and business of the Trust through formal, including public, meetings. Aside from the formal requirements of ethical approval for human research[10], the process of gaining access to the research site was, in itself, complex. The fundamental challenges lay in convincing the eventual participants in the research – both as individuals and then as part of organisational decision-making bodies – of the inherent validity of the research. This raises, in itself, an interesting question about the very subjects with which this research is concerned, in that one of the critical stages through which this research project had to pass was evaluation by the *medical* professionals who had taken up managerial roles within University Hospital Trust. Through a series of meetings and discussions with individual managers and directors of the Trust, a number of questions were asked about the conduct and purpose of this project, which these decision-makers made clear they needed to hear sufficient justification for both the *aims* of the research and the *methodology* in order to consent to participating in the research itself. This provides an interesting example of the ways in which the health system and hospitals are concerned with the maintenance of knowledge both of medicine and of those subjects which it deems to be related to the work and activities of the hospital and health system. As the investigator for this project, I was asked to demonstrate that the qualitative

---

[10] Approval for this research was granted by the Health Research Authority National Research Ethics Committee

investigation of a candidate hospital was inherently able to be used for the generation of some knowledge which would be held to be valid by some competent authority. It is for this reason, perhaps, that the orientation of this thesis to the phenomena under consideration, as outlined in the previous section, can be so explicitly positioned as *a priori* to the conduct of the fieldwork itself, simply because it was a pre-condition of being able to execute this research that such an orientation be explicitly determined and defended as an accepted way in which to generate new and valid knowledge about the operation of hospitals. The logic of a positivist scientific endeavor, whereby a pre-specified hypothesis is tested through the application of a more-or-less accepted method, was expected by (at least some of) the participants themselves to be applied, wherever possible, to the framing and conduct of this research. As a qualitative investigation, in which the ethnographer is implicitly engaged in an ongoing process of becoming sufficiently embedded within a field-site to understand the logic and practices by which that field operates, this was perhaps an uncomfortable fit, in that the preselection of precise variables and episodes of significance is difficult (or indeed, impossible).

What became clear, as the fieldwork was approved and permission to proceed was granted, was that in the absence of a mutually understood *method* by which new knowledge was to be created (and the research held to be valid and thus worthy of being conducted in University Hospital), the critical dimension upon which the fieldwork was evaluated was the *competence* of the investigator. In order to satisfy this scrutiny, it became necessary to establish and signal a social identity characterised by specific professional competence in the understanding of a complex institution beyond the application of an intellectual investigation into the hospital. This is not to say that this is the only means by which such scrutiny could be satisfied. My intention is to explicitly note that decision-makers within hospitals and the UK health system are concerned with *knowledge* and how it is created, who is able to create it, and that this research project was faced with precisely this challenge in seeking to gain access to the field it sought to examine.

Fieldwork for this research involved three distinct methods – namely ethnographic observation, video recording, and document collection – each producing particular types

of data. The intention behind collecting multiple types of data – observation, recorded interaction, and documents – is to enable the development of a more nuanced understanding of the case; to approach the practices of governance in University Hospital Trust from a number of perspectives. Although this goes some way to aligning with Stake's (1995, 2005) approach to a naturalistic case study (in the sense of enabling a detailed understanding of a phenomenon) some caution should be exercised in understanding this to be a complete or total picture of University Hospital Trust. The case study is, as set out in the beginning of this chapter, limited to the actions of public and patient governors within the hospital governance structures. As such, then, the purpose of each set of data is to illuminate that case whilst acknowledging that there is a broader organisational and natural context in which such phenomena occur. Each set of data is deployed for specific purposes, as summarised in the following table.

Data	Purpose
Ethnographic observation	Data collected through ethnographic observation is used to analyse the context in which meetings and governance activities occur, particularly the informal context of conversations between participants in the research prior to and immediately following each committee meeting.
Recorded meetings	Recorded interactions are used to analyse how the participants construct their roles within each governance meeting through their participation in social action. The use of recorded meetings enables the presentation of transcripts which show how participants are using language and interaction in such meetings.
Document collection	The documents collected for the fieldwork inform an understanding of the broader organisational and health system context in which observed and recorded social interactions occur.

Figure 3-1 Summary of data types

As stated above, the overarching purpose of collecting three distinct types of data is to enable multiple ways of understanding the actions of governors in the University Hospital Trust; to understand the ways in which individuals perform and construct their roles through talk during formal meetings, to enable an understanding of how those meetings are framed and embedded within ongoing social interactions through observation of the ongoing milieu of the hospital, and to locate the case study of University Hospital Trust within the broader social and policy context of the NHS.

Ethnographic observation

Observational fieldwork captured informal interactions and conversations with and between members of the University Hospital Trust governance and management committees, predominantly during pre-and-post meeting periods, as well as the public meetings of the Board of Directors. Observational fieldwork captured informal conversations held between research participants prior to and immediately after meetings (including those captured in video recordings). In addition, as highlighted above, the participants in the research were explicitly aware of the research process, and therefore the ethnographic period also involved informal interview and conversation with the participants, which included discussing the roles of elected representatives, the purpose of each meeting, and the matters under discussion within the Trust. In total, observation was conducted over an 18 month period (commenced in December, 2012, and concluded in July, 2014). The observation period included both full and partial meetings of the Council of Governors (including two Annual General Meetings, at which a public audience is present and invited), and meetings of the Board of Directors (six). These meetings are in addition to those recorded for the video-recorded data. Ethnographic observation included the period of time prior to meetings commencing (approximately 60 minutes) and after meetings (approximately 30 minutes), for each meeting. Additional ethnography was undertaken in parallel to both the recorded clinical management meeting (noted in Figure 3-2, below) and another single clinical management meeting (of the same committee). In total, observation covered the period before, during, and after a total of 31 meetings at which public and patient governors were present (including the 14 meetings recorded for the purposes of this research project).

Field notes were taken in two ways, determined by researcher participation in the processes being observed. In both cases, notes were hand-written, and totaled approximately 50 pages. For meeting observation in which I was not an active participant in the conversation, field notes were written during each meeting, recording the sequence of speakers in the meeting, the topic spoken about by each speaker, and a partial transcript of each meeting. In cases where meeting participants spoke from prepared material, this was recorded as a speaker talking about a particular topic, with more detailed notes taken of questions and subsequent discussion. Participants were identified by their role. Field notes of this kind were taken for all meetings included in the fieldwork, including the

recorded and non-recorded set. For informal conversations and interviews with participants, field notes were taken immediately after each conversation. Necessarily, this means that these notes consist of recollections, albeit close to the events themselves. In these cases, care was taken to record the aspects of the conversations upon which the participant placed emphasis or spent time elaborating, rather than to pre-determine which aspects would be relevant for the purpose of the research. These notes endeavoured to capture, as far as possible, the actual expression and spoken words used by the participants.

For the purposes of analysis, field notes were initially reviewed using an open-coding approach. This involved reviewing the notes in detail to identify the themes and issues discussed by participants throughout the field-work process. This approach was then refined following closer analysis of the recorded data-set to identify moments captured in the fieldwork which supported the recorded data. This enabled the selection of particular aspects of the ethnographic fieldwork for inclusion in the analysis chapters of this thesis.

Recorded meetings

The primary sites for the collection of video-recorded data are formal committee meetings held in University Hospital Trust. Direct video recordings were made of specific meetings in which elected patient and public Governors were members, in order to capture the participation of public and patient representatives in governance and management processes. There are three types of meetings represented in this case study, corresponding to the formal participation in governance of patient and public representatives, who are the focus of this study. The first type of meeting was the formal, public meetings of the "Council of Governors" (the body of which public and patient representatives, or Governors, are members). Council of Governors meetings are held quarterly (every three months), and are open to the public, as well as to other members of University Hospital Trust. The second type was private (i.e. only open to invited participants) committee meetings, termed "Working Groups", in which the Governors participate, and which formally report to the Council of Governors. Collectively, these Working Groups and the Council of Governors form the formal governance bodies of which the patient and public elected governors form part of the membership. In addition to these hospital governance

committees, one further type was examined in detail; a clinical management committee, concerned with the authorisation of pharmaceutical and other product purchases (in specialised circumstances). In total, this research captured approximately 37 hours of video-recordings. Recorded meetings are set out in the table, below.

Meeting type	Number recorded	Meeting duration (average)	Total hours (approximate)
Public (governance)	4	2 hours	8
Private (governance)	9	3 hours	27
Private (clinical management)	1	2 hours	2
			37

Figure 3-2 - Meetings of University Hospital Trust

These meetings represent a complete annual cycle of governance activities. In addition to the three public governance meetings captured in the recording for this project, an additional Annual General Meeting could not be recorded due to a large public attendance and the constraints imposed upon recording by the Hospital Trust. This meeting was included in the observational procedure for the project. Recordings commenced in November 2013 and concluded in July 2014.

Meetings were recorded using three (two in the case of the single clinical meeting, due to the physical constraints of the space in which the meeting was held) high-definition video cameras, positioned to capture each member of the committee in the total recording. Each meeting was held in a formal, dedicated meeting space. Each member of the committee is allocated a named space around a single large table or (depending on group size and room layout) around a series of tables arranged in a horseshoe configuration, behind a nameplate bearing both their name and their position on the Council of Governors or the Working Group. In addition, *ad hoc* participants and observers of the meetings were seated in an audience set of seating rows located to the side of the main meeting table. These *ad hoc* participants were captured via audio or, when called by a member of the committee to be seated at the main meeting table, included in the video recording. Transcribed data, where presented in the analysis, is shown in standard English, with italicised commentary to indicate interruptions, and co-occurring gesture and action by participants. Square brackets are used to indicate insertions, deletions and / or anonymised

portions; participants are referred to by titles in both the transcription and analysis. English punctuation has been used for the transcribed speech, with a period indicating a downward intonation (i.e. sentence final intonation) and commas indicating a brief pause[11].

Document collection

In addition to observation and recordings, copies of formal documentation for each meeting included in the recording and of each public Board meeting included in the observational procedure for this research were obtained, as well as critical policy documents (both local and national) and legislative instruments which describe the operation of the NHS and the Foundation Trust (both the general case and the specific University Hospital Trust). In total, 14 complete sets of meeting papers for recorded meetings, each comprising an Agenda, Minutes (of the previous meeting) and supporting discussion papers were collected. A further 10 sets of public Board meeting papers were obtained, each including the Agenda and Minutes of the previous Board meeting. Discussion papers for the Board meetings are not publicly disclosed and do not form part of the document collection.

Policy, legislative and corporate documents were:
- The relevant and in-force legislative instrument for the health and social care sector *(Health and Social Care Act 2012)*
- The Constitution of the University Foundation Trust
- On-line documents describing the operation of the NHS

These documents are analysed in chapter 4, placing the NHS and this analysis in context.

---

[11] See Appendix for transcription conventions.

Limitations

This section discusses the limitations of the methodology, and the potential impact that these limitations have for the conclusions and analysis presented in the subsequent chapters.

As set out in this methodology chapter, this research is a case study that uses fieldwork carried out in a single hospital to generate a corpus of data for analysis. Notwithstanding that there are multiple examples of case studies (including in-depth analysis of single sites that could, broadly, be considered analogous to case studies in the sense defined in this research, but are not necessarily set out as case studies by the authors), a case study necessarily presents a particular view of a single institution at the point in time that fieldwork was conducted. It is important to acknowledge that the analysis presented in this research demonstrates that the conclusions and arguments are consistent with the observed behaviour within this specific fieldwork setting, and that there is a possibility that, in other hospitals, or in the same hospital at other times, the behaviour observed might lead to different conclusions, or suggest different interpretations. This is an inherent, and in some ways unavoidable, limitation of the case study design, in that generalisability is limited to the extent that both alternative explanations for the observed behaviour cannot be entirely eliminated, and that the extent to which such behaviour might be observed in other similar situations is unknown. This limitation does not equate to invalidity of this approach in understanding the operation of governance in a hospital – put simply, this limitation means that the conclusions of this research must be understood as having potential generalisability and application to other, similar settings. This will be considered further in the conclusions for this thesis, specifically to identify the ways in which further research could be used to usefully support generalisability beyond the limitation of the case study.

In addition to this general limitation of the case study approach, it is critical to emphasise the relatively limited duration of fieldwork and thus the sample of data which are used to interrogate the specific hospital in this research. This is similar, broadly, to the limitation identified by Abma and Stake (2014) in discussing the naturalistic case study – the potential for different conclusions and interpretations to be drawn on the basis of different

interviews, or in the case of this research, if a different set of meetings (such as in a different year, for example) were sampled. Thus, within the definition of the case (as discussed in the opening of this chapter), it must be further understood that the particular window into that case is itself a further limitation – a specific and particular set of moments within a specific and particular example of the broader categories of NHS Foundation Trusts.

This limitation is addressed through contextualising the analysis of recorded and transcribed interaction in meetings within ethnographic observation of the immediate context in which those meetings occurred, and the broader policy context, interrogated through an analysis of policy documents collected as part of the document collection. This enables conclusions reached on the basis of behaviour within particular meetings to be triangulated against *other* actions observed during ethnographic fieldwork. In addition, as this ethnography involved direct conversational contact and informal discussion with the participants in those meetings, this ethnography includes understanding from participants themselves as to whether such meetings were typical or non-typical – as in, to what extent the participants regarded the recorded sample as a fair representation of meetings within University Hospital Trust. In addition, by situating the hospital within the health system context in which it operates, it is possible to understand to what extent this case study may be in turn representative or indicative of similar hospital settings within the NHS, and more broadly to analogous governance contexts within the global health-care context and beyond.

Analysis

The corpus for this research therefore consists of three distinct types of data: ethnographic observation, direct recordings and a set of documents. Taken together, they represent a sample of participation in the governance of a hospital by elected patient and public representatives. As fragmentary representations of a past occurrence, we must acknowledge what they do and do not show. They are traces of (social) actions having occurred; they show that a word was spoken, a document produced, an action recorded and later referred to in some way. The explicit orientation of this thesis – and perhaps

also one of the positions which it seeks to establish – is that we can understand governance as a form of socially constituted and socially achieved action, and that furthermore this social action is most usefully understood as the goal-directed activity of one subject intended to cause some effect in relation to another subject. It is therefore the task of the analysis of this thesis to examine how the empirical trace of such actions can be interrogated to reveal the in-the-moment unfolding of social actions and goal-directed behaviours. The fieldwork conducted and the data generated for this research project can be deployed to establish that certain behaviour occurred; through the subsequent analysis chapters I will establish how we can see such behaviour as being goal-directed in ways that are relevant to understanding patient and public participation in hospital management and governance. For this reason, therefore, the data sources deployed in each Chapter will vary, with some (such as chapters 5, 6 and 8) relying more heavily on the recorded corpus, whereas others (such as chapters 4 and 7) draw more from the documentary evidence gathered alongside the video-recordings.

Analysis of video-recorded data is informed by studies of talk in social interaction, particularly studies of how social interaction occurs in institutional settings (Drew & Heritage, 1992; Heritage & Clayman, 2010). This means examining the ways in which participants use language and other communicative resources, such as embodied actions, gestures, and use of material artefacts (Goodwin, 2000) to achieve social goals (Heritage, 2013). This approach aligns with aspects of Conversation Analysis (CA) in terms of examining how "the business of the social world" (Goodwin & Heritage, 1990, p. 283) is transacted through ordinary conversation (Schegloff, 1999). The relationship between how interaction occurs (through talk) and the institutional setting in which that talk is located has been of long-standing interest to researchers (as noted in the collection edited by Drew & Heritage, 1992). This has led to an extensive body of work which considers interaction in medical settings through applied Conversation Analysis (Heritage & Robinson, 2011). Examples include prescribing decisions (Stivers, 2007), eliciting medical problems (Heritage & Robinson, 2011; Robinson & Heritage, 2015), psychotherapy and counselling (Peräkylä, 1995), surgery (Hudak, et al., 2011), medical

education (Glenn, et al., 1999), and many others[12]. Other studies use similar but not identical methods for the analysis of talk and language use in medical settings; see, for example, Sarangi (and collaborators) use of discourse analysis (Roberts & Sarangi, 2005; Sarangi & Candlin, 2003; Zayts & Sarangi, 2013) which place greater weight on ethnographic data incorporated into the analysis.

As such, it is useful to consider this project and its approach as a form of *institutional ethnography*, to the extent that it is an account and case study that is constructed from *actualities* and how such actualities are embedded within a set of social contexts (Smith, 2005). This is a limited adoption of Smith's argument in relation to institutional ethnography[13]; the intention here is to emphasise that the analysis of actions and contexts in the hospital is grounded in the examination and understanding of the actual endogenous features of such behaviour and the context(s) in which it occurs. In analysing how practices are constituted in the everyday reality of hospital governance, whether through the analysis of recorded talk or through the interrogation of observation, the intention is to focus on the activities and experiences of those who are involved with the institution. The analysis of activity and experience is delimited through the extent to which any individual's actions are coordinated with another's (within the same institutional context). In other words, institutional ethnography examines an institution through the lived and coordinated activities and experiences of those within such an institution. Within this, the endogenous understanding of the actions of the self and others – achieved through language and social interaction – can show the moment-by-moment actuality (adopting Smith's 2005 terminology) of the institution. Analysis of documentary evidence enables an understanding of the context of such activities and experiences. Participant-observation is used to knit together context and moment-by-moment interaction, and to identify how observable actions were viewed by participants themselves, where captured through informal interview or discussed in non-recorded, informal conversations.

---

[12] This is a necessarily brief list of example studies only.

[13] It should be acknowledged that Smith's deployment of 'institutional ethnography' entails a deliberately radical critique of other sociological perspectives; discussion of these issues is beyond the scope of this research, but it is important to acknowledge that Smith means an ethnography which is not simply 'of an institution' but which is explicitly feminist and Marxist in orientation.

Selection of data for analysis

As described above, this research is based on a substantial corpus, which is then deployed in the following analysis chapters to support analysis which responds to the research questions set out in the introduction. The intention of this analysis is to engage in an explicitly interpretive analysis; to understand the ways in which the social actions of participants are constructing the roles and actions of elected patient and public governors in hospitals in the NHS. Thus, the intention of the analysis is to demonstrate how social actions – understood as actions achieved through language and social interaction – are deployed by and responded to by participants in meetings, and thus how the roles of the patients and public governors are created by and through such actions. The intention of this interpretive and qualitative approach is to demonstrate, through the use of selected episodes of talk and interaction and selected episodes from ethnographic observation, the ways in which such construction occurred, aligning to the approach to analysis set out in the previous section.

There is a question then about the selection of episodes of talk for inclusion in the following chapters; how are these episodes of talk chosen? I answer this question by way of what Copland & Creese (2015) have called a telling case – examples from the corpus of data which support a particular position or argument in the shortest and most easily understood space. In other words, the work of this analysis is to undertake the interpretive and analytical work as a researcher considering the totality of the case study, grounded in the ethnography, recorded data, and documents, and then to present selected episodes from that totality which efficiently and effectively support the arguments made. By using worked analysis and examples, the intention is to present a rich account of the case study, such that the reader is able to understand and interrogate the interpretive process of analysis and the findings supported by such analysis. The approach to analysis is guided by the research questions posed in the thesis, with the examples deployed so as to illustrate and illuminate how those specific questions are answered. This can present a challenge of selecting only those examples which are relevant to the questions at hand, and disregarding examples which may lead to or support other conclusions. The process outlined above defends against this risk. The analysis for this project involved the review

of the total corpus, with episodes and examples selected from across the corpus in full, rather than selecting episodes independently from a review of the total corpus.

Each research question is therefore addressed through a specific chapter in this analysis, with examples drawn from the corpus that usefully illustrate the particular issues raised within each question. This is set out in the table below:

Research question	Data and examples used in analysis	Chapter
Are different roles and social categories – including the roles established within a governance and management structure – relevant to decision-making processes?	Data are episodes of talk from a committee with an explicitly clinical remit – to make decisions about medicines funded in the hospital. This directly demonstrates how elected participants (and others) contribute to decision-making within a clinical setting.	5
How is expertise and knowledge used by participants in decision-making and governance?	Data are episodes of talk from confidential working groups (sub-committees), focusing on the topic of unsafe care and "never" events. These events are clinical instances in which the topic includes explicit deployment of expertise and knowledge to explain and construct a shared understanding of the topic (i.e. the safety event) itself.	6
How do governance and decision-making practices reveal the goals of participants?	Data are documentation and ethnographic observation of decisions made during committee meetings, including Board of Directors, sub-committees and Council of Governors[14]. These data are used to examine decisions and participants' discussion of such decisions, as evidence of goals and objectives in governance processes.	7

[14] See following chapter for detailed discussion of governance and management structures.

| How does the participation of non-expert representatives in governance and decision-making processes achieve the goals of 'patient representation'? | Data are episodes of talk in committee meetings in which the topic was the purpose and nature of representation. These episodes are used to demonstrate the relevance of this topic to participants themselves and the ways in which such goals are understood by those participants. | 8 |

Figure 3-3 Research questions and data

In each Chapter, some attention is given to the context in which these episodes of talk arise. This includes the policy context (i.e. the purpose of a hospital-specific committee which makes decisions about medicines, and what kinds of decisions they make, or the definition of unsafe care and "never" events); in each case, discussion of such context and relevant background is presented within the chapter in which episodes of talk or specific ethnographic examples are used as data.

In the following chapter, I undertake an analysis of the hospital in context. This serves to ground the thesis in a specific health system and organisational context. Importantly, this section also analyses some of the specific historical factors which are important to understand the operation of University Hospital Trust and the ways in which University Hospital Trust has constructed its governance operations through its constitution and other key organisational and policy documents. This chapter relies predominantly on contextual documentary analysis.

4. Situating the hospital in context

There are multiple dimensions to the context of a hospital. One of the most fundamental is the temporal context of the hospital; in the case of the University Hospital Trust, the predecessor hospital which forms the core of the Trust's tertiary care delivery pre-dates, by a number of centuries, the development of a systematic national health system, and owes its historical foundation to a charitable donation from a (more or less) private individual. Considered along this temporal axis, the hospital itself can be seen to be a durative point in the changing ways in which medical practice is understood, the ways in which health care is funded and delivered, and certainly the ways in which the economics of health and social care are organised and understood. Considered across national and market boundaries, organisational entities that are called hospitals, and that bear no small resemblance to one another, are common to any organised health system. From the emergency deployments of *Médecins Sans Frontièrs* to the research-driven institutions connected to large universities in the United States and the United Kingdom, the notion of a hospital can be found as a common touchpoint in the ways in which medical care is organised. To account for the temporal and international variation in the hospital is beyond the scope of this research; however, it is undeniable that activities of the hospital occur within these axes of time and place, and they are grounded within a specific context both in terms of contemporaneous events and in terms of the specific organisation of health care within which the hospital is embedded. The purpose of this chapter therefore is to outline relevant features of how health care is organised and delivered in England and discuss some specific events which are relevant to the time in which the fieldwork was conducted. In addition, this chapter will also discuss how University Hospital Trust intends for its governance to operate, based on the analysis of key documentary sources, and will outline the overarching structure of governance as implemented in the Trust during the fieldwork period.

The National Health Service in 2013

The National Health Service (NHS) was launched in 1948 by the Minister for Health, Aneurin Bevan. From its inception, it was founded with three core principles:

1. that it meet the needs of everyone
2. that it be free at the point of delivery

3. that it be based on clinical need, not ability to pay

In its own words, these principles have guided the development and operation of the NHS from this point until the present day (NHS, 2016). It is worth pausing at this point to make a comment on the relative importance of this history, before moving to a discussion of relevant contemporary events and detailed aspects of the NHS. The *discourse* of the founding of the NHS is that it was the first time (and certainly we can say that this was the case in British public policy) that the work of disparate medical and health professionals was brought under one umbrella organisation, financed through taxation receipts, with services delivered without charge at the point of care. The intention here is to emphasise that the narrative of the NHS is a discourse, in that it is a circulating idea in society, perpetuated by the publications of the system itself (see, for an example, the NHS public web presence, cited above). One of the critical features of this discursive formation of the NHS is that these principles are in some way unique and distinctive, and that they are necessarily consequential to the ways in which health care should be organised in England (by extension, this does include the semi-autonomous countries of the United Kingdom, but it should be noted that there are separate overarching or umbrella NHS national organisations for each territory). Although an in-depth analysis of the discursive formation of the NHS is beyond the scope of this thesis, I wish to be clear that the NHS is unique, but only insofar as any national system is more or less unique. It is not the case that the NHS is the only health system which delivers services that are free at the point of care; nor is it the case that it is the only health system which (recalling the core principles of the NHS) meets the needs of everyone, insofar as any system could be said to achieve this goal in its entirety. In an international context, a cursory glance at indicators of population health, as a measure of the effectiveness of an interventional health system, suggest that the UK NHS is successful at maintaining and improving health *but* only *as successful* as similarly developed nations (see, for example, OECD estimates of life expectancy at birth, which place the UK at 81.4 years compared to France at 82.8, Germany at 81.2, or Austria at 81.6[15]). None of these comparable countries have health systems which are directly financed through taxation receipts and delivered free at the point of care (all three are examples of compulsory private insurance markets with state-managed payment rates dispensed to at least partially competitive providers on the basis

---

[15] See for further detail, the collected OECD Health Statistics, 2016

of actual consumption, frequently with direct co-payment from patients), and yet all appear to meet the needs of their respective populations at least as well as the NHS (insofar as this can be measured by broad population health measures, such as life expectancy).

This suggests that the principles by which the NHS directs its activities, from its inception, are more closely related to a discursive formation of a particular way of doing health-related activities, rather than directly and linearly constitutive of some objectively determined goal of improving health. The importance of taking this perspective for the current analysis is that it emphasises that the ways in which activities within the NHS – be they governance and management activities, which are the focus of this analysis, or the at-bedside delivery of medical practices – are carried out are created by and through the mutually agreed discursively formed local practices of a particular field. Despite the logic of the clinic and the discourse of evidence-based medicine claiming an objectively determinable scientific rationale for the practice of medicine, the ways in which such practices are constituted can also be seen as being the product of these locally constitutive and co-constructed fields.

Turning, then, to the temporally and nationally specific context of the NHS in England at the time of this study, we can see the particular relevance of an appreciation for the history of the NHS. On the 1st of April, 2013, the *Health and Social Care Act 2012* came into force, representing a major change in the policy underpinnings and structures of the NHS. This was not without controversy; in the words of one analyst, in a think-tank published book describing the creation of this Act:

> 'Never Again?' tells the story of how and why the Health and Social Care Act 2012 – by far the most controversial piece of NHS legislation in more than two decades – became law.
> It relates the story of a political thriller – from the legislation's origins 20 years ago, through the development of the 2010 white paper "Liberating the NHS" and the resultant bill; a bill so controversial that it appeared at times as though the Government might lose it.
> It does so from the viewpoint of opponents and critics, but also from the point of view of the man with whom this legislation is uniquely identified – the current health secretary.

On the way, it explains just what it was that Andrew Lansley was trying to do and why the bill was so vast and controversial.

It details the events that shaped it – most notably the Coalition's now partly forgotten "programme for government". That document – cooked up purely by the politicians in Downing Street over 12 days immediately after the election in May 2010 – radically reshaped the health secretary's plans.

Sorting out the "disaster" in the "programme for government" turned what would have been merely a large shift of power and accountability within the NHS into a huge structural upheaval: one that allowed the reforms to be written up as the biggest reorganisation in the 63-year history of the NHS; and one that could become this Government's "poll tax". (Timmins, 2012, p. 5)

Further, in the conclusion to his analysis, Timmins writes:

So this might, after all – and despite the current consensus view among commentators, analysts and many senior figures in the NHS – prove over the long run to be not only the most successful piece of NHS legislation since the founding act in 1946 but its last major structural reorganisation, at least for many years. Stranger things have happened, though perhaps not many of them – particularly given the endless propensity of health ministers over 40 years to reorganise the way the service functions… The consensus view right now, however, is that it will largely fail, and at many levels. (Timmins, 2012, p. 128)

This commentary summarises, in essence, one of the critical contextual events that shaped the Trust on which this research is focused; a major, politically-directed reorganisation of the delivery, purchasing and oversight of care within the NHS. Timmins' emotive conjuring of the controversy is also echoed by other contemporary responses (Delamothe & Godlee, 2011; Kirkpatrick & McCabe, 2011; Lambert & Sowden, 2016). And yet, in some ways, these changes operate within the field established more than 60 years prior; the NHS remains a taxation-funded organisation, within which care is available without charge at the point of delivery (with two notable exceptions, being the provision of non-emergency dental services and the dispensing of prescription medications). Timmins characterises these reforms as structural, and this is largely an accurate position to take on the impact of the *Health and Social Care Act 2012*, in that it ushered in a systematic reorganisation of the ways in which health and social care is directed and controlled from the perspective of the *clinic* (i.e. from those who are professionally engaged as members within the various organisations of the NHS) but leaves fundamentally unchanged the ways in which care is delivered to patients, in the sense that the familiar infrastructures of general practice (GP) surgeries, hospitals and community pharmacies remain the ways in which patients (or those seeking to *become* patients) access health services. Thus we have the situation captured during the observational fieldwork conducted for this research in which a singular institution – University Hospital Trust – at once experiences

significant change and at the same time is changed little by such exogenous factors, in that it was prior to the reforms a large tertiary care hospital and it was after the reforms, still a large tertiary care hospital. What changed – and what were pre-figured into the operations and practices in the hospital *prior to* the Act coming into force – were the regulatory and oversight structures that surround the Trust, the legal empowerment of governors within the Trust, and the commissioning (or purchasing) arrangements that define the inter-organisational market for health services within the NHS.

Given that the implementation of the *Health and Social Care Act 2012* was pre-empted by local efforts to adjust prior to the Act coming into force, the focus of this discussion is on the new NHS structures and governance arrangements that came into force with the Act, with the relevant historical structures discussed[16] (where necessary). The NHS is no longer a single, monolithic organisation which is concerned with the delivery of health-care (and has not been for some time). Rather, it is a system through which health services are purchased for patients on behalf of the state (Newdick, 2005). The NHS defines its own structure hierarchically as follows (NHS, 2016):

> **The Secretary of State for Health**
> "The Secretary of State has overall responsibility for the work of the Department of Health (DH). DH provides strategic leadership for public health, the NHS and social care in England."
>
> **The Department of Health (DH)**
> "The DH is responsible for strategic leadership and funding for both health and social care in England. The DH is a ministerial department, supported by 23 agencies and public bodies…"
>
> **NHS England**
> "NHS England is an independent body, at arm's length to the government. It's [sic] main role is to set the priorities and direction of the NHS and to improve health and care outcomes for people in England … NHS England is the commissioner for primary care services such as GPs, pharmacists and dentists, including military health services and some specialised services…NHS England manages around £100 billion of the overall NHS budget and ensures that organisations are spending the allocated funds effectively. Resources are allocated to CCGs."
>
> **Clinical commissioning groups (CCGs)**

---

[16] As has already been noted, this research is neither a historical account, nor a discourse analysis, of the NHS, but seeks to contextualise the examination of *in situ* social practice in an ecologically valid representation of the field.

> "CCGs replaced primary care trusts (PCTs) on April 1 2013. CCGs are clinically led statutory NHS bodies responsible for the planning and commissioning of healthcare services for their local area. CCG members include GPs and other clinicians, such as nurses and consultants. They are responsible for about 60% of the NHS budget, commission most secondary care services, and play a part in the commissioning of GP services … NHS England and CCGs have a duty to involve their patients, carers and the public in decisions about the services they commission."

The additional supporting quasi non-governmental agencies (QUANGOs) attached to the Department of Health and NHS England (as noted above) are in addition to this core hierarchy[17]. Considering this core, we see that the NHS is structured as descending from the Secretary of State for Health, a government minister with responsibility for the provision of health care and the work of the Department of Health. Explicitly, the state is allocated responsibility for the provision of health and social care, and the intentionally distanced relationship between the state's delegated responsibility (i.e. from the state as a theoretical entity, to the government of the day, to the minister, to a bureaucratic organ, and so forth) is made clear. It is by the operation of these overarching structures that the NHS delivers health and social care, via the commission – the purchase (for simplicity, I will adopt the former term going forward) – of particular services, using funds allocated across these structures by the relevant minister (the Secretary of State for Health). Commissioning, for the most part, implies the establishment of long-term contracts or agreements between providers and commissioners. In many cases, there is limited competition; as commissioning occurs on behalf of the consumer via a restricted number of purchasers, commissioners can be seen to enjoy a monopsony (in which there is a single dominant purchaser in a market – the reverse of a monopoly in which there is a single or dominant supplier). Equally, however, they are faced with a *practical* monopoly, as these commissioning arrangements are implemented within a historically centrally planned health-care system in which limited service providers (such as hospitals) were funded within a particular area. Thus, whilst the commissioning relationship may be the purchase of services from a free choice of provider, the reality faced by many commissioners, particularly in 2013, was that there were limited alternative providers. Indeed, as the general position of the NHS (see the discussion of financial pressure, below) is that demand outstrips available supply of services, the issue for commissioners,

---

[17] https://www.gov.uk/government/organisations/department-of-health/about

like the patients on whose behalf they are purchasing, becomes one of available services to commission.

That said, the notion of *any qualified* provider (which predates, as noted by Newdick, cited above, the implementation of the 2012 Act) for NHS services means that whilst patient-consumers (Greener, 2003, 2004; Greener & Mannion, 2009) engage with a branded NHS provider, the provider can be private, a public body, or a joint venture. Perhaps the most widespread and common example of private provision on behalf of the NHS is the pharmacy sector, in which the retail dispensing of prescription medicines is almost entirely private sector (dominated, in fact, by a single large wholesale-retail-logistics corporation). Being a qualified provider is managed by regulatory agencies which sit adjacent to and serve the needs of the Department of Health and NHS England. For the purposes of this analysis, there are three adjacent bodies which are of particular interest. They are:

> *Monitor*[18] – responsible for the supervision and oversight of *Foundation Trusts*.
>
> *Care Quality Commission* (CQC)[19] – an independent body responsible for registration of services and ensuring that minimum foundational standards are met.
>
> *National Institute for Health and Clinical Excellence*[20] (NICE) – a non-departmental public body which sets out standards and guidelines for care and available medical treatment in England.

These bodies directly impact University Hospital Trust (and indeed, any Foundation Trust) in a number of ways. CQC supervision focuses on the *clinical* competence of a provider in ensuring that agreed-upon medical standards are met, and has oversight of the hospital as being *any* type of provider (although, of course, the standards and details of what services are provided are naturally different between a community pharmacy and a tertiary care hospital, for example). Monitor, on the other hand, is concerned with the Foundation Trust as a corporate entity, with financial performance, budgeting and future

---

[18] As of April, 2016, merged with a new body, *NHS Improvement*, see https://improvement.nhs.uk/ and https://www.gov.uk/government/organisations/monitor
[19] http://www.cqc.org.uk/
[20] http://www.nice.org.uk/

planning. In common with modern performance monitoring, quality assurance and improvement approaches, both Monitor and the CQC use frequent and ongoing monitoring of quantitative performance indicators combined with less frequent and more *ad hoc* in-depth (generally in-person) audits, in which a range of more qualitative data can be gathered about the activities of a hospital. NICE, by contrast, is a standard-*setting* agency, and produces clinical guidelines (i.e. establishes how particular conditions or diseases are appropriately diagnosed and subsequently treated, and which treatment approaches or medicines can be used). Providers are obliged to follow these guidelines, although they can provide care in addition to or beyond the guidelines. The activities of NICE in managing access to health care are known, colloquially, as enabling services to be "on the NHS". This will be further discussed with reference to the pricing and market access of pharmaceutical products.

In addition to structural reforms, the NHS was faced with two other significant challenges in 2013. The first is the economic pressure on the health system. The NHS, considered as a total expense from the perspective of government, was required to realise between £15 and £20 billion in expenditure reductions by 2014/15, whilst at the same time, demand for care was rising (Gainsbury, 2016; Roberts, et al., 2012). The second was a national scandal involving the Mid-Staffordshire NHS Foundation Trust, in which (in the words of the chairperson of the public inquiry) the "appalling suffering of many patients" (Francis, 2013, p. 3) was made public and resulted in a large-scale public inquiry into the culture and operation of the Mid-Staffordshire NHS Foundation Trust. This process, culminating in the release in 2013 of the "Francis Report" (Francis, 2013), would lead to targeted and mandated reforms being implemented in every NHS Foundation Trust. At the time, the Francis Report was viewed as an indictment of serious failings within the NHS which were leading to significant avoidable patient harm and, in some cases, death. The Francis Report, as well as the Government-led reversal of decades of gradual health system expansion, can be seen as fundamental challenges to the culture and ways of being that had hitherto characterised the NHS. In particular, within University Hospital Trust, the local (and for the most part informal, outside of recorded meetings) responses to the Francis Report highlighted that this directly challenged a dominant perception that the NHS was, by and large, *doing the right thing*. In fact, the NHS in 2013 was at the centre of multiple processes which arguably encapsulated a notion that the NHS was *not* doing

the right thing; it was too expensive, too complex, and was failing its patients to such a degree that the experiences of some patients in a single hospital were deemed to be indicative of such deep-rooted and endemic problems that *every similar provider* was required to respond. These factors, both the regulatory and governmental environment in which a hospital is situated, and these specific events (noting that the decision to impose reductions in funding on the NHS as a whole was if not politically motivated then at least potentially politically avoidable through the re-allocation of funding) that affect its operations, must be understood as informing the ways in which the *ideal* implementation of governance within a hospital, in this case a Foundation Trust, is translated into local practices.

Foundation Trusts

University Hospital Trust is an NHS Foundation Trust. It is critical to understand that this is a particular type of corporate entity, with specifically established ideas of ownership, control and accountability, and specifically constituted governance arrangements which differ from what might be considered normative governance arrangements. As has already been outlined, University Hospital Trust, like most NHS Foundation Trusts, is a large tertiary care hospital. Foundation Trusts are normatively hospitals, but this is not their defining characteristic. Foundation Trusts were established in England in 2002 by the then Secretary of Health, and were intended to be quasi-independent organisational units that, by virtue of greater degrees of autonomy from direct state control, could more easily adapt to the local needs of their respective populations, and more efficiently respond to economic conditions as a greater purchaser market was introduced into the operation of the NHS.

The first detailed statement of the purpose of the Foundation Trust dates from 2002, in the press release issued by the Secretary of State for Health.

> NHS Foundation Trusts will usher in a new era of public ownership where local communities control and own their own local hospitals. NHS Foundation Trusts will be part of the NHS, providing NHS services to NHS patients according to NHS principles … "They will be owned and controlled locally not nationally. Modelled on co-operatives and mutual organisations, NHS Foundation Trusts will have as their members local people, members of

staff and those representing key organisations such as PCTs. They will be its legal owners and they will elect the hospital governors. In place of central state ownership there will be genuine local public ownership." … By putting staff and public at the heart of this key public service these NHS hospitals will have the freedom to innovate and develop services better suited to the needs of the local community. (Department of Health, 2002)

The statement issued by the Secretary, Alan Milburn (quoted in the above excerpt), gives a clear summary of the original intent of Foundation Trusts. The intention behind the transfer of hospital ownership from the state to community was to increase direct local control of hospitals, and to concurrently increase the ability of such hospitals to manage their assets, enter into public and private contracts (including borrowing), and determine local labour (human resource) policy. Election, by the community owners, of hospital governors was part of the original design of Foundation Trusts, as set out by government policy and in the initial legislation establishing the first Foundation Trusts in 2003 (the *Health and Social Care (Community Health and Standards) Act 2003*). By the time of the *Health and Social Care Act 2012*, being established as a Foundation Trust had become a signal of organisational maturity, effectiveness and prestige (not to mention the policy goal of the Department of Health to increase the proportion of hospital providers who were Foundation Trusts); implementation of this goal has proved challenging for successive governments, as noted in the Francis Report (cited above), which (correctly) identified the push to achieve Foundation Trust status as a critical distraction from the delivery of safe and effective care. However, since their inception, elected public and patient governors have been a legislatively required feature of a Foundation Trust, intended to ensure that the local communities who owned such hospitals had a continued voice in the hospital's activities.

What, then, is a Foundation Trust? Firstly, it is a form of *trust*, which can be understood as a type of self-governing independent entity, which effectively has ownership of itself on behalf of some other entity (in this case the public) and is governed according to the rules of the trust. Specifically, the NHS Foundation Trusts are established by the *National Health Service Act 2006* (s30, p 1) as amended by the *Health and Social Care Act 2012* to be a public benefit corporation, constituted and authorised under the act to have a particular corporate structure. For the purposes of this discussion, a detailed analysis of the legal instrument is largely unnecessary; the critical points are that the Foundation

Trust is established as a corporation that is intended to be *membership based,* in that it is established as a self-owning trust on behalf of its members and that it is further required to have a particular governance structure, implemented in a constitution (similar to the articles of incorporation requirement in similar acts which allow for the creation of private companies). An NHS Foundation Trust, in other words, is a corporate entity which is specifically created to act for the benefit of its members, who are defined as those living within a particular geographic domain, and to have an elected governance body, the Council of Governors (referred to as a Board of Governors, prior to the 2012 act). As a corporate entity, Foundation Trusts have similar (although limited) freedoms to corporations; subject to the consent above certain limits and parameters, they can expense and borrow funds, they can engage and release staff, and they can merge or dissolve partnerships. In other words, we can see that the Foundation Trust combines the contract-forming powers of the firm with the representational demands of a public body.

Each Foundation Trust is required to operate according to a constitution which conforms to the requirements of current (i.e. as amended) legislation. Constitutions represent a documentary interpretation of the intent of such legislation and are furthermore specifically reviewed for authorisation by the regulator (Monitor) in order to assess fitness of purpose against legislative requirements. The interpretation of roles and responsibilities of members of the governance functions of a Foundation Trust, as represented in the Constitution, can therefore be taken as a reflection of the *intentions* and policy *goals* embedded within legislation (insofar as they are implemented) alongside the Constitution's function to formally set out the roles and definitions of trust members. According to the University Hospital Trust Constitution, which can be taken as a representative example of constitutions in general (given that all constitutions must correspond to a common legislated set of requirements), we can see that there are two critical governance bodies established; the Council of Governors and the Board of Directors. It should be pointed out that the governance structure of the Foundation Trust differs from a charity in this prescribed duality, which is not a feature of other types of trust or charity. Although governed by separate legislation, I would suggest that the governance of a charity and / or charitable trust can be (for the purposes of this analysis) considered broadly similar to the governance of a firm (in that there is a single appointed *agent* body of a variable size with duties set out in the constitution, equivalent to the acts

of incorporation). To simplify, NHS Foundation Trusts have a unique, dual governance structure (a Council and a Board), whereas other trusts and corporations both have a single supervisory body (a board of trustees / directors). This dual structure (as applied within University Hospital Trust) is set out in Figure 4.1, below.

Figure 4-1 - Governance of University Hospital Trust
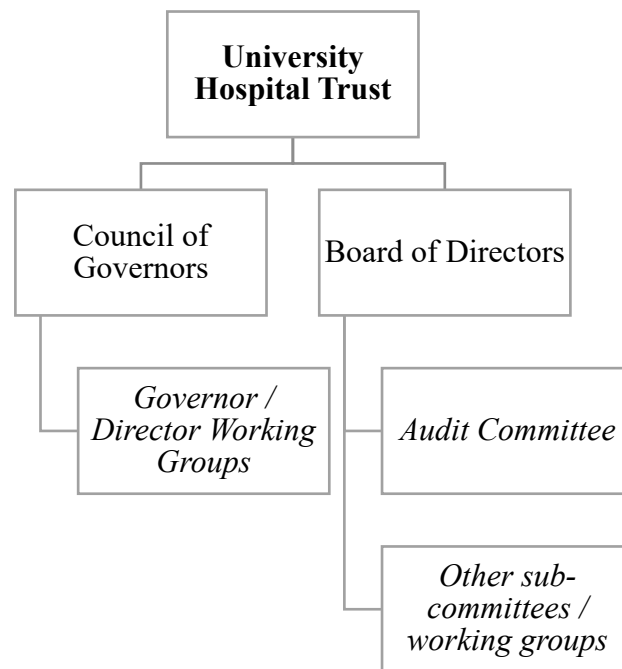
I will first discuss the Council of Governors. Members of the Council (the Governors) are elected by and from the members of the trust. Membership of a trust is by application, and members are allocated to three constituencies – staff, patients, and public. The public are defined geographically, by an area allocated to and agreed upon by the Trust; the constitution sets a minimum of 100 members for this constituency. Staff similarly are defined by employment or employment-like (covering honorary appointment) relationships to the Trust, with a minimum of 50 members. Patients are defined as "an individual who has attended and received treatment from the Trust at any of the Trust's hospitals as a patient within the period from 5 July 1948 to the date of application for

membership" (University Hospital Trust, 2013)[21]; minimum membership is 100, equal to public members. The Council of Governors' role is set out specifically in the Constitution:

a) representing the interests of members of the Trust and partnership organisations in the governance of the Trust regularly feeding back information about the Trust, its vision and its performance to the constituency they represent and confirming the appointment of the Advisers.

b) at a general meeting, appointing the non-executive directors, including the Chairman, of the Trust;

c) at a general meeting, appointing the Trust's auditor;

d) giving the views of the Council of Governors to the directors for the purposes of the preparation (by the directors) of the documents containing information as to the Trust's forward planning in respect of each financial year to be given to Monitor;

e) receiving at a public meeting, copies of the Trust's annual accounts, auditor reports and annual reports; and

f) informing Monitor if concerns about the performance of the Board of Directors cannot be resolved at local level.

This represents the constitution at the time of the fieldwork for this research; a complication that presents itself is that organisations, particularly in the NHS, are constantly evolving, and the Trust was, partly in response to the implementation of the *Health and Social Care Act 2012*, implementing a new Constitution during 2013-14, which modified the duties of the Council of Governors to match the *new* intention of the 2012 act. The Council was then, in addition to those roles above, granted a specific responsibility to hold Directors to account, and to call meetings of members. The former is the more significant change; specifically, the wording now calls for the Council of Governors to hold the non-executive Directors both individually and collectively to account for the performance of the Board. In addition, the 2012 act provided for the Council of Governors to authorise (by majority vote) any significant transactions entered into by a Trust, although this is underspecified, as significant transaction is not delimited

---

[21] University Hospital Trust Constitution references are to the text, but will omit both document name and paragraph structure to reduce identifiability of the participating organization

in the legislation and is only optionally included in any constitution. Taken together, both the initial and the post-2012 construction of the Council of Governors establish it as a clearly *supervisory* and *representational* body, with some superordinate powers over the Board of Directors. The role of the Council of Governors can be seen to be limited however in the extent to which it is expected to function as a group that directs the activities of the Foundation Trust. This is a clear difference from what might be considered a conventional corporate governance role, as I have defined it in the background chapter, in that the Council is not expected to represent the interests of *owners* or indeed the interests of the firm as an ongoing concern in the maximising of (share) owner value.

The role of the Council of Governors as explicitly representational can be seen as evidence for the idea of the public interest corporation being intentionally balanced between two more-or-less well understood ideas of how to collectively organise; 1) to adopt a membership-driven mutual cooperative group, which can be seen to be similar in some ways to the membership aspect of the public interest corporation, but 2) to retain a firm-centric ownership structure. By this I mean that, unlike a cooperative, where an individual producer within the cooperative or mutual is free to withdraw their capital (noting that in practice this might face certain restrictions), a share-holder cannot simply withdraw capital from a firm but must instead exchange that ownership position with someone else who is willing to own (part of) the firm. Similarly the membership of a Foundation Trust are not engaged in a mutual for two reasons, one being that they cannot withdraw even a notional share in the Trust and the second being the almost banal, that the membership are not required to have made an overt or direct capital investment in the Trust. The Council of Governors also has a somewhat broader representational remit than *solely* members of the Foundation Trust, although the two largest constituencies (by minimum membership and by estimated actual membership) are the public and patient groups. At University Hospital Trust, the members of the Council are 7 public governors, 8 patient Governors, 4 staff Governors, 10 partnership Governors (representing the Clinical Commissioning Group, the Local Authority, the partner University and other partners, including neighbouring Foundation Trusts) and up to 6 advisors. Aside from the advisors, all governors have an equal single voting right on the Council of Governors, which is formally constituted to make decisions by simple majority vote.

The Board of Directors is, unlike the Council of Governors, an appointed body, with a Chairperson selected by the incumbent Board of Directors and proposed to the Council of Governors for appointment. The remaining Directors are either *non-executive* or *executive* Directors. The latter are employees of the Foundation Trust, generally the managerial head of a function or significant unit of the Foundation Trust. At least one is required to be a registered medical practitioner / dentist and at least one is required to be a registered nurse or midwife (these roles are thus normatively the Chief Medical Officer and Chief Nurse of the hospital, as in the case of University Hospital Trust). The Foundation Trust Chief Executive Officer (CEO) is an Executive Director for the purposes of Board membership; the Chairperson is a non-executive (NE) Director. This group requires some scrutiny. The NE Directors are defined in the negative, as in they may be *disqualified* from acting as a Director (by reason of bankruptcy, criminal conviction, or similar) but there is no specific *qualification* for a NE Director[22] in the sense that there is no principle upon which the selection of these Directors is made. At first glance this might seem similar to Governors (who simply have to be members within a particular constituency) and perhaps not noteworthy, but it should be highlighted that (despite electoral challenges, which will be discussed in Chapter 8) the Governors are elected, rather than appointed. The NE Directors are a more-or-less free appointment to membership of the Board, at which they are (at least formally) peers to the professionally selected Executive Directors. As with the electoral model of the Council of Governors, the genealogy of the Board of Directors is essentially transparent, in that it bears similarities to the Directors of a corporate entity. The Board, in the corporate model, is conceptualised as being independent and indirectly subject to the direction of owners, who have a limited oversight and limited censure or control power over the Board (Bebchuck, 2005; Cziraki, et al., 2010). This can be seen to be similar to the relationship between the Foundation Trust Board and the Council of Governors, replacing the conventional shareholders with the Council of Governors. The *power* of the Board of

---

[22] It should be noted that there are some exceptions to this, in that a Foundation Trust can establish some requirements, such as local residence, or in the case of University Hospital Trust, the appointee to a nominated position in a partnership organisation.

Directors is a broad remit; the Constitution delegates the powers of the Trust (as in, contract forming) to the Board, which in turn can delegate them to any Director.

The responsibilities set out in the Constitution (University Hospital Trust, 2013) are:

a) exercising the powers of the Trust;

b) the effective management of the Trust;

c) in consultation with the Council of Governors, producing plans regarding the future development of the Trust;

d) through a report to meetings of the Council of Governors, feeding back information about the Trust, its strategy and its performance;

e) compliance with all obligations lawfully imposed upon the Trust by Monitor and any other statutory body or agency; and

f) approving the Trust's annual report and accounts.

The Board of Directors can be seen to be broadly similar to what is normatively seen in conventional corporate governance, in which an independent Board is appointed with a broad remit to ensure the effective management of the firm, to direct its activities and to make decisions about what the firm should be doing. The Foundation Trust Board is, as expected, somewhat more limited, in that the definition of the public interest corporation is constrained to be that the corporate entity must deliver health services (and furthermore places limits upon the percentage of activity that can be other than such health services). Within this constraint, the Board of Directors however appears to function similarly to a corporate Board, including a well-understood divide between the external NE Directors and the internal executive Directors who form the direct management structure of the organisation.

This governance structure is more-or-less unique to Foundation Trusts. The language which describes it – Directors, Governors, Trusts, members – is to some extent familiar, and yet it is made specific and particular to the context in which the Foundation Trust operates. This is a critical point to highlight for this analysis; that the governance structure which is embedded within the corporate (legislative and constitutional) structures of the Foundation Trust has dual bodies, in that there is an appointed Board of Directors with a broad remit and responsibility for the management of the Trust, alongside an elected

Council of Governors with a supervisory, representative and oversight role. This latter group, in practical terms, is the focus of this case study, in the sense that the patient and public Governors are members of the Council of Governors and its sub-committees, and are empowered only to select a single representative of the public and patient Governors to sit upon the Board of Directors (a Lead Governor). At University Hospital Trust, in keeping with practice in other NHS Foundation Trusts, elections are held annually for 50% of the elected positions, for fixed three-year terms defined in the Constitution. Potential candidates for election are solicited by University Hospital Trust through letter and email invitation to the Foundation Trust members, and through a permanent section on the Trust website detailing ways to be involved in the work of the hospital. Membership of the Foundation Trust – a prerequisite both for candidacy and enfranchisement – is by application to the Trust and requires that the prospective member live within the designated geographic catchment of the hospital. In 2012-15, University Hospital Trust's membership stood at approximately 20,000, which is less than 3% of the overall county population. Elections are held by postal ballot, and the elected future Governors are given a single day training course (facilitated by senior managers of University Hospital Trust). There are no pre-requisites other than membership of one of the defined constituencies and no prior criminal convictions.

Based on formal documentation of governance at University Hospital Trust, then, we can see only a limited role for the patient and the public, and we also see (arguably) overly simplistic definitions of these groups, in which patienthood is defined across a more than 60-year span, and public is reduced to a geographic selection. Most importantly, what I have described thus far are University Hospital Trusts' governance structures and practices as formally defined in its constitution. Whilst these definitions establish the number, process of selection, and to some extent the members of the Council and the existence of the Board of Directors, the specific role and remit of each (particularly in relation to each other) is not specifically defined in the Trust's written documentation. The *defined* roles of each body are limited to those specific responsibilities discussed above. These definitions do not necessarily reflect the practices of University Hospital Trust. What is needed to understand how patient and public Governors are engaged in the governance activities of the Foundation Trust is to understand how the meetings of these

groups, and the sub-ordinate (and more informal) sub-committees and (so-called) Working Groups, are used to implement the Trust's Constitution.

Governance in practice at University Hospital Trust

I wish to support two claims in this discussion of the practices of governance at University Hospital Trust. Both arise from the process of ethnography, by which I mean the everyday experience of being in the moment with the participants under observation, talking directly to them, and observing at first-hand the ways in which they went about the business of governing a large hospital. The first is that the practices of governance in the Trust support an argument for a *potentially* greater and more integral role for patient and public Governors than might be initially expected from the on-paper implementation of the relevant acts. The second is that governance processes are category-focused, in that they are constituted by and through the membership categories into which each subject is categorised. These membership categories can therefore be seen to be omni-relevant to the social space(s) and field(s) of governance, and I argue that this is a potentially important factor in how subjects are able to perform social actions in these contexts.

Beginning with the first question, we can see that there is a hierarchical relationship established between the Council of Governors and subordinate Working Groups who report to the Council. By design, the Council of Governors has a tightly defined formal membership, with a working majority required to be held by patient and public Governors, and the meeting frequency determined by the Trust Constitution. The meetings of the Council of Governors are public (as are Board meetings), with some closed sessions for the confirmation of appointments or decisions on commercially sensitive matters[23]. The Council of Governors is (as per the Trust's constitution) intended to be a formal decision-making body; the meetings run with a similar formality, with the order of business set out in a formal pre-circulated agenda, and business recorded in the

---

[23] As in, transactions where pre-decision disclosure would create a risk to the organisation or to the value of the transaction, or where information required to be used in making a decision would create a competitive advantage if publicly disclosed.

minutes which are agreed at the following meeting as being a true reflection of the immediately prior meeting. The Chair directs the conduct of the meeting by explicitly moving from one agenda item to another, and inviting non-members (generally expert members of the Trust's Board of Directors, or other senior staff members of the hospital) to speak during discussion of particular agenda items. The general conduct of a Council of Governors meeting is to confirm attendance, review minutes, and then move through standard reports from the subordinate committees which report to the Council of Governors, and then to consider any specific discussion items that have been placed on the agenda. The process by which the agenda is formed is largely opaque to the members of the Council. Agendas are determined by the managers of University Hospital Trust, in consultation with the Chair; responsibility for the agenda ultimately rests with the Chair, but was achieved through a process of proposal (by management) to the Chair with subsequent agreement. This might be a convenient model, particularly given the public (as in state-funded) nature of hospital operations in England, and invokes perhaps a Weberian perspective on the organisation of the hospital's activities. I wish to disrupt this slightly; I have previously discussed the distinction between *management* and *governance* as different activities within a firm (recalling that we can understand the hospital as a firm given a definition which depends on contractual relationships). From this view, we can see that the creation of the Council's agenda is the work of management, who are concerned with the ongoing activities of the hospital, rather than the product of governance, as such. This is notwithstanding that the duality of the Board / Council arrangements, as I have suggested above, produce perhaps a blurred distinction between which body is truly functioning as governance in the sense of directing the activities of the hospital. Through controlling the formal agenda of Council meetings, management have significant influence over the activities of the Governors; the purpose of the agenda is to endow upon certain topics an affordance to *be spoken of*, whereas topics left off the agenda are rarely raised in the blanket *any other business* items which (as per convention) follow the main agenda. This last point is important, in that the conduct of the Council of Governors meetings is intuitively familiar to an observer or participant who has been inculcated into the conventional practices of formal meetings. The successful progress of action across meetings and the acceptance of subjects of their role in these actions suggests that there is a shared orientation to this normative practice of how such processes occur, consistent with an understanding of how social practices in institutional contexts

are ongoingly constituted by the participants themselves (see, for example, collected research in Freed & Ehrlich, (2010)).

The subordinate working groups, and two other key committees within University Hospital Trust, are a slightly different matter. These subordinate groups have membership consisting of the Governors and Directors, and are each given a specific topic-based remit over which to consider the activities of University Hospital Trust. These arrangements are necessarily local, and are subject to change and re-design by management; at the conclusion of the field-work process, in fact, the structure of the working group was proposed by management (through the Executive Directors) to be changed to a new division of topics between groups. That said, the intention of such subordinate groups was consistent; to increase the involvement of Governors in University Hospital Trust by creating more frequent situations in which Governors could interact directly with Executive Directors and other staff members.

On the surface, these groups are similar to the Council of Governors in that they are conducted according to the similarly normativising conventions outlined above, whereby management determine and pre-specify an agenda, and the progression of the meeting is directed by a chair. There are however some differences that can be observed between the subordinate groups and the Council. Notably, the business of the Council is *public* whereas the subordinate groups are held *in camera*, unobserved by participants who are not themselves implicitly part of the work of the group[24]. A second difference which can be observed immediately is that the subordinate groups are a *wholly voluntary* activity. University Hospital Trust (as all Foundation Trusts) is required to have a Council of Governors, and is required to specify the membership, frequency of meetings, and the conduct of those meetings, through publicly accessible documentation which is further subject to the scrutiny of regulators for fitness of purpose. By contrast, the creation and

---

[24] With the obvious exception of, for some meetings, an observer and several video cameras; for the sake of clarity, it should be noted that all recordings and observations were made with the informed consent of all participants and that participants were free to withdraw consent at any point throughout the process.

design of these subordinate groups arises from University Hospital Trust itself (by which I mean collectively the management and Governors of the Trust). By creating specific fora in which Governors are afforded additional capacity to act, understanding action in this sense as being social action received by an other subject, the role of the patient and public Governor is clearly expanded beyond the formal public meetings of the Council of Governors. This can be further seen by the inclusion of the patient and public Governors on two specifically *clinical* decision-making groups, which respectively consider transplant and tissue donation / recipient matching, and purchase of medical technologies and products beyond the required formulary inclusions from NICE. A sample meeting of this latter body is discussed in chapter 5 of this thesis.

I have explicitly taken the position that we can usefully conceptualise of an individual in terms of being a *subject*. What influence does this subject / subjectivity conceptualisation have on the ongoing and everyday practices of governance as they can be seen in University Hospital Trust? In other words, why do we need to attend to a conceptualisation of individuals in order to understand what has been so far described as being an organisational process constructed through more-or-less formal structures? One of the most straightforward observations that can be made of these governance activities is how they occur; as face-to-face meetings, in which subjects are concerned with the exchange of social action between themselves and other subjects and the collaborative co-construction of the attended-to activity at hand. By this I mean that subjects cooperatively engage in a set of mutually intelligible social actions; this can be seen in that the meetings occur and follow a familiar, shared, and largely tacit format. Governance activities are achieved through the actions of subjects in social space, but this does not necessarily mean that the subjects *themselves* are orienting to other subjects in terms of a shared understanding of constructed subjectivity (and nor would this necessarily be expected). Rather, the composition of groups (Council, Board, sub-groups, and so forth) foregrounds the category to which each subject belongs. Each participant in a committee or group, put simply, is there because they satisfy some rule by which they can be said to be a member of some relevant category, and the composition of the group *must* contain (understanding *must* as limited to the rules established by University Hospital Trust itself) particular membership categories in order to be held (again, by the rules of the Trust itself) to be valid. The presence of any individual subject in a meeting

is therefore subordinate, in this sense, to the categorical identity to which they are understood to be assigned. This knowledge is not simply tacit or hidden. The category in which a subject is categorised is literally sign-posted, by name and title cards, set out at each meeting. The categorisation of a subject is both condition and authorisation of their presence in a particular meeting, and can thus be said to be part of the relevant and known (by each subject) context of each meeting. In this way, it can be said to be consequential for the social actions that they can be seen to perform, as the category to which they belong is part of the context understood by other subjects of such an action (and therefore can be seen to be part of the action itself).

Summary

In this chapter I have discussed the context of University Hospital Trust and the implementation of governance within it. I have also outlined how this implementation, as a case study, can be seen to relate to similar Foundation Trust hospitals. Importantly, we can see that the duality of governance within the Foundation Trust positions it between membership-based and ownership-based models of governance, with some elements bearing similarities to mutual, government and public bodies, and the implementation of an independent Board resembling aspects of standard corporate governance. I have also outlined how the inclusion of non-obligatory meetings suggests a greater potential role for patient and public Governors beyond the limited powers assigned in the Trust Constitution and exercised by the Council of Governors. Finally, I have argued that the category-oriented composition of groups at any level of the Trust's governance processes foreground the membership categories to which a subject can be seen to belong, and that this categorisation is therefore relevant to the actions performed by those subjects. In the following chapters, I will consider those actions in more detail through the examination of how particular meetings and topics can be understood in terms of social action and how Governors, in particular, perform these actions.

5. Shared decision-making about pharmaceutical products

In this chapter, I consider if distinctions between the roles and social categories of participants in governance committees are relevant to the process of decision-making. This is examined through an analysis of talk and social interaction between participants during the course of committee meetings. In the previous chapter examining the policy and legislative framework for governance in the NHS, I have shown that different categories of representatives and committee members are embedded within the structure of governance committees. In addition, there is a distinction accepted in the literature between lay and expert participants in committees, including in health settings (Abelson, et al., 2007; Baggott, 2005; Boivin, et al., 2014; Crawford, et al., 2002; Emmerich, 2009; Hogg & Williamson, 2001; Nilsen, et al., 2006; Mitton, et al., 2009; Wait & Nolte, 2006). Whilst these differences are commonly accepted both within the literature and within the context of the NHS, this analysis seeks to understand how different roles and categories can be seen to operate within a governance committee. As discussed by Housley & Fitzgerald (2002), categorisation, knowledge, and the recognition of knowledge within both formal and non-formal settings are fundamentally related. Understanding how categories and roles are organised and recognised by speakers can be used to explore how knowledge is used by participants.

This chapter analyses talk drawn from a single committee meeting within the corpus. The committee is University Hospital Trust's Drugs Committee, one of two committees at which public and patient representatives are routinely present which consider matters that are directly related to patient treatment[25]. The Committee makes specific decisions about the inclusion or exclusion of particular drugs and therapeutic agents in the hospital formulary. Each meeting is required to reach specific conclusions and decisions with respect to the matters put to it. For this reason, data from this meeting are useful in that they show how such decisions are made through talk, and how participants mobilise categories through talk in relation to those decisions.

---

[25] The other being the transplantation decision-making committee, excluded from the research data collection scope.

The talk within this committee presents a challenge to the focus of this research on elected public and patient representatives within the Foundation Trust. Although there are two elected Governors present at the Drugs Committee, neither of these members speak during the meeting – the decision-making process is achieved without the active participation through talk of the public / patient Governors. Data from talk in this meeting are included in this analysis for two reasons. Firstly, the research design of this study specified collecting data from each type of committee of which patient and public Governors are formal members. This included the Drugs and Transplant Committees, which are both considered by participants to be directly relevant to patient care and clinical practice. The second reason for including this meeting in the analysis arose from the participants themselves.

Fieldwork for this project involved both recordings and observation, as well as direct discussion and informal interviews with the participants. Immediately after the filming of the Drugs Committee, I was approached by one of the elected representatives. In the subsequent discussion, the Governor, who acts as a member of both the Drugs and Transplant committees, confirmed that the non-speaking participation in the meeting was usual; he would not normally talk during either committee meeting. He was aware of a distinction between the Drugs / Transplant committees and the other governance committees on the basis of this difference in participation by the public and patient governors. Nevertheless, the patient Governor felt that continued presence at and membership of the Drugs and Transplant Committees was an important part of the patient Governor role. This merits examination, particularly in relation to understanding the differences between the categories of lay and expert committee members.

The extracts of talk analysed in this chapter focus on knowledge and information that is used by subjects in a shared, collaborative decision-making process. The decision(s) considered are related to the purchase of pharmaceutical products by University Hospital Trust. I will first give an overview of some relevant aspects of how the pharmaceutical

market operates in England, and then examine how this translates into particular actions within University Hospital Trust.

Pharmaceutical pricing and market access in England

Direct spending on pharmaceutical products is a critical issue for developed health economies. Estimates from within the pharmaceutical industry itself anticipate an increase of US$349 billion from current levels to 2020, compared with US$182 billion in the five years to 2015[26]. For England alone, spending on prescription drugs in the community and hospital sectors was £15.5 billion in 2014/15, an increase of 7.8% on the prior year[27]. Aggregate spend on pharmaceuticals is not just the result of increasingly expensive medicines, or of increased demand for treatment; it is also the result of the decision to *use* the medicine, to *enable* the use of the medicine through including it in formulary lists, and to *accept* the increased expenditure that is the consequence of these actions.

Despite a common physiology and a common likely response to the various molecules packaged and sold as active therapeutic agents to treat disease, treatments are likely to vary for similar or identical conditions across countries. In one country, the standard of care for a rare cancer might be a complex, large molecule biologic (a monoclonal antibody-based product) that encourages the patient's own immune system to selectively target tumour cells. In another, the same cancer might be treated with a decades-old immunomodulatory drug, best known for its teratogenic side effects and not its capacity to extend life. In both cases, the treatments are likely to be effective (insofar as treatments are believed to be effective), and both are likely to be safe (within the accepted limits of risk versus reward). Physicians, particularly in developed nations such as England, can be assumed to be *aware* of, or could become aware of from the academic literature,

---

[26] Data sourced from IMS Health, a US-based company that tracks global pharmaceutical product sales and advises pharmaceutical manufacturers, see http://www.imshealth.com/en/thought-leadership/ims-institute
[27] Data sourced from the Health and Social Care Information Centre, http://www.hscic.gov.uk.

multiple treatment options, including those which they do not commonly use. Why, then, is there variation in the availability of treatments between countries? The logic of an evidence-based approach to medicine would suggest that, given a common humanity, we should expect that the most appropriate treatment for a condition would be the same in any health system, even if the organisational structures which are principally the focus of this analysis might vary. I am in part being disingenuous, as there are factors which explain how these differences between countries have arisen. Pharmaceutical products are often expensive, both in terms of the cost per patient and the aggregate cost to the health system of funding a product for all patients who need it. They are also, by their very nature, dangerous, and strictly regulated, and countries vary as to the regulatory body and regime that they use (notably being the divide between the United States Federal Drug Administration [FDA] and the European Union European Medicines Agency [EMA]). Pharmaceutical products need to both be able to be paid for within the health economy and be legally used for a particular disease (including instances where so-called off-label use is considered to be a legal use of a medicine for one disease when authorised for another). Health systems are faced with the challenges then of ensuring that appropriate products are used, that treatments are available to patients who might need them, and that neither the per-patient nor aggregate cost of these treatments exceeds available or available-for-use financial resources.

In England[28], there are a number of policy mechanisms which solve this problem for prescription medicines, setting aside the question of medicines which are available directly to consumers (referred to as over the counter medications). I should be clear at the outset that my intention here is not necessarily to critique how pharmaceutical products are priced or are granted access to the market (i.e. come to be available for purchase) in England, although there are certainly potential critiques that could be made, as in recent analysis of the high-profile Hepatitis C product *sofosbuvir* / Sovaldi (Roy & King, 2016). My intention here is to establish the context for what decisions are made at the level of a Foundation Trust and why those decisions are taken within a hospital. First

---

[28] And Wales, noting that Northern Ireland and Scotland are considered separately for the purposes of which pharmaceutical products are *routinely* funded through the NHS

and foremost, England is technically a free-pricing market for pharmaceutical products, in that manufacturers are free to set prices for their products and these prices are not subject to a rule-based adjustment at launch[29]. Any product that is granted a marketing authorisation (found to be safe and effective for use against an identified disease or therapeutic target) by the EMA can be sold in the UK, either via a listed price through retail (i.e. community pharmacy) distribution, or directly to hospitals. Products will be reimbursed (the cost funded by the NHS based on a *post-hoc* reconciliation through a largely automated central payment clearinghouse) if they are included on a valid NHS prescription form (referred to as an FP10), with the patient paying either a fixed prescription charge per prescribed item or no charge (for exempted categories, including certain long-term / chronic conditions and members of low-income households). For the hospital segment, similar reimbursement arrangements apply, although patients do not pay a prescription charge for any product dispensed in hospitals (whether as an admitted / in-patient or an out-patient). Prescription charges in England are fixed and uncapped, in that they are calculated per item and are a contribution to the overall cost of pharmaceutical products in the NHS, rather than related to the cost of the items prescribed. Thus, the NHS can in fact earn a profit (or rather, extract a rent) from patients when it dispenses products which are less than the prescription charge. Importantly, there are only limited restrictions on what items can be included on an FP10; once an item is included on a valid FP10, this authorises the dispensing of that product and the NHS is obliged to reimburse the cost of the product. Similarly, hospital-based medical practitioners are free to prescribe according to the needs of the patient. In practice, however, this is not the case, due in large part to the operation of the National Institute for Health and Clinical Effectiveness (NICE).

NICE plays a pivotal role in managing the so-called market access of products in England, principally through carrying out health technology assessments (HTA) and producing guidelines. HTA refers to the systematic evaluation of a new medical product or related technology (including surgical / other interventions), incorporating a review of the

---

[29] There are specific regulations and 5-year renewable negotiated industry agreements which constrain price changes post launch to ensure stability

clinical evidence for the product's effectiveness and safety, an analysis of the potential economic impact of the product, and mandatory consultation with patients, patient advocacy groups and physicians. Guidelines here refer to a variety of outputs of HTA and other NICE-directed processes whereby documented recommended ways to treat and diagnose conditions are published. For the NHS at large, NICE guidelines are critical. Commissioners (in this case, CCGs) are required to ensure that patients have access to any *recommended* treatment within a certain time period (noting that some specialised services, including very high-cost pharmaceutical products for rare diseases and cancers, are commissioned directly by NHS England, but are generally speaking still subject to review by NICE). For the practical purposes of the NHS, the NICE guidelines establish which treatments are routinely used, and under which circumstances. Thus, whilst a practitioner would be *legally* permitted to include any product on an FP10, prescribing outside of the NICE guidelines is monitored closely by commissioners. A positive recommendation from NICE means that a pharmaceutical product or medical technology is "on the NHS" and for hospitals this results in products being included in local formularies (the list of available pharmaceutical products). Individual service providers are not constrained to only treatments that are recommended by NICE and are free to include alternatives in formularies or choose to treat an individual patient with a specific and non-routine product. In addition, CCGs often have some degree of choice, particularly with competing medications from multiple suppliers which can be considered substitutable[30], with respect to some *options* within the guidelines (examples include acquisition of treatments for metabolic and cardiovascular diseases, which have multiple agents and multiple competitive manufacturers). For a hospital, there is a relatively high degree of freedom to develop a formulary which exceeds the minimum established by the NICE guidance, and hospitals maintain a formal committee-based decision-making body to manage the process for approving or rejecting individual funding requests (i.e. specific products being authorised for use for an individual patient) and formulary additions (where a novel agent will be used for all patients matching the indication, or target disease

---

[30] This is of course a simplification, but to be clear I here mean substitutable in the sense of economic goods, rather than the limited pharmaceutical use of substitution to refer to the use of a 'generic' version of a drug containing the same molecule as a 'branded' (and more expensive) version.

/ condition). At University Hospital Trust, the Drugs Committee[31] makes decisions about formulary expansion, local adaptations of NICE guidance, individual funding and new treatment technologies.

Local decisions, local participants

The work of the Drugs Committee is necessarily specific in nature. The Drugs Committee's primary business is to consider submissions from doctors on the staff of University Hospital Trust and respond either negatively or positively to those requests. It responds to the local exigencies of individual physician's preferences and to the needs of individual patients, rather than stewarding a national policy (as in the decisions made by NICE) or a multi-jurisdiction authorisation (as in the determinations made by the EMA). This is not to understate the importance of this formulary group; rather it is to emphasise the limitations of national policy within the context of the NHS. The architecture of the system is such that national policy is not expected, by the practitioners working within tertiary care centres, to provide adequate guidance for the delivery of care in all circumstances, and thus the Drugs Committee, and parallel bodies in other Foundation Trusts, can be seen as being a local solution to this limitation. This can be seen as, in a sense, a success of the Foundation Trust model, in that the design of the public interest corporation enables the creation of local decision-making processes that have the capacity to respond to the specific needs within the hospital and population which it serves. That said, it suggests that this inherent flexibility is necessary precisely because of a limitation to the national decision process, and that the standard of care does not sufficiently meet the needs of patients to such a degree that a systematic (rather than wholly exceptional) process is required to manage local variation and customisation of these national standards. There is an open question here, then, about which position along continuum between a national standard versus local customisation is better; certainly, it is difficult to argue that the in-aggregate result of these policies is necessarily negative (given that we can say that the NHS broadly meets its objectives of supporting the health of the population in general). In the specific case of University Hospital Trust, it is (from, perhaps, the perspective of those patients for whom it is the most practical tertiary centre)

---

[31] Note that this is a pseudonym.

associated with a research university and is generally regarded as a highly innovative hospital, although not one without significant challenges when objectively compared by its regulators to performance standards, as will be discussed in Chapter 7. Notwithstanding this problematising of local decision making, these local and hospital-specific issues are the remit of the Drugs Committee, both by responding to particular requests from physicians, and in reviewing the hospital formulary (the list of products that are available to be prescribed in the hospital).

The Drugs Committee is composed of a particular membership, defined by terms of reference. The Committee has a number of official and *ex officio* (attendees who contribute to the work of the Committee by virtue of their position but are not given voting rights) members[32]. The Committee is chaired by a consultant physician (consultant being the appellation for the most senior grade of hospital-based physician in the British system[33]), supported by an administrative staff-member (a non-medically-qualified support person) and advised by a representative of the Trust's financial management function. Remaining members of the Committee are representatives of the CCG, the medical staff of the hospital, the lead pharmacist of University Hospital Trust and two patient Governors. As in the previous discussion, the membership of the Committee is constituted categorically; each member of the committee is explicitly intended to represent some function or the hospital and their presence in the space is both conditional on and a signal of this membership categorisation. Understanding the transformation of the social space into one in which these categorical identities are relevant enables us to understand that subjects have a dual role in such meetings, and that membership categorisation enables us to see how a social process contributes to the co-construction of the particular social space of the committee.

---

[32] 12 total participants attended the meeting recorded for this research.

[33] Generally speaking, a consultant can be considered equivalent to an *attending physician* in the US and Canada, or to a *specialist* in Australia; a qualified medical professional who has completed medical education, general (intern or foundation) practical training, and further postgraduate training in a particular speciality (registrar and specialist registrar)

In Figure 5-1, the meeting of the Drugs Committee is shown (de-identified). The members of the Committee sit around three sides of a single table; in the upper right corner of Figure 5-1, at one end of the table, a physician is presenting a submission to the Drugs Committee, requesting that a particular high-cost treatment be added to the formulary for use in select types of orthopaedic trauma surgery. The members of the Committee each have a name card (visible as folded card triangles before each seated individual) which gives their name and position.

Figure 5-1 - Drugs Committee

These meetings are constituted as multi-party face-to-face interactions, in which subjects mutually constitute themselves and one another as particular types of contributors to these interactions. I will not dwell over-long on the interactional exposition of meeting spaces; the conversation analytic literature on institutional talk[34] establishes the ongoing co-construction of *how* meetings are realised as such through the medium of interaction. However, within this intersubjectively achieved interactional meeting, I argue that the duality of subjects (in terms of being both a subject and a member of a particular category) is of particular importance to how committees composed of *representatives* operate and how decisions are made, as speakers are not simply co-equal subjects (or equally elected representative members of a committee) but specifically representatives of a *membership category* which is *presumed* to include other members. In other words, it is the specific role of each subject thus categorised to speak on behalf of that category and specifically not on behalf of other categories of participants present in the meeting. This can be seen

---

[34] See for example Potter & Hepburn (2010), Heritage & Clayman (2010), Freed & Ehrhlich (2010)

both in the literal configuration of the social space – the placement of name cards, for example – and in the interactional progression of the meetings themselves. In the opening segments of the meeting, the Committee is concerned with reviewing an action list, which raises a number of topics for discussion. At points throughout this discussion, the Chair of the meeting (seated at the left-hand side in the image above) asks for specific input from particular members as *representative* of the opinion of the group or organisation which they are held to represent.

One of the physicians – a surgeon – presenting a submission to the Drugs Committee is an example of categorisation work in action. The surgeon attended the Drugs Committee to give a verbal presentation, and to answer questions; in other words, to perform social actions which do not explicitly require special equipment or clothing. And yet, he attended the Committee meeting in surgical 'scrubs' (standard-issue uniform clothing) including a long surgical gown and a cap. The (notional) purpose of 'scrubs' is to promote cleanliness and reduce contamination in hospital environments; by convention, most British physicians and nursing staff instead wear either a version of everyday attire (noting that the wearing of ties and long sleeves is discouraged in the NHS, to reduce bacterial contamination) or a standard uniform, rather than 'scrubs', which are more usual as attire for US hospital physicians. It can be thus, in the English context, considered somewhat unusual for a consultant to be wearing 'scrubs' outside of a specifically required context. It should also be noted that 'scrubs' are strictly color-coded, with only surgeons permitted to wear light green. The point of highlighting this is that, whilst we may be able to hypothesise some other rational explanation for *why* the surgeon concerned chose to attend the Drugs Committee attired in a way that *is only permitted* as a surgeon, the fact that he did so becomes part of the social space. His choice of attire becomes available to be observed by other participants. This means that he can be observed by others to be doing something (performing a category-bound action) which is restricted to the category of which he is a member (wearing light green surgical garb, including disposable and sterile elements which were, by virtue of having been worn outside a sterile environment, now no longer fit for their strictly medical purpose). These actions then categorise him both to the locally specific category of surgeons within the hospital (as in, his formal role in relation to the Committee) but also, I argue, mobilise into the social space his *clinical* identity. Taken as being social actions, by wearing

'scrubs' he is ensuring that, *a priori* to his subsequent social action(s), his identity as a member of the category of surgeons is made available to be taken up by others in the social space. This establishes a distinction; not just a member of the clinic, but further distinguishes him from other clinicians. It is perhaps also interesting to note that, of the multiple submissions captured in this data, this particular surgeon was the only physician to attend in specifically clinical clothing.

Knowledge and decisions

In this discussion, I focus on how the specific local decisions are made in the context of the Drugs Committee, and the kind of *knowledge* about the product which is constructed as being relevant to that decision. Prior to this discussion, however, it may be useful to have a brief overview of data about pharmaceutical products. Typically, pharmaceutical products are required to demonstrate that they are efficacious (have some quantifiable effect which is seen to improve health) and that they are safe (that the benefits of their efficacy can be seen to outweigh any risk or actual adverse effects). Manufacturers of pharmaceutical products conduct *clinical trials* classified into three phases once a potential product has moved into human use; Phase 1 trials to prove that administering the product to humans is safe and has predicable effects, Phase 2 trials to assess the potential efficacy (generally in a short-term duration of therapy and with a limited population), and finally Phase 3 trials which are intended to simulate the use of the product in real world conditions, in comparison to an appropriate trial comparator and with subjects randomised to the investigational or control groups. Naturally, trial designs vary widely depending on the condition (smaller trials for rarer and more acute conditions, with examples of products in use without Phase 3 trials for late-stage cancer treatments, or larger and long-term trials for chronic diseases, such as the requirement established by the FDA to produce cardiovascular outcomes trials for new agents treating Type 2 diabetes mellitus). Despite this variance, there is, generally speaking, a common frame in which trials are understood as belonging to Phase 1, 2 or 3. In addition to clinical trial data generated by manufacturer-sponsored research, drugs are often investigated by independent or government-sponsored researchers (meaning here clinical investigation, not the drug discovery process), which can generate published research that describes the clinical usage of the product, often in conditions comparable to the manufacturer-

sponsored trial settings. This is of course the briefest of possible summaries, and it should be acknowledged that there are multiple dimensions to consider in examining the development of clinical evidence for pharmaceutical products, and how that evidence is then disseminated, used, and (in some cases) abused in the pursuit of increased prices for pharmaceutical products, and increasing sales. The work of the Drugs Committee can, indeed, be considered as one of the end results of such controversies, as it shows how local decisions about drugs are made on the basis of such information, and what knowledge is more or less valued by such decision-makers.

Turning then to the process by which the Drugs Committee makes positive or negative recommendations about a particular submission, it is possible to say that there is a generally standard process which is followed. First, a request is made for the purchase (or in the cases discussed herein, formulary inclusion) of a product. This request identifies the product, the cost of that product, the indication for which it will be used, and the likely impact of that use. Indication, as it is used in the pharmaceutical and clinical setting, is a statement which defines the *disease* and the *population* for which the benefits are greater than the risks[35]. Each product has an approved indication from the EMA. England is somewhat unusual in that NICE recommendations and guidelines will frequently restrict the use of a product *beyond* the approved (label) indication (for example, restricting only to a sub-set of all eligible patients, or only for patients following the use of an alternative). This documentary request is part of the Committee's papers, the submitting physician is asked to attend in person, and is then invited to give an overview of the request. In the extract below, this introduction is shown, spoken by the Chair and then the immediately subsequent overview given by the surgeon, for a submission to include in formulary a high-cost product which is intended for use in orthopaedic trauma of the lower limb.

> **Committee Chair:** Perhaps just tell us a little about the product, why you think it should be included in formulary?
> **Surgeon**: Well, in a nutshell, I'm an orthopaedic surgeon, and I specialise in trauma and in particular compound injuries to the tibia and lower leg. Since we became a major trauma centre we've seen an increase in the number of major traumas coming here, and whilst we're doing our best with the technology we have available to us, for the complex injuries we're seeing,

[35] Based on the EMA definition.

about a third of them are coming back for a second procedure, sometimes third and fourth procedures because of the complexity of their injuries. In some fairly large randomised trials, the earliest published in 2002, people looked at using not just different mechanical products, like nails and plates and things, but having a biological interaction with the fracture itself. And they looked at bone morphogenic protein type 2, and it was impregnated in a collagen fleece which is absorbable and has a profile where it dissolves, the bone morphogenic protein is dissolving over a period of time, it's accreting a better blood supply to that area and stimulating new bone formation. A number of meta-analysis have now been done on different randomised controlled trials using this and the evidence is that using this reduces the rate of reoperation rate from around 30% to around 15%, so it's halving your reoperation rate for complex tibial fractures that are open, so it's the worst type of tibial fractures. And so, the problem is it's expensive, so there's also been some health economic studies looking at the cost of spending the money upfront and then the cost of the secondary intervention if you need it because you didn't get it, didn't heal up first time, and it depends on the country, so they've looked at France, Germany and the UK, and the average savings per patient if it's used in this indication, in the worst type of tibial fracture, on the first occasion, is around 6000 euros per patient. So because you are halving the number of patients that have to come back for a secondary intervention, the complexity of that for a hospital like [University Hospital Trust] is that we get paid for every intervention, so, ah, putting this medicine on the first one brings us an upfront cost which is difficult. Having said that, if it's agreed with the commissioners, in many cases, especially use of bone morphogenic protein used for other situations, we have bone morphogenic protein type 7 used for non-union fractures which is even more expensive, perhaps if we could agree something with the commissioners up-front perhaps we could have a deal where they would reduce their costs in the long run because we wouldn't see so many patients coming back, but before we can agree anything with the commissioners they wanted to know whether or not it was a safe drug to use and whether or not our [Drugs Committee] felt that it was something that our hospital wanted to have on the formulary in certain specific indications.

Committee Chair: Thank you very much. Questions?

Turning to this episode of talk from the submitting surgeon, we see at the outset the foregrounding of the category membership, in addition to the choice of 'scrubs' and surgical gown, as discussed above. We can see the subordinate specificity as a claim to a particular expertise; not only a member of the clinic, not only a surgeon, but also specialising in a further sub-speciality in that field; the speaker introduces himself by saying "I'm an orthopaedic surgeon", and detailing expertise in a particular sub-field and surgical type within orthopaedic surgery. This action is potentially noticeable because of its sequential positioning; the question asked, by the Committee Chair, is about the *product* and *why it should be included in formulary* (approved for use within the hospital). By choosing to respond *first* with a reference to his own identity – his belonging to a category of *surgeon* – the speaker demonstrates that, at least for him, this identity is

relevant to the prior speaker's question. The response is designed as a valid following turn from the Committee Chair's question; sequentially, the answer is given in the normative interactional position following a question and can thus be read by the other participants in the interaction that it is intended to be a response to that question. This reading of the interaction from a sequential perspective is reinforced by the un-markedness of the response; by this, I mean that the Surgeon's answer has no features which indicate that the speaker considers the response to be other than a socially appropriate and normative action in response to another action – he is producing a reply in response to a question. The question / answer can be seen to form an adjacency pair (to adopt the terminology of Sacks, Schegloff & Jefferson (1974) in the analysis of talk in everyday life). These sequential features support an interpretation that, at least for the Surgeon himself, the information presented in his answer is seen as relevant (to the question being asked). This is supported by the immediately following turn from the Committee Chair, which thanks the Surgeon and then opens for further questions from the other participants in the meeting. In terms of the turns at talk, the Committee Chair has asked a question, the Surgeon has produced a relevant and appropriate response (an answer) and the Committee Chair has then accepted that response as relevant to the question asked, by opening the conversational floor to other speakers. This is not only the ongoing management of turn-taking and sequential interaction in talk, but also shows that neither the Surgeon nor the Committee Chair identify a need for conversational repair; the flow of turn-taking is valid in that a question is followed by a relevant answer and accepted in this case by the original questioner.

The Committee Chair has raised two specific, linked topics, which can be glossed for the purposes of this discussion as being product-related. The question is specific – it can be read as requesting particular information, which does not specifically ask for the identity or professional role of the speaker. By reading the question in this literal sense, the preferred response is then to respond with information which is relevant to the product. Following an understanding of the sequential nature of talk in interaction, the following talk, unless specifically marked as being *other* than a second-pair part or response, can

then be read as the response to the question[36]. In considering the Surgeon's choice to produce a response which begins with an identity claim, rather than a response about the *product*, there are two possible explanations. Firstly that the Surgeon's response is other than a second pair part or secondly that it is considered – as I suggest above – to be an appropriate and adequate opening to a response to the question asked. Given that no one has questioned this formulation of his response and that the Surgeon is locally licensed interactionally to produce a long episode of uninterrupted talk, it is reasonable to read his response as having been heard by the audience as a normatively appropriate formulation of his response. This sequential positioning of topics – a question that asks about the *product* followed by an answer which begins with reference to the professional identity of the speaker, suggests that the speaker is, through this social action embedded in talk, constructing a relationship between the product topic and his own interactionally relevant (categorical) identity – i.e. the fact that the speaker is a surgeon is relevant to the question of the product and why it should be included in formulary (approved by the committee).

This is further supported by the other choices that the speaker has made; as mentioned above, he is, unusually for the participants in committees across University Hospital Trust, dressed in surgical 'scrubs' and gown. Both in his physical presentation and in his talk, his categorical identity – as a surgeon – is foregrounded and made relevant to the work of the committee. By making a claim to be a surgeon, and then further refining that category to a specific *type* of surgeon with particular focus – "I specialise in trauma and in particular compound fractures…" – the Surgeon is constructing himself as an occupant of a particular categorical identity. The sequential deployment of this identity as the opening part of his response to a question that is not *specifically* about identity is what serves to construct a relationship between the topic at hand and this categorical identity. In other words, the categorical identity adopted by the subject is refined, through his social actions achieved through talk, to be tightly coupled to the topic under discussion. Following the logic of Sacks' model of membership categorisation, we can say that this deploys into the social space some relevant set of shared social knowledge. I suggest that this action by the subject (the surgeon) in this case is intended, as might be expected, to

---

[36] See Goodwin & Heritage 1990, Sacks, Schegloff & Jefferson 1974, Schegloff 2007

orient other subjects to the relevant *knowledge*, conceptualised as a kind of capital, that he (the surgeon) possesses but which the other subjects do not. Expertise, conceptualised as the rights to make an epistemic claim or to disrupt others' claims over epistemic territory, can be seen to be actively deployed by the subject through the self-categorising action of both *presenting (acting) as* and *speaking as* a member of a specifically and locally relevant category (in this case, an orthopaedic surgeon specialising in lower limb injury); this can be seen, then, as an exemplar of the categorisation which I discussed and argued for in the previous chapter.

We can see the knowledge which is presented as the basis on which the Drugs Committee is expected to decide about whether to include this pharmaceutical product (an implantable collagen matrix, containing a protein which stimulates leukocyte activity and bone development) in University Hospital Trust's formulary. The surgeon mobilises the idea of "randomised controlled trials" to support the use of this product. We can see that for the surgeon there are some relevant dimensions to these trials – the size ("fairly large"), what might be called well-establishedness (age, "earliest in 2002"). The specifics are not necessarily interesting beyond the particular case under discussion; what is interesting in this example is the way in which the surgeon establishes that there are some relevant parameters by which the knowledge about a *clinical* topic can be defined and evaluated. This suggests that the *evaluation* of knowledge is something about which the surgeon is able to speak; he stakes a claim to the relevant epistemic space and establishes a relevant domain of knowledge (Heritage, 2012) (for the purposes of determining future treatment possibilities, i.e. through the decision-making work of the Drugs Committee). This is linked to the categorisation discussed above; the surgeon's claim to expertise, or the extent to which he asserts a valid epistemic claim over the domain of knowledge about the pharmaceutical product, is constructed by the subject himself as being a function of his self-categorisation.

This can be seen in a response to a subsequent question in the same meeting about the use of the protein in spinal repair, to which he immediately and off-handedly replies, "Well I know nothing about spines". This remark needs some interrogation. It is evidently hyperbolic, as we can assume that an orthopaedic surgeon who has successfully completed medical training and is currently held to be fit to practice would have at least

a basic knowledge of the anatomy of the spine. What the surgeon attends to here is not his knowledge of the spine as such, but his (self-constructed and self-limited) capacity to make a claim to the epistemic space of knowledge about the *product* as it relates to the spine. The purpose of the surgeon's introduction – as an orthopaedic surgeon with a particular specialisation – can be seen therefore as a pre-figuring of this differential claim over relevant knowledge. By aligning a claim over knowledge relating to the use of a product for tibial fracture, and then by denying that he possesses such expertise in a (related) surgical field, the surgeon's actions construct an orientation to knowledge such that the affordance (capacity) to perform a social action in relation to his proposed product-related knowledge, or in other words to contribute to the shared construction of an agreed-upon *medical gaze*, is limited to the members of a highly specific category. The surgeon's speech serves to construct the idea that there is a relationship between membership category and knowledge; it is both a specific claim in relation to the subject matter at hand (a product for tibial fracture repair) and it is a claim for the validity of this relationship, between role or membership category and some knowledge or expertise. Arguably, that this goes un-marked and un-challenged by the other subjects then suggests that this is accepted[37]. These actions show how the ongoing creation of a social space by subjects, and the use of membership categorisation, is in turn part of how the Drugs Committee is constituted through and by knowledge, as subjects exchange and orient to the claims over relevant knowledge.

The members of the Drugs Committee, after the introduction to a submission, have the opportunity to ask questions of the physician making the submission. As in the example question above, for the most part these continue to co-construct a shared set of knowledge about the pharmaceutical product, supported by reference to copies of clinical trial data or other types of putatively valid medical knowledge presented to the Drugs Committee (two examples are mentioned by the surgeon, in the excerpt above; meta-analyses and health economics studies). The topics that the Drugs Committee raise are interesting; although the questioning sequence is introduced in all cases included in this research

---

[37] See Parton (2014) for a discussion of epistemic stance in professional contexts.

project[38] by the Committee Chair with, "Any questions?" the sequence of topics is similar in all three cases. Whilst naturally this is likely to be part of the shared practices and conventions of how such meetings are conducted, what is notable is that the topics that are constructed as specifically clinical (efficacy, safety) are discussed first, and then subsequent to the establishment of the biological effect and use by physicians of the product, the topic then turns to price and cost[39] of the product. This mirrors the order of each introduction (as shown above), moving through the clinical usage of the product, establishing some (positioned as) valid knowledge, and then finally moving to the discussion of pricing, product cost and funding (to adopt the language of the subjects themselves).

As the Drugs Committee considers a submission, it first collaboratively establishes and agrees on the validity of the submitting physician's proposed knowledge about the product (through questioning and then accepting clinical knowledge as valid), and then begins to consider the economic implications of the product. Here it is worth being mindful that in most cases, the submitting physicians, focus at least partially on the *cost effectiveness* of a product, and on comparative cost, as in the following example:

> **Physician**: [continuing from past speech] We start with methotrexate, we treat pretty much everybody with moderate to severe disease. If they're not benefiting from that or they're not tolerating, we switch to subcutaneous. This is a new development, in the past not looked on favourably by GPs, but now we can do it, it's licensed medication, and we will avoid people going on to biologics by putting them on to subcutaneous with less intolerability issues. The next point, rituximab, is the cheapest biologic by far and it will become cheaper because of bioequivalents [biosimilars], it's really exciting […] so there are cost savings to be realised

---

[38] A single meeting was recorded, showing pre-and-post decision committee business and consideration of three separate submissions.

[39] Price is used to refer to the cost of acquiring a sellable unit of the product, whereas cost refers to the total cost of treating a patient with that product. Conventionally, multiple units are required to treat a patient, and so price is generally lower than cost.

In this extract of talk, the speaker is a consultant rheumatologist, presenting a submission to the Drugs Committee regarding the inclusion of *biologic*[40] agents in the hospital's normal or standard treatment approach for rheumatoid arthritis and similar inflammatory joint conditions. The speaker gives an outline of a treatment pathway or a sequence of drugs that are used for the treatment of rheumatoid arthritis.

The Physician uses a number of specific technical terms – the names of two drug products (methotrexate, rituximab), a drug class (biologics and the related term bioequivalents), and a route of administration (subcutaneous). As discussed by Drew & Heritage (1992), specialised vocabulary choice is a way in which participants evoke and orient to institutional context and lay claim to institutional identities (see also Housley & Fitzgerald 2002). The Physician's use of specific lexical items can be read as a claim to relevant medical knowledge; the Physician is self-categorising into a particular category-based identity of a treating physician. The Physician uses "we" in describing treatment actions. "We" is used to refer to the other members of the category to which the Physician belongs. "GPs" (general practitioners) are invoked as separate from the "we" group; as in, GPs are said not to like the decisions made by the group referred to as "we". The treating physician category can be read then as being a specific category of physicians, distinct from other doctors. This category identity is already available to the other participants, in the sense that they are aware from the meeting papers who the Physician is, and which department he is representing to the Drugs Committee. The Physician's talk makes the category relevant to the interaction at hand; it mobilises into the interaction a specific aspect of the institutional context in which the interaction occurs – namely, that the speaker belongs to a particular category of medical specialists.

---

[40] Biologic refers to a broad group of therapeutic agents, distinguished from other drugs by being 'large' molecules (composed of complex chains of carbon and other atoms) produced by living cells. This term can include hormones (such as insulin) or more commonly (as in this context) 'monoclonal antibodies', referring to drugs which are therapeutic proteins that (in many cases) bind to a specific site on a target cell to inhibit or provoke a particular immune-mediated response in the patient.

In this extract, the Physician also makes relevant the topic of cost saving and cost efficiency in making decisions about medicines. This emphasis on cost savings from spending on high-cost drugs stems from national policy, which mandates that NICE examine the cost effectiveness of any new product as part of making a decision about whether or not it should be routinely commissioned as part of the NHS. In practical terms, this translates to a reluctance to adopt new and high-cost medications without an economic justification. At the level of the hospital, this translates in each example into the identification of avoided cost, rather than the addition of benefit to the patient. In each case, when speaking of future treatments (as in the repeated surgery example, above) or the aggregate cost of readmitted rescue episodes for rheumatoid arthritis, an economic benefit is interpreted as being a benefit that accrues to either the hospital directly or to the commissioners (in the longer term) by avoiding future expenditure or by sufficiently targeting the use of a (comparatively) cheaper product, which is anticipated to become cheaper due to future competition[41] and avoiding the use of a more expensive alternative.

Considering purely the flow of finances within the NHS, this is consistent with who pays for high-cost pharmaceuticals, as patients will either face no charge, or a fixed charge that is inelastic with respect to the actual acquisition cost of a product. That said, the construction of economic benefit as accruing on the basis of payment is, in a sense, incomplete, as it does not consider the economic benefit of the improved *health* that the patient might experience as a result of one treatment over another. In this sense, then, the hospital-level decision-making process diverges from the (stated policy and official position on) considerations at national policy-making levels, where benefit is considered explicitly in terms of (largely artificial) constructs of adjusted patient life-years gained or lost to particular illness[42]. Furthermore, the focus on acquisition cost at the hospital and

---

[41] Rituximab, the product discussed in the second example, is a monoclonal antibody indicated for rheumatoid arthritis (among other diseases). Bioequivalent / biosimilar in this context refers to a near-identical molecule produced by a competitor once the patent protection on rituximab has expired; biosimilar is used as large-molecule biologic therapies are produced by cloning and cell-culture-based production technologies which have been determined by regulators to not produce 'identical' (as in the generic medicines sector) copies of the original, but only 'similar' versions.
[42] See https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-technology-appraisal-guidance

commissioning level seen in the Drugs Committee also suggests that the economic incentives that are faced by hospitals and commissioners are more properly thought of as financial incentives, in that they are concerned with the allocation of funds and the available budgets to expense, rather than investment for the greatest economic utility in general.

Closing and decisions

The following is taken from a submission to include new options for patients with ulcerative colitis; the request is to use a high-cost biologic therapy for patients who have previously been treated with azathioprine (a generic, small-molecule immunosuppressant, used extensively for idiopathic and rare autoimmune diseases, multiple sclerosis, and in certain post-solid-organ transplant cases) and who require an intervention to treat a flare of the disease and then a substitute maintenance therapy. The biologic is an alternative to cyclosporine (another generic small-molecule immunosuppressant, considered unacceptably toxic for long-term use in ulcerative colitis).

Chair: Thank you very much and I'll get you our [unintelligible].
Submitting physicians stand and exit, nodding to the members of the Committee
Chair: So, in terms of the clinical case here, any comments or questions? It seems entirely reasonable to me
Committee members shake their heads, murmur "no"
Physician: It's a small population, so
Pharmacist (1): It might be a small number of people, but know that regionally it is quite carefully, um, in terms of prioritising for funding because even though it's a very small pool patients compared to what NICE have said about maintenance therapy the [regional committee] has looked at it and there doesn't seem to be any evidence that actually in the long term prevents colectomy so it's more delaying the inevitable which we might consider to not be the highest priority for funding at the moment, given the financial situation.
Pharmacist (2): It depends really what our local commissioners say but I suppose there is a risk that we might get some post-penalties, prescribing penalties.
Pharmacist (1): Yep.
Finance: It's on the drug list as being excluded, but it says it's commissioned against ulcerative colitis
Pharmacist (1): It's for rescue therapy, though,
Finance: Oh, well, I'm not that specific, so *(laughs)*
Pharmacist (2): But they have argued very much that they don't agree with this indication, so we need to really, see

Chair: *(Interrupting)* So in terms of clinical case, it seems we're reasonable happy with this one [overlapping / unintelligible] it comes back to the funding issue.
CCG: No, we haven't, we haven't got a problem with that, we've had IFRs [individual funding requests] for those before and we've agreed most of them, I mean, I think this year we've had about two so he's about right on the number and we've already been funding, across the patch.
Pharmacist (2): But [regional committee] been very negative about this
CCG: Well yes, but they've looked at the costs and they think everyone should just have a colectomy and well *(throws hands up in the air)*

This extract shows the Drugs Committee moving towards a decision; the submitting physicians exit and are non-present for the discussion of their case. In this instance, the Drugs Committee goes on to endorse the case, and refer to the CCG for funding (contravening the regional committee's recommendation). This is achieved through talk – as in, the process of moving from the physician's presentation of the case for a drug decision is then the subject of discussion between the remaining participants in the committee. What I wish to highlight in this brief transcription from the recording is the *interactional* nature of the process; there are multiple subjects involved in the discussion, including a non-clinical expert (a finance representative, noting that the CCG representative on this particular committee is also a pharmacist). Each of the speakers – constituting all the members of the committee *except* the patient representatives and one administrative member of hospital staff[43] – makes a contribution to the decision process, by taking a turn at talk, as shown in the above transcript. There are both positive and negative opinions advanced by those subjects; Pharmacist (1) and Pharmacist (2) both noting the challenges that the product has faced in gaining a positive recommendation at a regional (i.e. serving multiple hospitals) committee which considers implementation of NICE guidance and formulary advice. The Chair interrupts, and is interrupted (or rather, spoken over) in turn, and reframes the *negative* opinion given by Pharmacist (1) and Pharmacist (2). What is notable here is that the Chair frames the preceding talk through describing a collective stance, or position, that the committee is taking, by saying that "we" [the Committee] are "happy" with respect to the clinical decision, and that the potential negative decision is related to a "funding issue" (i.e. the question of whether it is justified to allocate regional or hospital funds to a particular treatment). This is despite, as stated by Pharmacist (1) in his initial talk, there being no evidence that this particular

---

[43] This staff member was present to take notes (minutes) of the meeting.

treatment leads to a change in long term outcomes for ulcerative colitis; the end state for patients (a colectomy, referring to a surgical resection of the large bowel) being delayed by treatment with a high-cost product, not changed.

Whilst the Chair and the pharmacists frame the challenge to approving the product in terms of cost, the participants' own talk shows an awareness of some features of the product which are related to patient outcomes (and therefore the clinical case). Examining the turns at talk from Pharmacist (1) and Pharmacist (2) and then the Chair's interruption, it is not entirely clear that the Chair's summary – that the Committee is broadly satisfied with the clinical case – is supported by the *content* of the talk. It is at least possible that the objections raised by the pharmacists are in fact within this clinical domain, related to the outcomes and lack of evidence raised by Pharmacist (1). By interrupting and reframing the prior talk, however, the Chair is not simply seeking to reflect the *fact* or *content* of what others on the committee have said, but to reframe it and constitute that talk in a specific and particular way. By making a broad statement regarding the collective stance of the committee (with respect to a clinical case), he is using his utterance as a way to close out a particular topic and shift to another, relevant topic – the question of funding. It is this shift in topic – framing the prior talk as being primarily concerned with clinical and then moving to funding which opens the floor of the discussion to the subsequent speaker, the representative from the CCG[44]. This shift – achieved through the Chair's interruption – constitutes a proposed position (that the Committee is *de facto* in agreement) and then invites contribution *only* on the remaining area of disagreement.

The funding discussion continues, in the above, with the CCG representative outlining a process by which funding can be allocated at a regional level, replacing the individual, per-patient funding referred to in the above extract. This is followed by a closing-out sequence (Raymond & Zimmerman, 2016). The Committee's decision is achieved through *talk* rather than through a formal vote (recalling that the Trust's committees have

---

[44] Clinical Commissioning Group. The speaker is shown as 'CCG' in the transcribed extract.

either formally by constitution or less formally by terms of reference a distinction between members and *ex-officio*, non-voting members). This is shown in the below extract of talk:

> **Finance**: *(Addressing CCG)* So you'll come back after the January meeting if there's any
> **CCG**: *(Interrupting)* It'll come back after the January meeting.
> **Pharmacist (1)**: No this just needs to send everything *(holds up papers)* to the CCG and they'll send it back to us after
> **CCG**: Yep, yep *(nodding)*
> **Chair:** Ok, so I think we've got [name]

What can be seen in the above extract is the end of a sequence in which a number of subjects have agreed the future actions to be taken, ending with the Finance and CCG representatives clarifying the process by which a decision will be taken forward. The Chair then closes the entire topic-at-hand by moving to the next submission by mentioning the name of the submitting physician, in the final line of the above transcript. The decision about the pharmaceutical product itself is dispersed across talk; it is an agreement to pursue some future actions, rather than a strict positive or negative vote. A decision is reached through the closing of the topic and moving to the next. There is no obligation for all members of the Committee to speak in order for the decision to be taken, and the absence of a formal vote means that there is no other mechanism by which non-speaking members of the Committee directly participate in a decision.

That the Chair can perform this action without objection from the other committee members supports the proposition that participants accept such agreement to arise through talk, rather than be *specifically* accounted for by a vote or similar more explicit process. By taking a next turn at talk (for the following speaker, the CCG representative) and allowing the discussion to continue in line with the topic shift introduced by the Chair (in the case of the other participants), the other members of the Committee signal their acceptance and alignment with the process by which this agreement has come about. Again, as in the earlier example, the un-markedness of this process indicates that the Committee members regard this as a valid interactional mechanism by which an agreement is determined to have been reached. The decision (the collective position taken by the Committee) is made visible in the interaction through an utterance produced by

the Chair. This is taken by other participants as being a valid way to achieve a decision. This move by the Chair might also be taken to reflect an assessment that no other speakers are entitled to or qualified to object to the position reached; by closing off the topic at hand, the Chair suggests that no further input is required or relevant.

Participation and speech

The Drugs Committee meeting presents a challenge to understanding the role of patient Governors in the hospital. The patient Governors are present in the meeting as first-hand observers of the decision-making process. They do not, in these data, actively participate through talk in this process. Discussion with the patient Governors, after the video-recorded meeting, gives some further information about this. One of the patient Governors included in the recording expressed that the patient Governors agreed that being part of the Committee was important; it was an important part of their role in the Trust to attend the Drugs and Transplant committee meetings, even if they didn't have anything to say. He also offered an account for this; that he did not really feel qualified to contribute to the discussion, as it was mostly technical, but that they were there if they were needed. He felt that, despite not speaking during the meeting, he and the other patient Governor were fulfilling an aspect of their role as governors, and that they were still valid members of the Committee. The patient Governor raised two important ideas in discussing the Drugs Committee. Firstly, that observing and being present in the meeting was performing their role as a Governor. Secondly, that a reason for their choice not to speak during the meeting was related to a perceived difference in expertise and knowledge between himself and the other participants.

Despite not speaking in the decision-making process, the patient Governors are nonetheless part of the meeting. They are physically seated at the table, receive the same meeting papers and materials as other participants, and are recorded in the minutes as present. The patient Governors are participants on at least two levels – they are physically co-present in the space in which the interaction occurs, and the institution in which the interaction occurs acknowledges their presence through the records kept of the activity – minutes and agenda papers which describe the meeting having occurred and the decisions

made by the Committee. That a co-present but non-speaking participant can be considered part of an interaction has been acknowledged by social interaction research. As discussed by Levinson (1988), although the dyadic model of ordinary conversation provides a prototypical participation framework of speakers and hearers, these categories alone are not sufficient for all roles in interaction. Levinson's (1988) work opens up the possibility of roles in interaction being other than speakers and hearers, particularly in institutionally ordered interactions. The meeting minutes and agenda papers support the argument that the patient Governors are fulfilling an institutionally ordered role by being present in the meeting; their presence is recorded as a sufficient and necessary condition of the meeting being formed correctly – they are members of the Committee who are expected to be present and whose presence (or correspondingly absence, in the case of apologies to a meeting) is noted by other participants. That they do not speak during the meetings is not seen by other participants or by the institution as a violation of their expected role in the interaction.

This suggests that whilst these data show a distinction between speaking and non-speaking participants in the work of the Drugs Committee, the participation framework (Goodwin & Goodwin, 2004; Goodwin, 2007) which enables the interaction to occur includes and allows for non-speaking participants who fulfil an institutionally ordered role. However, that the patient Governors are participants in the interaction is not equivalent to participating in the decision-making process which is achieved through that interaction. The patient Governors observe the decision-making process happening, but it is not possible from these data to determine if their presence has any impact on the decisions made. The other speakers – the Chair, doctors, representatives of the CCG and so forth – are aware of these co-present and non-speaking participants, but it is not possible to determine from the data if those speakers make different choices as a result of this awareness.

Decisions of the Drugs Committee are made by speakers who are categorised by their talk and action as being in expert categories; these participants are doctors, pharmacists, representatives of the CCG, and representatives of hospital managerial functions. The *ex officio* members of the Committee (who represent hospital managerial and administrative

functions, seated to the left and right of the Chair) provide technical information related to the status of documents and of negotiations between the Clinical Commissioning Group and University Hospital Trust. As suggested by the account offered by the patient Governor, the talk is mostly technical in that the information presented to the Drugs Committee by speakers is specifically related to the expertise of those speakers. By claiming membership of a particular category – i.e. by producing talk and actions which can be recognised as being category-relevant – speakers are asserting a claim to a particular domain of knowledge in which their speech has epistemic validity (Heritage, 2012). Taking a turn at talk then asserts the relevance of that speech for the decision-making process at hand. By simultaneously asserting their epistemic positioning with respect to a domain of knowledge and taking a turn at talk which contains information which is accessible to others in the interaction, speakers are asserting both that the information is valid (they have a valid epistemic status with respect to that knowledge) and that it is relevant (that it contributes to the work of the Drugs Committee). That the speech is mostly technical, in the words of the patient Governor, reflects that the talk in the Drugs Committee consists of claims to epistemic status and the positioning of knowledge as relevant to the work of the Committee. The patient Governors do not make such claims; they do not assert an epistemic status with respect to a domain of knowledge and then simultaneously position that knowledge as relevant to the Drugs Committee. Equally, the other participants – notably the Chair – does not specifically invite speech from the patient Governors; i.e. the domains of knowledge which are mobilised by other speakers are sufficient to reach a valid decision through talk.

Summary

In this Chapter, I have discussed the work of a clinical committee, in which the business of the Drugs Committee was focused on the ongoing clinical management of the hospital (i.e. the execution of its day-to-day activities). In doing so, I outlined the decision-making process for pharmaceutical products in England, and then discussed what implications this national context has for hospitals. I have shown that the decision-making process at hospital level shows how subjects orient to knowledge and the claims that (other) subjects can make over such knowledge. I have also discussed how the empirical findings suggest some complexities in conceptualising how a non-speaking participant can be seen to

contribute to a decision-making process which is achieved through talk. Specifically considering the first research question, this chapter has used examples from a committee focused on a domain in which expertise and knowledge is made relevant to decision making by participants. The findings of this chapter are somewhat equivocal, in that there is in these data collected for this research a distinction between the speaking participants (i.e. the non-elected, expert members of the committee and the physicians presenting a case for decision) and the non-speaking, elected representatives. This suggests that there are potentially barriers for patient and public representatives making a contribution to such decisions in the same or similar ways to how decisions are contributed to by the experts. This is because the decisions within these committees are achieved through talk – the decisions are made through a process of ongoing interaction and mutual cooperation with the discussion of the committee. The decision is made by experts through talk, with no contribution through talk made by the elected patient and public representatives. Whilst the patient and public representatives can be said to be participants in the committee and thus participate in making decisions through their presence and tacit cooperation with the decision-making process, it is nonetheless clear that, at least in this case study, their contribution to decision-making could be characterised as a passive oversight, rather than an active contribution to such decisions. The individual participants in this study confirmed during informal discussion and ethnographic observation of both the meeting analysed in this chapter and similar meetings of the Drugs Committee that this passive attendance was typical or normal for the Drugs Committee (and similar clinical committees, particularly the committee with oversight of blood and organ donation / transplant).

Within the confines of an analysis of conversational interaction, it is not possible to determine what (if any) specific impact the patient and public representatives had on decisions made in the Drugs Committee. Whilst this is a limitation of a conversation-focused approach to examining the work of a governance committee, analysis of the talk within the committee highlights why this negative finding is important. The speakers within the meeting are engaged in making decisions which arise and are agreed through talk. Expert speakers make their social categories – their membership of a particular group – relevant to the talk at hand. The category of public or patient is not made relevant to these decisions. Thus, whilst the documentary record of such committees would note the

attendance and presence of public and patient representatives, it would not identify, as this analysis has done, that there is a distinction between how the experts contribute to decisions – through talk and making their category membership relevant – compared to the lay members of the committee – who do not speak. The limitations of this finding should be acknowledged; this distinction was usual for a particular hospital as a case study. It is not possible to conclude that this would be similar in other hospitals.

In the following Chapter, I will examine how Governors discuss clinical events (i.e. situations involving actual patient care, in some way) within governance meeting contexts, and further discuss how knowledge and expertise are deployed and made relevant by participants in governance and decision-making processes.

6. Unsafe care, "never" events and patients

This chapter moves the focus of analysis from the work of a group with a specifically clinical remit to the sub-committees which report to the formal governance group (the Council of Governors). These Working Groups, as discussed in chapter 4, are created by University Hospital Trust with the explicit intention of creating greater affordances for action and increasing the opportunities for Governors to be directly involved in directing the work of the Trust. As more informal groups than the Council or Board defined in the Constitution, the structure of these sub-committees (in terms of their group composition and remit) is inherently less stable than the Council of Governors. An illustration of this is that the working groups or sub-committees change over time. The working groups examined in this fieldwork were superseded by a different set of committees with different nomenclature, new remits, and new membership selected from the Council and Board at the conclusion of field. During the ethnography and fieldwork for this thesis, there were three working groups that reported to the Board of Governors. Each Working Group had three scheduled meetings annually. The three groups and their main focus are set out below:

Forward Planning	*Financial and strategic planning for University Hospital Trust*
Governance & Assurance	*Performance / assurance reviews and governance framework*
Quality & Public Engagement	*Monitoring of quality indicators and planning of public engagement, including events led by Governors and hospital staff*

The fieldwork captured a complete annual cycle of meetings for each working group. Each working group meeting was chaired by an elected Governor, and attended by Executive Directors of University Hospital Trust. Attendance by Executive Directors and other senior hospital staff-members was determined by topics on the agenda of each meeting of the working group, with Executive Directors attending to speak to a particular topic. At each meeting of a working group, discussion of agenda items (other than committee items such as attendance and acceptance of minutes) followed a common pattern. An Executive Director or other senior member of hospital management in attendance would give a brief oral presentation regarding the topic at hand, followed by a period of questioning and then a move to the next agenda item, initiated by the Chair of

the working group. This was common to all working groups in University Hospital Trust, and was consistent across the fieldwork data. Exceptions to this structure occurred in only a small number of cases; one item in the Quality and Patient Engagement working group involved a formal audio-visual presentation from a paediatric (teenage) patient involvement group[45], and in the case of some items which were presented as written reports for noting or for information only. In these latter cases, the Chair would raise the topic, note the report, and open the floor for discussion.

In this chapter, I analyse examples of the typical topic discussion structure, in which an Executive Director presents an opening or framing narrative to the working group, followed by questions from the public and patient Governors. In the fieldwork data, the topics presented by Executive Directors across the working groups were varied – discussion topics included financial and strategic planning for the hospital, hospital-acquired infection management, potential reforms to end of life care processes, improving community engagement, care quality indicators, hospital performance monitoring, and patient safety events. The allocation of particular discussion topics to a specific working group was determined by the scope and terms of reference of each group, which in turn had been developed by University Hospital Trust and (as noted above) was subsequently altered significantly following the end of data collection. To understand the actions of patient and public Governors in subordinate groups, then, I propose that it is more useful to examine how a particular *topic* or *event* forms a locus of governance actions and deliberation, rather than to attend to the distribution of activity across organisational structures which are not only potentially changeable but demonstrably fluid even over a relatively short period of time. By examining a particular topic, in this case defined as types of events occurring within the hospital, I am able to focus predominantly on the social construction of governance actions and activities in relation to phenomena which occur independently of the organisational structure through which they are examined, and which can be reasonably assumed to be of continuing relevance to any further subordinate committee(s) in the same Trust, and of relevance to similar Foundation Trusts.

---

[45] Captured in fieldwork notes only; ethics clearance prevented the recording of research participants less than 18 years of age.

Specifically, this chapter examines how Governors and Executive Directors discuss patient harm and "never" events, with a focus on addressing research question two – how expertise and knowledge can be deployed to shape governance and decision-making. In this analysis, I examine the ways in which Executive Directors deploy knowledge within narrative explanations of "never" events. In these narrative descriptions, the Executive Directors can be seen to be taking particular positions on the "never" events themselves. I argue that these narratives function to present information to the working group and to shape how Governors can respond to these "never" events. The Executive Directors are constructing an interpretation of a "never" event; by doing so, they create a set of potential positions and stances to which Governors can align. This is achieved through claiming authority and knowledge over particular relevant domains of knowledge. This chapter discusses two instances of "never" events reported to a working group; one involving a retained guidewire, and one involving an incorrect implanted prosthesis. I will first discuss the "never" event as it is defined within the NHS, and then turn to how such events are represented and co-constructed during governance processes.

Safety and "never" events

Proposing a straightforward definition and understanding of what constitutes safe medical intervention, and what the obligations of health-care professionals are to the stewardship of patient safety, is a task that is without doubt significantly greater than the scope of this analysis. It should be acknowledged at the outset that there are key problems in defining what constitutes safe; what level of benefit for an individual patient outweighs the risks of increasing severity of disease, for example. At what stage do adverse effects become greater than the disease that is regulated by an intervention? Indeed, should such questions be classified as being relevant to an understanding of safety, or are they more properly considered as issues of bioethics? Despite these (and other) ongoing conceptual challenges, it is manifestly the case that there exist *practical* definitions of safety, harm, and risk which are used by health-care systems globally. Patient safety is one of the priorities of the World Health Organisation (WHO, 2008), for example, structured around three themes (reduction of hospital acquired infections, improved surgical safety, and

improved medication utilisation) from the inception of the patient safety initiative in 2004. Similarly, the Cochrane Collaboration held a workshop in 2015 to examine how its systematic reviews could support improvements in patient safety (Tort, et al., 2015). In examining how University Hospital Trust deals with issues of patient safety, I propose that the most relevant definition and understanding of safety is that which arises from the context in which the Trust operates, noting that this is the definition as used in practice and is reflective of how a potentially inchoate and complex concept (safe health care) is deployed within this specific context, rather than a proposed absolute or ideal definition.

Turning then to the NHS context, the responsibility to deliver safe care is one of the fundamental standards required of care providers, and is subject to regulation by the Care Quality Commission (CQC). Specifically, for NHS trusts (including Foundation Trusts), the regulation is (deliberately) simple, requiring that care is delivered in a safe way for service users, with the intent to prevent both unsafe care or treatment, and to prevent avoidable harm or risk of harm[46]. The broad regulation is accompanied by guidance which sets out more specific processes which must be followed in order for a provider to satisfy the CQC that It is meeting this fundamental standard. These processes are intentionally non-exhaustive; providers are expected to demonstrate that they have done everything reasonably practicable to provide safe care and treatment. Safety standards are monitored in two principal ways in Foundation Trusts. Firstly, the CQC maintains a program of scheduled and random inspections of all care providers, and is empowered to require corrective actions, increase supervision, make specific recommendations or prevent a provider from continuing to operate, on the basis of such inspections. Although inspections include a checklist-based approach, in which specific good practices are monitored, safety monitoring by the CQC includes more investigatory and unstructured examination of records, observational practices, site visits and interviews to determine whether a provider is safe. Alongside these formal inspections, Foundation Trusts also monitor internally, and in comparison, to other, similar hospitals, a range of measures which are used as a way to determine the relative (in relation to other hospitals) and absolute (in relation to defined thresholds) safety of a service, generally in between formal

---

[46] For further detail, see the CQC website http://www.cqc.org.uk/

inspections and as part of governance and management processes. These safety measures are included in the periodic monitoring and supervisory role of Monitor (the Foundation Trust regulator) in overseeing the activities of Foundation Trusts.

The definition of patient safety can be seen as being intimately bound up in the measurement of it. The influential Dr Foster Unit at Imperial College London, working in collaboration with the NHS National Institutes for Health Research, has published a number of reports on the quantitative measurement of patient safety (Tsang, et al., 2008) (Dr Foster Unit, 2008) (Aylin, et al., 2010) (Mastellos & Aylin, 2012), which have been used to establish a series of standardised performance measures and indicators which enable the systematic monitoring of patient safety in hospitals. Although (particularly for standardised mortality rates) there are additional statistical procedures specified for some measures, the essential nature of these indicators is that they are a calculated percentage of a specified clinical event occurring within a particular population. Events can include diagnosis of infection, occurrence of a fracture, or mortality, within populations such as admitted patients (i.e. for hospital acquired infections), post-operative patients (for new fractures), or adjusted on the basis of *expected* or *risk of* mortality (in the case of standardised hospital mortality rates). These measures are then used as being robust estimates of the safety of a hospital; lower event rates are equated with safer care. From this logic, it is possible to see that safety in the NHS is defined as the avoidance of an event, where such an event is defined as being a negative (or unsafe) outcome. Moreover, if we interrogate the notion of a standardised rate further, we can see that there is implicitly an expected negative event rate, particularly for mortality rates. In other words, the measurement of patient safety inherently creates an expectation that it is acceptable for a certain number of patients to die whilst undergoing medical treatment, and that events within the expected rate do not constitute an unsafe outcome.

There is a point that must be made, here, regarding the genealogy of safety and performance measurements. As cited above, the quantitative measurement of patient safety in England is heavily influenced by the statistical analysis of a specialist academic unit. There are some fundamental questions that might be asked about the role of private finance in the design of these measures, given that Dr Foster is a vendor of data to measure

safety and performance of hospitals and also funds the work of this unit. Certainly, if we accept that there are questions to be asked about the complicity of the pharmaceutical industry in inflating drug prices, then I would suggest that there are similar questions to be asked about a vendor contributing to a customer (the NHS) defining the products that the vendor will subsequently provide. This is perhaps something of a surface issue. What I argue is far more important to establish about this way of measuring patient safety is that it is inherently an imposition of the medical gaze onto the patient subject. In the NHS' definition of safety we see how Foucault's understanding of the clinic (Foucault, 1973) is central to the configuration and design of the health system itself, in the sense of the ways that it monitors and determines that it is achieving its goals with respect to patient care. By defining safety measures *a priori* in terms of events, the NHS inherently strips from the process the experience and perspective of the patient. Events require the medical gaze; they require the patient to become subject to the diagnostic force of the clinic and for that diagnosing gaze to then determine, based on the agreed-to definitions *of the clinic itself* whether such an event falls into a category which is expected (and therefore safe) or not (and therefore unsafe). The patient is unable to self-diagnose in a way that will be recognised as valid by medical practitioners and by the clinic. This is inherent to Foucault's conceptualisation of subjectification. The patient is thus disempowered and excluded from the process of determining whether care was safe or unsafe. The patient is unable to intervene through participation in the diagnostic process, and is unable to interpolate into the measurement of safety a definition outside of the discourses of the clinic, given that safety is predefined according to the avoidance of harm against agreed ways of measuring and diagnosing that harm has occurred.

Although some of these concerns are echoed in the emerging concerns of the sociology of patient safety (Waring, 2007; Waring, et al., 2016; Allen, et al., 2016; Freeman, et al., 2016), I suggest that taking up Foucault's understanding of the intimate entwinement of knowledge and power in the operation of the clinic enables a more radical view. My argument is that the medical gaze inherent in defining an adverse event, including the acceptance of some level of error or some level of acceptable risk (Waring, et al., 2016), is inescapably the power of the clinic to regulate the bodies and experiences of patients. This is not to say that it is *ill-intentioned* (necessarily), but to set out that even the investigation of the patient experience, or the inclusion of some element of patient voice,

as discussed in the research collected in the Allen, et al. (2016) special issue of *Sociology of Health & Illness*, is still within the subjectification of the medical gaze and the power of the clinic. The creation of the patient-subject is inherently due to the operation and imposition – the literal penetration of the body – by the medical gaze. Experience *as a patient* and *of a* patient is defined by the creation of patienthood by and through the logic and discourse of the clinic. This is a central problematic for the clinic (in the sense used by Foucault) both in the imposition of diagnostic criteria for the determining of safety and in the apprehension of the patient voice. The clinic defines the terms according to which patient voices become intelligible and relevant in the clinical context; the clinic cannot understand the patient voice unless it first creates it.

The definition of safety events in the case presented in this thesis and in the NHS in England demonstrate a lack of patient-subject experience in institutional definitions of safety. The rates of safety events are routinely monitored. Some specific events are subject to a greater level of investigation and regulation. These are referred to as "never" events. These are a predetermined list of 25 events that are "serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers" (Keogh & Cummings, 2012). The policy on never events was first established by Keogh and Cummings in 2012, and this definition is taken from the policy in force during the fieldwork for this thesis (dated 2012). The policy has subsequently been updated (2015)[47]. The list of never events included within the 2012 policy are:

- Surgical events
  - Wrong site surgery
  - Wrong implant / prosthesis
  - Retained foreign object post-operation
- Medication events
  - Wrongly prepared high-risk injectable medication
  - Maladministration of a potassium-containing solution
  - Wrong route administration of chemotherapy

---

[47] See https://www.england.nhs.uk/patientsafety/never-events/

- o Wrong route administration of an oral / enteral therapy

- o Intravenous administration of an epidural medication

- o Maladministration of insulin

- o Overdose of midazolam during conscious sedation

- o Opioid overdose in an opioid-naïve patient

- o Inappropriate administration of daily oral methotrexate

- Mental health

  - o Suicide using non-collapsible rails

  - o Escape of a transferred prisoner

- General healthcare

  - o Falls from unrestricted windows

  - o Entrapment in bedrails

  - o Transfusion of ABO-incompatible blood components

  - o Transplantation of ABO-incompatible organs as a result of error

  - o Misplaced naso- or oro-gastric tubes

  - o Wrong gas administered

  - o Failure to monitor and respond to oxygen saturation

  - o Air embolism

  - o Misidentification of patients

  - o Severe scalding of patients

- Maternity

  - o Maternal death due to postpartum haemorrhage after elective caesarean section

Reviewing the development of "never" events policy back to 2004, or more than a decade of defining which events in hospitals constitute serious and preventable failings, there is no evidence of systematic consultation with or input from patients in the definition of "never" events[48]. The list (reproduced above) is, from the perspective of the clinic, doubtlessly non-arbitrary, but the distinctions between a "never" event and an acceptable

---

[48] There is some limited evidence of patient input into *precursor activities* of related bodies (such as the inclusion of lay representatives in the National Confidential Inquiry into Patient Outcome and Death, which as a body has contributory representatives on the Surgical Services Expert Group, who consider 'safety' in surgical pathways).

negative outcome are the construct of and therefore represent the functioning of the *power* of the clinic in the contemporary NHS. Furthermore, the classification of an event as belonging to a "never" event category is entirely dependent on the cooperation and collaboration of the clinic to agree that the circumstances of an event match the requirements (of its own definitions). To be entirely blunt; if an individual attends an NHS hospital and dies, it is the decision *of that hospital* whether that death should not have occurred or is just a death in the course of medical care. This is inescapably problematic, no matter how well-intentioned the design of a public disclosure scheme, in the extent to which it exposes that the regulating power of the clinic has ultimate authority over the classification of experience, over whether care is safe, over whether an event should or should not have occurred. Whilst there may be other means – *ad hoc* complaints, legal proceedings – by which a patient-subject can resist the logic of the clinic, it is a struggle against the constraints placed on the patient-subject. This is not to say that there is not a natural order to deaths that occur during or in parallel to medical intervention. I do not reject entirely the validity of the biological basis of disease and of biomedicine. My intention here is to emphasise that the way in which an event is understood as being either the *most serious* of failings, the occurrence rate of which should be 0, or a tolerated potential outcome is determined by and through the ordering of things within the clinic. Following this logic, my argument is that to subvert this and to assert an alternative understanding of a medical event is therefore likely to be the site of struggle for a particular subject.

For the patient Governors, the "never" event becomes relevant as a *post hoc* notification. Once the medical system (i.e. the hospital) has classified and determined that a circumstance is within the definition of a "never" event, a provider is required to follow a standardised incident response process, the emphasis in which is on both reporting and recording the event, and on learning from the event, so as to find ways to prevent it occurring in a future, similar circumstance. Interestingly, the emphasis in the "never" event process is on explicitly examining the contextual and institutional conditions under which the event occurred, presuming that failure is embedded within a particular context and is the product of that context, rather than the responsibility of an individual. In the words of the policy document:

> "The causes of a patient safety incident cannot simply be linked to the actions of the individual healthcare staff involved. All incidents are also linked to the system in which the individuals were working. Looking at what was wrong in the system helps organisations to learn lessons that can prevent the incident recurring." (Keogh & Cummings, 2012, p. 6)

The process by which a "never" event is to be investigated, although subject to local constraints, is set out in broad terms in the policy. The first stages are to inform patient(s) and caregiver(s), and then the commissioning body and regulators. Following this informing step, a local investigation process is expected to take place, at the end of which a report to the (public) Council of Governors is made. In practice, and in line with the intention of the policy to promote a culture in which disclosure of safety concerns by medical staff are encouraged, "never" events are reported to Governors and Directors as soon as they are identified by the University Hospital Trust. It is at this point, during a confidential meeting between Governors and Directors in a subordinate group, reporting to the Council of Governors, that we can begin to see how these "never" events in practice are structured and how the patient Governors are engaged in responding to them.

Disclosure, narratives and subjects in "never" events

The series of meetings at which "never" events were discussed is formed as a Working Group composed of Governors, Executive Directors and Non-executive Directors. Governors representing all three constituencies (staff, patients, and the public) were in attendance in both discussions that are sampled in this analysis[49]. In common across all the subordinate groups, the working group is chaired by an elected member of the group itself (in this case an elected patient Governor). The remit of the working group, as described by University Hospital Trust, is the quality of care and the development of the patient experience. This translates into a combination of recurring / ongoing monitoring (through standing agenda items) of clinical quality indicators and discussion of discrete issues and projects which are felt to directly affect, or potentially affect, the patient experience. The determination of each agenda of the working group is largely the

---

[49] Governors representing local area partners (including the associated research university, closely linked specialist NHS Foundation Trusts, the local authority, and the Clinical Commissioning Group) were not members of the working groups.

responsibility of a designated Executive Director[50] supported by a management function within the Trust; some consultation is done informally with the Chair of the group. It is critical to note that this is a private and confidential meeting, in which the only standing record[51] is the minutes controlled by the management of the Trust. As might be expected, these minutes (as the official record of the group's discussion and deliberation) are reviewed for accuracy at the following meeting of the working group; in practice, the minutes are almost always accepted as presented, with only very minor corrections proposed across 18 months of observation and recordings. It is, I propose, critical to understand that the transformation of a deliberative process achieved through a face-to-face discussion into a written description (the minutes) is implicitly bound up in the enactment of the social position by the subject(s) responsible for this transformation (Trust management). Abbreviated written minutes can therefore be seen to be only partially reflective of the totality of a deliberative process, both because of their deliberately summative nature (describing a process and outcomes, rather than verbatim reporting), but also because we can see these written documents as a social action in and of themselves. They are a projection outward into the shared social space of a proposed re-interpretation of past actions, a re-configuration of social space according to the goal(s) of the subject producing them, in the same way that any social action can be seen to be similarly concerned with shifting or maintaining the relative social position of subjects.

Introducing "never" events to the working group is done as a verbal report, given by an Executive Director. Executive Directors are employees of the Trust; members of the Board with (delegated) responsibility for exercising the powers of the Trust in a specific area of their expertise. Executive Directors are thus, in the model of governance based on the theory of the firm, *agents* in the sense of solving the principal-agent problem; they embody the function of the firm which directs its activities according to the interests of owners, and they are also *management*, in the sense that they are defined (categorically) by membership of a locally structured and understood organisational role. The actions of Executive Directors can therefore be viewed as being, if not equivalent to, then at least

---

[50] In this case a non-medically qualified ED with responsibility for patient liaison.

[51] Excepting the recordings captured for this research.

importantly constitutive of the actions of the Trust as a corporate entity in total. In the following extract from a working group meeting, an Executive Director introduces the verbal report of a "never" event, as an addendum to a quantitative performance report (the "September report" referred to in the transcript):

> **Executive Director:** I think first of all most of you will be aware that um, although I think *(shuffles papers)* there was a never event reported in October although this report relates to September we'd had a never event by the time we'd written the September report. This never event *(pauses)* relates to a retained guidewire. It was carried out by an extremely proficient individual, very experienced and senior person. It was done in an area outside of that person's ordinary area of work, which was felt to be a contributory factor. The investigation has been carried out and the draft report has now been circulated for factual checking. Again, in terms of the never event committee, we'll return to that particular area and review and see whether we have forgotten or, it's sort of, looked over the lessons we learnt from the first never event which was related to a guidewire that was retained. We'll pick up all the actions and make sure that everything that is learned from this process is again revisited and embedded in our practice. There were some immediate steps taken straight after the never event, there was a reissue of the current standards and expectations regarding guidewire removal. All senior medical and nursing staff were informed about it and again we tried to very rapidly get the lessons learned out amongst the clinical staff. But I think if we're able to I think the main thing we're learning is, the report hasn't been issued yet but I can probably tell you what the main lesson is, and I think that's about when you're working outside your normal area of work you have to make sure you take your normal practices with you. That's sometimes not as easy as you think it would be but what we will do is we'll ensure that across the whole organisation the documents we use to confirm removal of the guidewire is used and I think that the other thing we've been doing regularly since then is a Trust wide audit around guidewires to ensure everyone is doing them. So I won't say anything more on that unless there are specific questions.

The Executive Director is, in this verbal report, producing a narrative account of an event which has occurred in the Trust. In the context of the working group, the other participants do not have access to the "never" event itself; what the other participants have access to is the Executive Director's construction of the "never" event through this brief narrative. The initial identification of a "never" event is required to be reported in turn to each member of the Trust's governance bodies (the Board of Directors and the Council of Governors), so each member of the group is aware that a "never" event has occurred, but not any of the *details* of this event, which are investigated through the *clinical* governance

of the hospital[52]. The Governors had been informed, via email, prior to the meeting, that a never event had been reported within University Hospital Trust. Verbatim records of discussion are not kept by the Trust; written records of never event investigations are issued at a significant delay from the actual event, following the conclusion of the investigation process undertaken by clinical staff – this is in fact referenced by the Executive Director, in saying that the "report has been circulated for factual checking", but not, importantly, provided to the members of the working group.

The Executive Director (in this instance a non-medically qualified Director) is thus, in this brief outline and description, providing more-or-less the sum total of what the group knows about the "never" event. Certainly, as is seen in the subsequent questioning, it is the sole source of information about the event which is salient to the responses made by the patient Governors. The "never" event in question relates to a relatively common procedure, in which a cannula (a hollow tube) is placed into a hollow organ (vein, artery, anatomical cavity) using a metal wire to guide the flexible tube into the final location. This is an invasive procedure, involving the introduction of a foreign object into the body of another subject, the puncturing of skin and the intimate exploration of the subject's hidden spaces. In this case, a segment of the wire was not successfully removed from the patients' body. It should also be noted that, at a subsequent meeting nearly six months later, this particular "never" event is disclosed as having been reclassified. The biological facts were the same; a piece of wire introduced into the body of a patient was retained within that body, but the locus of responsibility was moved from the doctor who performed that procedure to an unknown and unquantifiable equipment failure. Thus, the event was shifted, in its eventual understanding within the Trust, from a "never" event to an acceptable outcome of medical intervention (again, an example of how the restatement of the past through the written records of a corporate entity can be seen as an intentional reconfiguration of history). That said, at the time of this meeting, the "never" event was understood by the Trust to be the result of (in the words of the policy) an incident linked to the system in which the individual was working, an event which should have been

---

[52] Note that the clinical governance structure is separate to the corporate governance structure, although it eventually reports to the Board of Directors through the Executive Directors with responsibility for clinical domains.

wholly avoidable. The ways in which the "never" event was spoken of, and the positioning of subjects with respect to the event at the time, are still relevant for understanding how Governors and Directors respond to such events and their roles in relation to them.

The Executive Director is using language to construct the event; to report a narrative back to the Committee. Examining how the Executive Director does this through this narrative reveals a particular orientation to the event and to the subject(s) involved. There is a contrast in the Executive Director's narrative between the *patient* and the *doctor* who performed the procedure in question. The *patient* is almost entirely absent from the account. Examining the Executive Director's talk, the patient must be inferred from the presence of a procedure; that a guidewire was retained implies that it was retained *in some person*, but the subject is unrepresented. The Executive Director's words are that the "…never event relates to a retained guidewire"; the description of the event does not refer to the patient directly. Other subjects, listening and seeing this account, must assume the presence of the patient from the logic of medical practice. The members of the working group must infer that the use of a guidewire should be taken to mean that the guidewire was used on a patient. The Executive Director's statement constructs the procedure as the focus of the event, rather than the patient, or indeed the outcome of that procedure for the patient. The focus of this account is on the discrete and specific medical action in the absence of the body on which it was done.

A subject – a person – is introduced in this account; the doctor who performed the procedure. In comparison to the absence of the patient-subject, the positioning of the doctor-subject is emphasised and deliberate. The *competence* of the individual is reinforced and restated so as to remove all possibility of doubt. The doctor is described as "extremely proficient" and as a "very experienced and senior person". Seniority and experience are positioned then as being relevant forms of capital, possessed by this subject, which in turn can be seen as being positioned as being empowered and to have acted correctly in the medical context. This can perhaps be read in contrast with the absence of the patient and the implied appropriateness of the medical intervention; whilst the doctor is explicitly positioned as a subject relative to others in the social space, the

patient's subjectivity is left unstated and void. Whilst not explicitly positioned as subordinate to the doctor, the patient cannot be said to be constructed by the Executive Director's narrative as a valid and complete subject with respect to the doctor. The Executive Director uses "proficient", "experienced", and "senior" to describe the doctor; the doctor is a person and an individual with particular characteristics, which contrasts directly with the lack of description of the patient involved in the "never" event. By choosing to describe the doctor in terms of (medical) proficiency and experience, the Executive Director makes those characteristics of her or his identity relevant to the topic of the interaction. The emphasis on the doctor's experience and seniority is interesting given the findings of the investigation outlined by the Executive Director. At this stage, the Trust's findings indicate that the guidewire was retained at least partly due to the doctor acting outside his or her usual area of work. The proficiency of the doctor can be read as being positioned, at least potentially, as mitigating a suggestion that the doctor was not, in fact, competent to perform the intervention in the context in which it was done.

The Executive Director's narrative concludes with a limited acceptance of potential inquiry from the group. Given that this group is specifically created by the Trust to afford greater opportunities for interaction between Directors and Governors, this position taken by the reporting Executive Director seems contradictory to this overarching purpose. The Executive Director admits only the possibility of *specific* questions, but clearly positions the narrative given as the complete statement that should be provided to Governors. Unlike in the previous detailed examination of meeting processes (in chapter 5), in this case, the patient and public Governors do respond, and ask a number of questions. The initial sequence of questions discusses a prior "never" event (not described in the narrative above) and the subsequent investigation into device design, followed by specific questions which are related to the narrative presented by the Executive Director, which are discussed in further detail below.

An interactional feature of these question sequences supports the argument that the Executive Director has a *limited* acceptance of further inquiry. In the two examples, each question begins with a formulaic introductory phrase, such as "Just a quick question.."

(in the first example, below) or "Can I just ask something?" (in the second). There are competing potential explanations for these moves by Governors; in all cases, the speakers do not pause or hesitate before continuing to speak, suggesting that they are not expecting a response to the opening question (i.e. that the utterances are question-like in linguistic construction but are not questions in terms of seeking a response which would determine future action). This could suggest that these utterances are used as a form of politeness talk, or as part of the ongoing cooperative management of turn-taking in conversation (in the manner of Sacks, Schegloff & Jefferson, and others as previously cited). I suggest that the use of these opening questions is in *response* to the Executive Director's use of "specific questions". The patient and public Governors employ conversational moves to align to the limitations which the Executive Director suggests apply to the questions which they are permitted to ask; the questions which are allowable responses to the "never" event narrative are only those which are specific. By using this question-introduction, the public and patient Governors take up the position that there *may be* a negative response to the *allowability* or the *appropriateness* of their (substantive) question (i.e. the question related to the "never" event). This suggests that the *roles* of the patient and public Governors are *defined by* the actions which are permitted by University Hospital Trust, as represented by the Executive Directors (by the management of the institution).

Returning to the retained guidewire narrative, patient and public Governors ask specific questions in relation to that "never" event. In the first example of questions related to the "never" event, a patient Governor asks about the procedure itself:

> **Patient Governor (1):** Just a quick question on the technicalities – when they insert the guidewire, does it disappear from view?
> **Executive Director:** No it shouldn't disappear from view *(pauses)* it's quite difficult to describe it without actually doing it *(pauses)* you have a needle, and you push the guidewire through and the needle's about this long *(indicates length with hands)* and you take the needle off, and you have the guidewire sticking out the skin and you make a little nick in the skin, and then you push a slightly longer cannula along the tube, over the guidewire and it, obviously, people are slightly different in anatomy and length and it, ah, slightly adds a challenge, occasionally. But essentially what should happen is you always hold on to the guidewire as you push the cannula over the guidewire. If you have the guidewire hanging out too far, there's the risk of it becoming contaminated because it sort of flops about so it hits their head or it hits other parts of their anatomy, but obviously if it's too short and fingers

are slippy, the guidewire's slippy, then sometimes you can lose hold of it, but essentially you should always hang on to that guidewire as you push in. But it is quite easy to be distracted, so one of the system designs we were talking was something that almost sort of stops the whole guidewire from going in.
Public Governor (1): Almost like a stopper?

The Executive Director, in this case, is not medically qualified, but responds by giving a description of an intervention which matches (broadly) the Seldinger technique (Seldinger, 1953) for the introduction of a cannula. It is interesting, here, that the Executive Director mobilises what might be termed *clinical* knowledge in making a response to the question. The Executive Director begins with the words "it's quite difficult to describe it without actually doing it", pauses, and then proceeds to give a detailed description of the technique, supplemented with gestures that depict the length of the needle, and follow the description of the technique (making a 'pushing' gesture when saying "push a slightly longer cannula along the tube" and making a vertical downward motion with one hand to accompany "make a little nick in the skin"). By answering the Patient Governor's question, the Executive Director implicitly makes a claim to a particular epistemic status with respect to that question; i.e. that she is sufficiently knowledgeable to produce a relevant answer. In the talk and accompanying gesture, the Executive Director is positioning herself as having some relevant knowledge (K+, following Heritage, 2012) of the clinical technique, and proposing a series of facts about the technique. Her use of clinical knowledge (i.e. knowledge which pertains to performing a medical procedure and the use of a medical technology) is accepted by the other participants as being a valid response to the question. By positioning herself as being able to deploy clinical knowledge in response to the Governor's question, the Executive Director creates this idea of the procedure and its inherent risks as a fact for the working group.

It bears noting that the procedure described in fact precludes the use of a "stopper" (although this is a suggestion by a public Governor, one with which the Executive Director subsequently agrees in the following talk). The risk that is identified in this response – of the guidewire disappearing from view – is a known complication of the

Seldinger technique, as a review of the clinical literature or basic instructional materials[53] demonstrates. Notwithstanding the critique of "never" events advanced in the previous section, the intention is to categorise those medical incidents which are held to be wholly avoidable as being qualitatively different from any other. The retention of a guidewire is, by the logic of the NHS, a systematic failure which should not have occurred. And yet, the construction of the event through the narrative presented by the Executive Director would seem to be at odds with this definition. In the outline of the procedure, the risks are presented as being natural, inevitable products of circumstance. It is "quite easy to be distracted", and moreover the gross anatomy of the patient is implicated as a source of "challenge". I propose that the Executive Director's construction of the event, seen here through the deployment of expertise, is seeking to frame a shared interpretation of the "never" event[54] in which the risk of retention is located within the variable anatomy, of a patient, the potential for distraction and the capacity of the clinician performing the technique to grip the guidewire. The Executive Director is taking a particular position with respect to the risk of guidewire insertion; this is most clearly seen in the "distraction". The qualification of distraction as "quite easy" is a non-neutral description of the risk; not merely that a risk of distraction can be identified, but that the Executive Director has specific knowledge of how difficult or not is it to be distracted, and therefore how likely this risk is to occur. By taking this position within an utterance that, in turn, positions the Executive Director as knowledgeable with respect to the technique, "quite easy" can be read as a position taken with expertise; i.e. that it is available as a factual and accurate description of the risk.

The Executive Director's discussion of the "technicalities" is framed as a general description of a technique, rather than a specific description of the "never" event in

---

[53] For example, http://www.ebmconsult.com/articles/seldinger-technique-intravenous-iv-placement

[54] Recalling that, at the stage, the Trust's knowledge of the 'never event' is that it was a retained guidewire event to which the contributory factor was the action of a physician; I would argue that we should orient to how the Executive Director constructs the event in relation to what was known at the time of the event, as there is no suggestion in the reporting and narrative that there is an alternative, equipment-related explanation. This is not made known to the working group until nearly 6 months later.

question. This can be understood from the Executive Director's use of the present and conditional tense throughout the description, as well as the second-person pronoun; "you have" and "you should". Risks are located with this general description, rather than related to the specific event in question. By locating risks within this general description, the Executive Director's talk can be read as suggesting that the "never" event arises from such risks, rather than from a specific sequence of events or failings that relate to the unique circumstances of the event which occurred. It is this emphasis on general, rather than specific, which suggests a resistance to the definition of the "never" event. The threshold within the NHS never events policy for a retained foreign object post-operation is 0; any single incident results in financial penalties for the Foundation Trust in question. The "never" events policy describes circumstances in which objects can be retained within a patient post-operatively but not constitute a "never" event[55]. The guidewire falls outside of these definitions and examples given in the published policy. The definition of the "never" event is that it is an event that should not have occurred if safeguards had been followed. However, following the Executive Director's explanation of the guidewire insertion technique, distraction is "quite easy", and there are at least two other sources of risk in the procedure (anatomy and "slippiness") which suggest rather than an unusual failing in the most serious category classified by the NHS, a retained guidewire is a product of multiple and easy risk(s).

A similar use of clinical knowledge to frame the "never" event can be seen in the final question relating to this event, in which a second patient Governor asks about how the retention of the wire was missed. This is the final discussion of this event during this working group meeting. At the prompting of the Chair's final question, the Executive Director then takes up the next topic of conversation (the standing quantitative performance report), ending the discussion of the "never" event at the end of this segment of talk.

---

[55] This is defined in the 2012 policy and includes objects retained post-operatively where there is limited risk of harm to the patient and/or the risk of harm from retrieving the object is greater than the risk of leaving the object retained.

> **Patient Governor (2):** Can I just ask something? I don't know if this was in a theatre case, where they count stuff out and they count it back in again. Was this in a theatre situation, or, um?
> **Executive Director:** No.
> **Patient Governor (2):** So, is it possible to have logged things that have been used and you're logging them back again?
> **Executive Director:** Part of the, part of the process of trying to prevent this from happening is that you witness the removal of the guidewire. But I have to say while that's a very sensible idea, if you're in an emergency situation, for instance in an ED where you have 90 patients in an ED, you're lucky to have any nurse with you because they're looking after three or four patients. So whilst that's an eminently sensible idea, in reality I can see-
> **Chair (Patient Governor):** [overlapping] It isn't always feasible.
> **Executive Director:** It doesn't always happen, or someone looks over their shoulder and says yeah fine
> **Chair (Patient Governor):** Okay, would you like to carry on with the report then?

Although noting that the Chair is complicit in moving the topic of conversation forward, onwards from the "never" event, and that this undoubtedly is contributory to the extent to which patient Governors are able to ask additional questions beyond this point, the main argument that I wish to make in relation to the Executive Director's answers to inquiry is shown in this extract. As in the previous response, risks associated with the removal of a guidewire are constructed as part of routine and unremarkable clinical practice, and therefore part of mitigating information related to the "never" event. The Executive Director, despite stating that the process of guidewire removal calls for a "witness" to the removal, argues against the practicality of this process. Again, as in the previous answer to a patient Governor's question, the Executive Director creates a (fictive) clinical situation to support an argument that resists the fundamental logic of the "never" event (that it is a failure and is, in all cases, intolerable). By invoking the practicalities of the clinical setting, the Executive Director positions herself as holding knowledge which the patient and public Governors do not. The exigencies of the clinic are positioned as routine and part of the natural order. The practices of the (imagined) "ED" (Emergency Department) are deployed as sufficient evidence for why the patient Governor's suggestion is not immediately applicable; the Executive Director knows how the ED works, whereas the patient Governor does not. The validity of the Executive Director's response is predicated on her epistemic access to clinical practice within the ED; it is this epistemic positioning which enables her to state that the patient Governor's suggestion is not "in reality" going to happen. The patient Governor's action lacks this epistemic position and access to clinical knowledge, and can therefore be rejected as

failing to match how the ED chooses to structure its activities by and through such knowledge. In both sequences of talk, the Executive Director's discussion of the "never" event relies upon and is framed by her access to a particular epistemic domain – knowledge of medical technique and clinical practice – which is contrasted with the patient Governors' respective lack of access to this domain.

The second "never" event was reported to the same working group six months after the retained guidewire incident. In this case, the speaking Executive Director was medically qualified[56] (and, importantly, a different individual from the speaker discussed above). The event in question was the implantation of an incorrect prosthesis, in this case a total replacement hip joint. Artificial joints are manufactured in (at least) two primary components, a ball (replacing the femoral head) and a sleeve or cup (replacing the acetabulum, or the hollow socket in the pelvis). Implants are available in a variety of sizes and are intended to be used in matching sizes. In the incident in question, the incorrect (too large) sized sleeve was implanted in a patient. The Executive Director has given an overview of the "never" event as being related to a hip replacement, given a brief explanation of the different sizes of prostheses, and then proceeds to end the narrative of the event with the following description:

> **Executive Director:** [Describing never event] … the error, which we spotted because the nurse restocking when she or he flashed through the barcode on the prosthesis used said ah this doesn't match with this and reported it. Patient by that time was in recovery. Interestingly, if the patient had been still under anaesthetic and on the table it wouldn't have been a never event but the same error, so this is the slightly vacuous nature of the world in which we function. Um. Patient was apologised to, re-anaesthetised, right joint replaced and everything confirmed to the patient and the subsequent surgery was uneventful. *(Pauses)* I suspect, although I can't be confident, that there are probably a very significant minority of patients who've had hip joints with the wrong bit and the wrong bit *(gestures taking objects from space with both hands)* and they go round clinking, I suspect if we hadn't changed it, the patient would have had a slightly loose arrangement, basically.

---

[56] For avoidance of doubt, I have used medically qualified here to refer to any Executive Director with a nursing, midwifery, dental or medical qualification, and current registration. This is to reduce the likelihood of identifying an individual from the reported data.

In this brief closing narrative, the Executive Director does two actions. Firstly, he gives a narrative description of what happened in the "never" event, and then continues after a brief pause to provide a closing assessment of the never event in which he relates potential general effects of an incorrect joint replacement.

In describing the event, two actors are identified; the nurse and the patient. Unlike in the retained guidewire example, in this narrative the patient is more explicitly present. There is a distinction between the nurse and the patient. The patient is subject to the actions of others; the only role for the patient in this brief narrative is to accept what is done to his or her body and to have a social action directed at them ("patient was apologised to")[57]. Whilst the actions of the nurse in identifying the error are described in some detail, including the (imagined) speech, the patient is afforded no such role. This is seen explicitly through the Executive Director's talk. The nurse's actions are described using active verbs – "restocking", "flashed", "reported", and most importantly, "said". The nurse is ascribed characteristic and restricted properties of a subject (speech, social action), whereas there are no such characteristics associated with the patient, who has no subjectivity (in the sense of a mutually understood positioning in the social space). The absence of the patient's subjectivity elides the patient's perspective on the event in question; how the patient responded to the apology, or participated in a decision to re-operate, are not presented as relevant by the Executive Director, whereas the actions of the nurse in identifying the error are relevant. Furthermore, the outcome for that patient is only described in limited detail; the only information is that the "subsequent surgery" was uneventful. This is, to some degree, similar to the retained guidewire incident, in which how the event impacts the patient, and the specific patient's perspective on the event, is absent from the narrative description of the event.

The conclusion to the Executive Director's narrative is a sequence in which, accompanied by a pantomime of selecting objects from space, a hypothetical situation is proposed in

---

[57] Note that the transcript is verbatim and 'patient' is used by the Executive Director, most likely as a pseudonym to ensure that the individual's identity is not disclosed.

which the implantation of an incorrect prosthetic is essentially positioned as non-serious. The Executive Director is making a claim that this "slightly loose arrangement" is non-serious; in doing so, he deploys clinical expertise and knowledge. The Executive Director takes an epistemic stance by saying "I suspect, although I can't be confident, that…". This is a claim to epistemic access to a domain of knowledge about hip replacements; the Executive Director has at least some knowledge of this domain. This claim is made 'weak', or 'hedged', through the use of "suspect" and "can't be confident". Although this epistemic marker is less definite than (for example) 'I know', by using this, the Executive Director positions himself as knowledgeable (K+). He then states that a "very significant minority" of hip replacement recipients have "wrong bits". The use of an epistemic marker both qualifies the Executive Director's claim (suspicion rather than certainty) whilst simultaneously positioning himself with respect to a relevant body of clinical knowledge regarding hip replacement recipients. In this sequence of talk, the Executive Director makes relevant particular information, in the sense that he produces that information and it is available to other participants in the interaction. Part of this information is within the narrative description of the specific "never" event. Following this narrative (after the pause in the extract, above), the Executive Director is providing further information, concerning hip joint replacements in general.

As discussed above, the Executive Director specifically deploys an epistemic stance in framing this information. Further, by locating this information in talk close to the narrative about the specific "never" event, it is reasonable to assume that the Executive Director intends this information to be understood as relevant to the specific "never" event. This general hip joint information is both connected to the Executive Director's access to a relevant epistemic (knowledge) domain and to the preceding narrative. The relevance of hip joints in general to the specific "never" event is established by proximity in the Executive Director's talk; a common-sense interpretation that sequentially ordered talk is understood as related. His talk constitutes a claim that he has access to a domain of knowledge (albeit qualified). By producing this sequentially in the same turn at talk as the narrative, he positions both his access to this domain and the subsequent information as being relevant to the preceding narrative. I argue that what is important about the concepts that the Executive Director deploys in his talk is that he frames this additional information about the "clinking" and "loose" outcomes for patients in terms of his access

to an epistemic domain. Although this information is qualified by the use of "suspect" and "can't be confident", the Executive Director is asserting through this talk both that there exists an epistemic domain (understood as some relevant body of knowledge about hip joint replacements and outcomes) and that he has sufficient access to that domain to take an epistemic stance with respect to it.

The consequences are downplayed; "they go round clinking" with a "slightly loose arrangement" is used to forecast a fictive view of a possible scenario in which an incorrect implant has no important or clinically relevant outcome for the patient. In this somewhat offhand remark, the Executive Director demonstrates (aside from a somewhat callous attitude to the futures of hip replacement recipients) how expertise is used to construct and divide the lived experience of the patient into the medical and non-medical. The Executive Director is making a decision to make relevant to other speakers some outcomes; these are, in his talk, limited to "clinking" and "loose". In his talk, this is presented as a relatively minor or non-serious outcome; the patients still "go round" (in his words), and his statement suggests that this is the limit of what an incorrect hip joint might cause, for a patient. This may, or may not, be the case; what is important for this analysis is not the *actual* outcomes for incorrect hip joint implantation, but that the Executive Director's talk is establishing this as the relevant information available to other speakers in the interaction. By preferencing these outcomes the Executive Director is stating for the other members of the working group that the most relevant impact of a mis-matched hip-joint is limited to some characteristic of joint mobility. It is clear from this segment of talk that the Executive Director regards these as being minor in nature; his remarks suggest that this looseness is, if not precisely a desired outcome, certainly within a set of acceptable surgical outcomes (i.e. patients do not require subsequent treatment or other intervention as a result of this mis-matched / loose arrangement). On the basis of the Executive Director's talk, then, it would be reasonable to assume that a mis-matched hip-joint does not present a significant or consequential risk to patients, and that there are some number of patients in such a situation.

In establishing these concepts, the Executive Director is implicitly making a choice about what outcomes to raise as relevant to the "never" event topic – he is choosing to say this

particular utterance, over any other possible utterance. I argue that this decision to speak of some outcomes – to present particular information in a particular way – can be understood as indicative of the Executive Director's internal conceptualisation of the subject matter itself. By framing this discussion of outcomes in terms of his access to an epistemic domain, the Executive Director is further making relevant his status with respect to a relevant area of knowledge; his statement is valid because he is able to assert some degree of epistemic authority. I argue that what this shows is the Executive Director's conceptualisation of patients (at least with respect to recipients of hip joints). I argue that he restricts patients and outcomes to this limited set of physical characteristics; he specifies that the impact on patients is physical and mobility related. The suggested or imagined minority of "clinking" patients are not, in the Executive Director's talk, affected in some other way; there is no space in the Executive Director's construction of those outcomes for the subjectivity of patients to be affected, either positively or negatively, by the receipt of a "loose" hip. The patient-subject is missing; in his or her place is the patient as an object upon which medical interventions are performed, without the intersubjective and mutually understood co-positioning within social space that occurs with another subject.

By limiting outcomes to the relevant physical, joint-related motion (loose or otherwise), the Executive Director is in turn limiting the conceptualisation of those patients in terms of their individual, subjective experience(s). He is first saying that he has some knowledge (framed, as discussed above, as suspect, but signalling his epistemic claim), and then saying that these physical outcomes are what is within that domain of knowledge. In other words, he makes the claim that he knows about hip joint outcomes, and that what is knownis that patients with incorrect hip joints only have "loose" or "clinking" arrangements. What is salient about this is that it demonstrates how he deploys expertise and knowledge to construct a shared orientation to what constitutes relevant outcomes for a patients; delimiting as knowable only these physical properties. I argue that we know that it is *possible* for patients to express and have a range of positions and intersubjective relationships – they will think, feel, and have particular attitudes and responses which they will express to others as part of their everyday lives. This intersubjective positioning of the self does not form part of what the Executive Director makes relevant to the other participants. His talk divides the experience of the patients of

whom he speaks into the relevant outcomes from a hip joint replacement and non-relevant, non-mentioned outcomes. By doing so through a frame of his access to an epistemic domain, the Executive Director implicates his medical expertise in this process.

The comments about hip joints made by the Executive Director are only a brief moment in the overall meeting. I argue that this specific moment of talk is important and justifies close attention because it shows how expertise, signalled through an epistemic stance, is deployed by one speaker to propose a shared understanding of the "never" event. I argue that the Executive Director's talk is not a neutral, position-free presentation of fact. The Executive Director is presenting a particular perspective on what a mis-matched hip joint means – how it should be understood by the other participants. Based on his talk, the impacts of the specific error being discussed, and of mis-matched joints in general, seem relatively minor – a straightforward replacement when discovered or a simple "looseness" for the "significant minority". The narrative of the specific case at University Hospital Trust ends with a subsequent surgery that is explicitly described as "uneventful". This description emphasises routine and expected outcomes from this medical intervention, and his "significant minority" claim extends this to suggest that even the error is in some way part of routine and unremarked medical practice. I argue that by making this connection between the specific event and general possible outcomes in hip replacement, the Executive Director invites the other participants to understand the seriousness of the specific event in terms of these outcomes. In doing so, he shows that what is relevant to his perspective is the physical domain, rather than patient-relevant or subjective outcomes; what happens within the physical *joint* rather than in the experience of those individuals.

In this meeting of the working group, the Executive Director then shifts the topic of talk from a specific "never" event (the hip joint) to focus on how such events are tallied and accrued against the Trust's annual reporting. He does this by continuing to speak; there is no intervening discussion amongst the Governors or other attendees at the working group between the Executive Director's talk about the specific hip joint event and the number of "never" events in total that will be shown in the Trust's report. This change in topic focus is foreshadowed by the Executive Director's "vacuous nature" comment, as

shown in the transcript (above). He highlights that the definition of a "never" event in this case means that the same fundamental error (the placement of an incorrectly sized artificial joint into the tissue of another human) is only a "never" event if the surgical procedure has completed[58]. In the talk which followed this narrative sequence in the meeting, the Executive Director opened up discussion of the final tally of events for the Trust (of three possible "never" events that occurred within the Trust or affecting the Trust's patients in the most recent quarter). The possible outcomes for this tally are that the event could be maintained on the Trust's "books" by the end of the year, or be discounted and re-categorised as part of expected medical practice, or be allocated to partner organisations. The subsequent talk does not include specific questions or responses from the Governors in relation to the hip joint replacement "never" event.

Response and resistance

Although these are, by their very nature, isolated incidents, examining how "never" events are presented by hospital managers to the patient / public Governors suggests some important features of how the social space of hospital governance is structured. By viewing governance through the lens of being a social space that is constituted by the actions of subjects, we can see how the actions of the Executive Directors *as well as* the structuring discourses of safety are complicit in constraining the possible social actions that Governors are able to perform. Furthermore, I argue that these examples of the way in which Executive Directors construct "never" events through narratives demonstrate that this "never" event framework is ultimately founded upon and dependent on the positioning work of subjects within hospitals. These phenomena are mutually interdependent, in that the positioning work performed by Executive Directors, in acting-as (by which I mean the literal speaking on behalf of) the Trust, is a critical factor both in how "never" events are construed and in how, in turn, Governors are (dis)empowered to act.

---

[58] As in, if the incorrect joint had been identified during the initial implantation, then it would have been replaced prior to finishing the surgical procedure and allowing the patient to recover from anaesthesia. This means that, even if the wrong joint had been used initially, it only meets the definition of a 'never event' if it is retained within the patient after the end of surgery and the closure (e.g. suture) of incisions.

To begin with, I propose the *ordering* of topics is important here. In common to the reports of "never" events in these private meetings is the introduction of those events to the group by an Executive Director. As I have argued in the analysis above, the ways in which the events are framed through these narratives establishes a possible positioning within a shared social space, in which we understand medical actors as subjects and the events as being characterised by unavoidable risks and limited or non-specific long-term consequence. In the case of the retained guidewire event, subsequent reclassification of the event from "never" to an acceptable clinical occurrence was reported and positioned as a *positive* outcome for the Trust. Although it did not alter what literally occurred during the past event, in that a guidewire was retained within a patient, it was reported as a positive outcome as it confirmed for the Trust that no clinical error had occurred. The emphasis and orientation of the narrative construction of these past events by the Executive Directors is on the event's impact on the Trust, and on the inherent *correctness of action* of the *clinical* subjects involved. In the second example analysed above, the framing of recounting the nurse's actions in discovering and reporting the "never" event is given prominence in the Executive Director's account, whereas (in earlier discussion, not shown above) he describes the *original* error (the specifying and supply of the incorrect part of the prosthesis) as "simple miscommunication", giving no agency and ascribing that miscommunication to no particular subject or role in the hospital. In this, the clinic has the first-mover advantage, in that the agents through which the actions of the Trust are performed are able to assert this set of positionings as being possible and plausible given the pre-existing social space. It then becomes incumbent upon the following subjects (following in the sense of a sequential ordering of social actions performed relative to one-another) to respond in some way to that set of possible positionings.

How, then, is this response structured by the action of the initial speaker? I argue that at least a partial answer can be found in re-examining Habermas' ideal speech situation, and the proposed theses summarised by Thompson (1981). Specifically, if we take as read Habermas' proposition that all speech contains within it a fundamental claim to validity and to moral rightness, then the response following speech from the Executive Directors

is required to either affirm and align with these claims, or be constructed so as to refute these claims directly. The concept of alignment does not speak to motivation; it could indicate a positive agreement, or encompass an acquiescence from indifference, or concern about the social consequence of refuting a claim made by a prior speaker. The problem presented in this meeting is that the Governors do not respond specifically to this narrative, either to align or to refute. What occurs is that the Governors continue to participate in the meeting. The topic shifts from a specific "never" event to the question of which events would be included in the Trust's annual reporting, and some Governors participate in this discussion by asking questions. The Governors are selecting the next sequentially available opportunity to perform a social action, and doing so in a way that is a response to a sequence of talk which includes both the narrative and a shift in topic. No individual Governor makes a specific position about this narrative relevant through talk. By remaining silent on this specific topic, the Governors leave unsaid an explicit alignment, but also do not dispute or explicitly disalign with the positioning done by the Executive Director. I suggest that this means that what then forms the relevant context for the meeting – the shared ground which is available to participants – is solely the Executive Director's position. By continuing to participate in the meeting discussion in general, the Governors (indeed all the participants in the meeting) signal that there is no need to confront or dispute the claims made by the prior speaker. This does not constitute evidence that the Governors definitively agree with or explicitly align with the Executive Director, but it leaves open the possibility that they do align, at least to some extent. To conclude otherwise, would require evidence in the subsequent talk that a speaker (i.e. a Governor) is directly confronting the claims to validity and authenticity inherent in the social action (achieved through speech acts) of the prior speaking subject.

The discussion of the retained guidewire event shows patient Governors asking questions following an initial narrative from an Executive Director. As I argue above, a relevant response is understood to be an action that implicitly confirms and accepts the validity claim(s) of the prior action. Questions expand the content or topic of talk beyond the initial narrative; the questions seek additional information. Such questions, I argue, are a way that a responding speaker could be seen to resist or confront the validity claims of prior talk. In the example of the retained guidewire event, the Executive Director's talk carries within it the claim that it is valid for the things of which it has spoken. In response

to the initial narrative, the patient Governors then ask questions (analysed earlier in this chapter). This is unlike the hip joint example. I suggest, although this is limited in the extent to which it can be supported by data analysis, that this questioning could be seen as a way in which the Governors can resist the locutionary force of the Executive Director's narrative. By taking up the next turn at talk and raising questions, the patient Governors have an opportunity to expand the topic of the "never" event; opening up the possibility of relevant contributions which are not framed by the Executive Director. The responses that are valid for the patient Governors to make are limited; the Executive Director explicitly states that she will not speak about the "never" event unless there are "specific questions". This initial-speaker framing of what is and is not relevant, and what she will or will not respond to, reduces the capacity of the patient and public Governors to respond freely in ways that are likely to be understood as relevant to the topic at hand. The Governors are limited in the extent to which their responses are understood by the first-speaking subject as relevant contributions. The Executive Director does not seek to engage their expertise of patienthood and patient experience or leave the floor open and neutral for the next speaker to determine relevance. Instead, what is constructed in her talk as relevant to the "never" event topic is limited and constrained both in that it is her expertise and knowledge which is relevant, and that she will only answer specific questions (rather than any question). The responses from Governors are limited in the extent to which this is constructed as relevant to the "never" event by the first-speaking subject.

This was borne out, at least to some degree, through observation of meetings and the pre- and post- meeting actions of patient and public Governors, particularly in relation to the role of such Governors with respect to "never" events. The involvement of patient and public Governors in "never" events was delimited and controlled by hospital management; the presentation of a report to the working group and then, successively, to the Board of Governors, was presented by Executive Directors as being in fulfilment of an administrative requirement imposed upon University Hospital Trust by the "never" event policy. As such, the role of the patient and public Governor was configured to be a more-or-less passive witness to the execution of such a process, which was controlled by hospital management (including clinical management and senior medical staff). Despite the purpose of smaller committees being to increase engagement between Governors,

Executive and Non-Executive Directors, the terms of such engagement were consistently dictated by Executive Directors – by hospital management. Throughout the observation of the working groups, the role of such groups in *acting* in relation to information provided to them by management was limited to asking (some) questions within the working group session itself. The "never" event process was presented as a *fait accompli* – not merely the system-wide definition of such events (over which it is likely that an individual hospital would have limited influence) but also the specific actions taken by University Hospital Trust in relation to "never" events, in terms of how the investigations were conducted and what remedies or solutions were implemented within University Hospital Trust. By limiting the engagement of Governors to the *receipt* of reported "never" events and accompanying investigations, hospital management inherently limit the ways in which patient and public Governors are able to act in relation to these events.

This mirrored, consistently, the ways in which the Governors' actions within University Hospital Trust were limited by hospital management, in terms of being constrained to specific meetings and management-organised actions within the hospital. This is not necessarily a *problem*, as such. Certainly, it is possible to see how patient privacy and clinical necessity mean that the hospital needs to closely control both literal physical access to day-to-day operations, and to restrict access to detailed information which might compromise patient privacy. What is apparent, however, across the observation, is that patient and public Governors were aware of their limited involvement in both serious challenges for the Trust, such as "never" events, as well as in other day-to-day operations. This was expressed by Governors, observed particularly during pre- and post- meeting conversation, as a frustration that they were not able to contribute more to solutions for "never" events. These concerns, expressed outside of meetings, perhaps suggest that the participants in such meetings were aware, at least to some degree, of the extent to which the social actions of hospital management in constructing narratives of "never" events was constructing the possible responses that Governors were able to make within a legitimised and formal meeting.

Summary

The discussion of "never" events and safety in this chapter considers specific talk about events which occur within a broader regulatory framework for the safety and quality of health care delivered in the NHS. The "never" event is a particular category of medical error, defined by the NHS as events which represent failings in clinical process and should be avoidable events which have the potential for significant patient harm. These events, although defined in ways which may not be immediately apparent to be patient-centred, in the sense that they involve errors which the health system has defined for itself as representing serious failings, are clearly incidents in which the risk of harm to patients is great. Because of this, never events require University Hospital Trust (like other Trusts or non-Foundation Trust hospitals or health care settings) to investigate and to report these events through their governance and management structures. What this means is that these events, although rare and exceptional by nature, trigger an equally infrequent encounter between managers and elected Governors, in which there is an explicit discussion of clinical practice in relation to a "never" event. These discussions are important for two reasons. Firstly, it is clear from the policy itself that elected members of governance are expected to be involved in the broader processes of learning and review which are intended to be executed by the Trust in relation to these serious clinical incidents. Secondly, I suggest that these discussions provide an important example of how managers frame clinical practice in engaging with public and patient Governors.

These examples illustrate that the sequential organisation of talk in these meetings has consequences for how Governors are able to be involved in discussing "never" events. In the first example (considering the retained guidewire), the Executive Director explicitly seeks to limit discussion to "specific questions", disclaiming further comment. Although there is subsequent questioning, framed by the Governors as "just" regarding "technicalities", the Executive Director's initial turn at talk does not leave the floor entirely open for the next speaker; I argue that this is what prompts the next speaker to frame a question as explicitly responding to this acceptance only of "specific" questions. In the second example, the Executive Director uses his turn to shift topics from a specific "never" event to a broader issue of accounting for multiple events in annual performance reporting, and the Governors do not respond directly to the event in question. I suggest that this initial position in the sequential ordering of talk about safety events is used by

the Executive Directors to create preferred and dispreferred responses from the elected Governors – explicitly in the first example, and by continuing to another topic in the second. In doing so, the Executive Directors are able to shape and construct the potential response from Governors and their engagement in a "never" event reporting process through the sequential organisation of talk in a meeting.

This chapter has considered how expertise and knowledge is deployed in hospital governance and management, addressing research question 2 using talk about "never" events as an example. I argue that hospital managers position as knowledgeable (K+) with respect to a relevant domain of clinical knowledge. By making specific choices in how and when to speak, participants deploy knowledge into the ongoing work of the committee (itself achieved through talk and social interaction). The Executive Directors speak with authority; they position themselves as presenting reliable information to the other participants. Knowledge and expertise which relates to clinical and medical matters is deployed by the Executive Directors as they do so. This knowledge and expertise is used by speakers to direct how a topic can be responded to, and to frame narratives reported to the committee. The patient and public Governors do not deploy their access to patient experience as a counter or a resistance to the framing of narratives and topics. They respond to the Executive Directors in ways which are constructed by talk which presents the hospital perspective. Although it is possible that they could choose to respond in some other ways than shown in the examples, what this analysis suggests is that the participants do not see some other perspective as relevant to a "never" event. What is relevant is knowledge about the clinic; about how procedures are performed, and about what the impact of a medical procedure is in terms defined by the medically / clinically knowledgeable speaker.

I argue that the Executive Directors' presentation of "never" events is not simply fact that is available for interpretation by other participants. Rather, both managers are engaged in taking an interpretive position with respect to the specific "never" events. In their talk, they propose a perspective on the "never" event which is then available for the other participants, and forms part of the available-to-all ongoing social context of the meeting. In both the examples analysed in this chapter, this interpretive position towards the

160

"never" event minimises consequences for patients. The "never" event is understood predominantly through the actions of hospital staff. Risks and potential poor outcomes for patients are minimised; hospital staff actions are unquestioned, and (as shown in the discussion of the retained guidewire) the expertise and experience of those staff positioned as positive. The "never" event itself is questioned by an Executive Director; it is part of a "vacuous" world, rather than representing (as defined within the overarching policy) a serious and systemic failure. By downplaying negative impact of the "never" event, the hospital is able to resist the seriousness of such events, and instead construct through talk a positioning in which the "never" event is understood as less a serious failing of a system of clinical practice, and more as a technical or definitional matter. I argue that this interpretive positioning is a means by which the hospital can resist the logic of the system within which it is embedded, and how the hospital itself is regulated. The "never" event is understood through the interpretive work of hospital manager. Although the policy framework itself is not constructed in terms of a patient or public perspective on what might be a serious adverse outcome, the involvement of elected Governors in "never" event reporting suggests that the intent of the "never" event policy is to engage multiple perspectives and experiences in understanding the consequences and actions arising from such events. It is challenging to see, from the evidence of how patient and public Governors interact in meetings with hospital managers, that reporting "never" events to governance groups is connected to change or response from the hospital to relation to "never" events. The choices made by Executive Directors in reporting "never" events to the committee construct how patient and public Governors can respond; what is relevant is the interpretation of the event supported by the Executive Directors' epistemic positioning.

In the following chapter, I consider this question of regulation, performance monitoring, and surveillance more broadly, and move the focus of analysis from specific, momentary examples to a broader and overarching perspective on governance in University Hospital Trust.

7. Targets, frameworks and management

Whereas in the preceding chapters the focus of analysis has been on the ongoing construal of a social space through interactionally achieved action and how this illuminates the role of patient and public Governors, in the following analysis I take a somewhat broader perspective on the hospital and the function of governance within it. In chapter 4, I situated the hospital in context in terms of the policy frameworks and implementation through practice of such frameworks. The following chapters then examined specific situations in which particular types of knowledge and claims to expertise are deployed within governance processes, and the moment-by-moment impacts on participation and response that this can be seen to have. In this chapter, I argue for a relationship between the *content* or *topics* of these moment-by-moment social actions (i.e. the discussions that are the work of governance committees) and the policy regimes in which the hospital is situated. Further, I argue that examining emergent orientations of subjects to the conditions of the health system (specifically to the financial and resource constraints of a public health system) suggests a potential radical re-analysis of how public *services*, such as health care, might be governed. Central to this argument and analysis is an understanding of how hospitals are measured and monitored by the regulatory bodies which are the supervisors of hospitals, focusing on the NHS and University Hospital Trust in particular. I begin, therefore, by discussing performance measurement and indicators in the NHS. This chapter is focused on answering the third research question, how governance and decision-making practices can be seen to reveal the goals of participants in those practices.

Indicators and performance

The use of performance indicators, metrics, or measures is of course not unique to health care. In almost any industry or sphere of organised activity, there is some collection of ways to estimate, calculate, and thereby compare the performance of one function over another, or determine the efficiency of one worker compared to another. This was observed by Weber, in identifying the connection between rationality (calculation) and modern capitalism (Weber, 1919 [1946]). Weber's contribution here is twofold. Firstly, Weber's proposition and conceptualisation of rationality and rational action is positioned as a guiding logic in the analysis of institutions conducted by scholars of management

and performance systems (Townley, 2002). Indeed, the Weberian ideal type of bureaucratic organisation has been suggested to have become largely synonymous with the modern organisation (Dunleavy & Hood, 1994), such that the Weberian perspective can be seen to be near-equivalent to an appreciation for the actual practices of contemporary (public sector) organisations. As argued by Dunleavy & Hood (1994), Weber's proposal of the ideal type began as an abstraction from structures not yet shared by all organisations, but now we can see that the hierarchical organisation of positions, the separation of individual and role, and the reliance on files for the storage and retrieval of organisational knowledge have become normative features of the public organisation (and, indeed, of many large private organisations, as well, although noting that Dunleavy & Hood's analysis is constrained to the public / state sector). The return to Weber as a foundational thinker in approaching the analysis of such organisations is therefore unsurprising.

The second contribution which we must acknowledge is Weber's proposal of the connection between calculability and mastery. By this I mean that Weber observes that rationality is a means by which control over the natural order is imposed through the use of rational methods and calculation. The capacity to calculate with respect to some phenomenon brings it within the aegis of rational control (and hence to within the project of modern capitalism). Although (correctly) noting the limitations of their deployment of Weber (and Habermas', partially) conceptualisation of rationality, Broadbent & Laughlin (2009) argue for this explicit connection between the rationality proposed by Weber and contemporary performance management (and measurement) systems[59]. Their model, building on previous work on conceptualising performance measurement, emphasises that alongside the (notorious) balanced scorecard (Kaplan & Norton, 1996) approach to measuring performance, a conceptualisation of the use of calculation to measure performance must encompass not just the definition of outcomes but also the exertion of control over the means by which those outcomes are achieved. My intention, at this stage of the analysis, is to neither explicitly adopt nor to reject these approaches and models of

---

[59] Systems used here to refer to both (social) practices and (literal) technologies / techniques.

organisational behaviour in the analysis of an institution. Whilst, undoubtedly, the approach taken in this research owes a great deal to a Weberian (not to mention *Parsonian*) intellectual heritage, it must be stated that the study of organisations through the lens of Weber's proposal of rationality (as in the above cited research) is not equivalent to the deployment of an ethnographic and ethnomethodologically-informed approach to subjects and social actions (as in this project).

It should also be noted that (excepting *new public management*, which I will discuss shortly) the development of measurements in the corporate domain can be broadly understood as falling into two categories or domains of activity. The first is that encapsulated in the *balanced scorecard* approach (as cited above), in which the objectives of a firm are translated into measurable points of data which inform strategic decision making. Thus, if an objective of the firm is to increase profits, an element on the scorecard would consequentially be an indicator of current profit (most likely expressed as a margin). Similarly, a firm might have an objective to increase a less tangible asset, such as *brand equity*. An indicator might then be constructed which *indirectly* measures this, such as mentions on internet-based social media or a synthetic metric produced by a vendor of such information. This activity can be seen to arise predominantly from within the firm. This differentiates the first category from the second, which are performance indicators or measures that are produced (noting that this is a simplification) by external parties, generally to assess return on (financial) capital which might be invested in the firm. Examples can include debt-equity or price to equity ratios used to assess publicly traded companies, giving an indication as to whether ownership of stock in the company is good or bad (i.e. will increase or decrease in value).

When considering public sector organisations, particularly those that are situated within the UK context of new public management (Dunleavy & Hood, 1994; Osborne & McLaughlin, 2002; Dunleavy, et al., 2006), this dichotomy breaks down somewhat. New public management, in this context, refers to the development of a doctrine of how public services should be managed and provided that emerged in UK public policy in the 1980s and 1990s, part of which included the notion that public services should be continuously monitored against explicit standards and measures of performance. Whilst these

performance measures might seem to be similar (in surface definition or technical formulation) to those that arise in *private* or *commercial* (i.e. non state sponsored) management approaches, we can see that the origin of measures that arise from new public management are distinct in that they are imposed upon service providers. This imposition is generally enforced through contractual agreements between the funder and the provider, which thus have the capacity to not only specify which measures and standards should apply, but also to specify the *values* or *targets* that those measures should reach. Although noting that new public management is not necessarily a hegemonic or homogeneous approach to management, the point here is that (as in the discussion of the organisational structures of the NHS) there is a degree of what might be called institutional hybridity, in the sense that these doctrinaire approaches to how public services should be structured seek to import so-called commercial models of management into the public sector, but by doing so they can be seen to in fact create entirely *new* hybrid forms. Just as the governance structures of the Foundation Trust were argued to be drawn from both a membership-oriented and an ownership-oriented model of governance, so too does the imposition of mandatory measures impose a logic which is commercial-*like* but differs fundamentally in the design and origin of the measures from the private sector approach that it emulates (i.e. performance measurement and management)[60].

The influence of new performance management can be seen clearly in the design of performance measurement in the NHS. Current[61] performance measures and the framework for assessment can be traced back to the NHS 'Performance Assessment Framework', first introduced in 1997. It was claimed (at the time) to be a deployment of the balanced scorecard approach for the NHS (Chang, et al., 2002). This framework used six dimensions to assess performance in the NHS (brief examples of measures in each dimension are given in the list, below):

1. Health improvement (rates of death and serious injury)
2. Fair access (waiting times, surgery lists and GP availability)

---

[60] It should be noted that I draw a distinction between performance measurement and indicators and agreed accounting standards (such as the Sarbanes-Oxley Act of 2002).
[61] As in, at the time of fieldwork.

3. Effective delivery (immunisations, inappropriate interventions, return home rates)

4. Efficiency (length of stay, maternity and mental health costs)

5. Patient experience (Emergency department waiting times, satisfaction scores)

6. Health outcomes from NHS care (deaths in hospital, cancer survival rates)

Under each dimension proposed by the Department of Health, a number of measures (essentially, proposed calculations based on available data) were defined that would enable, from the perspective of the Department of Health, managers and regulators to have a clear and rounded view of the performance of the NHS. This framework was to apply to the NHS as a total system, with performance of subordinate regionalised health authorities measured by NHS England, and the providers within each region measured in turn. Following the introduction of a measurement framework, performance targets quickly followed, with the first set of Trust ratings published in 2001 (Bevan & Hood, 2006). The impact of public target monitoring, enabled by the imposition of measures, is seen as being a net positive despite challenges in implementation and local acceptance (Chang, 2007). Bevan & Hood (2006) state unequivocally that "[n]obody would want to return to the NHS performance before the introduction of targets, with over 20% of patients spending more than four hours in accident and emergency and patients waiting more than 18 months for elective admission". Whilst, on a *prima facie* examination, this seems to be a perfectly reasonable position (in that it appears preferable to wait less than to wait more), we should be cautious in accepting the logic that this espouses – that improvement in a measure is more-or-less equivalent to an improvement in the NHS in general.

Taking the first target, which continues to be used frequently in the contemporary NHS, we should question the purpose of this measure. Ostensibly, it is designed to address concerns about prolonged emergency department stays due to (over)crowding within acute hospitals. Delayed emergency care is thus positioned as being indicative of both specific crowding within an urgent care service *and* congestion within the hospital more broadly. But to what purpose should waiting time in emergency departments for all patients be reduced? Certainly, we can understand that this matches an implicit patient preference (for less waiting) but can we say that shorter emergency waiting is associated with better outcomes from care? In at least one meta-analysis of studies on UK Foundation Trusts, no clear relationship with health outcomes was detected for reduced

emergency waiting times (Jones & Schimanski, 2010). As an example, then, we can see that the introduction of the 4-hour emergency room target has reduced waiting time, but we should be aware that this is not necessarily indicative of any improvement in health or treatment outcomes beyond that. In the words of a 2003 analysis from the World Health Organisation (despite being prefaced by a statement that "measurement is central to … quality improvement"):

> The publication of performance statistics as "league tables" aims to encourage improvement, to empower patient choice and to demonstrate a commitment to transparency. Evidence suggests that this increases public interest and management attention to data quality, but it does not appear to have much effect on performance. (Shaw, 2003)

Although acknowledging the relative age of this report (with more than a decade since publication), it is notable for its apparent contradictory endorsement of measurement and performance improvement regimes whilst noting the comparative lack of evidence for a link between the statistical indicators, league tables, and performance. This, perhaps, reflects an underlying tension in a widespread public policy movement which embedded monitoring and measurement as central to the development of effective public services, although a further analysis of this in the broader public policy arena is beyond the scope of this thesis.

For University Hospital Trust as a provider of NHS services, performance measures and indicator-driven monitoring of hospital performance are integral to the (contractual) relationship(s) between the hospital, commissioners, and regulators. The Trust has multiple external relationships to multiple stakeholders, as outlined in Chapter 4. On a contractual level, there are multiple *related* commissioners (payers) for health care services; oncology treatment, for example, is commissioned directly by NHS England (and administered through the regionalised NHS units), whereas other secondary care services (non-cytostatic / non-cytotoxic treatments for patients otherwise admitted for oncology) are commissioned and funded by the Clinical Commissioning Group (CCG). In general terms, the *dominant* commissioner for any Foundation Trust is the CCG; each Foundation Trust therefore has a contract with the CCG which sets out the terms of the services which it agrees to provide for the CCG. Performance against these contracts – both the provision of the services themselves (i.e. patient number) and measures relating to those services – is therefore monitored by the CCG. Trusts are also overseen by the

specific Foundation Trust regulator (Monitor), which uses a select list of measures[62] to assess risk, assigning a *governance risk rating* and a *continuity of services risk rating* to each Trust. And as providers, hospitals are also monitored by the Care Quality Commission (as in the previous chapter considering safety and "never" events), which in turn utilises its own collection of indicators as part of intelligence monitoring for its ongoing program of ensuring that providers meet minimum standards for care delivery. University Hospital Trust is thus faced with a proliferation of at least potential targets (and monitoring) against a large number of specific indicators, each relating to one or multiple contractual relationships. This, rather obviously, results in a degree of complexity in how performance and indicators are examined during governance meetings within the Trust.

The relationships between University Hospital Trust and the external bodies are summarised in the following diagram:
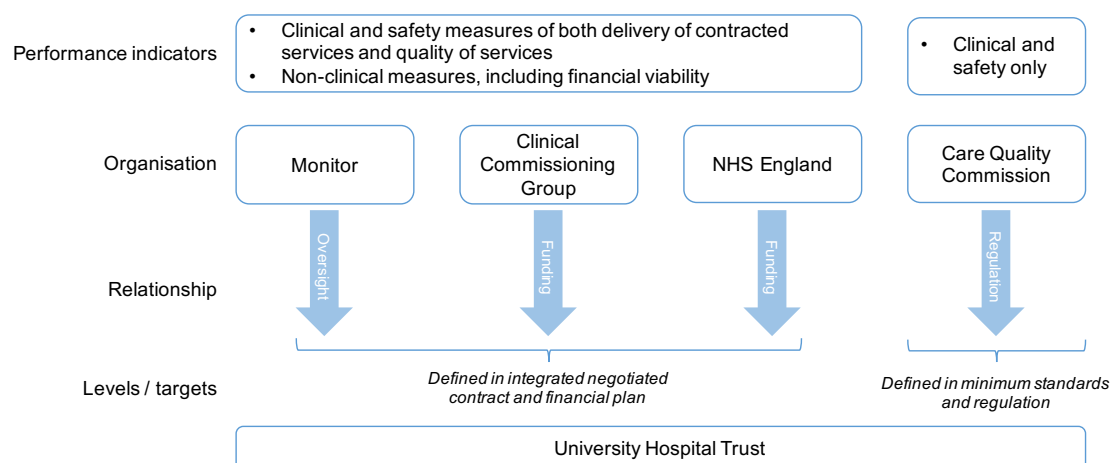
Figure 7-1 - Summary of UHT external performance monitoring

The Trust's main contract and business plan is authorised by Monitor, as the regulator of NHS Foundation Trusts. The contract and plan are negotiated, on a cyclical basis of annual update with periodic major revisions, with Monitor as the sector regulator and oversight body, the Clinical Commissioning Group (CCG) as the funder of routine NHS care, and NHS England as the funder of specialised services, such as oncology and

---

[62] See, for example, https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/455893/RAF_revised_25_August.pdf

transplant medicine. This process involves defining the amount of each service that will be offered (i.e. the volume of specific designated procedures and treatments), as well as quantified points (thresholds or targets) above or below which financial penalties can be imposed or rewards offered to the Trust.

In the following section, I discuss the specific implementation of indicator and performance monitoring at University Hospital Trust and the ways in which patient and public Governors were engaged in monitoring the performance of the Trust.

Monitoring performance

For University Hospital Trust (during the fieldwork period), performance monitoring was achieved through an integrated single document, produced periodically and circulated to members of governance groups by the management of the Trust. As a document, it averaged nearly 50 pages in length, and included both qualitative commentary from managers (often Executive Directors), as well as quantitative data sourced principally from the various information technology systems which support the Trust's operations. The explicit aim of the integrated report was to give a complete overview of the status and performance of the Trust, and included measures selected by managers as relevant to monitoring the performance of the organisation, measures agreed as national priorities, measures agreed with local commissioners, and regulatory indicators. Before discussing some of these measures in more detail, and the roles that patient and public Governors took up with respect to those measures, I would like to take a moment to consider the question of complexity and totality as embodied (in a sense) in the University Hospital Trust integrated report. An anonymised summary page from this report is reproduced below (Figure 7.2 – Quality scorecard):

Quality Scorecard

Harm free care

Indicators	Data to:	Trend	Target	Mar-14	Apr-14	May-14	FYtD	LTM
Critical Incidents								
Never events	May	⇔	0	0	1	1	2	3
Serious incidents	May	⇩		2	7	8	15	67
Actual harm incidents	May			119	102	128	230	1280
Actual harm incident rate	May	⇩	<= 0.20%	0.16%	0.14%	0.18%	0.17%	0.15%
Safety thermometer								
Patient safety thermometer (new harm only)	May	⇩	98%	98.6%	99.3%	98.5%	98.9%	98.4%
Hospital acquired new pressure ulcers	May	⇩		3	1	4	5	31
Infection Control								
MRSA bacteraemias	May	⇔	0	0	0	0	0	4
Clostridium difficile cases	May	⇩	<= 61	5	3	4	7	41

Delay free

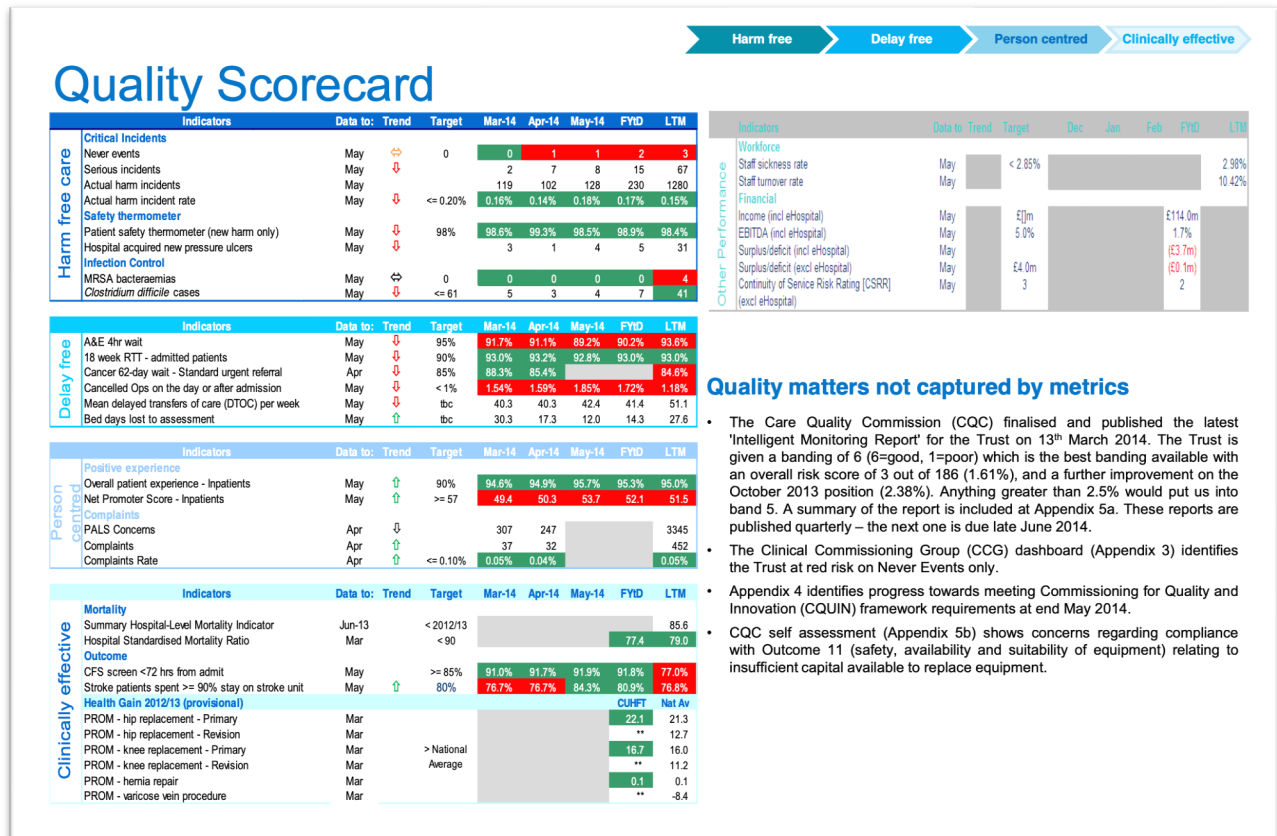| Indicators	Data to:	Trend	Target	Mar-14	Apr-14	May-14	FYtD	LTM
A&E 4hr wait	May	⇩	95%	91.7%	91.1%	89.2%	90.2%	93.6%
18 week RTT - admitted patients	May	⇩	90%	93.0%	93.2%	92.8%	93.0%	93.0%
Cancer 62-day wait - Standard urgent referral	Apr	⇩	85%	88.3%	85.4%			84.6%
Cancelled Ops on the day or after admission	May	⇩	< 1%	1.54%	1.59%	1.85%	1.72%	1.18%
Mean delayed transfers of care (DTOC) per week	May	⇩	tbc	40.3	40.3	42.4	41.4	51.1
Bed days lost to assessment	May	⇧	tbc	30.3	17.3	12.0	14.3	27.6

Person centred

Indicators	Data to:	Trend	Target	Mar-14	Apr-14	May-14	FYtD	LTM
Positive experience								
Overall patient experience - Inpatients	May	⇧	90%	94.6%	94.9%	95.7%	95.3%	95.0%
Net Promoter Score - Inpatients	May	⇧	>= 57	49.4	50.3	53.7	52.1	51.5
Complaints								
PALS Concerns	Apr	⇩		307	247			3345
Complaints	Apr	⇧		37	32			452
Complaints Rate	Apr	⇧	<= 0.10%	0.05%	0.04%			0.05%

Clinically effective

Indicators	Data to:	Trend	Target	Mar-14	Apr-14	May-14	FYtD	LTM
Mortality								
Summary Hospital-Level Mortality Indicator	Jun-13		< 2012/13					85.6
Hospital Standardised Mortality Ratio	Mar		< 90				77.4	79.0
Outcome								
CFS screen <72 hrs from admit	May		>= 85%	91.0%	91.7%	91.9%	91.8%	77.0%
Stroke patients spent >= 90% stay on stroke unit	May	⇧	80%	76.7%	76.7%	84.3%	80.9%	76.8%

Health Gain 2012/13 (provisional)	Data to:	Target	CUHFT	Nat Av
PROM - hip replacement - Primary	Mar		22.1	21.3
PROM - hip replacement - Revision	Mar		**	12.7
PROM - knee replacement - Primary	Mar	> National	16.7	16.0
PROM - knee replacement - Revision	Mar	Average	**	11.2
PROM - hernia repair	Mar		0.1	0.1
PROM - varicose vein procedure	Mar		**	-8.4

Other Performance

Indicators	Data to	Trend	Target	Dec	Jan	Feb	FYtD	LTM
Workforce								
Staff sickness rate	May		< 2.85%					2.98%
Staff turnover rate	May							10.42%
Financial								
Income (incl eHospital)	May		£[]m				£114.0m	
EBITDA (incl eHospital)	May		5.0%				1.7%	
Surplus/deficit (incl eHospital)	May						(£3.7m)	
Surplus/deficit (excl eHospital)	May		£4.0m				(£0.1m)	
Continuity of Service Risk Rating [CSRR] (excl eHospital)	May		3				2	

Quality matters not captured by metrics

- The Care Quality Commission (CQC) finalised and published the latest 'Intelligent Monitoring Report' for the Trust on 13th March 2014. The Trust is given a banding of 6 (6=good, 1=poor) which is the best banding available with an overall risk score of 3 out of 186 (1.61%), and a further improvement on the October 2013 position (2.38%). Anything greater than 2.5% would put us into band 5. A summary of the report is included at Appendix 5a. These reports are published quarterly – the next one is due late June 2014.
- The Clinical Commissioning Group (CCG) dashboard (Appendix 3) identifies the Trust at red risk on Never Events only.
- Appendix 4 identifies progress towards meeting Commissioning for Quality and Innovation (CQUIN) framework requirements at end May 2014.
- CQC self assessment (Appendix 5b) shows concerns regarding compliance with Outcome 11 (safety, availability and suitability of equipment) relating to insufficient capital available to replace equipment.

Figure 7-2 - Quality Scorecard

This quality scorecard shows how the Trust defines and measures its own performance, presenting metrics that fall within five categories, four of which are defined and given a specific nomenclature, and one category which is titled other. It uses, in many places, an intuitive visual code to frame indicators as good (green) or bad (red). The categories established by the Trust as describing its performance are:

- Harm free care
- Delay free [care]
- Person centred [care]
- Clinically effective [care]

The organisation and production of this set of measures can be seen as a collectively produced action, performed by management (recalling the definition of management as being both the internal roles defined within the organisation and also the Executive Directors who fulfil a governing *agent* role in solving the principal-agent problem). The use of particular measures, and of identifying how those measures are interrelated,

differentiated, or measure different aspects of a hospital, is not merely reflective of activity in the hospital but is a projection by particular subjects of a *position*. Similarly to how we can understand the verbal social action as inherently carrying with it its own claims of validity, so too should we understand the multimodal formation of a social action through a collectively produced document as carrying with it multiplex claims to validity within the social space. Understood in this way, we can understand that the four categories represent what is most salient about the hospital for the managers producing the report; the translation of the organisation's understanding of its purpose into measurable activities that can be monitored to ensure, in turn, that those purposes are being fulfilled.

The categories themselves can then be seen as relevant objects for analysis in understanding how governance is performed through the ongoing development of a social space, as we can see the categories under which performance is monitored as being made complicit (by the proposing subjects) in the construction of social space. The observation that I wish to make about these categories is that they are *clinically* focused, in that they are categories which related to the business of the Trust as defined as the delivery of specifically delimited health care services. Each grouping – each named purpose of the Trust – can be specifically related to medical intervention and treatment. At the outset, then, we can see that there is an implicit prioritisation of these objectives embedded within performance monitoring in University Hospital Trust. Clinically-related objectives, and the monitoring of performance measures thought to relate to the (as referred to) quality of health care, are given prominence over the measures of the Trust's *financial* performance. This subverts, to some extent, the expected logic of the interests of an (otherwise unspecified) economic firm, in which the normative expectation is that the interests of the firm are in maximising profit. Here, we can see that *a priori* of the action of Governors in contributing to performance monitoring, the agents (in the sense of principal-agent) who are responsible for directing the actions of the hospital have put forward a position that the clinical aspects of hospital performance and activity are to be prioritised over the financial.

This is not, of course, achieved in a vacuum; as the prior discussion on the emergence of performance monitoring in the NHS has suggested, the ways in which performance should be defined and monitored is at least to some extent defined by the NHS itself through the contractual relationships which it establishes with semi-autonomous providers such as Foundation Trusts. The NHS, through the establishment of data collection and information sharing architectures (principally the mandatory data collections required of Foundation Trusts through the Health and Social Care Information Centre, since re-titled as NHS Digital) and the inclusion of specific *options* for measures in the standard contract which is required to be used between Commissioners and providers, can be seen to critically influence the perspective on relevant domains of hospital performance taken by those hospitals. In addition, the inclusion of those measures – both the obligation for them to be monitored and the creation of specific targets against them – within contracts effectively creates an *economic* incentive for non-financial performance. This is an explicit intention of these indicators and targets for the NHS; to create economic incentives for particular (desired) behaviours and disincentives that encourage providers to ensure that poor outcomes are avoided (Mannion, et al., 2007), although it is worth noting that Mannion and co-authors questioned whether the extrinsic motivation of managers (modelled as agents in a principal-agent relationship with the Department of Health as principal) by an overarching body was as influential as an intrinsic motivation related to the delivery of care.

Whether or not the extrinsic economic incentives constructed *inter alia* through contracts and regulation are the origin of prioritising quality of care over purely financial performance, the way in which performance information is presented in governance-in-practice in University Hospital Trust aligns with both the incentives and the ways in which the NHS suggests that hospitals monitor performance. This is not to say that there are not inconsistencies between how a regulator or an external body might view Trust performance, and how the Trust views its performance. University Hospital Trust is a case in point of such difference; the Trust has been one of many that have been placed into special measures (enhanced regulatory supervision) as the result of poor performance. The past experience of special measures and the future prospect of sanction should be considered as part of the context for how the performance was understood and oriented to in governance committees.

As I have discussed above, the way in which the Trust presents targets and performance reporting focuses predominantly on the clinical aspects of the hospital, with financial performance tracked as other in the integrated performance report. For this reason, I will start with care-related measures and how Governors utilised them in understanding the hospital, before discussing financial performance in a subsequent section. The focus here is on how patient and public Governors can be seen to understand, deploy, and utilise these performance indicators. As highlighted in the discussion of how the committees and groups within the Trust are organised (see chapter 4), the *distribution* of topics across specific groups is locally dependent and determined by the Trust itself, and much of the performance management content was moved, at the conclusion of this fieldwork, from the subordinate working groups to the main Council of Governors meeting. This was with the express intention of ensuring that the full Council of Governors was able to discuss each aspect of the integrated report; again, this can be taken as supporting the contention advanced above, that the integrated performance report itself represents a position taken by the organisation on how its activities should be viewed (i.e. that hospital activity necessarily encompasses and should be understood across the multiple domains proposed in the report).

In the context of governance meetings, then, the presentation of performance information took a routinised form. The integrated performance report forms the sole *documentary* reference for the discussion of hospital performance. The core measures are summarised in Figure 3; for each measure, the Governors are provided with additional detail. This generally includes historical (trend) data and relevant benchmarks (such as national average or the organisation's target). In addition to the supporting detail below the Trust's selected measures, Governors are also given the *external* measures of the Trust; the current CQUIN (Commissioning for Quality and Innovation) targets and the CCG scorecard. In the case of CQUIN figures, performance against these specific targets is linked to economic incentives determined in the CCG contract. There are specific financial penalties for breaching CQUIN targets; by comparison, the disincentive for breaching minimum standards specified by either the CQC or Monitor is enhanced regulation and reduced autonomy through increased direct intervention in the

management of the Trust. Based on this integrated report document, an Executive Director then provides a verbal report to the group. Much like the summary reports discussed in detail in the previous chapter (regarding "never" events), these statements are interpretive positions taken by the Executive Director on the performance of the Trust, which align with the position presented in the integrated report. Governors were thus presented with a set of documents which presented progressively more detailed information describing the performance of the Trust, contextualised and positioned by both a documentary position (the red and green highlights of good or bad performance, shown above) and the positioning work of an Executive Director.

Performance indicators when presented in this way can therefore be conceptualised as a transformation of knowledge and expertise. By taking information about specific clinical incidents and phenomena, transforming those data into a single point which can be interpreted relative to another value, *and* then performing that interpretation (even in this simplistic, binary way of red / green), the members of expert categories within the Trust both make a claim that this information and positioning is valid, but also commit to that positioning based on information which is abstracted from its natural context and through this abstraction made more appreciable without expertise. Patient and public governors could systematically respond to and interrogate performance indicators; the task of questioning and responding to performance indicators shifted from either the null participation of a clinical management meeting, or the limited questioning of specific "never" events, to interrogation of the meaning of performance for the Trust. Governors accepted the positioning of good / bad performance as a valid claim, but were concerned then with understanding the consequences and potential actions that could be taken in relation to that performance. By this I mean that the Governors would explicitly seek information about both the incentives linked to performance indicators *and* what was anticipated to change in the activities of the Trust. In governance meetings, then, the role of the Executive Director was construed as providing information both about performance and about the activities of the Trust, and the role of Governors was to seek to *understand* the performance information presented to them and the relationship that proposed activities had to those measures.

An example of this activity between Governors and Executive Directors is the ongoing management of hospital acquired infections. University Hospital Trust had two targets – maximum thresholds – for the number of C. diff (*Clostridium difficile*) and MRSA (methicillin resistant *staphylococcus aureus*) in the Trust for each year. An example of the data associated with C. diff infection is presented in the below Figure.
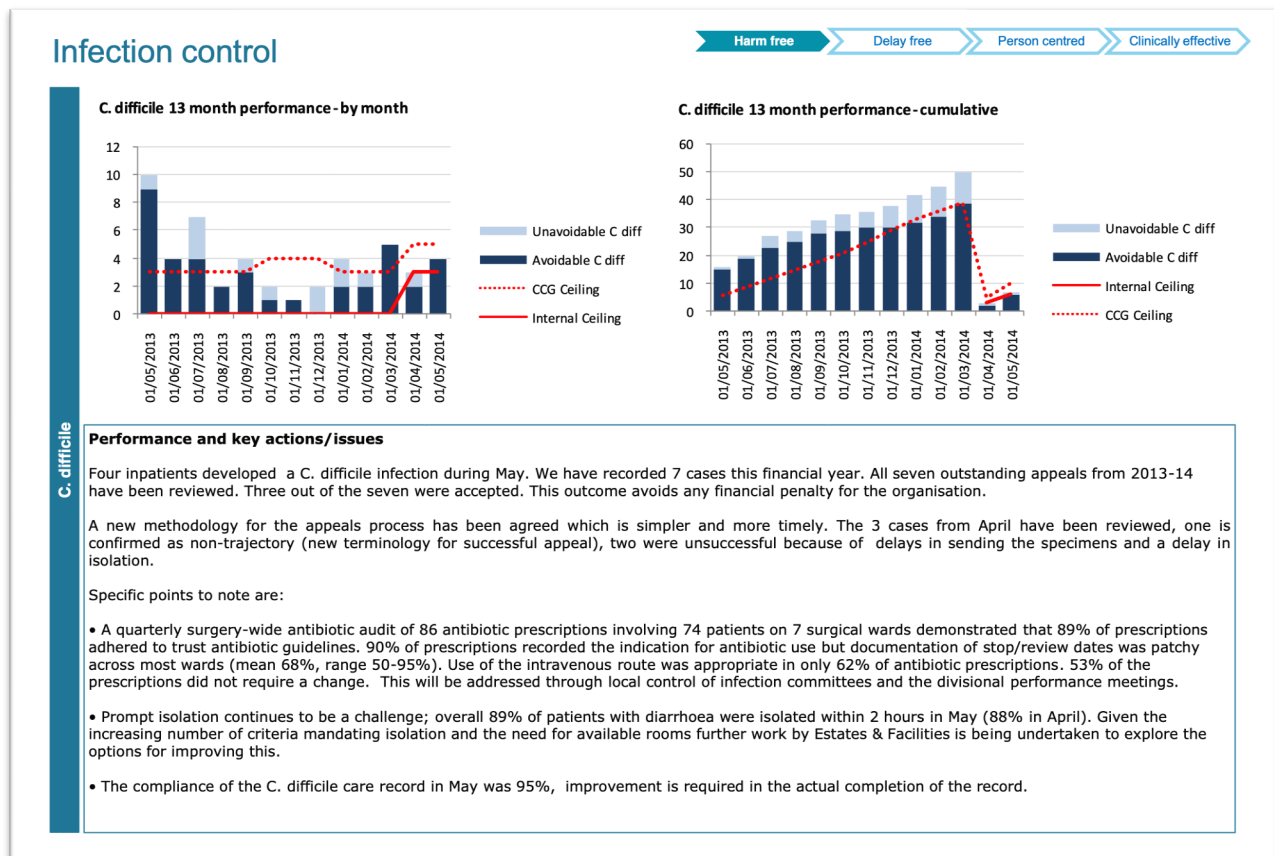

Figure 7-3 - Infection control data

The Trust's C. diff target is formulated as an aggregating trajectory; a monthly target which represents the progress towards the total annual cases of C. diff that are expected within the Trust. The target operates therefore in two ways, both as a maximum threshold for a year, and also the rate at which that maximum threshold can be reached. Exceeding the number is linked to a financial penalty (effectively a fine) for each case in excess of the trajectory target. Combating C. diff involves multiple strategies from the Trust; changes to clinical procedures, rotation of wards and equipment, acceleration of pathology testing pathways, increasing promotion of hand-wash procedures. I argue that we can see this measure as the end result of a process which begins with a biological event (bacterial colonisation), with subsequent interpretation through the medical and

175

pathological gaze (diagnosis), and transforms this into a single figure that can be (to adopt Weber's language) made calculable. By doing so, it opens up the possibility for Governors to question and seek to understand the performance of the Trust, and to then further understand how each action that can change the current position of the target is linked to a change in that target. In other words, patient and public Governors are able to use the positioning of calculable figures proposed by Executive Directors to understand the potential future positioning of those figures; in more practice-oriented terms, by transforming clinical practices into measures which are interpretable through a logic which is shared between Executive Directors and Governors, there are greater affordances for deliberative communicative action between Executive Directors (as the more expert subjects in the social space, in the domain of the clinic) and patient / public Governors.

In examining how Governors were engaged in performance discussions, there appeared to be two salient dimensions of performance measures which I will discuss prior to moving to financial metrics and performance. Firstly, patient and public Governors attend to hospital performance as it is represented through the measures presented to them. Secondly, I critically examine the purpose of this monitoring in the project of new public management.

The first observation is, in some ways, expected, and indeed it provides evidence of behaviour in practice that matches predicted attention to measures from health economics studies (Goddard, et al., 2000). Goddard et al argue that the introduction of specific short term information (measures) leads to myopia in agents, or a focus on short-term issues over longer-term trends and outcomes. I suggest that we can refine this argument based on understanding how data are used within a hospital. Rather than claim that there is a specifically *time-horizon* impact (short-term focus over long-term), I argue that the impact of performance measures is to focus attention on the *specific measure* rather than the time horizon as such. Governors – and other participants in meetings – talked about each measure, working sequentially through the content of the performance report, described earlier in this chapter as a routinised performance report. Taking the example of the C. diff report (reproduced above), the focus of the discussion was on the change in the *reported* numbers shown in the report, relative to the thresholds agreed with the CCG.

By this, I mean that the performance report itself determined a conversational topic for participants, with the conversation structured by and limited to the information presented on the report itself. In the case of C. diff reporting, the narrative information within the report is an example of how this report shaped the focus of Governor attention during meetings. The performance report notes that there were 7 cases in the (current) financial year, with 7 outstanding appeals from the 2013-14 financial year resolved. The report notes that the outcome of those appeals avoids a financial penalty for the Trust. This illustrates the performance information given to Governors – information which highlights and orients readers to relatively small numbers (<10, given that the Trust is responsible for well in excess of 1 million patient treatment episodes each year), and presents contextual information (such as antibiotic policy adherence and isolation procedures) in relation to the relatively small pool of patients with C. diff infection.

As Governors discussed this report, as with other, similar performance indicator reports, the focus of such conversations was on data and information as presented within that report – the reports functioned as a way to open up a topic for conversation across Governors and management representatives, but inherently *limited* that conversation to those measures. This was consistently observed across meetings; performance reporting and scorecards focused the attention of participants on the information contained within those reports to the *exclusion* of other information. It is this topic attention and focus that I refer to as myopia; a focus on the specific measures contained in the reports. Considering the broader reporting framework – the full gamut of measures that were presented to the Council of Governors and Board of Directors – a further effect was observed, in that the measures that were specifically tied to financial incentives were discussed more extensively, and more frequently, than those not specifically tied to financial incentives. The inclusion of these financial incentive outcomes (the past appeals and changed appeal process) in the C. diff report is an example of how these financial incentives are included in the performance reports, and thus are made relevant to the meetings in which they are discussed.

Although, on the surface, this might seem like an argument that incentivisation can lead to gaming of such measures by managers (a familiar argument from the economic

literature, see commentary in Goddard, et al., cited above), I suggest that we can consider the myopic effect as separate from gaming. Part of the reason that I suggest that measure myopia should be separable from gaming is the structure of incentives and the principal-agent separation in the NHS. If we consider the *board* (i.e. the Directors) as agents, then we can see that economic incentives that apply to the Foundation Trust are intended to incentivise their behaviour, and that there are (for example) individual payment schemes which act as incentives for individual managers (BMJ, 1986) to attend to firm performance. This can in addition be seen as further evidence for the impact of new public management on the NHS. This incentive link serves perhaps as a sufficient explanation in considering *agents* specifically, but this seems to be rather weaker when considering the attention of volunteer, unpaid patient and public Governors. We then must decide whether we consider Governors to be agents for whom the economic interests of the firm (hospital) act as an incentive, or whether the claim to authority present in the measure itself is a consequential driver of Governor's behaviour. I would suggest that if we view measures as being the abstraction of otherwise opaque clinical activity and subsequent transformation into a calculable form, then the latter explanation may perhaps be linked to Governors. In other words, myopia can be seen as a product of the ways in which measures socially construct a shared space that is used in turn in the ongoing achievement of social actions which are necessary for governance to occur.

As I have argued throughout this analysis, we can see that the ways in which hospitals define and measure performance within their internal governance processes is inherently connected to the ways in which the overarching hospital system establishes a performance monitoring framework. This is in line with the doctrine of new public management, and it is therefore unsurprising to see that the hierarchical imposition of incentives and monitoring is successful in embedding system-sponsored measures in the day-to-day practices of governance at hospital level. There is an open question, here, about the *end goal* of this activity. Although, as I have discussed above, we can see that there are certain specific objectives that can be attributed to performance monitoring, the everyday experience of these measures (as in, the ways in which Governors and Directors relate to them) is that they are essentially solipsistic. By this I mean that the relationship between the measure and what is held to be the objective goal of the hospital organisation is not seen to be clear, by members of Trust governance. In certain circumstances, this was

illustrated by Directors of the Trust through identifying inconsistencies in the measures of hospital performance. Using standardised mortality ratios, University Hospital Trust outperformed both most hospitals in the country and most comparable *types* of hospital (large, university-linked tertiary care centres), meaning people were less likely to die during care at University Hospital Trust than statistically expected given the inherent risk of death for their diagnosis. The Executive Directors of the Trust took this as evidence that University Hospital Trust was in the most fundamental ways a good hospital, doing the right thing. This was seen to be inconsistent with the *regulatory* view of the hospital, which identified an overall inadequate level of care due to failure to meet specific measures and targets. By juxtaposing these two pieces of data, Executive Directors expressed a certain cynicism of the validity of performance measures, whilst simultaneously continuing to monitor the hospital's performance against those measures. Reliance on measures for structuring interactions between Executive Directors and Governors limited the extent to which this perspective could be effectively explored in the context of Trust governance, reducing a potential critique of measurement in the NHS to a series of asides and offhand remarks in private, closed-door meetings. Under the current constraints and incentives faced by Foundation Trusts, these successive layers of monitoring and surveillance are obligatory, and ensure that each Trust constructs within itself a systematic way of ensuring that such monitoring is both performed and *seen to be* performed.

We can understand that the imposition of measurement is (inherently) self-serving and solipsistic in that it carries with it a moral certitude of the measures themselves; a particular measure becomes valid in the sense that it can be included within a system of measurement, and becomes a valid topic for decision-making and discussion within governance, because it is included within the measurement system. The precise measures must be assumed to be sufficiently correct, because failure to comply with the logic of measurement is disaffiliative to the (system) structures imposed upon the NHS by its own programs of surveillance. By aligning to the regimes of measurement, Trusts are both responding to economic incentives, reproducing within themselves a transformation of expertise into calculable and comparable indicators, and becoming subject to the disciplinary authority of the organising system. What the ethnographic observation of governance practices identifies for us, in addition to this, is that there are visible tensions

and points of resistance to this disciplinary power (as also suggested in the "never" events analysis of the prior chapter). That said, there are some aspects of how subjects in governance align to *financial* performance which suggest, potentially, a path forward to rethinking governance of hospitals and health care. It is to this second point that I turn now.

Financial performance and economic incentives

In this section, I consider the financial performance of University Hospital Trust, and what the orientation of subjects during governance practices to this performance might suggest about a radical repositioning of hospital and health-care governance. Financial performance is considered through the same mechanism(s) as performance in the specifically clinical domain; a brief table titled "Other Performance" in Figure 7-3 shows a selection of financial metrics. These, as with other groupings of metrics, are accompanied by details of income and expenditure and the Trust's balance sheet. However, to understand how subjects orient to these financial *outcomes*, it is necessary to give a brief overview of budgets and how income is earned in NHS Foundation Trusts, at least as it relates to the delivery of NHS-funded services (as in, excluding specifically research-related or other sources of income). Hospital services under the NHS are paid based on the actual delivery of care through a fixed tariff case-mix based system (similar to what is known as 'diagnosis related groups' and referred to as 'Payment by Results'). Contracts between commissioners and providers specify which services are to be provided, and can further specify case-mix and financial targets (as in, specific target or predicted numbers of patients or treatment events in particular categories). In some cases, these targets may be linked to a financial incentive based on what is referred to as a risk-share / gain-share model, in which (for treatment events) *exceeding* the number predicted results in a lower financial return to the provider, whereas *under*achieving results in only a partial loss of revenue.

An example of this for University Hospital Trust was emergency department procedures. Target patient volume in emergency departments, in aggregate, had been set at a fixed level for the local health economy. For each patient event up to each provider's predicted

share of that volume, the provider was paid the full amount as per the fixed tariff. For any treatment over the target, the provider was only paid a percentage of the fixed tariff, with the difference between the fixed tariff and the hospital payment sequestered into a regional fund held by the commissioners and the local authority. This is one example; it is within the scope of contracts between providers and CCGs to establish local prices beyond the fixed tariff, or to establish a range of shared revenue models. Penalties, as mentioned in the previous section, obviously apply over and above this model to reduce total payments to hospitals. Each Foundation Trust's annual plan (including financial projections) is subject to review and approval by the regulator, Monitor, and the assumptions of this financial plan are transformed into a budget against which the Trust is expected to monitor its performance (as in the discussion in the prior section). Financial incentives faced by each Foundation Trust are structured around both clinical and financial targets – that is to say, against the output of the hospital's production of health-care. Thus, although the way in which Foundation Trusts *earn* income is through delivery of care, centrally planned budgets and expenditure targets are still a fundamental feature of the contemporary NHS, with the explicit aim of managing (generally reducing) public expenditure on health care. Targets and incentives are designed to reduce the risk, to the funders of NHS services, of a provider *over*-delivering care (i.e. of exceeding budgeted expenditure).

As a starting point, then, I propose that when we conceptualise financial performance of Foundation Trusts, we take a perspective which includes both the *production* aspects (i.e. the earning of income through the delivery of health-care) and the *incentives* which are structured against a planned budget / financial projection. Under current budgetary and financial incentive arrangements, controls on NHS Foundation Trusts are structured such that the risk of increased demand (for health-care services) can be contained at the provider level, by constraining the income generated from health care delivery to pre-specified contracts and budgets. The risk of costs exceeding the income generated from activities is also held at provider level; monitoring expenditure relative to income and the resulting risk to service delivery is one of Monitor's core focuses in its assessment and measurement of Trust performance. That said, the focus of this discussion is mainly on the *demand* for health-care (from a particular provider) and the *budgets* which that provider is monitored against.

Implicit in this system of monitoring – indeed, arguably in any such framework – is an assumption that in the absence of such monitoring an adverse and unwanted outcome will occur. Proceeding on the basis of this assumption, we should consider what the structure of financial incentives suggest about NHS Foundation Trusts – or rather, we should consider what these incentives demonstrate about how the performance measurement system constructs Foundation Trusts and assumes the likely behaviour of those Trusts to be. Notwithstanding local variations and the adjustments to final income which may result from specific penalties, there is a general architecture to the funding of hospitals within the NHS which can be simplified down to an assumption that hospitals earn at least marginal revenue from each additional treatment event. By this, I mean an assumption that, in a simplified economic production model of the hospital, we see that its output is (at least one unit of) treatment events, which in turn is consumed according to local demand for treatment. Although for certain services the hospital may face diminishing returns (i.e. decreasing marginal revenue) I assume, for this analysis, that treatment events are in most circumstances at least marginal revenue positive. Very simply, I propose a theoretical model of the hospital as a producer of treatment, for which it earns revenue, as an approximation of the delivery of services in the NHS. If we take this model of a treatment-producing hospital and assume that it is placed under the budget / target monitoring constraints faced by University Hospital Trust, then the *purpose* of these constraints can be made somewhat clearer. Absent specific constraints and incentives not to do otherwise, it would be logical (in the strictly economic sense) to assume that the hospital as a producer would continue to treat until the supply of health-care reached equilibrium with local demand. As, within the NHS, consumption and purchaser roles are separate, consumer demand for health-care (patient treatment demand) exceeds the purchaser demand (i.e. the amount of money that NHS payers are willing to expend), the purchaser must either regulate consumer demand or (in the case of the NHS) regulate production (supply).

This (rather simple) economic sketch of local demand and supply for health care services is meant to illustrate one critical assumption, common to all consumption models which assume supply / demand will move to equilibrium. This assumption, which we can see as

inherent in the regulation of supply that is achieved through budgetary management, is that a firm (i.e. a hospital) when faced with increasing demand will also increase supply, because the firm's actions are governed by a simple profit-maximising motivation. This is of course a hypothetical model, and is necessarily detached from the reality of hospital planning and budgeting; the intention is to propose that, along with the *practices* of management which were imported into the public sector with new public management, certain *assumptions* about the incentives and motivations of corporate or corporate-like actors were also imported and are implicit in the ways in which regulation is designed around these bodies. Further evidence of this perspective inherent in thinking about health systems can be seen in policy work which looks to the *next* step in how health should be regulated, which in turn looks to public services with explicitly profit (rent) seeking actors, such as utilities (Dixon, et al., 2011).

The question that this research project is uniquely positioned to address, in relation to this, is does the way in which Governors and Directors evaluate and orient to the financial performance of the Foundation Trust support this view of motivation in an English hospital? Or, put slightly differently, can we see profit-seeking agents in the governance meetings of University Hospital Trust? When considering the ways in which financial performance was examined in governance, we can see that as with clinical quality indicators University Hospital Trust utilises the measures and metrics that are embedded within the incentives and regulatory framework of the NHS. In considering financial performance, Executive Directors orient to particular metrics (chiefly progress against budget and retained surplus, disregarding interest and other capital charges) which can be seen to align with the overarching regulatory structure proposed and enforced by Monitor. This is broadly similar to how quality measures are utilised in governance. However, unlike clinical performance indicators which are *lag* indicators, in that they are reflective of past performance, evaluation of financial performance in University Hospital Trust involved *projection* into the future, based on expected budget. In this, then, the Executive Directors were able to take a position relative to future demand for services in the Trust. Future demand was constructed intersubjectively across Governors and Directors (Executive / Non-executive) as a challenge, or a pressure. Although there were times when this increased demand was explicitly linked to success (such as increased emergency department utilisation linked to increasing expertise in major trauma and

stroke), future increases in patient numbers were constructed predominantly as a risk for University Hospital Trust. Increasing demand would, for the Trust, mean that available capacity would be taken up (as in, the limits of the hospitals output would be reached).

This *perspective* or *orientation* to increasing demand for health-care is unsurprising (as highlighted in the background discussion for this thesis, concern over increasing health expenditure is shared by governments), and it aligns with the incentives and constrained budgets of NHS payers. That said, the extent to which increasing demand for limited resources was a *shared concern* within the hospital suggests that the assumption that I argue for above – that the hospital is inherently similar to a profit-seeking corporate actor – does not wholly apply to English hospitals (and by extension, to Directors and Governors of hospitals). This is echoed in the orientation of the medically qualified Executive Directors to the shared regional investment pools outlined above; in these cases, the Executive Directors showed a *positive* orientation both to foregone revenue *and* to regional cooperative activities designed to *reduce* demand for the hospital's services; in particular, a shared winter plan to better coordinate *non-hospital* care services and reduce avoidable hospital admissions for vulnerable populations during colder weather. These orientations and positioning were subtle, shared alignments between Governors, as representatives of patients and the public, and the Directors of the Trust, that were created across discussion of both University Hospital Trust's financial position and the relative financial positions of other NHS providers in the area. Indeed, the inclusion of potentially competitive providers on the Council of Governors can be taken as an indication that University Hospital Trust viewed itself as a non-competing entity. The behaviour of Governors and Executive Directors, in relation to seeking profit and additional revenue, can be understood as more closely aligned to the *public interest* mission of a Foundation Trust, than the *income* expanding or *profit-seeking* motivations of a more straightforward corporate actor.

This is not to claim that this observation falsifies the proposition that imposing measurement and budget-related incentives on hospital trusts in England has an effect. That said, if the hospital was a more purely profit seeking actor, I would argue that we would see, in the attitudes and position work in governance groups, a more explicit

seeking of ways to game or avoid the specific incentives / sanctions that limit the hospital, as an individual corporate actor, from capturing a greater comparative share of even a limited local budget; in comparison to a utilities provider facing fixed costs, each actor can be expected to seek to grow its share of the market at the expense of other actors. What I argue is that the way in which Directors and Governors talk about future demand suggests that the hospital is oriented to more than dynamics of supply and demand in considering its future actions. This additional set of concerns, I argue, can be broadly conceptualised as being an orientation to the impact of the *potential* increase in supply-side use of available resources for health-care. Resources for health-care, here, is understood as equivalent to the funding available to be spent on health, as allocated at a national level. The concern of the hospital is driven by a shared awareness, occasionally explicitly stated by participants in governance meetings, of "limited budgets" or "budget constraints" at a *national* and *regional* level. Often, this is euphemistically glossed as the "current climate". These concerns can be seen as an emergent property of a shared and mutually held set of positions in the governance functions of University Hospital Trust. Both Governors and Directors share a concern for University Hospital Trust, both for the *immediate* future of the hospital and its current performance against its obligations, and for its longer-term objectives. This is (generally) consistent with what would be expected of the governance of a firm. What is distinct are the complementary concerns that the Governors and Directors have for the specific impact that the hospital could have on available budgets *beyond* itself. Increased activity by University Hospital Trust is understood to have a cost of reduced ability to *pay for* activity elsewhere, and *vice-versa*, given excess demand as a (more or less) expected precondition. Non-profit-generating activities, in addition, were seen as being *moral* obligations that the Trust had to maintain.

In the case of a highly specialised transplant service which generally represented a significant financial risk to the Trust (paradoxically, the tariff for the service was relatively generous, but predicting low N demand meant that surplus or deficit for the service as a whole could be driven by as few as 1 or 2 cases), the position taken by Directors and subsequently aligned with by Governors was that the Trust should maintain capacity *on behalf of* the system, rather than ensure a profitable and predictable surgical service. In essence, my argument is that we can see that governance in hospitals is, in its orientation to demand, concerned with more than supply, demand, and specific incentives

or constraints faced by the individual hospital. The implications of this argument are that it suggests a potential alternative lens through which to consider the governance and management of hospitals, and thus the measures and regulatory practices that might be required. In the following section, I consider this potential from the perspective of health funding as a common pool resource management problem. That said, it should be noted explicitly that the ways in which Directors and Governors orient to budgets and performance measures now is, inherently, a product of the context in which these subjects operate. Thus, whilst I consider health-care from a common pool resource perspective, I do not necessarily claim that this is consistent with or an underlying part of *current* governance practices. Rather, on the basis of emergent concerns and orientations that can be seen in the ethnographic examination of governance, I seek to argue that common pool resource approaches might be a fruitful avenue to guide a reconsideration and reconfiguration of hospital governance, at least as it relates to financial oversight.

Health care financing as common pool resources

I begin this section by giving a brief overview of Ostrom's (2009) framework for analysing emergent self-organising common pool resource management systems, as well as her earlier framework (Ostrom, 1990), and then consider how this might be considered applicable to health-care. Gilson (2003) argues that Ostrom's work on intrinsic motivations contributes to a conclusion that trust building between providers and at the patient-provider interface is critical to creating health care systems that are both inherently trust-worthy and that matter to society. There has been some analysis of how common pool resource management might be applied to fixed-cap physician budgets, and highlighted that the applicability of common property analysis in health-care has been limited to the general condition of *scarcity*, rather than to the *management* characteristics of the commons as proposed by Ostrom (Hurley & Card, 1996). It should also be noted that it is possible to see how common pool problems can be characterised in shared capital (financing) resources (Kapur, 2002). In a 2015 policy analysis, Ham & Alderwick (2015) leverage aspects of Ostrom's proposals to suggest a *geographically* determined (in their words, place based) way of configuring enhanced networks of care within the NHS. This analysis positions the proposition of the common pool to argue that:

> Organisations commissioning and providing care with a common pool of limited resources find themselves in a zero-sum game in which winners co-

> exist with losers in a set of relationships that are often fragile. Failure to act collectively is likely to result in poor outcomes for the population and at worst a descent into a 'war of all against all', to borrow the words of the philosopher Thomas Hobbes. The central argument of this paper is that NHS organisations must work together and with others to govern the common resources available for meeting their population's health needs. (Ham & Alderwick, 2015, p. 6)

This observation, whilst positioning limited financial resources as a common pool resource, does not extend the analysis to a consideration of how governance practices within hospitals can be seen to be consistent with and therefore *supportive of* a view of health-care financing as a common pool resource. That said, there appears to have been limited application of Ostrom's emergent systems analysis, which aims to establish comparison between examinations of emergent properties of institutions, in health-care or specifically in hospitals.

It should be pointed out that, to some degree, this analysis is predicated on a somewhat different definition of health to that found in economic literature. In the discussion of the hospital in the prior section, I have intentionally framed the production function of a hypothetical hospital as having as an output health *services*, a consumer good that faces a consumer-led demand. However, the notion of health is frequently characterised as a public good, further characterised by having a high degree of difficulty in excluding potential beneficiaries, and a low level of subtractibility. In essence, this positions health as being a good that can be simultaneously consumed by many (without reducing the overall amount of health available), and for which there is both a moral imperative to *include* and a difficulty in *excluding* an individual from consuming. In the following analysis, I should be clear that I am not arguing for health *per se* as a common pool resource, nor do I conflate the notion of health services with health. The focus in this analysis is whether the *financial resources* that can be expended on health can be seen as a common pool resource.

Common pool resources, as discussed by Ostrom (2010), are types of economic goods which are both highly subtractable and have high difficulty in excluding potential beneficiaries. They differ importantly from public goods and are similar to consumer goods in that they are inherently finite and consumption by one party reduces the total available for another. And conversely they are similar to public goods in that they are

difficult to exclude multiple beneficiaries from accessing, unlike club or toll goods, which are both easily excludable and have low subtractability.

		Subtractability of use	
		Low	*High*
Difficulty of excluding potential beneficiaries	*High*	Common pool resources	Public goods
	Low	Consumer goods	Toll goods

Figure 7-4 - Types of goods (Adapted from Ostrom 2010)

The prototypical or canonical example of a common pool resource – and those most frequently examined both in theory and in field studies – are natural resources, such as waterways, fisheries and forests. In these examples, as in the more theoretical definition, it is possible to see that there is a limited-regenerating resource pool, which multiple actors can exploit for gain (i.e. to carry out an economic activity using that resource). Users of common pool resources are said to have certain (property) rights to those resources, defined as:

> (i) access—the right to enter a specified property, (ii) withdrawal—the right to harvest specific products from a resource, (iii) management—the right to transform the resource and regulate internal use patterns, (iv) exclusion—the right to decide who will have access, withdrawal, or management rights, and (v) alienation—the right to lease or sell any of the other four rights. (Ostrom, 2010, p. 651)

Common pool resources are therefore understood both in terms of the analysis of the goods themselves (in relation to other goods) and the rights which can be seen to be exercised over those resources. It is important to note that these rights are expressed by Ostrom as being those that individuals can have *cumulatively* over the common pool resource; as in, it is not a necessary condition that each individual have *every* right over the resource. Common pool resources are those which multiple economic actors can be said to have a legitimate right to consume (as encapsulated by the property rights set out above) *and* where such consumption will (at least in a short-run time horizon) reduce the total amount of the resource available to other economic actors. Intuitively, understanding common pool resources in the setting of natural resources, such as fisheries, is more-or-less straightforward, in that there must be at any one point a finite number of fish available for multiple competing fishers.

Identifying a set of goods or a type of resource as being a common pool (as in the policy analysis cited above) is fundamentally straightforward. The intention here is to examine whether the positions on hospital performance taken by Directors and Governors are supportive of a view that there are some emergent properties of how hospitals are managed in the NHS which can be seen as a system of common pool resource *management*. This refers to a system which is self-organised by the users of a resource, which has a number of critical design principles, as described by Ostrom (2010)[63], which include rule-governed use, conflict resolution, and a number of other features. It is possible to see, in a more or less straightforward manner, that the imposition of budgetary control over limited financial resources (as in the NHS) produces a system which *resembles* an emergent common pool resource management solution. However, Ostrom *in addition* to the design principles which are frequently associated with common pool resource management, identifies a framework for the analysis of *sustainability* of social-ecological systems (Ostrom, 2009) which seeks to understand the *self-organising behaviour* of resource users rather than government-imposed systems. Furthermore, Ostrom proposes that some variables are more (positively or negatively) determinative of the sustainability of those systems, understood as the extent to which those systems are successful at managing common pool resources such that the utility of all users is maximised (or at least approaches a Pareto optimality). These critical variables that can be seen as determinative of the emergence of sustainable (i.e. effective) common pool resource management systems are:

> *Size of resource system* – For land-related resource systems, such as forests, very large territories are unlikely to be self-organized given the high costs of defining boundaries … Very small territories do not generate substantial flows of valuable products. Thus, moderate territorial size is most conducive to self-organization
> *Productivity of system* – A resource system's current productivity has a curvilinear effect on self-organization across all sectors … Users need to observe some scarcity before they invest in self-organization
> *Predictability of system dynamics* – System dynamics need to be sufficiently predictable that users can estimate what would happen if they were to establish particular harvesting rules or no- entry territories …

---

[63] Ostrom cites Cox, Michael, Gwen Arnold, and Sergio Villamayor-Tomás. 2009. "A Review and Reassessment of Design Principles for Community-Based Natural Resource Management." Unpublished, based on her previous work.

Unpredictability at a small scale may lead users of pastoral systems to organize at larger scales to increase overall predictability

Resource unit mobility – Due to the costs of observing and managing a system, self-organization is less likely with mobile resource units, such as wildlife or water in an unregulated river, than with stationary units such as trees and plants or water in a lake

Number of users – The impact of group size on the transaction costs of self-organizing tends to be negative given the higher costs of getting users together and agreeing on changes … Thus, group size is always relevant, but its effect on self-organization depends on other SES variables and the types of management tasks envisioned.

Leadership – When some users of any type of resource system have entrepreneurial skills and are respected as local leaders as a result of prior organization for other purposes, self-organization is more likely

Norms/social capital – Users of all types of resource systems who share moral and ethical standards regarding how to behave in groups they form, and thus the norms of reciprocity, and have sufficient trust in one another to keep agreements will face lower transaction costs in reaching agreements and lower costs of monitoring

Knowledge of the SES [social-ecological system] – When users share common knowledge of relevant SES attributes, how their actions affect each other, and rules used in other SESs, they will perceive lower costs of organizing.

Importance of resource to users – In successful cases of self-organization, users are either dependent on the [resource] for a substantial portion of their livelihoods or attach high value to the sustainability of the resource.

Collective-choice rules – When users … have full autonomy at the collective-choice level to craft and enforce some of their own rules, they face lower transaction costs as well as lower costs in defending a resource against invasion by others

Adapted from Ostrom (2009)

Following Ostrom's ontology, we can understand these as falling into:

a) resource systems and unit-related variables (size, productivity, predictability, mobility)
b) user-related variables (number, leadership, social capital, knowledge, importance, collective choice)

I suggest that for an analysis of health-care financing, group (a) are more straightforward; as a liquid capital, total size can be said to be less important for transaction cost, and we can see that financing is scarce, relatively predictable, and although mobile is highly *monitorable*. It is the user-related variables in group (b) which support an argument that the behaviour of NHS governance participants can be seen as a potentially emergent, self-organising system of common pool resource management.

The most important aspects of observed governance orientation to financial incentives and performance are the ways in which these show *knowledge* of the system, and the implicit adoption of *collective-choice* rules. Put in straightforward terms, I argue that we can see that by orienting positively to – and collectively participating in – activities which would reduce University Hospital Trust's market share (as in, the percentage of the common pool resource which it was using), Directors and Governors demonstrate that they are inherently aware of the system in which they operate, and the (potential) effects of their actions on other users of the common pool resource. By viewing the actions of agents (in the sense of principal-agent relationships in the firm) in this way, we can see that rather than appearing to act in ways that are counter to the profit and market share maximising aims of the firm, agents are instead acting in ways which are consistent with their knowledge of the common pool system in which they are acting. Similarly, by responding to increasing demand as a negative (i.e. as a "pressure" or "challenge", rather than an unmet market need), we can see that Trust Directors and Governors are implicitly acting with an awareness that meeting increased demand requires greater use of the common pool resource.

This can also be seen in the relationship(s) between University Hospital Trust and neighbouring hospitals. Within the greater county area covered by the Clinical Commissioning Group, there are a number of both private and publicly-owned hospitals; two large Foundation Trusts (including University Hospital Trust) offering medical, surgical, and specialist care across a range of specialisms, a single specialist Foundation Trust (focusing on one specific domain of medicine[64]), as well as private hospitals operated by Ramsay Health, Spire Healthcare, and Nuffield Health. As a tertiary care centre, some services offered by University Hospital Trust (notably transplant surgery and major trauma) are not offered by other providers; no private providers offer emergency medical services, maternity, or critical care services. Outwith the CCG area, University Hospital Trust has similar overlapping services with other Foundation Trusts, also offering similar services in most areas with some exceptions[65]. As discussed

---

[64] Not specified to preserve participant anonymity
[65] As in the example of transplant medicine, discussed previously

previously, Governors and Executive Directors had a shared positive alignment towards actions that aimed to *reduce* demand for University Hospital Trust services and increase utilisation of other NHS providers, as well as a shared concern for the relative financial position of other providers. This extended to providers which *directly* competed with University Hospital Trust, at least for the delivery of some services[66], in that a substitutable or similar service could be delivered by a similar provider (i.e. a large Foundation Trust hospital). The availability of sufficient supply (in terms of hospital capacity) and the funding available (the common pool resource) was oriented to in terms of a shared, regional concern, rather than a case of competing firms aiming to independently maximise return on capital through increased market share. This positive orientation was most clearly seen in collaborative planning between the nearby specialised hospital and University Hospital Trust. The specialised hospital, facing an ageing and no longer fit-for-purpose physical infrastructure, needed to be re-built or re-located in order to continue to deliver patient services. In a (theoretical) competitive market, this can be seen as an opportunity for University Hospital Trust to expand its services – to enter the market for these specialised services – and thereby to replace the specialised hospital, the incumbent provider. University Hospital Trust, if acting competitively, would have needed to consider barriers to market entry, and may have concluded that the potential return was less than the required investment, and hospital managers may have determined not to enter the market (to offer those services within University Hospital Trust).

The observed actions of University Hospital Trust were, rather than competitive, explicitly co-operative. The Chief Executive Officer of the specialist Trust was a member of the Council of Governors, with the *explicit* aim of enabling such cooperation and ensuring a smooth transition of services during the planned relocation of the specialist hospital. Progress towards this outcome was reported to University Hospital Trust, and the members of the Council responded positively as plans advanced to preserve the specialised hospital and transition to a new physical infrastructure. Two independent

---

[66] Noting that University Hospital Trust holds a regional monopoly position on some highly specialised medical services

providers established ways to collaborate, and to ensure shared use of both financial resources (in terms of capital available to support additional infrastructure) and physical resources (in terms of land available to build a new hospital building). In doing so, the firms also acted cooperatively to preserve a regional monopoly position – to maintain the specialised hospital's sole provider status. From the perspective of the participants in University Hospital Trust's governance processes, this had a number of salient benefits; to preserve successful ways of performing specific medical procedures, to maintain a set of highly specialised skills with limited utility in other medical domains, and to ensure that a successful record of high-quality patient outcomes and pioneering innovation could continue. Such aims were oriented to explicitly in casual talk prior to and following meetings; a shared, regional exemplar of positive cooperation to optimise patient outcomes and deliver effective care. By seeing available health-care financing as a common pool resource, cooperative consumption of the resource and the prioritisation of *other* aims can be seen as consistent with the economic incentives faced by participants. Contrastingly (leaving aside the question of competition law and regulation of monopoly or dominant market positions), the prioritisation of other aims over maximising return (i.e. by increasing market share or entering into a new market) is less consistent with a theory of competitive private firms[67].

We can see that the aims of Foundation Trust governance participants, at least as they related to the evaluation of a hospital's financial performance, are consistent with a concern for sustainable use of common pool resources, and thus constitute, I argue, an emergent property of a potential sustainable system. In relation to my second claim (that we can see an implicit adoption of collective-choice rules) the situation is perhaps more

---

[67] Private providers were only discussed in isolated cases, during the fieldwork period. During fieldwork, initial negotiations were underway to plan a jointly operated, privately-funded hospital with University Hospital Trust and a non-disclosed private provider. Although these negotiations are not included in the formal scope of the research, Governors were informed of the planned partnership, which was explicitly positioned as being complementary to, and non-competitive with, the services delivered by the NHS-funded operations of University Hospital Trust. This may suggest that outside the conditions of a *limited* pool of health-care financing (such as NHS funding), managers in hospitals may act in ways more consistent with private firms, i.e. seeking opportunities to expand by entering new markets.

opaque. By this, I mean that we can see that the Trust orients to its own financial performance and future demand in ways that assume, fundamentally, that other users of the common pool resource will act in similar ways. The Trust's assumption, in acting in ways which are consistent with a fair use of the common pool resource, is that other actors (other providers) will also use common resources fairly. The corollary to this is that actions taken on behalf of other common pool users (i.e. the use of health-care financing to maintain a specific productive capacity for a specialised service) will be understood by those users as being a fair use of the common pool resource. I suggest that these features of Trust governance can be seen as the beginnings, at least, of a shared set of rules for using the common pool (Ostrom, 1998). As I stated at the outset of this analysis, of course, these are not emergent properties without a context. The *actions* of Trusts are constrained, and thus the economic behaviours of the Trust as an entity are limited to the extent to which the intervention of commissioners (for example) can prevent excessive resource usage. It is the ways in which motivations to act and orientations towards the use of resources are constructed (by subjects in governance committees) in a shared social space that suggest the potential for common pool resource management as a way to reconfigure the management and governance of hospitals. By attending to the ways that participants seek to self-organise, it may be possible to identify governance approaches that could increase the sustainability of health-care financing in England. Rather than assuming that such change would necessarily require additional enforcement, policy intervention, and supervision, the orientations of Executive Directors and Governors suggest that incentives at hospital level may already be aligned with this sustainable use of financial common pool resources.

Summary

In this chapter, I have discussed targets and performance measures that are used within the NHS. These measures and metrics are interpreted as being the implementation of new public management in the NHS. In addition, we can interpret the use of measures as being an imposition of rationality and calculability. I have argued that performance indicators in governance processes can be seen as a set of positions taken by Executive Directors and responded to by Governors, and that Governors respond by interrogating both performance and the expected actions of the Trust in relation to that performance. Finally,

I have considered how Trusts orient to financial and budget performance. By considering the orientation of Executive Directors and Governors to system-level shared financial pressures as being consistent with the properties of a sustainable common pool resource management system, I suggest that this perspective may be useful in considering the incentives and subsequent behaviour of agents in hospitals. The approach of new public management, which assumed that the management practices of the private sector are inherently superior to the natural public sector approach and furthermore seeks to impose private sector practices, can therefore be seen to impose monitoring and incentive structures which are (at least potentially) counter to the self-organising potential of health-care organisations. In this, we can perhaps see a contradiction (in policy terms) between the establishment of Foundation Trusts as public interest corporations and the socially constructed / constructive discourses of monitoring / measurement in new public management.

This analysis, then, addresses research question three, focusing on how governance and decision-making practices reveal the goals of participants. By considering how managers and participants in governance decisions respond to performance measures and incentives, some important observations can be made regarding the goals of those participants, with respect to governance and decision-making. As shown in the analysis, the imposition of measures themselves can be seen as influencing the extent to which discussion in governance and management committees is reflective of the goals of the participants themselves or, alternatively, reflective of how behaviour is incentivised through monitoring and measurement itself. By considering performance reports as an anchor for the focus of participant attention, we can see that such performance reports will themselves determine what can be observed, at least to some degree. Considering the participants more broadly, I also suggest that governance and management processes in hospitals show that the goals of managers are to use finite health-care resources in a way that leads to a shared benefit across multiple consumers of a shared resource. In this way, we can suggest that the goals of hospital managers are, rather than tied fully to performance of a specific hospital or organisation, concerned with impact for the broader categories of all hospitals and health-care professionals, at least within the context of a predominantly public health system, such as the NHS.

In the following chapter, I return to the question of the agents in governance processes. This final analysis chapter will consider the nature of elected representatives (patient and public Governors) as being either *delegates* or *representatives* of their respective constituencies, and the ways that this is seen to be important by subjects at University Hospital Trust.

8. Representative / delegate

The idea of the public corporation is one with a long history in British political, social, and economic life. Notwithstanding the practice of the British monarch issuing Royal charters (such as those issued to the East India Company and the British South Africa Company, circa 1600 and 1889 respectively) to profit-seeking enterprises[68], we can see that the establishment of the British Broadcasting Corporation (BBC) is perhaps the first systematic use of a distinct term for a corporation that acts not in its own interest, but in the interests of a public on whose behalf it was specifically envisaged and ushered into being (Chester, 1953). Foundation Trusts, as *public interest* corporations, can be seen as a contemporary evolution of aspects of modern English public life; part of a narrative evolution of public policy options that are used in practice in the creation of contemporary Britain. And yet, by considering the development of a corporate entity which has both a Board (an appointed body of *executive* and *non-executive* Directors) and an elected Council, we can see that there is hybridity to the formation of the Foundation Trust which creates a space in which there is uncertainty about how this representational function should be interpreted. In this chapter, my intent is to set out how this uncertainty can be seen in the explicit discussions between Governors of the Trust, and to examine subjects' own understanding of the mandate-independence controversy as a way to understand how subjects structure their own roles within the governance of the hospital. This chapter addresses research question four, considering how patient and public governors achieve the goal of representation in hospital governance.

Appointed and elected subjects

One of the fundamental and underlying issues that we are presented with, when considering the Foundation Trust, is how to understand and interpret the purposes of its governance structures. Although we can see the stated aims of such structures (as discussed in previous analysis), there are inherent challenges in understanding the purposes of the Council of Governors relative to the Board of Directors, in terms of the

---

[68] Noting that these entities have been argued to have had roles which are other than profit seeking, including performing functions which are otherwise the role of a sovereign state.

role that each body takes with respect to directing the activities of the hospital. From the *realpolitik* of the hospital-in-practice and the day-to-day performance of its activities, we can see that the Board of Directors is, as its nomenclature suggests, similar in general terms to the Board of a firm; the Directors act as agents for the principal (owners), and this is understood in a system with inherently diversified ownership as equivalent to acting according to the interests of the hospital itself. The role of the Council of Governors, and by extension the role of the elected patient and public representatives who sit upon the Council, is perhaps more opaque. We can see that, in relation to specific discussions and particular types of issues, Governors have the capacity to respond to and question the positions taken by Executive Directors; arguably, this fulfils a purpose of providing oversight of the activities of the hospital. Furthermore, the requirement that the Council authorise significant transactions, and approve the appointment of Directors (once proposed) also clearly fulfils (at least in strictly mechanistic terms) an oversight function. And, at the most basic, the Council of Governors is a specific way in which subjects within patient and public categories can be involved in the governance of a hospital. As outlined in the previous analysis, it is possible to see that the interests of Executive Directors and Governors, particularly with respect to the incentives of the hospital to pursue certain economic actions, are similar and are based on a shared orientation to the goals of the hospital. This would seem to suggest that, whilst we can introduce conceptual complications into the Council / Board model in Foundation Trusts, the hospital-in-practice is a functional success, in that we can see that in certain fundamental ways, there is a broad agreement between and across participating subjects about what the hospital should do and (again, in a broad sense) how the hospital should go about doing it. That said, I would suggest that we can see distinct purposes embodied in the creation of a Board and the Council.

The inherent difference between the Board and the Council, aside from the purposes and duties that are assigned to them under a Foundation Trust's constitution and the enabling legislation, is that the Board is an appointed body, whereas the Council is (at least a majority) elected. I suggest that this difference demonstrates the expectations of each group which are encoded in the culture and structures of the organisation, and implicitly understood by the participants in those groups. The process by which a subject is appointed to a position on the Board, whether an Executive or Non-executive Director, is

one in which at least some other subject has made at least one choice. As in, a candidate for appointment to the Board of a Hospital has been intentionally selected through some mechanism which enabled the candidate to be chosen from all other possible candidates. The point here is that the presentation of an option for confirmation implies that some mechanism has been used, and furthermore, I suggest that this is inherently understood as being some rational choice (or set of choices) based upon the proposed subject's fitness for membership of the Board of Directors. As in, the process of appointing a Board member inherently stakes a claim that a rational choice has occurred. This choice is assumed to relate to the qualities specifically possessed by the individual subject; some combination of knowledge, social capital, *et cetera*, which means that they should be appointed as Directors. In the case of Executive Directors, this is of course formalised through the *employment* selection process; using this as an example, we can claim that at least *part* of the choices that another subject might infer about a prospective Board member is that they therefore possess, in relation to the hospital, some specific *expertise*.

By contrast, as set out in the discussion of governance structures at University Hospital Trust, patient and public representatives are elected. Whilst the process of appointment implies a highly specific rational choice closely coupled to qualities of the subject chosen, elections can instead be seen as an aggregate of choices which are made by largely unknown electors with uncertain knowledge about the candidates standing in that election; whilst Directors make a specific claim to legitimacy by virtue of qualities specific to an individual subject, the claims-making of an elected representative (Saward, 2006; Severs, 2010) can be seen as a property of both the electorate which he or she represents and the inherent validity ascribed to the electoral process by other subjects (as distinct from the deployment of claim in relation to authority, as in the prior analysis). The point of drawing out this distinction between the different categories of subjects in hospital governance is to explain the shared knowledge held by the subjects themselves about their own configuration and positioning in the social space; the subjects themselves were aware that the Directors (and some partner Governors) were appointed to their roles as *experts*, and some were *elected*. This latter category and the role that these elected participants should take with respect to their constituencies was an explicit *topic* for the Governors, in that they discussed (both formally and informally) what their obligations were to the members that they represented.

The central theme, expressed across multiple meetings, is the fundamental question of whether elected representatives are expected to act on *behalf of* the constituency that they represent, or whether they are expected to *seek the views* of the constituency. There are a number of different dimensions to this question. Firstly, there is the core distinction between what might be thought of as a *delegation* positioned against an expectation that the Governors represent the *interests* of their constituents. This is summarised by Pitkin (1967) in the following:

> Should (must) a representative do what his constituents want, and be bound by mandates or instructions from them; or should (must) he be free to act as seems best to him in pursuit of their welfare? (Pitkin, 1967, p. 145)

This mandate-independence controversy is, in Pitkin's analysis, left fundamentally unsolved; what Pitkin's question illuminates is that there are two polarised viewpoints on the nature of representation. It is not a product of the circumstances of the Trust *per se* which gives rise to the question of whether Governors should act as seems best or do what constituents want, but rather a property of representational systems in general. What is interesting about the elected subjects at University Hospital Trust is that this issue is sufficiently salient for the elected subjects to raise it both as a discrete topic about which to make particular decisions (i.e. to agree a position along a spectrum from mandate to independence) *and* for this question to be discussed in relation to other decisions and decision-making processes. This former point raises another dimension to this question for University Hospital Trust; should there be a single agreed model for what Governors should do (in relation to mandate-independence) or is this a matter that is continually available for debate and renegotiation? Indeed, as a corollary, is it possible for there to be multiple interpretations of the role of Governors in acting as delegates or independent representatives?

Before continuing to the question of independence, mandate, and delegation, it is worthwhile revisiting the constituency of the Foundation Trust. The paucity of the membership base compared to the population served by the hospital is remarkable, in that a membership of approximately 3% of the addressable population would seem to produce only a very marginally representative result in elections (even at 100% voting participation). This was a concern noted (informally) during the course of this research

project through discussions with members of University Hospital Foundation Trust staff. Whilst membership could be obtained by any prospective member through a registration form, and written information about Trust membership was displayed within the Hospital, increasing the number of members was not a current area of activity for the Trust. The only active recruitment had been during the initial establishment of the Foundation Trust, during which time a public letter distribution was used to recruit members. Regulatory reviews of University Hospital Trust both prior to this project, and after the completion of fieldwork, did not mention membership numbers, suggesting that there is a degree of indifference or disinterest at multiple levels in the NHS in the proportion of *potential* Foundation Trust members who do, in fact, seek membership.

Reflections on responsibility

Attending to the role of elected Governors with respect to their constituencies is not merely of purely analytical interest. Instead, it is a central problematic of how Governors understand their own roles within the Trust. Elected Governors represent three constituencies (as outlined in prior discussion); patients, the public, and staff. It should be said at the outset that these discussions of role and the self-expressed doubts about the responsibilities of Governors come *from* the patient and public Governors (between whom, as should by now be apparent from the analysis of the actions of Governors, there is a limited distinction[69] in practice). Staff Governors, although mentioned in passing by *other* Governors (as can be seen in one of the transcripts below), did not themselves express or otherwise explicitly demonstrate the same concern with the nature of their representative function.

Within University Hospital Trust, the mandate-independence controversy was expressed in terms of seeking opinions or asking for feedback from members of the Trust. In the following extract from a private working group meeting, a Public Governor talks about

---

[69] It should also be noted that Foundation Trusts are *obliged* to have Governors who represent members (patients and the public) but have discretion over whether these are distinct constituencies.

an obligation to canvass members. This specific section of talk is taken from a discussion of University Hospital Trust's annual plan, a document which is submitted to Monitor (the sector regulator) and which sets out the significant (strategic) actions intended to be taken by the Trust in the future. To contextualise the comments of the Public Governor, the Hospital Manager in the below transcript has, in the immediately preceding talk (not shown in transcript), outlined aspects of University Hospital Trust's potential future actions which are "confidential" and (more importantly) likely to be considered contentious by local communities, involving the possible relocation of certain medical services within the region. In the preamble to an explanation of these potentially contentious plans, the Hospital Manager has asked elected Governors to participate in the development of the annual plan by giving their "views" and by "seeking feedback".

> **Hospital Manager:** …[continues] we'd have to think very carefully about how we might open that up, I think.
> **Public Governor:** So how do we therefore canvass the opinions of our members on the annual plan?
> **Hospital Manager:** *(Shrugs, shakes head, loud exhalation)*
> **Public Governor:** If that's a requirement of us, to do?
> **Hospital Manager:** Right
> **Public Governor:** My question is, if… if this… this is confidential and contentious, how are we actually addressing that?
> **Hospital Manager:** Well I think there is plenty here which is not confidential but we are going to have to put in the bits across the health economy that are contentious and my thought is we just need to think very carefully with our partners how we do that because that… those contentions aren't just [University Hospital Trust] they are across all the others in [CCG area]. What we've put in to the [continues]

In this segment of talk, the Public Governor explicitly introduces a specific construction of the relationship between the Governors and the constituencies from which they have been elected. In his initial question, the Governor asks how "we" (the Governors) "canvass the opinions of our members". In the talk, both the Hospital Manager and the Public Governor use "we" and "us" in talking about future actions that will be taken in relation to the development of the annual plan. Both speakers are making relevant the group of people who will be performing a future action. Coupled with the use of the pronouns "I" and "my", these pronouns show how the speakers construct themselves and others as individual actors and as part of a group. In the first utterance in the above extract, the Hospital Manager deploys "we" and "I", both with the predicate "think" ("we'd have to *think*…" and "I *think*" [emphasis added]). The Public Governor's utterance, the next turn in response to the Hospital Manager, also uses "we" ("how do we…"). Each use of "we", however, is used by the speakers to refer to different collective groups. This can be

understood by considering the category-bound actions[70] encoded in the predicates for each use of "we". The Hospital Manager uses "we" + think, which includes the possibility of all members of the working group performing that action. This opens the reading of the Hospital Manager's use of "we" as referring to the working group collectively. The Public Governor, by contrast, uses "we" + "canvass" [as in, obtain opinions from non-present members of the Trust, i.e. the public]. This "canvassing" action can only be performed by those members of the working group who are fulfilling a *representative* function – the elected governors who have members to canvass. The Hospital Manager's use of "we" is *inclusive* – both the speaker and all the hearers of "we" are included as at least *possible* members of the group doing the action. The Public Governor's use of "we" is *exclusive*, by contrast, and limited only to those hearers who can (like the speaker) perform a particular action. The Hospital Manager's use of "we" in relation to the formulation of the canvassing process (saying "we are going to have to put in the bits", above) constructs a process which is shared across the working group (i.e. including the Hospital Manager). This process is the precursor to canvassing; an action reserved for the elected members of the working group.

This exchange between the Governor and the Hospital Manager encapsulates a number of issues within University Hospital Trust, by constructing the role of the Governor as being to take information from within meetings of the Trust to members, sample a set of reactions, and then act upon that sample of opinions. By framing this notion in terms of canvassing opinions, the Governor is explicitly saying that this sampling will be broad, and that this breadth of direct sampling of members' opinions would run counter to the confidentiality and sensitivity of the material discussed directly with the Governors themselves.. The Public Governor raises the obligation to seek direct information from constituents as an *unasnwered* question ("If that's a requirement"). For University Hospital Trust, this was critical; in parallel to these meetings (as will be shown below) activity supported by the Trust Chairperson and the Non-executive Directors was seeking to define elected Governors as being required to act according to a mandate and to seek

---

[70] In the sense used by Sacks, as in actions that are understood by participants as being performed by members of a particular membership category.

regular input and opinions from constituents. In the case of the sequence above, the Public Governor was an active participant (and vocally supportive) of what can be glossed as the mandate side of the debate. In the above sequence, therefore, the Governor is positioning this requirement (to seek input from members) as a challenge to keeping aspects of the Trust's future plans confidential. Seeking input from constituents was constructed by Governors as a way of reaching a form of radical transparency with respect to the activities of University Hospital Trust, in that implicit in their understanding of how input would be received would be (as in the example above) the *transmission* of knowledge about the Trust. That is to say, that for Governors who supported and reflected on representation through mandate, achieving this effective mandate was predicated on the precondition that the public would be able to be adequately informed about the activities of University Hospital Trust and the decisions that their representatives sought to make on their behalf.

This can be seen as, perhaps, an in-practice move towards a deliberative democracy, as in that the actions of Governors in seeking input is to establish a kind of diffuse participation. And yet, implicit in the Hospital Manager's resistance to this open disclosure is the assumption that limited-participation closed-door decisions about contentious issues are better. Indeed, the issue-at-hand is characterised by the Hospital Manager by and through its technicalities; it is positioned as a series of related decisions that require sufficient expertise to make, and that wider contention would be more-or-less meaningless. The Hospital Manager is, in effect, arguing that restricting public access to information is justified by the potential public response to that information. Furthermore, the Manager's position is that the governance of the trust (including Public and Patient Governors) can be given access to such information, and can participate in decision-making on the basis of that information, without necessarily sharing that information with the Foundation Trust membership more broadly. However, this presents a dual challenge within the context of University Hospital Trust, in that both the Governors are presented with an internally-constructed requirement to canvass (i.e. to act within a mandate) and yet are restricted from fully fulfilling that role by the requirements (as suggested by the Hospital Manager) of maintaining confidentiality and managing potentially contentious material.

The speakers' respective use of inclusive / exclusive "we" illuminates how this challenge can be seen in the exchange between the Hospital Manager and the Public Governor. The Hospital Manager's "we" sets up an inclusive, collective position for the other participants to take up; a shared stance[71] or position with which the other speakers can align (agree) or disalign (disagree). Framing this collective stance is the Hospital Manager's use of an epistemic marker ("I think"); this serves to mark for the other participants that the Hospital Manager is proposing a possible collective position encoded through an inclusive "we" statement, but that this is still a matter of some uncertainty (i.e. considering an epistemic quality of think compared to know; as in, less certain or less knowledgeable on some cline between states of knowledge[72]). The Public Governor's utterance is a direct response to this possible shared positioning; it can be read as an utterance which dis-aligns with the proposed position through reconfiguring the possibility of a shared stance; by making relevant the distinctive and different role of the elected Governors, the speaker orients to these differences rather than accepts the proposed inclusive grouping embedded within the Hospital Manager's speech. This is not an *overt* or *direct* challenge; the exchange is brief and within the confines of normative conversational interaction. The intent here is to illustrate the ways in which speakers deploy everyday communicative resources (i.e. speech) in conversational interaction, and how this can be read as achieving particular interactional goals that are relevant to the social and organisational context in which those interactions occur.

Within the context of University Hospital Trust's Governors, it is possible to see that participants are engaged in a construction of authority and legitimacy related to the appointed / elected distinction raised above; the legitimacy and authority of an elected representative's contributions are predicated upon how representation is understood, in terms of both the requirement to act on the basis of direct opinions gathered from a Governor's constituency of electors, and the challenges that acting on confidential or restricted information might present to that requirement. Governors need to have recourse

---

[71] In the sense of an evaluative, rather than epistemic or affective stance.
[72] See for further discussion Heritage, as previously cited

to a locally agreed understanding of what constitutes valid representation in order to claim authority. In the situation set out above, under the conditions proposed by the Trust Chairperson and Non-executive Directors with the support of some elected Governors, the elected Governors would have *reduced* legitimacy and authority to assert a valid claim in relation to those matters about which they had been unable to seek a *specific* mandate.

By establishing a local and shared definition of elected representatives that more closely resembles a mandated delegate, University Hospital Trust can be seen to potentially establish some important limits on the authority and remit of elected Governors; to wit, that the claims to legitimate input could thus potentially be limited to those issues about which they have been able to canvass. This limitation is offset by the inclusion of elected Governors in the consideration of what material should and should not remain confidential, and how this information should be presented to members. As seen in the Hospital Manager's talk, the Public Governor in this example is included within the group considering what information, and in what manner, to present to members. This implies that the members of Trust governance committees have a shared understanding that there are some matters for which elected Governors will be unable to seek a specific mandate, both thorough the exercise of individual discretion and though shared decisions about what material should be included in canvassing with members (i.e. mandate-seeking processes).

The refinement of Governor roles towards a locally-defined representative role is explicitly set out in the actions of the Trust Chairperson, as shown in the below transcript.

> **Trust Chairperson**: For those Governors who were here earlier, you will have heard of the task and finish group so that was established to look at both Governor's inward looking responsibilities and roles in relation to holding Non-Executive Directors to account for the performance of the Board, and looking at interaction with Executive and Non-Exec Directors in particular, and also focusing outwards in your role and responsibilities as Governors to represent the membership and the public. Ah. Quite distinctive roles. We, ah, met twice, because it was meant to be a task but it had a finish and we did make quite a bit of progress, and that was made up of Governors, Non-Executive Directors and I think one or two Exec Directors, and I'd particularly like to thank all the Governor and non-exec members who

attended those, ah, two meetings, and on looking out- well, actually, do you want to talk about looking outwards and looking inwards?

Public Governor (Lead): Yeah-um. We covered quite a bit of it earlier on when we were talking through the refresher training and how we envisage engaging with the public. I think as a board of Governors we've done an excellent job of the inward facing role, there's obviously been a lot of evolution in that process and the reason the three working groups were established. I think as I said earlier with the integrated report we have an excellent opportunity to condense down our inward facing role into one meeting with a second meeting based predominantly on what the communications group have been doing to push that second part that I mentioned that I think we could do better which is engaging with our constituents, with the patients, with the public and with the staff. And particularly in closing that loop, we get a lot of information through the Governors and we do a great job of raising that up to the Board of Directors, we need to feed that information back to the staff, to the patients and to the public [continues]

Notwithstanding the potential challenges to Governor's claims-making that I set out above (acknowledging that in this sense the representational idea of a claim is perhaps more relevant than the *epistemic* sense in which I have used it in the prior chapters), what is interesting here is that the process by which University Hospital Trust is reconfiguring for itself a representational role is not solely conducted by those representatives themselves. As stated by the Chairperson of the Trust, the so-called "task and finish group"[73] which proposed both changes to the private meeting structure and considered the obligation of Governors to seek input from their constituents was composed of both the elected representatives who would be directly affected by this change as well as Directors. In this group, a particularly strong interpretation of a delegate-mandate model was proposed to be adopted within University Hospital Trust, in which the primary role of elected Governors was to ensure (adopting the words of the subjects themselves) "feedback" and "closing the loop" between the otherwise disconnected "stakeholders" of the hospital. This was seen (by the Chair of the "task and finish group") as a refinement and a clarification of the role of elected Governors, and as establishing a clear purpose for the elected patient and public representatives. Within the work of the group, representation was interpreted as being an efficient solution to the controlled flow of selected information between the Board of Directors and the electoral constituencies; i.e.

---

[73] Although meetings of this "task and finish" group were not included within the recorded corpus of this research, brief interviews during observation were performed with the Group Chair, an elected Governor.

to adopt both an inward (towards the management of the organisation, as in the role of a Board member in overseeing the actions of a corporation) and an outward role, in conveying selected information from University Hospital Trust to members. This proposed shift was, indeed, interpreted and resisted by elected Governors who participated in the "task and finish group" as being a potential reduction in the capacity of the Governors to oversee the Non-executive Directors (to "hold [them] to account", in the words of the Chairperson, transcribed above), particularly as this coincided with a literal reduction in the number of confidential meetings between Directors and Governors, and thus a consequent reduction in the frequency of reports and data provided to Governors. This streamlining ("condense down") of the "inward" role of the Governors was positioned within the "task and finish group" as enabling a greater "outward" role for the Governors. I argue that this outward role is in effect a linguistic framing of an explicit move towards a delegate-mandate role for the Governors, in which the responsibility of the Governors is explicitly aligned to the transmission of information between the constituencies and the management of the Trust. The reported resistance to this change within the "task and finish group" suggests that more time for the "inward" role was seen (at least by some Governors) as being of a higher value than the "outward" role.

These two excerpts, although not co-located within the same meeting, are nevertheless useful to consider simultaneously, as they illustrate a tension that I observed within University Hospital Trusts' interpretation of the representative / delegate role of elected Governors. The overarching direction of the Trust was towards a role for elected Governors which focused on the transmission of information both from and to their constituent members. This is shown in the endorsement of these changes by the Chairperson of the Trust. The Governors would retain their constitutional and legislative functions (on the Council of Governors) but would have lower engagement in other confidential, internal meetings, and would be expected to have more formal engagement and communication with their constituencies. The emphasis on information flow clearly aligns with a more delegate-mandate model, in which the actions of Governors are constructed in terms of the opinions of members when facing "inwards", and the feedback of Trust responses to members. When considered alongside the first extract, the challenges of this shift become apparent; by restricting information flow from within the Trust to members (via Governors), the legitimacy of Governor's actions as a delegate-

mandate in relation to such restricted information is inherently reduced in the sense that to comment on such information would be to inherently act outside the locally constructed notion of the role of an elected Governor. Nor, indeed, can the Governor act wholly in accordance with the changed expectations of the Trust, in that only some issues or concerns might be able to be included in feedback to public, patient, and staff Trust members.

Interest and self-selection

A final point should be made in relation to the representative nature of elected patient and public Governors, in terms of the ways in which those representatives are self-selecting. Although, as I have stated in the analysis of the policy structures of Foundation Trusts, the qualification for a Governor is membership of the constituency which one represents, this does not in practice equate to a non-biased selection of Governors. By this, I mean that the *other* requisite feature of a Governor is that they must *nominate* for election to the Council. Put simply, a Governor must volunteer (and subsequently stand for election).

At first, this seems to be a perfectly straightforward observation, and one that is expected for an elected position (i.e. that those elected are expected to seek office). However, across the observation period and during ethnographic research focused on the participation of elected governors, what emerged from discussion with the Governors and the staff of the Trust were a set of common characteristics shared by a number of the Governors. Throughout the observation period, informal conversational interactions with the elected representatives enabled the backgrounds and biographies of those individuals to become known, as they made it relevant through out-of-session comments, through discussion pre and post recorded meeting business, and during the observation period which preceded recording of meetings. Through this substantial period of ethnographic observation, the backgrounds and relevant biographical details of the volunteer, elected Governors can be considered to have been made part of the ethnographic data which underpins this research, as they made those backgrounds relevant through the peri- and post- meeting discussions captured during such observation.

The majority of the elected Governors had an additional connection to what might be called the health industry, distinct from and other than their involvement in University Hospital Trust. Several were retired allied health and nursing professionals; one was a current executive of a health-related business. Another resigned during the fieldwork, becoming a professional patient advocate and citing a conflict of interest. Governors in general were older; of the 11 individual patient and public Governors who participated in the recordings for this research, only 3 were aged less than 50 years at the time of the recordings. Only 1 elected Governor was in full-time employment (disregarding the Governor who resigned), with the remaining Governors either retired or not currently participating in the workforce. Many of the elected Governors had been elected to multiple terms, some to the extent that they were unable to stand for an additional term by the end of the fieldwork process, and many had sought elected positions in other community or local governance bodies (notably parish councils, but including patient advocacy / involvement groups related to other service providers). None were of non-European ethnic backgrounds and all spoke English as a first language. Gender was evenly distributed. Based on this, it is possible to construct a projection of the hypothetical archetypal elected Governor, at least in the local context of University Hospital Trust. He or she is white, English-speaking, at or above retirement age, and unlikely to be working. The archetypal Governor has some involvement in health-care, either through a past (lapsed) professional qualification or through another employment / economic connection. He or she, in addition, is likely to have been involved in the Trust in the past or will remain involved for a relatively long period of time.

I suggest that this can potentially be seen as relevant to understanding Governors as it illuminates that the subjects themselves are not a *representative sample* of their constituencies. There are perhaps some structural reasons why this is so; participation in hospital governance takes a relatively large time commitment (even for attendance at the minimum number of meetings) and often takes place at times when employees might not be able to attend (close to business hours). A prospective Governor must be able to devote unpaid time to the activity in which they are engaged, and do so without necessarily any

direct (financial) benefit[74]. Primary care-givers of school-aged children face child-care constraints; it is hardly a stretch to propose that this may discourage (younger) women from joining the Governors. I do not pretend to enumerate comprehensively barriers to participation, merely to establish that there are (at least some) identifiable barriers and that they likely contribute to *who stands* (for election). The Governors and staff of University Hospital Trust were aware of these (potential) constraints, and that the elected Governors had generally similar backgrounds. That the Governors were not, in effect, an unbiased sample of their constituencies, was seen by the staff of the Trust, in particular, as being a source of "concern". By this I mean that Trust staff were actively engaged in activities to broaden the nominees for Governor positions, including mail-out campaigns to members of the Trust, public information available throughout the hospital itself, and the creation of an auxiliary consultative body for patients younger than 18 as a pre-cursor to more formal involvement in the governance of the Trust. Although the Governors were aware of this "concern", and were further aware of the activities being undertaken by the staff, in general the Governors did not see the relative homogeneity of the elected representatives as an inherent problem, or as an issue which would reduce their effectiveness in discharging their responsibilities. This difference in levels of concern illustrates the distinction between the role of the Governors as a representative sample of patient / public expertise and experience, and the role of a Governor as an elected member of the Trust's governance processes.

During the observation period, it was apparent that the perspective of Non-executive Directors, Executive Directors and trust staff was that the role of Governors was, as suggested in the previous section, to provide a specific set of patient and public expertise relevant to that hospital. From this perspective, then, it becomes clear that given the demographics of self-nominated Governors, there is insufficient variety of patient *experience* to adequately provide patient-sourced expertise and knowledge for the purposes of the hospital. Potentially therefore we can see the efforts of the Board to encourage codification of *representation* as mandate-seeking as being a solution to the self-selection problem. As in, by requiring a consultative process, the Board assures itself

---

[74] It should be noted here that Non-executive Directors and Chairs are remunerated at a fixed rate and reimbursed for expenses.

that a wider sample of patient and public input has been sought than that represented by the relatively concentrated demographic categories that describe elected Governors. The actions of the Board and the Chair then can thus be seen as being attempts to *solve* a representational challenge, and increase the patient and public expertise that is included within decision-making processes.

This raises a question about the function of the Council of Governors. I argue that the focus on representational functions by the Board could be seen as a misinterpretation of how a Council of Governors can be seen in relation to the hospital and the Board of Directors in a principal-agent-firm view of the hospital. By viewing the elected Governors as providing expertise sourced from and grounded in consultation with their constituencies, the role of Governors in overseeing and, in some circumstances, authorising the Board is de-emphasised. The oversight that the Council of Governors are empowered (by the Trust constitution) to exercise over the Board of Directors suggests that the Council operates as the principal – the owner – of the hospital. The Trust, through its constitution, has defined a necessary governance function that must be performed by elected representatives. Self-selection, even within a narrow demographic, can be seen as the *willingness* to perform a specific function under an elected office. This perspective was, across the observation of Governors within the Trust, consistently held by the elected representatives; as individuals, each had chosen to make a contribution to the work of the Trust, and had nominated themselves for election as an appropriate way of making such a contribution.

The role of the Governor is to perform a particular function within the hospital, as defined in the organisation's constitution; membership of a particular group (and thus being the elected representative of that group) was seen by a number of the elected Governors as being a *qualifying condition* rather than an ongoing obligation to engage directly and frequently with constituents. This contribution was framed as being part of a necessary function of the Trust itself, rather than (in the codified version of representation as mandate-seeking) providing a conduit for specific expertise. By viewing the Council of Governors principally as a mechanism by which the Trust has determined for itself that its members should exercise oversight over the Board, the elected representatives do not necessarily need to be a fair sample of the particular membership constituencies (patients

/ public); they simply need to meet particular criteria and be able to participate in meetings.

The findings from this research do not indicate if either a more balanced sample of a constituency or a more codified mandate-seeking representative function is likely to be superior to the practices observed during this project. However, these findings do show that there are at least two differing perspectives on the purpose of elected Governors. From one perspective, the Governors can provide expertise related to their constituencies. The implication of this is that Governors who are within a relatively narrow demographic, with pre-existing connections to the Trust and the health industry, are unlikely to adequately provide this expertise without the canvassing and mandate-seeking discussed in this chapter. The actions of the Board are therefore part of an attempt to solve this perceived problem. The alternative perspective is that the Council of Governors, as a body, performs a governance function within the Trust. Election from a particular constituency serves as a mechanism to choose the membership of the Council of Governors. From this perspective, a relatively narrow demographic for elected Governors does not conflict with fulfilling this function; rather, the governance function of the Council enables people from within those constituencies to contribute to the Trust. The representational model put forward by the Board, rather than solving a problem, was perceived as a change in the purpose and function of the elected Governors, by the elected Governors themselves.

Summary

In this analysis I have discussed the ways in which the subjects themselves raise aspects of the mandate-independence controversy in relation to Governors at University Hospital Trust. I suggest that the response to potential change in the locally accepted interpretation of Governor's obligation to their constituents can be taken as indicating that Governors may value oversight more highly than feedback loops. Both Governors' and others' concern for defining the elected representative role can be seen in the actions (achieved through talk) of subjects in governance. Finally, I suggest that the characteristics shared by Governors demonstrate that they are not a (demographically) representative sample of

the broader population and that this could be problematic if Councils are seen as fundamentally serving the same purpose as patient involvement activities, in which the patients represent a set of knowledge and expertise related to themselves as patients.

In considering research question four, the findings of this chapter suggest that understanding the extent to which patient and public Governors achieve a goal of representation is fundamentally dependent on an interpretation of representation. Notwithstanding the issues of demographic or statistical representation, this chapter highlights that *elected representation* as done in University Hospital Trust illustrates the importance of a *definition* of representation. Determining at what point in a mandate - independence or representative – delegate model that definition lies is critical. A clear understanding of whether a specific set of representational functions or practices meets certain goals relies on such a definition. As demonstrated in this analysis, the participants in governance processes in University Hospital Trust were actively considering this problem. This raises a clear challenge for understanding the extent to which patient and public representation in governance has achieved particular aims; are these processes effective? By what yardstick or metric could their effectiveness be measured? This chapter reveals not that there can be a particular *objective* measure of effectiveness, or that there is an adequacy to the *amount* or *type* of representation. Rather, I suggest that the mandate - independence controversy and the awareness of its importance within University Hospital Trust demonstrates that the goals of patient and public representation need to be configured, understood, and evaluated relative to a position on mandate – independence. In other words – is independent oversight from an individual elected by a constituency sufficient to claim that representation is a success? Or does a clear mandate need to be sought from that constituency, and if so by what mechanism should that occur? My findings suggest that – for University Hospital Trust – these questions remained unanswered and this means that a clear statement of what goals should be met by patient representation within hospital governance is (at least within this case study) not possible to define.

In the following and final chapter of this thesis, I draw together the analysis and provide an overview of the research findings, as well as suggest future implications of this research.

9. Conclusions

Directing the activities of a hospital is undeniably complex. Hospitals are vital nodal points in health care systems that are required to provide medical services that meet the needs of the most vulnerable, that treat the most challenging illnesses, that offer supportive care across the lifespan, and across the stages of life from birth to death. I do not question – and nor has it been the intent of this research to question – that there are demonstrably successful acute care hospitals in England, including University Hospital Trust. Every day at University Hospital Trust, acts of extraordinary technical precision and ability are performed which meaningfully improve the lives of patients, from the attention to hand-washing that forms the bedrock of infection control, to simultaneous multi-organ transplants, to participation in the clinical development of new drugs and technologies. That the hospital can be seen as being able to provide medical services under the organisational and governance conditions it presently faces is unquestioned. The purpose of this research is to examine the details of this complexity. In this, I see this project as uniquely advantaged. As discussed in the methodological approach, one of the critical challenges that this project faced was convincing University Hospital Trust to open itself up to the ethnographic gaze, and by extension, convincing the broader research ethics committees that this constituted legitimate inquiry into the actions of people. By doing so as someone outside the clinic, and outside the pressures of a need to generate *implementable* findings (as characterise the many policy reports and sponsored projects that consider the NHS), this research project is able to examine the practices of subjects in governance and deploy (in a sense) the *privilege* of the ethnographer in generating an understanding of how the hospital is governed.

The central focus of this research is elected public and patient representatives; the Governors of a Foundation Trust. These elected members of a governing Council form a required part of how the hospital is governed, within the legislative and policy frameworks which created Foundation Trusts within NHS England. In chapter 4, I discussed this broader framework, and the local implementation of these requirements within a case study hospital. I argued that the design of Foundation Trust governance can be understood as a hybrid, sharing some features of a firm, and some features of a mutual, with two distinct governing bodies concerned with the management of the hospital. The

Foundation Trust has both an appointed, independent Board of Directors, and an elected Council of Governors. I suggest that the Board of Directors can be understood as agents (Jensen & Meckling, 1976), who are empowered to act on behalf of the owners of the firm (the hospital) and direct its activities in ways which are consistent with those owning interests. This would mean that the Council of Governors are implicitly the owners or principals of the firm. There is some logical consistency to this conclusion, in that the Foundation Trust is intended to act in the public interest without being owned directly by the public as shareholders. The Council, in this model, is a substitute for the shareholder and the Annual General Meeting, and we can see similar powers ascribed to the Council as allocated to shareholders. And yet the day-to-day interaction between the Council and the Board would suggest that this model is at least not straightforwardly applicable, given that there is frequent interaction between Directors and Governors without (in the principal-agent model) the concentration of firm ownership that would be implied by the numbers of Governors. This construct also does not take into account the elected representative nature of Governors, which remains as a somewhat uncomfortable addition to the model of Council-as-principal. As I argue in chapter 8, the elected representative nature of Governors is seen as a relevant feature of their role within the Foundation Trust, and not referred to by participants as equivalent to a shareholder model or a traditional corporate governance role (particularly given the existence of the Board of Directors). This leads to the conclusion that Foundation Trust governance is a hybrid form in which the role of patient and public governors is more-or-less unique, compared to other organisations or corporations.

Each specific hospital is required to implement this hybrid structure through its constitution, which is specific to each Foundation Trust. Whilst there are structural similarities across Foundation Trusts, there is substantial local variation in how subordinate committee structures (those which report to the Board of Directors and Council of Governors) involve patient and public representatives, and the remit of those subordinate groups. The focus of Governor involvement is through these locally-defined sets of committees and working groups. This motivated the design of this study; to follow, within a case study hospital, how Governors are involved in different types of committee meetings, and to understand how their roles as elected representatives are made relevant to decision-making. These meetings are conducted through face-to-face social

interaction, in which participants engage in talk. Policy and organisational practices create the roles of elected Governors and define which meetings they attend, but the performance of that role, and how public and patient Governors contribute to the work of the Trust, Is achieved by and through interactions which occur within such meetings. As I discussed in chapter 4, in the case study conducted for this research, there are three broad categories of meeting types. Firstly, there are committees which consider explicitly clinical matters, and which are concerned with making decisions about what treatments are used by the hospital, and (in the case of transplant committees) specific patient treatments. Secondly, the internal and informal working groups, which are subordinate committees that report to permanent governance committees. These working groups are informal in that they are not defined within the Trust constitution, and can be agreed to be created by the Council of Governors or Board of Directors. In the case of University Hospital Trust, these working groups were created to enable greater opportunity for interaction between elected Governors and Directors (both Executive and Non-executive). Finally, formal governance committees are those which are created by the Trust constitution, and which are required by the regulatory and legal framework for NHS Trusts. Elected patient and public representatives – the Governors – are present at these meetings; the central question is how they contribute to those meetings, and how their role as patient and public representatives is part of how such meetings function.

The approach taken in this research is at an intersectional point between differing, and perhaps uncomfortably connected, perspectives. This research has taken the position that social interaction and talk within institutional contexts can be analysed to support conclusions regarding the institution and the social actors within that institutional context. This takes an interactional approach to understanding human social behaviour, following research on governance (Potter & Hepburn, 2010), organisations and institutions (such as Drew & Heritage, 1992; Heritage, 2013; Psathas, 1999), medical and social care contexts (such as Peräkylä, 1997; Robinson & Heritage, 2015; Stivers, 2007), and the conversation analytic tradition in social research (following the work of Harvey Sacks, Gail Jefferson and Emmanuel Schegloff). Simultaneously, this research is concerned with specific forms of activity which are motivated by (as discussed above) a legislative, policy, and organisational context. The encounters between participants considered in this study are planned and purposeful; they fulfil a function defined by the governance and management

structure of the hospital. Following Bourdieu's (2005) critique of management theory as being chiefly concerned with constructing the practices which it purports to analyse, this thesis has explicitly sought to conceptualise the purpose of governance and management in terms of how these structures arise as a response to managing collective economic activity. This approach follows Coase (1937, 1960). This tension is unavoidable, in that it reflects the conditions within the Foundation Trust itself. The purpose is not to reconcile a theory of the firm with a theory of social action in interaction, but to acknowledge that they represent different perspectives on the same phenomena. The actions of participants in governance within the University Hospital Trust were achieved through talk. At the same time, however, I argue that the talk reveals how those actors are responding to the constraints and incentives that they face within the specific confines of the hospital as a firm. Management theories, and the theory of the firm, as outlined in the background, can be seen both as theoretical models of inter- and intra- firm behaviour, and as contributing to the construction of that behaviour. As these theories of governance and management point out themselves, the company is a particular contractual and legal fiction, created for achieving a set of agreed contractual relations between individuals. The theory of a principal-agent relationship, and the relationship between firms in competitive markets, can be seen as a valid theoretical model for a set of circumstances which those theories are also helping to create, through reinforcing how management is understood and how firms, agents, and other economic actors are expected to behave. By contrast, the analysis of social action and organisational behaviour, as put forward by Schegloff and others, orients to the ongoing achievement of social actions and interaction by and through participant action. The tension between approaching a committee meeting both as a site of talk-in-interaction within an institutional context and as a site of management and economic action responds to what ethnography reveals about the hospital; this is what occurs during governance meetings. This tension is necessary to consider the nature of talk in such meetings – how action is achieved by participants – as well as how that action relates to the collective economic activity of the hospital.

The motivating purpose of this project was to understand how patient and public representatives contribute to hospital governance. Patient and public involvement (PPI) in managing and directing health care has a long-standing history, as noted in Crawford, et al. (2002), who review active participation in planning and development of health

services by patients and potential future patients. In the UK context, PPI takes many forms, including in Foundation Trust governance, lay membership of advisory and ethics committees, and inclusion in forums and consultative processes. As discussed in the review of the literature, there is considerable disagreement about the purpose of such efforts, as noted by Martin (2008a); see also Wright, et al. (2012) who explicitly reject the notion of PPI as a mechanism for developing and improving health services. Prior research has argued that there are significant limitations to public and patient involvement; Callaghan and Wistow (2006a) (2006b) argue that the differential social capital between a medical / managerial elite and public / patient representatives contributes to such limitation. This is similar to findings from studies of lay committee members and public participation processes in the UK (NHS) context which suggest that there are divergent views of roles for public representatives (Litva et al, 2009) and a lack of clarity from hospital staff about such roles (Nathan et al, 2010). Participatory processes have been argued to be a technology of legitimation, whereby public authority and support is co-opted by government to support and legitimise decision-making (Harrison and Mort, 1998). Weinberg (2007) identifies a more general shift in democracy towards participatory and consensus-based models as animating increased user engagement in social and care services. Policies which promote PPI (and studies of such policies, such as Emmerich, 2009) focus on including the patient perspective in decision-making as the goal of such initiatives and processes.

What this suggests is that although public and patient involvement has been a feature of health systems for some time (see, for example, Epstein's history of HIV/AIDS activism, Epstein, 1996), it remains an area which is poorly understood. The purpose of public and patient involvement, the forms or roles for public and patient (either as individuals or through representatives), and the impact on health systems are contested[75]. In the context

[75] It should be acknowledged that public and patient involvement is necessarily constrained to specific contexts. This is because, particularly for making decisions about health systems, such involvement necessarily aligns to the structure of a health system itself. This means that there is likely to be both significant variation between administrative jurisdictions (e.g. between countries) and across time as government policy changes, in terms of what public and patient involvement occurs, and what purposes it is intended to serve within that system and policy context.

of a specific hospital, such as University Hospital Trust, the presence of elected representatives in governance is both part of this contested ground of PPI more broadly, and the hospital's response to mandated requirements to be a Foundation Trust. University Hospital Trust, as a case study of public and patient involvement, represents a setting in which I argue it is possible to examine this contested space of PPI in action. This analysis traces the involvement of public and patient representatives from their engagement in meetings and decision-making which is most directly related to clinical care, through working groups and meetings between the Governors and Directors, and then to the Council of Governors.

In the first meeting analysed in chapter 5, I considered examples drawn from decision-making about drug products that can be used in the hospital. In my case study data, decisions about which drugs are used by the hospital are made through talk, in a meeting which included Governors as participants. I argued that category-based identities are relevant to these decision-making processes. Informed by membership categorisation analysis (MCA), I argued that participants signal the categories to which they belong through talk and visible action, such as name-cards placed in the meeting room, and the wearing of surgical gowns and scrubs. I argued that participants deploy these category-based identities to make claims to authority, and to establish their credibility to contribute to the decision-making process. Who is speaking, and the perspective from which they contribute to decisions, is relevant to decisions made within the hospital. What this analysis showed in relation to public and patient involvement and the role of the elected Governors was less clear. There was a clear distinction between Governors and other participants; the Governors, although physically present and stated to be members of the committee in the minutes and organisational record of decisions, did not speak during these meetings. The Governors can be said to be (minimally) subjects who are part of the social space, in the sense that they have the capacity to observe and be observed by others. From the perspective of the Governors themselves, this non-speaking participation was a form of involvement or oversight of decisions. The Governors can be said to be part of a social space in the sense of Bourdieu (1989). From this perspective, the positions taken by speaking subjects can be understood as relative to the unrevealed and unknown positions of the Governors. The speaking members of the committee collectively make decisions with the knowledge that those decisions are observed by the Governors. An

interactional analysis of these decisions, however, does not show that the categories of public and patient are made relevant, or demonstrate if or how the positions taken by others are specifically relative to a non-speaking subject. Although acknowledging that there is a body of work which extends interactional analysis beyond talk (see, for instance, Goodwin, 2000; Heath & Luff, 2007), these approaches still require that (as in talk) there is a discernible visible action made by a participant which is then taken up by or responded to by another participant. Participants who do not use an overt communicative modality (such as talk or gesture)[76] are opaque to an interactional analysis.

What cannot be accounted for through such an analysis is the impression of the Governors I spoke to during the ethnography; that they felt that their presence constituted participation in the decision-making process, and that it was important that they were included as members of the Committee. The Governors felt that they lacked credibility and knowledge to make a contribution through talk, unlike other speakers who made their category membership relevant as part of their claims to credibility. This finding suggests that although the identities of speakers, understood in terms of social categories, can be seen to be relevant to decision-making, not all categories may be understood to be equally credible or relevant. This identification of non-speaking subjects in an interaction also suggests the need for considering how to expand approaches to social interaction and conversation analysis. Although the Governors do not speak, they are present in the interaction; they form part of the recipient group for whom each speaker designs their turn at talk. What cannot be determined from an analysis of talk is if there is any difference in what the surgeon or the committee chair said, or the decisions made, due to the presence of these potential speakers.

The importance of knowledge in clinical and medical contexts is well-established, particularly in studies of doctor-patient interaction (Stivers, 2007; Heritage, 2012). In considering talk which occurs between elected representatives (e.g. the Governors) and

---

[76] Or who are not overtly included in the turn-by-turn unfolding of talk by other participants, such as in shown Goodwin's studies of communication with an aphasic man unable to conventionally respond in conversation

hospital representatives, I argued that hospital representatives position as knowledgeable (K+) with respect to a relevant domain of medical knowledge, and that this positioning is used as a claim of authority and to assert reliability. I argued that the ways in which even the most serious of safety failings are positioned suggests that there is capacity within the clinic to minimise the potential harm implicit in "never" events, and to deploy specific clinical knowledge to resist what could be glossed as taking responsibility for incidents which are, inherently, defined by the superordinate structures of the hospital itself. The deployment of knowledge and privileged epistemic access is the means by which this is achieved in the Executive Directors' respective talk, to support taking particular positions to which the elected Governors must then respond. The *sequential* aspects of governance processes give a first-mover advantage to the establishment of relevant objects in the social space to Executive Directors (as compared to patient and public Governors). To be clear, I refer not solely to the communicative achievement of sequential action, but to the sequence of oriented-to positions that are put forward by subjects. This is dependent on the turn-by-turn construal of a shared social space.

I suggest that this construction of proposition-response may be inherently constraining of the actions of Governors. This is because the ways in which shared, relevant concepts and positions are first proposed encapsulates a claim to *validity* of that positioning and the acceptability of the Executive Director's turn. The second-mover – the Governor - then faces a dual task of asserting some valid position with respect to the object *and* considering their position relative to the claimed validity if they choose to take a turn at talk and take a position. Governors, as the second-movers, also need to determine whether or not to respond in a way consistent with the end of the Executive Director's turn (i.e. asking a question if asked to do so). These kinds of decisions are familiar to studies of social interaction, such as Potter & Hepburn (2010) in governance settings, in that they are part of how speakers manage sequentially-ordered talk in interaction. What I suggest is novel is the impact that this can be seen to have on the process of governance; potentially, the implication for future research is to consider how differences in the micro-structuring of governance processes could potentially result in different outcomes.

I argue that by deploying epistmic stance-taking to assert authority and establishing particular positions relative to topics of interest in governance meetings, the initial speakers – the Executive Directors – are exerting influence over the governance process. They are taking a position – proposing what will be understood as a valid next turn at talk, or explicitly evaluating the seriousness of an incident. By positions, I mean here how subjects are understood relative to one-another in Bourdieu's notion of the social space, and by extension therefore the subjectivity (or their positioning relative to other subjects or relevant objects) in that social space. This is, of course, a subtle impact; I do not claim that we can see direct (certainly in the case of University Hospital Trust) challenge of, or change in, the activities of the hospital on the basis of patient and public representative actions. Certainly, the analysis of "never" events suggests that the presence of patient *representatives* does not necessarily increase the orientation to a patient *perspective* in the discussion of critical safety issues.

In considering how Governors position through talk, this case study suggests a *negative* finding when considering knowledge and expertise in decision-making. In participating in governance, the deployment of *patient knowledge* or *patient expertise* was notable by its absence. Although, as I have argued, the category to which a particular subject belonged was made relevant through the unfolding process of governance meetings, the relevance of patient experience as a source of expertise or of specifically useful knowledge appeared to be limited, or virtually non-existent. In some ways, this is perhaps unsurprising, in that the presentations of *topics* discussed in governance did not explicitly call for some specific item or discrete unit of knowledge (noting that this is naturally something of a simplification). Clinical expertise and knowledge was, as I have shown, deployed as relevant to the work of governance committees, but not so patient or public experience. Whilst in the *specific* implementations of patient involvement programs that have been examined in the literature (such as input into research programs), the involvement of patients is explicitly framed as accessing *experience* and *expertise*, elected subjects in governance have no such frame and do not, in addition, appear to mobilise their own expertise and experience in order to make a claim to an epistemic space. In relation to the discussion of positioning and overt action above, it can be hypothesised, perhaps, that these two phenomena are interrelated, in that patient and public representatives are constrained from overt action due to a compromised capacity

to make a valid epistemic claim in the context of the hospital. This would appear to agree with analysis of scientific knowledge and claims to authority (as discussed by Epstein, 1996), in that patients are obliged to adopt the logic and language of medicine and the hospital in order to be seen as valid (i.e. that the patient experience expressed in its original terms is not regarded as a valid contribution). It is interesting that in the context of hospital governance, we see this predominantly as a *constraint* on patient / public expertise (and action). Potentially, we could posit that this may be due to the deployment of *measures* and *indicators* in governance, in that it is the work of the *hospital* which is transformed and made calculable. This transformation of clinical activity into linguistic and semiotic forms which are permeable to non-medical understanding may reduce the *need* felt by (non-medical) subjects to adopt the language and expertise of the hospital, despite the evident use of clinical knowledge by *medical* subjects as a relevant form of capital.

This suggests that the logic of the clinic (Foucault, 1973) – the configuration of medical knowledge and the medical gaze – is similarly present within the ways in which governance processes are carried out in the Foundation Trust.. Further, this suggests that the transformation of clinical activity referred to above – i.e. the rendering of clinical activity within calculable and measurable forms – does not disrupt, or at least does not wholly disrupt, the concept of the clinic as constructed by and through medical knowledge and the medical gaze. Expertise in the language and practice of the clinic remains, even within a structure deliberately created to enable other expertise to be brought to bear, of critical importance to engaging not only in what might be thought of as specifically technical activity (i.e. the practice of medicine), but also to activities which are perhaps more similar to other contexts, to other organisations in which groups of individuals meet to consider and discuss the operation of a large and complex institution.

In chapter 7, through an examination of performance measurement, I argued that both the elected representatives and the appointed management (Directors) of the hospital share an orientation to the financial performance of hospitals which suggests that they inherently understand the objectives of the hospital as being beyond profit or market-share maximising. Despite the construction of incentives through external structures and

policy, I argued that the orientation and positioning of governance participants suggest at least the potential to see aspects of English hospital governance as an emerging sustainable system in which shared health-care financing is seen as a common pool resource. I argued that the behaviour of participants in governance, particularly hospital managers, demonstrates that the goals of these participants are aligned to shared, common-pool consumption, in that they are concerned with the diminishing pool of resources rather than with the pure financial / economic interests either of themselves or (as financially incentivised managers) of the hospital (in the sense of maximising revenue / profit for the hospital). Considering this finding in the context of new public management, I argued that the imposition of private sector style management approaches may be questionable in the context of public health-care such as the NHS.

Thematically, one of the concerns of this research has been to consider the question of directing hospital activities from a perspective that considers the relationships between subjects within a collective economic activity. This was introduced as being a perspective on management and governance as being the activity of an *agent* acting on behalf of the *principal* (the owners of the firm). I argued for an understanding of Foundation Trusts as a hybrid organisation, in which there are features both of a mutual and a principal-agent structure. As a consequence of this hybridity, the imposition of *new public management* into the hospital setting should be questioned. The underlying logic, as discussed previously, of this doctrine was that private organisations (i.e. those owned and managed under the conventional models of the firm, in which principal interests in maximising return are aligned with the incentives of agents) were superior in terms of management and efficiency than public (state) organisations. In the case of hospitals, as discussed, this leads to the imposition of particular financial targets, of particular measures, and the creation and development of managerial structures which echo those found in corporate entities. In consequence, both in terms of the hybridity of the Foundation Trust, and the orientation to common pool resources discussed in chapter 7, I argue that the imposition of corporate-inspired incentives and management is not necessarily appropriate for the Foundation Trust model. The emergent and self-organising orientation to health-care financing as a shared resource, not just within the hospital but across a health system, suggests that actors and decision-makers within the hospital system are responding to economic motivations and incentives which vary significantly from those assumed to

exist within a firm. Simply put, attempting to run a hospital similarly to a corporation fails to acknowledge the potential differences that can be observed between competitive firm actions (and manager decisions), and the motivations and decisions that have been explored in this analysis.

Rather than seeking to impose management that arises from competitive firm contexts, the design of hospital governance and management should, I argue, respond to the potential for common pool management within health-care, particularly in economic contexts such as the UK in which health-care financing can be, and is, conceptualised by actors within the system in terms of a common, shared, and finite resource. This argument is made possible through the tension introduced in this analysis – by simultaneously considering the implications of a management theory for an NHS Foundaton Trust *and* exploring how social actors are engaged in the moment-by-moment and ongoing work of creating an organisation. The aim is not to reconcile these two branches of enquiry; rather, my argument is that there is a perspective on organisations which presumes a particular set of economic relations and self-interested responses to incentives. New public management has followed this logic to design incentives and management approaches for organisations, including hospitals. By orienting to the social actions of individuals within University Hospital Trust, it is possible to identify aspects of decision-making processes, made relevant and responded to by the participants themselves, which suggest an alternative set of economic incentives and relations may be at play, namely, the orientation to common pool resources, as discussed by Elinor Ostrom (1990).

Governors are elected, as discussed in chapters 4 and 7. Whilst acknowledging that, within the specific case study Trust examined in this research, there are limitations to the membership (and thus the electorate), this election process nevertheless embeds an elected representative function within the structure of Foundation Trusts. This rightly suggests the importance of understanding the elected Governors as being part of a participatory and deliberative democratic development. This is perhaps supported by embedding of electoral logic into the structure of an organisation through an Act of Parliament (as in the case of a Foundation Trust); patient and public Governors then become a form of participatory and deliberative democracy, albeit within a specific

organisation. The findings of this thesis can be understood as potentially relevant for an understanding of deliberative democracy. The deployment of knowledge and expertise to resist challenge and questioning can be read as suggesting that deliberative democracy is limited in its potential applicability to domains, such as medicine, where technical knowledge is held to be of particular importance. The analysis presented in this thesis suggests that, whilst this can indeed be seen in analysing how patient and public Governors engage with representatives of the hospital, this deployment of knowledge and expertise is active and, at least to some degree, intentional on the part of hospital management. The relevance and importance of expertise and knowledge – clinical knowledge in this case – is created by and through the actions of speakers themselves, and this suggests in turn that whilst there are limitations to deliberative and participatory democracy in health decision-making *under current models* (as shown particularly in the non-speaking governors making decisions about drugs), alternative interactional models might address these limitations. Similarly to the argument put forward about understanding the impact of public and patient involvement through social action, rather than through measures defined by the clinic, analysis of how expertise is used by hospital management may suggest ways to improve how *other* expertise might be more effectively deployed in deliberative processes.

In addition, the discussion between participants about the nature and purpose of an elected representative is illuminating. The mandate or delegate distinction was of clear importance to the participants themselves. This is a fundamental question of a democratic system – given an electoral process, what is the obligation of an elected representative to the electorate? This research cannot, and does not claim, to resolve this fundamental question. However, the findings of this research suggest that an important component of participatory and deliberative democratic processes may need to be a clearer definition and understanding of this mandate or delegate distinction. In the case of University Hospital Trust, the conflict between the interests of a health service in keeping certain aspects of its operations confidential and the duties of an elected representative add a further dimension to this question. To maintain confidentiality within a set of elected and appointed governors and directors, the elected representatives *inherently* need to follow a mandate model, whilst carrying some reporting back functions of the delegate model. That participants felt these issues were unresolved and relevant to the work of the elected

representatives might suggest that specific positions on these issues could usefully be incorporated into the electoral process itself; rather than the organisation defining a model of mandate or delegate functions, enabling the electorate to choose both a representative *and* the model by which that representative should operate.

This project has explored the role of patient and public representatives in governing a single hospital. As discussed in the methodology, there are some limitations of a single case study. Chiefly, these limitations relate to supporting that findings are generalisable to other, similar hospitals. A single case study does not eliminate the possibility that these findings are particular to a specific hospital (i.e. to the single case study). Arguably University Hospital, the specific field site used for this project, has a particular regional and historically-driven identity, in that it is situated with close links to a major research university and associated research-oriented businesses. The specificity of this identity may mean that participants' actions within this site are a product of its specific context, rather than generalisable to, even similarly academically and industry-sited, hospitals across NHS England. Conducting a set of case studies across multiple hospital sites would be an effective way to address this question. However, what this case study contributes is demonstrating, simply put, that there are useful observations about how public and patient representation and governance functions within the NHS which can be supported by an analysis of talk and social action. Comparison across multiple sites would support conclusions about whether the local practices described in this project are more likely to be associated with a specific hospital or institution, or are consistent across hospital sites and therefore more likely to be associated with the health system in which such hospitals are situated.

More broadly, the methodological design of this case study addresses, at least in part, the limitations of a single case design (Stake, 2005; Yin, 2003). This case study is designed to be accountable to the analysis of specific phenomena which occur within the confines of a bounded case – the use of social action by participants within meetings to perform and express their institutional roles. The utility of the single case is to demonstrate an empirical basis for the testing and development of this hypothesis. The extent to which such roles vary in definition and expression across hospitals is clearly of importance; in

a comparative case study approach, it would likely be necessary to narrow the focus of analysis to only some specific aspects of the roles of patient and public representatives. The single case approach created the opportunity to contrast different types of meetings within the hospital, and to identify episodes of talk for analysis across the sample of meetings collected. This usefully demonstrated the difference between the closer-to-clinical meeting (the Drugs Committee), and the Working Group and Council of Governors. A single case study, such as this, demonstrates at least some of the possible actions which can be performed by participants in a particular context – future analysis across multiple sites would add a greater understanding of variation in such action, and could suggest potentially causative connections between different types of hospitals and other features of a local context.

By approaching governance as a socially situated activity, this research is able to demonstrate that the practices by which subjects perform their roles and how local practices create affordances for action are critical to what such patient and public representatives achieve in their governance roles. Furthermore, I have shown how understanding the hospital through multiple perspectives – as a locus of knowledge and medical power, as a collective economic activity, and as the potential site of participatory and deliberative democratic action – can suggest how governance roles and actions can be understood. Examining the role of patient and public Governors has naturally involved understanding the roles of Directors and how they construct their understanding of hospitals, governance, and patients. It is a clear implication of this research that there is significant scope to further explore the opportunities for new ways to govern hospitals, and to consider the utility of new models for the economic interaction between providers and funders of health-care. Finally, this research demonstrates the value of opening up the hospital to observation; to taking the ethnographic gaze within the clinic to uncover the hitherto-unobserved practices which are, fundamentally, consequential to the lives and wellbeing of the public at large.

10. Bibliography

Abelson, J., Giacomini, M., Lehoux, P. & Gauvin, F., 2007. Bringing 'the public' into health technology assessment and coverage policy decisions: from principles to practice. Health policy, 82(1), pp. 37-50.

Abma, T. A. & Stake, R. E., 2014. Science of the particular: An advocacy of naturalistic case study in health research. Qualitative health research, 24(8), pp. 1150-1161.

Allen, D., Braithwaite, J., Sandall, J. & Waring, J., 2016. Towards a sociology of healthcare safety and quality. Sociology of Health & Illness, Volume 38, pp. 181-197.

Allen, P. et al., 2012. Organizational Form as a Mechanism to Involve Staff, Public and Users in Public Services: A Study of the Governance of NHS Foundation Trusts. Social Policy & Administration, Volume 46, pp. 239-257.

Armstrong, D., 1994. Bodies of knowledge/Knowledge of bodies. In: C. Jones & R. Porter, eds. Reassessing Foucault: Power, medicine and the body. London: Routledge, pp. 17-27.

Armstrong, D., 1995. The subject and the social in medicine: An appreciation of Michel Foucault. Sociology of Health & Illness, Volume 7, pp. 108-117.

Aylin, P., Bottle, A., Jen, M. & Middleton, S., 2010. HSMR mortality indicators [methodology], London: Imperial College London.

Baggott, R., 2005. A Funny Thing Happened on the Way to the Forum? Reforming Patient and Public Involvement in the NHS in England. Public administration, 83(3), pp. 533-551.

Bebchuck, L., 2005. The Case for Increasing Shareholder Power. Harvard Law Review, Volume 118, pp. 833-914.

Bennington, L., 2010. Review of the corporate and healthcare governance literature. Journal of Management & Organization, Volume 16, pp. 314-333.

Bevan, G. & Hood, C., 2006. Have targets improved performance in the English NHS?. BMJ, Volume 332, pp. 419-422.

BMJ, 1986. Performance related pay for NHS managers. BMJ, Volume 293, p. 708.

Boivin, A., Lehoux, P., Burgers, J. & Grol, R., 2014. What Are the Key Ingredients for Effective Public Involvement in Health Care Improvement and Policy Decisions? A Randomized Trial Process Evaluation. The Milbank Quarterly, Volume 92, pp. 319-350.

Botje, D. et al., 2014. Is having quality as an item on the executive board agenda associated with the implementation of quality management systems in European hospitals: a quantitative analysis. International Journal for Quality in Health Care , Volume 26, pp. 92-99.

Bourdieu, P., 1989. Social space and symbolic power. Sociological Theory, Volume 7, pp. 14-25.

Bourdieu, P., 1990. The logic of practice. San Francisco: Stanford University Press.

Bourdieu, P., 1992. Language and symbolic power. Cambridge: Polity.

Bourdieu, P., 2005. The social structures of the economy. Cambridge: Polity.

Bradshaw, P., 2008. Service user involvement in the NHS in England: genuine user participation or a dogma-driven folly?. Journal of Nursing Managment, Volume 16, pp. 673-681.

Broadbent, J. & Laughlin, R., 2009. Performance management systems: A conceptual model. Management Accounting Research, Volume 20, pp. 283-295.

Buchner, V., Schreyogg, J. & Schultz, C., 2013. The impact of the board's strategy-setting role on board-management relations and hospital performance. Health Care Management Review, 0(0), p. 0.

Callaghan, G. & Wistow, G., 2006a. Publics, patients, citizens, consumers: Power and decision-making in primary health care. Public Administration, Volume 84, pp. 583-601.

Callaghan, G. & Wistow, G., 2006b. Governance and public involvement in the British National Health Service: Understanding difficulties and developments. Social Science & Medicine, Volume 63, pp. 2289-2300.

Chambers, N. & Cornforth, C., 2010. The role of corporate governance and boards in organisational performance. In: K. Walshe, G. Harvey & P. Jas, eds. Connecting Knowledge and Performance in Public Services. Cambridge: Cambridge University Press, pp. 99-127.

Chang, L., 2007. The NHS performance assessment framework as a balanced scorecard approach: Limitations and implications. International Journal of Public Sector Management, Volume 20, pp. 101-117.

Chang, L., Lin, S. & Northcott, D., 2002. The NHS Performance Assessment Framework: A "balanced scorecard" approach?. Journal of Management in Medicine, Volume 16, pp. 345-358.

Chester, D., 1953. Public corporation and the classification of administrative bodies. Political Studies, Volume 1, pp. 34-52.

Cronin, C., 1996. Bourdieu and Foucault on power and modernity. Philosophy and social criticism, Volume 22, pp. 55-85.

Coase, R., 1937. The nature of the firm. Economica, Volume 4, pp. 386-405.

Coase, R., 1960. The problem of social cost. The Journal of Law and Economics, Volume 3, pp. 1-44.

Conlisk, J., 1996. Why bounded rationality? Journal of Economic Literature, Volume 34, pp. 669-700.

Contandriopoulos, D., 2004. A sociological perspective on public participation in health care. Social Science & Medicine, Volume 58, pp. 321-330.

Copland, F. & Creese, A., 2015. Linguistic ethnography: Collecting, analysing and presenting data. Thousand Oaks: SAGE.

Crawford, M. et al., 2002. Systematic review of involving patients in the planning and development of health care. BMJ, Volume 325, pp. 1263-1268.

Crowe, S. et al., 2011. The case study approach. BMC Med Res Methodol, 11(100).

Currie, G., Dingwall, R., Kitchener, M. & Waring, J., 2012. Let's dance: Organization studies, medical sociology and health policy. Social Science & Medicine, Volume 74, pp. 273-280.

Cziraki, P., Renneboog, L. & Szilagyi, P., 2010. Shareholder Activism through Proxy Proposals: The European Perspective. European Financial Management, Volume 16, pp. 738-777.

Davies, C., Wetherell, M. & Barnett, E., 2006. Citizens at the centre: Deliberative participation in healthcare decisions. Bristol: The Policy Press.

Delamothe, T. & Godlee, F., 2011. Dr Lansley's Monster. BMJ, Volume 343, p. d408.

Dent, M., 2003. Managing doctors and saving a hospital: Irony, rhetoric and actor networks. Organization, Volume 10, pp. 107-127.

Dent, M. 2005. Post-New Public Management in public sector hospitals? The UK, Germany and Italy. Policy and Politics, Volume 33, pp. 626-636.

Dent, M., 2006. Patient choice and medicine in health care. Public Management Review, Volume 8, pp. 449-462.

Dent, M., Howorth, C., Mueller, F. & Preuschoft, C., 2004. Archetype transition in the German health service? The attempted modernization of hospitals in a North German state. Public Administration, Volume 82, pp. 727-742.

Department of Health, 2002. Power and resources shift to NHS frontline - Milburn (Archived). [Online] Available at: http://webarchive.nationalarchives.gov.uk/+/http://www.dh.gov.uk/en/Publicationsandstatistics/Pressreleases/DH_4026008 [Accessed September 2017].

Dixon, A., Harris, T. & Mundle, C., 2011. Economic regulation in health care: What can we learn from other regulators?, s.l.: The King's Fund.

Dr Foster Unit, 2008. Patient safety indications [specification], London: Imperial College London.

Drew, P. & Heritage, J., 1992. Talk at work: Interaction in institutional settings. Cambridge: Cambridge University Press.

Drew, P., Raymond, G. & Weinberg, D., 2006. Talk and interaction in social research methods. London: Sage Publications.

Dunleavy, P. & Hood, C., 1994. From old public administration to new public management. Public Money & Management, Volume 14, pp. 9-16.

Dunleavy, P., Margetts, H., Bastow, S. & Tinkler, J., 2006. New Public Management Is Dead—Long Live Digital-Era Governance. Journal of Public Administration Research & Theory, Volume 16, pp. 467-494.

Duran, A., DuBois, H. & Saltman, R., 2011. The evolving role of hospitals and recent concepts of public sector governance. In: A. Duran, H. DuBois & R. Saltman, eds. Governing Public Hospitals: Reform strategies and the movement towards institutional autonomy. Copenhagen: WHO, pp. 15-35.

Duranti, A., 1997. Linguistic anthropology. Cambridge: Cambridge University Press.

Edwards, G., 2009. The stance matrix [Unpublished thesis, Master of Arts]. s.l.:University of Melbourne.

Emmerich, N., 2009. On the ethics committee: the expert member, the lay member and the absentee ethicist. Research ethics review, 5(1), pp. 9-13.

Epstein, S., 1995. The Construction of Lay Expertise: AIDS Activism and the Forging of Credibility in the Reform of Clinical Trials. Science, Technology, & Human Values, pp. 408-437.

Epstein, S., 1996. Impure science: AIDS, activism and the politics of knowledge. Berkeley: University of California Press.

Exworth, M., Powell, M. & Mohan, J. 1999. Markets, bureaucracy and public management: The NHS: Quasi-market, quasi-hierarchy and quasi-network? Public Money and Management, Volume 19, Issue 4, pp. 15-22.

Financial Reporting Council, 2016. The UK Corporate Governance Code, London: FRC.

Fondacaro, M. & Weinberg, D., 2002. Concepts of Social Justice in Community Psychology: Toward a Social Ecological Epistemology. American Journal of Community Psychology, Volume 30, pp. 473-492.

Ford-Eickhoff, K., Plowman, D. & McDaniel Jr., R., 2011. Hospital boards and hospital strategic focus: The impact of board involvement in strategic decision making. Health Care Management Review, Volume 36, pp. 145-154.

Foucault, M., 1973. The birth of the clinic. London: Routledge.

Foucault, M., 1982. The subject and power. Critical Inquiry, Volume 8, pp. 777-795.

Foucault, M., 1989. The archeaology of knowledge. Oxford: Routledge.

Francis, R., 2013. Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, s.l.: s.n.

Freed, F. & Ehrhlich, S. eds., 2010. Why do you ask?. Oxford: Oxford University Press.

Freeman, T., Millar, R., Mannion, R. & Davies, H., 2016. Enacting corporate governance of healthcare safety and quality: a dramaturgy of hospital boards in England. Sociology of Health & Illness , Volume 38, pp. 233-251.

Gainsbury, S., 2016. Feeling the crunch: NHS Finances to 2020, s.l.: The Nuffield Trust.

Garfinkel, H., 1967. Studies in Ethnomethodology. Englewood Cliffs(NJ): Prentice-Hall.

Gilson, L., 2003. Trust and the development of health care as a social institution. Social science & medicine, Volume 56, pp. 1453-1468.

Glenn, P., Koschmann, T. & Conlee, M., 1999. Theory presentation and assessment in a problem-based learning group. Discourse processes, 27(2), pp. 119-133.

Goddard, M., Mannion, R. & Smith, P., 2000. Enhancing performance in health care: A theoretical perspective on agency and information. Health economics, Volume 9, pp. 95-107.

Goffman, I., 1997a. The neglected situation. In: C. Lemert & A. Branaman, eds. The Goffman Reader. Malden(MA): Blackwell, pp. 229-233.

Goffman, I., 1997b. The interaction order. In: C. Lemert & A. Branaman, eds. The Goffman Reader. Malden(MA): Blackwell, pp. 233-261.

Goodall, A., 2011. Physician-leaders and hospital performance: Is there an association?. Social Science & Medicine, Volume 73, pp. 535-539.

Goodwin, C., 2000. Action and embodiment within situated human interaction. Journal of Pragmatics, 32(10), pp. 1489-1522.

Goodwin, C., 2007. Participation, stance and affect in the organisation of activities. Discourse & Society, 18(1), pp. 53-73.

Goodwin, C. & Goodwin, M., 2004. Participation. In: The Blackwell Companion to Linguistic Anthropology. Malden: Blackwell, pp. 222-244.

Goodwin, C. & Heritage, J., 1990. Conversation analysis. Annual Review of Anthropology, Volume 19, pp. 283-307.

Granovetter, M., 1985. Economic action and social structure: The problem of embeddedness. American Journal of Sociology, Volume 91, pp. 481-510.

Greener, I., 2003. Patient choice in the NHS: The view from economic sociology. Social theory & Health, Volume 1, pp. 72-89.

Greener, I., 2004. The new political economy of the UK NHS. Critical Public Health, Volume 14, pp. 239-250.

Greener, I. & Mannion, R., 2009. Patient choice in the NHS: What is the effect of choice policies on patients and relationships in health economies?. Public Money & Management, Volume 29, pp. 95-100.

Grosskopf, S. & Valdermanis, V., 1987. Measuring hospital performance: A non-parametric approach. Journal of Health Economics, Volume 6, pp. 89-107.

Habermas, J., 1996. Between Facts and Norms: Contributions to a Discourse Theory of Law and Democracy. Cambridge(MA): MIT Press.

Habermas, J., 2001. On the pragmatics of social interaction. Cambridge(Mass): The MIT Press.

Ham, C. & Alderwick, H., 2015. Place based systems of care: A way forward for the NHS, London: The King's Fund.

Hannus, S. & Simola, H., 2010. The effects of power mechanisms in education: Bringing Foucault and Bourdieu together. Power and Education, Volume 2, pp. 1-17.

Harrison, S. & Mort, M., 1998. Which champions, which people? Public and user involvement in health care as a technology of legitimation. Social Policy & Administration, Volume 32, pp. 60-70.

Heath, C. & Luff, P., 2007. Gesture and institutional interaction: Figuring bids in auctions of fine art and antiques. Gesture, 7(2), pp. 215-240.

Heritage, J., 2012. Epistemics in Action: Action formation and territories of knowledge. Research on Language and Social Interaction, Volume 45, pp. 1-29.

Heritage, J., 2013. Language and social institutions: The conversation analytic view. Journal of Foreign Languages, Volume 4, pp. 2-26.

Heritage, J. & Clayman, S., 2010. Talk in action: Identities, institutions and interactions. Malden: Wiley-Blackwell.

Heritage, J. & Clayman, S., 2010. Talk in action: Interations, identities and institutions. Malden(MA): Blackwell.

Heritage, J. & Robinson, J., 2011. 'Some' vs 'Any' medical issues: Encouraging patients to reveal their unmet medical concerns. In: C. Antaki, ed. Applied Conversation Analysis: Changing Institutional Practices. Basingstoke: Palgrave-Macmillan, pp. 15-31.

Hester, S. & Francis, D., 2003. Analysing visually available mundane order: A walk to the supermarket. Visual Studies, 18(1), pp. 36-46.

Hoffman, E. & Spitzer, M., 2011. The enduring power of Coase. The Journal of Law and Economics, Volume 54, pp. S63-S76.

Hogg, C. & Williamson, C., 2001. Whose interests do lay people represent? Towards an understanding of the role of lay people as members of committees. Health expectations, Volume 4, pp. 2-9.

Hood, C., 1991. A public management for all seasons? Public Administration, Volume 69, pp. 3-19.

Housley, W. & Fitzgerald, R., 2002. The reconsidered model of membership categorisation analysis. Qualitative Research, 2(1), pp. 59-83.

Hudak, P., Clark, S. & Raymond, G., 2011. How surgeons design treatment recommendations in orthopaedic surgery. Social science & medicine, 73(7), pp. 1028-1036.

Hurley, J. & Card, R., 1996. Global physician budgets as common property resources. Canadian Medical Association Journal, Volume 154, pp. 1161-1168.

Jensen, M. & Meckling, W., 1976. Theory of the Firm: Managerial Behavior, Agency Costs and Ownership Structure. Journal of Financial Economics, Volume 3, pp. 305-260.

Jha, A. & Epstein, A., 2010. Hospital Governance And The Quality Of Care. Health Affairs, Volume 29, pp. 182-187.

Jones, C. & Porter, R. eds., 1994. Reassessing Foucault: Power, Medicine and the Body. London: Routledge.

Jones, P. & Schimanski, K., 2010. The four hour target to reduce emergency department 'waiting time': A systematic review of clinical outcomes. Emergency Medicine Australasia, Volume 22, pp. 391-398.

Kane, N., Clark, J. & Rivenson, H., 2009. The internal processes and behavioral dynamics of hospital boards: An exploration of differences between high- and low-performing hospitals. Health Care Management Review, Volume 34, pp. 80-91.

Kaplan, R. & Norton, D., 1996. The balanced scorecard: Translating strategy into action. Cambridge(MA): Harvard Business Review Press.

Kapur, D., 2002. The Common Pool Dilemma of Global Public Goods: Lessons from the World Bank's Net Income and Reserves. World Development , Volume 30, pp. 337-354.

Keogh, B. & Cummings, J., 2012. The never events policy framework, s.l.: NHS.

Kirkpatrick, I. et al., 2016. Medicine and management in European hospitals: a comparative overview. BMC Health Services Research, 16(Supp 2), pp. 7-14.

Kirkpatrick, I. & McCabe, C., 2011. A full blooded market system: at what cost to the NHS?. BMJ, Volume 343, p. d3238.

Klaes, M. & Sent, EM., 2005. A conceptual history of the emergence of bounded rationality. History of Political Economy, Volume 37, Number 1, pp. 27-59.

Kuhlmann, E., Rangitt, Y. & von Knorring, M., 2016. Medicine and management: looking inside the box of changing hospital governance. BMC Health Services Research, Volume 16, pp. 59-64.

Lambert, M. & Sowden, S., 2016. Revisiting the risks associated with health and healthcare reform in England: perspective of Faculty of Public Health members. Journal of Public Health.

Learmonth, M., Martin, G. & Warwick, P., 2009. Ordinary and effective: the Catch-22 in managing the public voice in health care?. Health Expectations, Volume 12, pp. 106-115.

LeBlanc, R. & Schwartz, M., 2007. The black box of board process: Gaining access to a difficult subject. Corporate Governance: An international review, Volume 15, pp. 843-851.

Lega, F., Prenestini, A. & Spurgeon, P., 2013. Is Management Essential to Improving the Performance and Sustainability of Health Care Systems and Organizations? A Systematic Review and a Roadmap for Future Studies. Value in Health, Volume 16, pp. S46-S51.

Lega, F. & Satirana, M., 2016. Making doctors manage... but how? Recent developments in the Italian NHS. BMC Health Services Research, 16(Supp 2), pp. 65-72.

Lehoux, P., Daudelin, G. & Abelson, J., 2012. The unbearable lightness of citizens within public deliberation processes. Social Science & Medicine, Volume 74, pp. 1843-1850.

Levinson, S., 1988. Putting linguistics on a proper footing: Explorations in Goffman's participation framework. s.l.:Polity Press.

Lieblich, A., Tuval-Mashiach, R. & Zilber, T., 1998. Narrative analysis: Reading analysis and interpretation. Thousand Oaks(CA): SAGE.

Litva, A. et al., 2009. Lay perceptions of the desired role and type of user involvement in clinical governance. Health expectations, Volume 12, pp. 81-91.

Luckmann, T., 2008. On social interaction and the communicative construction of personal identity, knowledge and reality. Organisation Studies, Volume 29, pp. 277-290.

Lupton, D., 1997. Foucault and the medicalisation critique. In: A. Petersen & R. Bunton, eds. Foucault, Health and Medicine. London: Routledge, pp. 94-112.

MacIntosh, R., Beech, N. & Martin, G., 2012. Dialogues and dialetics: Limits to clinician/manager interaction in healthcare organizations. Social Science & Medicine, Volume 74, pp. 332-339.

Mannion, R., Goddard, M. & Bate, A., 2007. Aligning incentives and motivations in healthcare: The case of earned autonomy. Financial Accountability & Management, Volume 23, pp. 401-419.

Martin, G., 2008a. 'Ordinary people only': knowledge, representativeness, and the publics of public participation in healthcare. Sociology of Health & Illness, Volume 30, pp. 35-54.

Martin, G., 2008b. Representativeness, legitimacy and power in public involvement in health-service management. Social science & medicine, Volume 67, pp. 1757-1765.

Martin, G., 2009a. Whose health, whose care, whose say? Some comments on public involvement in new NHS commissioning arrangements. Critical Public Health, Volume 19, pp. 123-132.

Martin, G., 2009b. Public and User Participation in Public Service Delivery: Tensions in Policy and Practice. Sociology Compass, Volume 3, pp. 310-326.

Martin, G., 2011. The Third sector, user involvement and public service reform: A case study in the co-governance of health service provision. Public Administration, Volume 89, pp. 909-932.

Martin, G., 2012. Citizens, publics, others and their role in participatory processes: A commentary on Lehoux, Daudelin and Abelson. Social science & medicine, Volume 74, pp. 1851-1853.

Martin, G. & Finn, R., 2011. Patients as team members: opportunities, challenges and paradoxes of including patients in multi-professional healthcare teams. Sociology of Health & Illness, Volume 33, pp. 1050-1065.

Martin, G. & Learmonth, M., 2012. A critical account of the rise and spread of 'leadership': The case of UK healthcare. Social Science & Medicine, Volume 74, pp. 281-288.

Mastellos, N. & Aylin, P., 2012. Quality and Safety in Primary Care: An Exploration of the Factors Hindering the Effective Use of Information in Care Pathways, London: Imperial College London.

McNulty, T., Zattoni, A. & Douglas, T., 2013. Developing Corporate Governance Research through Qualitative Methods: A Review of Previous Studies. Corporate Governance: An International Review, Volume 21, pp. 183-198.

Milewa, T., 2004. Local Participatory Democracy in Britain's Health Service: Innovation or Fragmentation of a Universal Citizenship?. Social Policy & Administration, Volume 38, pp. 240-252.

Millar, R., Manion, R., Freeman, T. & Davies, H., 2013. Hospital Board Oversight of Quality and Patient Safety: A Narrative Review and Synthesis of Recent Empirical Research. The Milbank Quarterly, Volume 91, pp. 738-770.

Mitton, C. et al., 2009. Public participation in health care priority setting: A scoping review. Health Policy, Volume 91, pp. 219-228.

Mockford, C., Staniszewska, S., Griffiths, F. & Herron-Marx, S., 2012. The impact of patient and public involvement on UK NHS health care: a systematic review. International Journal for Quality in Health Care , Volume 24, pp. 28-38.

Mold, A., 2010. Patient Groups and the Construction of the Patient-Consumer in Britain: An Historical Overview. Journal of Social Policy, Volume 39, pp. 505-521.

Moran, M., 2003. The British regulatory state: High modernism and hyper-innovation. Oxford: Oxford University Press.

Nathan, S., Johnston, L. & Braithwaite, J., 2010. The role of community representatives on health service committees: staff expectations vs reality. Health expectations, Volume 14, pp. 272-284.

Newdick, C., 2005. Who should we treat? Rights, rationing and resources in the NHS. 2nd ed. Oxford: Oxford University Press.

NHS, 2016. About the NHS. [Online] Available at: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx [Accessed 1 8 2016].

NHS, 2016. The NHS in England. [Online] Available at: http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx [Accessed 1 8 2016].

NICE, 2002. Report of the first meeting of Citizens Council. [Online] Available at: https://www.nice.org.uk/Media/Default/Get-involved/Citizens-Council/Reports/CCReport01ClinicalNeed.pdf [Accessed September 2017].

Nilsen, E. et al., 2006. Methods of consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material. Cochrane Database of Systematic Reviews, Volume 3.

Ochs, E., 1996. Linguistic resources for socializing humanity. In: S. G. J. Levinson, ed. Rethinking linguistic relativity. Cambridge: Cambridge University Press, pp. 407-437.

Organisation for Economic Co-operation and Development, 2009. Achieving better value for money in health-care. Paris: OECD.

Organisation for Economic Co-operation and Development, 2010. Value for money in health spending. Paris: OECD.

Osborne, S. & McLaughlin, K., 2002. The New Public Management in context. In: K. McLaughlin, S. Osborne & E. Ferlie, eds. New Public Management: Current trends and future prospects. London: Routledge, pp. 7-15.

Ostrom, E., 1990. Governing the Commons: the Evolution of Institutions for Collective Action. Cambridge: Cambridge University Press.

Ostrom, E., 1998. A Behavioral approach to the Rational Choice Theory of collective action. American Political Science Review, Volume 92, pp. 1-22.

Ostrom, E., 2005. Understanding institutional diversity. Princeton(N.J.): Princeton University Press.

Ostrom, E., 2009. A general framework for analysing sustainability of social-ecological systems. Science, Volume 325, pp. 419-422.

Ostrom, E., 2010. Beyond Markets and States: Polycentric Governance of Complex Economic Systems. American Economic Review, Volume 100, pp. 641-672.

Parton, K., 2014. Epistemic stance in orchestral interation. Social Semiotics, Volume 24, pp. 402-419.

Peräkylä, A., 1995. AIDS counselling: Institutional interaction and clinical practice. Cambridge: Cambridge University Press.

Peräkylä, A., 1997. Conversation analysis: A new model of research in doctor-patient communication. Journal of the Royal Society of Medicine, Volume 90, pp. 205-208.

Petchey, R. P. et al., 2012. Allied Health Professionals and Management: Final Report, s.l.: NIHR Service Delivery and Organisation Program.

Petterson, I., Nyland, K. & Kaarboe, K., 2012. Governance and the functions of boards An empirical study of hospital boards in Norway. Health Policy, Volume 107, pp. 269-275.

Pitkin, H., 1967. The concept of representation. Berkeley: University of California Press.

Potter, J. & Hepburn, A., 2010. A kind of governance. In: N. Llwellyn & J. Hindmarsh, eds. Organisation, Interaction & Practice: Studies of ethnomethodology and conversation analysis. Cambridge: Cambridge University Press, pp. 49-74.

Powell, W., 1990. Neither market nor hierarchy: Network forms of organisation. Research in Organizational Behavior, Volume 12, pp. 295-336.

Psathas, G., 1999. Studying the organisation in action: Membership categorization and interaction analysis. Human Studies, Volume 22, pp. 139-162.

Pye, A. & Pettigrew, A., 2005. Studying Board Context, Process and Dynamics: Some Challenges for the Future. British Journal of Management, Volume 16, pp. S27-S38.

Raymond, G. & Zimmerman, D., 2016. Closing matters: Alignment and misalignment in sequence and call closings in institutional interaction. Discourse studies, 18(6), pp. 716-736.

Roberts, A., Marshall, L. & Charlesworth, A., 2012. A decade of austerity?, s.l.: The Nuffield Trust.

Roberts, C. & Sarangi, S., 2005. Theme-oriented discourse analysis of medical encounters. Medical education, 39(6), pp. 632-640.

Robinson, J. & Heritage, J., 2015. How patients understand physicians' solicitations of additional concerns: implications for up-front agenda setting in primary care. Health Communication, 31(4), pp. 434-444.

Roy, V. & King, L., 2016. Betting on hepatitis C: how financial speculation in drug development influences access to medicines. BMJ, Volume 354, p. i3718.

Sacks, H., 1995. Lectures on conversation. Cambridge(Mass.): Blackwell.

Sacks, H., Schegloff, E. & Jefferson, G., 1974. A simplest schematics for the organization of turn-taking for conversation. Language, Volume 50, pp. 696-735.

Salter, B., 2006. Governing UK medical performance: A struggle for policy dominance. Health Policy, Volume 82, pp. 263-275.

Saltman, R., Duran, A. & DuBois, H. eds., 2011. Governing Public Hospitals. Copenhagen: WHO.

Samra-Fredericks, D., 2000. Doing 'Boards in action' research: An ethnographic approach for the capture and analysis of directors' and senior managers' interactive routines. Corporate Governance, Volume 8, pp. 244-257.

Samra-Fredericks, D., 2004. Understanding the production of 'strategy' and 'organization' through talk amongst managerial elites. Culture and Organisation, Volume 10, pp. 121-141.

Sarangi, S. & Candlin, C., 2003. Categorization and explanation of risk: A discourse analytical perspective. Health, risk & society, 5(2), pp. 115-124.

Saward, M., 2006. The representative claim. Contemporary Political Theory, Volume 5, pp. 297-318.

Schegloff, E., 1999. Discourse, pragmatics, conversation, analysis. Discourse studies, 1(4), pp. 405-435.

Schegloff, E., 2000. Overlapping talk and the organisation of turn-taking for conversation. Language in Society, Volume 29, pp. 1-63.

Schegloff, E., 2007. A tutorial on membership categorization. Journal of Pragmatics, Volume 39, pp. 462-482.

Schegloff, E., 2007. Sequence organisation in interaction. Cambridge: Cambridge University Press.

Schlosser, J., 2013. Bourdieu and Foucault: A conceptual integration towards an empirical sociology of prisons. Critical criminology, Volume 21, pp. 31-46.

Seldinger, S., 1953. Catheter Replacement of the Needle in Percutaneous Arteriography: A new technique. Acta Radiologica, Volume 39, pp. 368-376.

Severs, E., 2010. Representation as claims-making. Quid responsiveness?. Representation, Volume 46, pp. 411-423.

Shaw, C., 2003. How can hospital performance be measured and monitored? , Copenhagen: WHO.

Simon, H., 1959. Theories of decision making in economics and behavioural sciences. The American Economic Review, Volume 49, pp. 253-283.

Simon, H., 1964. Theories of bounded rationality. CIP Working Paper 66.

Smith, D., 2005. Institutional ethnography. Oxford: AltaMira Press.

Smith, P. et al., 2012. Leadership and governance in seven developed health systesm. Health Policy, Volume 106, pp. 37-49.

Smith, R., 2017. Membership categorisation, category-relevant spaces, and perception-in- action: the case of disputes between cyclists and drivers. Journal of Pragmatics, Volume 118, pp. 120-133.

Stake, R., 1995. The art of case study research. Thousand Oaks: Sage Publications.

Stake, R., 2005. Qualitative case studies. In: N. Denzin & Y. Lincoln, eds. The SAGE Handbook of Qualitative Research. Thousand Oaks: Sage Publications, pp. 443-466.

Stivers, T., 2007. Prescribing under pressure: Parent-physician conversations and antibiotics. Oxford: Oxford University Press.

Sutton, E., Eborall, H. & Martin, G., 2015. Patient involvement in patient safety: Current experiences, insights from the wider literature, promising opportunities?. Public Management Review, Volume 17, pp. 72-89.

Thompson, J., 1981. Critical Hermeneutics: A Study in the Thought of Paul Ricoeur and Jurgen Habermas. Cambridge: Cambridge University Press.

Timmins, N., 2012. Never again? The story of the Health and Social Care Act 2012. London: The Institute for Government.

Tort, S., Tovey, D. & Lyddiatt, A., 2015. Patient safety within Cochrane: can we create a patient safety portfolio to support the global drive for safer health care?. Vienna, John Wiley & Sons.

Townley, B., 2002. The Role of Competing Rationalities in Institutional Change. Academy of Management Journal, Volume 45, pp. 163-179.

Tritter, J., 2009. Revolution or evolution: the challenges of conceptualizing patient and public involvement in a consumerist world. Health Expectations, Volume 12, pp. 275-287.

Tsai, T. C. et al., 2015. Hospital Board And Management Practices Are Strongly Related To Hospital Performance On Clinical Quality Metrics. Health Affairs, 34(8), pp. 1304-1311.

Tsang, C., Palmer, W. & Aylin, P., 2008. Patient safety indicators: A systematic review of the literature, London: Imperial College London.

University Hospital Trust, 2013. Constitution. s.l.:s.n.

VanWynsberghe, R. & Khan, S., 2007. Redefining case study. International Journal of Qualitative Methods, 6(2).

Venkatapuram, S., 2011. Health Justice. Cambridge: Polity.

Veronesi, G., Kirkpatrick, I. & Vallascas, F., 2013. Clinicians on the board: What difference does it make?. Social Science & Medicine, Volume 77, pp. 147-155.

Veronesi, G., Kirkpatrick, I. & Vallascas, F., 2014. Does clinical management improve efficiency? Evidence from the English National Health Service. Public Money & Management, 34(1), pp. 35-42.

Wacquant, L. & Bourdieu, P., 1992. An invitation to reflexive sociology. Chicago: Chicago University Press.

Wait, S. & Nolte, E., 2006. Public involvement policies in public health: Exploring their conceptual basis. Health Economics, Policy and Law, Volume 1, pp. 149-162.

Walshe, K., 2003. Foundation hospitals: a new direction for NHS reform? Journal of the Royal Society of Medicine, Volume 96, pp. 106-110.

Waring, J., 2007. Adaptive regulation or governmentality: patient safety and the changing regulation of medicine. Sociology of Health & Illness, Volume 29, pp. 163-179.

Waring, J., Allen, D., Braithwaite, J. & Sandall, J., 2016. Healthcare quality and safety: a review of policy, practice and research.. Sociology of Health & Illness, Volume 38, pp. 198-215.

Weber, M., 1919 [1946]. Science as a vocation. In: H. Gerth & C. Mills, eds. From Max Weber: Essays in Sociology. Oxford: Oxford University Press, pp. 129-156.

Weber, M., 1978. Economy and society. Berkeley: University of California Press.

Weinberg, D., 2005. Of others inside. Philadelphia: Temple University Press.

Weinberg, D., 2007. Habermas, Rights, and the Learning Disabled Citizen. Social Theory & Health, Volume 5, pp. 70-87.

WHO, 2008. World Alliance for Patient Safety - Progress Report 2006/2007, Geneva: World Health Organisation.

Williamson, O., 2005. The economics of governance. American Economic Review, Volume 95, pp. 1-18.

Wright, J. et al., 2012. The new governance arrangements for NHS Foundation Trusts: Reframing governors as meta-regulators. Public Administration, Volume 90, pp. 351-369.

Yin, R., 2003. Case study research. Thousand Oaks: Sage Publications.

Zachariadis, M., Oborn, E., Barrett, M. & Zollinger-Read, P., 2013. Leadership of healthcare commissioning networks in England: a mixed-methods study on clinical commissioning groups. BMJ Open, Volume 3, p. e002112.

Zayts, O. & Sarangi, S., 2013. Modes of risk explanation in telephone consultations between nurses and parents for a genetic condition. Health, risk & society, 15(2), pp. 194-215.

Zona, F. & Zattoni, A., 2007. Beyond the Black Box of Demography: board processes and task effectiveness within Italian firms. Corporate Governance, Volume 15, pp. 852-864.

Appendix – Transcription conventions

Talk is transcribed into standard English, with conventionalised spelling. Double quotation marks (" ") are used to indicate direct quotation from transcribed talk used in the text.

Speakers are indicated in **bold** type. Pseudonyms have been assigned based on organisational role / title. Numbers **(1)** and **(2)** are used to distinguish between multiple speakers with the same role / title.

(italics)	Gesture or co-occurring action
.	Downward (sentence final) intonation
?	Upward (question) intonation
,	Micro-pause
(Pause)	Long pause
[ ]	Square brackets are used to indicate an insertion or commentary, including inaudible or indistinct speech.
…	Ellipses indicate edited preceding or subsequent talk