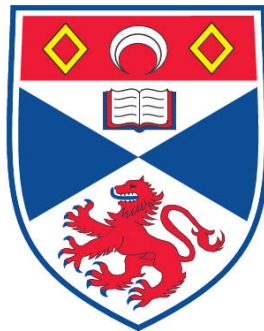


**MANAGED CLINICAL AND CARE NETWORKS (MCNS) AND WORK:
AN ETHNOGRAPHIC STUDY FOR NON-PRIORITISED CLINICAL
CONDITIONS IN NHS SCOTLAND**

Anne Duguid

**A Thesis Submitted for the Degree of PhD
at the
University of St. Andrews**



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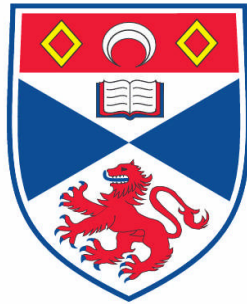
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(MCNS) AND WORK: AN ETHNOGRAPHIC STUDY
FOR NON-PRIORITISED CLINICAL CONDITIONS
IN NHS SCOTLAND

Anne Duguid



This thesis is submitted in partial fulfilment for the degree of PhD
at the
University of St Andrews

15th May 2012

**Managed Clinical and Care Networks (MCNs)
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An ethnographic study of MCNs for non-
prioritised clinical conditions in NHS Scotland**

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Thesis submitted for the degree of PhD

15th May 2012

Managed clinical and care networks (MCNs) have emerged in Scotland as a collaborative form of organising within health and between health and social services. Bringing together disparate disciplines and professions their aim has been to allow work across service and sector boundaries to improve care for patients. Whilst MCN prevalence has increased and policy has moved to centralise this method of organising, many research questions remain. These include: how can we understand the form, function and impact of MCNs, and further, what are the underlying motivations for practitioners and managers to organise in this way?

Focussing in on the *work* of 3 voluntary MCNs operating in Scotland, the centrality of *practice* emerges. Practice is defined broadly to encompass both the interactions between practitioner-patient and practitioner-population. From this, the MCN becomes conceptualised as a set of activities focussed around ground-level clinical MCN service issues and top-level policy direction.

Through considering work the interplay between ethics and scientific evidence emerges. The inherent *uncertainty* and *suffering* of daily practice comes to the fore, these concepts are brought together within a framework, *morals-in-practice*. Further, using the hermeneutic dynamics of *alterity*, *openness* and *transcendence*, MCNs can be understood as providing a space to foster creative responses to the *wicked problems* created by health and social service design and delivery.

The organising opportunities provided by MCNs thus arguably serve several organisational and social functions, providing a forum to: mutually support and respond to the intrinsically challenging nature of practice understood; debate *morals-in-practice* helping to ensuring collective clinical governance; sharing of organisational knowledge; planning, delivery and audit of services; and creatively respond to wicked problems.

By focussing in on the work, the practice particularities of each individual MCN are resultantly emphasised, whilst still maintaining recognition that much of the NHS

operational context is more widely shared. Through this these voluntary MCNs, at least, can be viewed as an organising form which has emerged in response to the complexities of modern health and social service, care, design and delivery.

DECLARATIONS

1. Candidate's declarations:

I, Anne Duguid hereby certify that this thesis, which is approximately 78,589 words in length, has been written by me, that it is the record of work carried out by me and that it has not been submitted in any previous application for a higher degree.

I was admitted as a research student in November, 2006 and as a candidate for the degree of PhD in November, 2006; the higher study for which this is a record was carried out in the University of St Andrews between 2006 and 2011.

23/11/11

2. Supervisor's declaration:

I hereby certify that the candidate has fulfilled the conditions of the Resolution and Regulations appropriate for the degree of PhD in the University of St Andrews and that the candidate is qualified to submit this thesis in application for that degree.

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***To my husband Alan, you are my anchor
and to my son Alan, you are my
inspiration.***

***To my parents Helen and Richard, I am
truly blessed to be loved so much.***

I am gifted to share this journey with you.

Nothing in the world can take the place of persistence.

Talent will not; nothing is more common than unsuccessful men with talent.

Genius will not; unrewarded genius is almost a proverb.

Education will not; the world is full of educated derelicts.

Persistence and determination alone are omnipotent.

***The slogan 'Press On' has solved and always will solve the problems of the human
race.***

Calvin Coolidge

30th president of US (1872 - 1933)

ACKNOWLEDGEMENTS

To undertake a thesis is undoubtedly to choose a challenging road. This journey has without doubt been made more scenic by those special people who have given me their time, interest and support. It is here I wish to acknowledge my fellow journey men.

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To Prof Nicholas Davey, you opened my mind once again to the joy of philosophy at its most vibrant and creative. You idiot proofed me and helped me become a lot less ignorant. Here's to serendipity.

To Prof Faisal Ahmed, you are my friend and boss. You showed your faith by letting me return. For this, I thank you for your crazy trust. To Prof Iain Dearie, my faithful journeyman. To Lyn Jones who gave me my first job and set me on this road.

To my colleagues at CSEAR, University of St. Andrews, School of Management, Prof Rob Gray OBE, Sue Gray and Dr Lynn Christie. Thank you for quietly shutting the door and letting me rant till my rant ran out.

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Thank you to all the MCN members who gave their time and allowed me the privilege of watching them go about their daily work. There would be no thesis without you. Thank you to my funders, the Chief Scientist Office, who made the whole process economically viable.

I would also like to thank the various Librarians at University of Dundee, School of Nursing, Kirkcaldy and Burntisland Public Library for letting me use their electricity

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Finally, I would like to say the biggest thank you to my family. To my mum, Helen, who cared for my small son so that I could work on the thesis and fed me often. To my dad, Richard, who never lost interest in hearing about every new theory or fact I had ‘found’. To my husband, Alan, whose eye to the post-graduation meal, never wavered, so sure was his faith that I would complete. And finally to my son, Alan, the PhD orphan, you kept me grounded and constantly reminded me what life was really about.

Thank you all, this thesis is dedicated to you.

PERSONAL REFLECTIONS

A thesis is a journey. It starts by being pointed in the direction of the library, and told to ‘*go make something original that adds to the body of knowledge*’. Along the way, there are many challenges, many dark holes and many moments of wondrous luminescence. But mainly, there is loneliness and perseverance.

When I started this research I was a lot younger and a different person. I was a psychologist-come-qualitative researcher, who had spent a long time wondering about effectiveness and efficiency of teams, MDTs and MCNs. My understanding was predominantly positivist and I was fairly confident I knew what I knew.

I set off with the typical arrogance of youth, concerned not with the journey but the end result - I would understand the totality of the NHS, get a big gold star and life would be one ambitious upward trajectory.

Instead the journey proved rockier than anticipated. I stumbled. I tripped. I often fell on my face. I picked myself up frequently. I regularly sat staring into space hoping that somehow something would ‘*emerge*’. I read and read and read some more, often becoming frustrated that THE answer couldn’t just be grabbed from a book and plonked on top of my real world sites.

What I knew I knew slipped from my fingers. I was left with knowing that I didn’t know.

And it is this revelation that I will take from the thesis. For whilst I have learnt methodology, practical and theoretical, engaged with modes of thinking that made my mind crackle, discovered that much to my disappointment, no-one will ever force you to write and that I am more tenacious than I ever realised; this all comparatively fades into significance. For what the PhD has taught me, is that for truly interesting things to happen, not knowing, is a very good place to start.

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GLOSSARY OF ABBREVIATIONS

CHD	Coronary Heart Disease
CHP	Community Health Partnership
CSBS	Clinical Standards Board for Scotland
DARTS	Diabetes Audit and Research in Tayside Scotland
DoH	Department of Health
DSDs	Disorders of Sexual Differentiation
EBM	Evidence-based medicine
HB	Health Board
HDL	Health Department Letter
HEAT	Health improvement Efficiency Access Treatment
ICP	Integrated Care Pathway
IRVS	Integrated Regional Vascular Services
ISD	Information and Statistics Division
JPIAF	Joint Performance Information and Assessment Framework
LHCC	Local Health Care Co-operative
MCN	Managed Clinical Network

MDT	Multidisciplinary Team
MEL	Management Executive Letter
NSD	National Services Division
PFPI	Patient Focus and Public Involvement
RCT	randomised controlled trial
SCI-DC	Scottish Care Information - Diabetes Collaboration
SIGN	Scottish Intercollegiate Guidelines Network
SNA	Structural Network Analysis

CHAPTER 1: INTRODUCTION AND OVERVIEW

1.1 MANAGED CLINICAL AND CARE NETWORKS (MCNS)

Managed Clinical and Care Networks were first introduced into Scottish policy in the Acute Services Review (1998) and implemented in a Management Executive Letter in 1999 (MEL (1999)10). In the intervening 12 years MCNs have spread widely and now operate for a range of conditions, services and specialities. Defined by the Scottish Health Department in terms of a set of core principles, MCNs aim to improve patient care and health service delivery by breaking through problematic boundaries between professionals, services and sectors.

Embedded within wider policy on *whole system* planning, *integrated* service and *partnership* working, MCNs have been mobilised as an operational extension of this holistic narrative. MCNs have enjoyed a high policy profile being viewed as implementing strategy through localised planning and delivery, whilst simultaneously providing ‘real world’ representation of *joined up* services. MCNs have been well placed to capitalise on changes in strategic direction, being able to rapidly refine their defining characteristics as policy makers have requested new forms of healthcare activity in response to changes in context.

An observation of policy salience does not speak, however, to why clinical practitioners have regularly and voluntarily organised themselves into MCN groupings. Although there has been a notable increase in networked forms of operations throughout the health service (noted by Ferlie and Pettigrew in 1996) and indeed in the wider world of non-public sector organisations (Ouchi, 1980), it does not appear inevitable that MCNs would have the popularity they appear to have with health service workers. The existence of networks in the wider organisational environment does not alone appear sufficient to explain the attraction of collective forms of cross-boundary working for policymakers, managers or healthcare practitioners.

When considering cross-boundary organising, it becomes apparent that there are many barriers and challenges to any form of collective endeavours. Broadly put, collaborative practice is assumed to need a clear set of shared goals (Poulton and West, 1993) without which, collaborations can often fall in a state of *collaborative inertia* (Huxham and Vangen, 2004). Translated more specifically to MCNs, cross-boundary working often comes with a cost in terms of time and effort (Guthrie *et al*, 2003). Thus as collaborative ventures, MCNs are potentially high risk.

However, the potential benefits of this way of organising are claimed to be many. These include: more equitable service provision for patients; prevention of duplication of effort and resources; multi-professional and multisite working; agreed care protocols and pathways across the network area; diversity of professional contributions; promoting a focus on patient access to and experience of care; identifying and sharing scarce *existing* resources, for example, specialist medical and clinical practitioners; enabling *release of*, or *joint investments in* scarce or costly resources, for example, giving practitioners the opportunity to focus on sub-specialities; reducing barriers to the coordinated provision of services; providing a means of accounting for service performance across health care organisation; and so on (Cropper, Hopper and Spencer, 2002; Brooks and Greenley, 2006). Why though these numerous benefits should be forthcoming from simply organising in this way is neither self-evident nor adequately explained.

This suggests that whilst the claimed impact of MCN organising may be considerable, attaining success from a collaborative venture may be costly. The differential between what the MCN is argued to potentially achieve and what is actually empirically achieved thus becomes of interest. Indeed when we consider empirical work on MCNs this tension appears to be central to how MCNs are experienced. Tangible (few) and intangible (many) outcomes simultaneously present (Guthrie *et al*, 2009), with evaluative work struggling to unpick evidence of hard outcomes solely attributable to MCNs, embedded as they are within the wider NHS (Hamilton *et al*, 2005).

The study therefore turns to this question *why do practitioners and managers organise themselves in this way?* Focussing on ground-level activity (what people

actually *do* in a MCN), the MCN is considered through the mundane and everyday (Tsoukas and Knudsen, 2005). The study considers the localised *work* of MCN members, to consider whether what practitioners and managers are faced with and what they do could go some way to explaining why they organise in this way. Organised around shared clinical subject matters, or *sachen* (partial understandings which taken together create the illusion of a unitary whole), the MCN becomes understood not an organisational form in which activity is merely embedded, but alternatively emerges as an extension of the work which occurs within the context, that is, *practice*. This work or *practice* is predominantly clinical, managerial or policy in focus and is understood as referring to both the practitioner-patient and practitioner-population unit of analysis (HDL (2007) 21).

To better understand work it was necessary to consider the debates and dilemmas which were of importance to clinical practitioners and managers. I attempt to provide some coherence to these themes through an organising frame – *morals-in-practice*. *Morals-in-practice* is used to examine the dynamic relationship between ethics and scientific evidence, which then becomes action. This organising strategy allows a comparison of the similar pressures faced by MCN members across the 3 field sites, MCNs for Addictions, Disorders of Sexual Dysfunction (DSDs) and Dementia, for example, ensuring *clinical governance*.

Turning to *wicked problems* (Rittel and Webber, 1973), I consider how the intractability and unfolding nature of these problems requires particular types of *leadership* and *authority* (Grint, 2005). Further, how the solutions to these problems require may need particular organising dynamics. I mobilise the hermeneutic concepts of *alterity*, *openness*, *logos*, and *transcendence* (Davey, 2006) to suggest that structural difference, being vulnerable to new ideas and ways of thinking, and the unstable nature of language may explain the dynamic necessary for creative problem-solving.

I suggest that MCNs can be understood as a functional organising answer to questions which are posed by everyday practice (Grondin, 1995). In the MCN practitioners and managers are coming together in an attempt to tackle those questions which are beyond the individual to answer, questions which instead require collective

consideration and creative answers. These assumptions leads me to construct a theoretical ideal type, the *hermeneutic community*, defined as – ‘*a forum where difference is purposefully drawn together, in order, that vulnerability to the unstable nature of language can disrupt practice to achieve creative ends.*’ I am suggesting that the MCN understood as a hermeneutic community, is the organising answer to those questions set by work.

1.2 THESIS OVERVIEW

The thesis is organised in the following chapters.

In chapter two, an historical account of MCN policy development is provided. The aim is to help contextualise the political background in which the ‘idea’ of the MCN evolved: tracking it from conceptual inception as an as yet unrefined possibility, through to its central positioning in mainstream strategic thinking. It argues that the MCN model has evolved to reflect wider changes in healthcare policy and politics. The result is an increased remit bringing into question the likelihood of achieving the stated outputs and outcomes of the MCN.

In chapter three, the central literatures on MCNs specifically and networks more broadly is presented. Presenting the main concepts which have been used to understand MCNs, the role of the boundary spanner and the concepts of nodes and ties are explained. As structurally informed theorising underpins existing research the strengths and limitations of this position is discussed. I suggest that that structurally influenced thinking creates modes of engagement and understanding which may be of limited help for my present purposes. In doing so, I suggest an alternative trajectory of enquiry.

In chapter four, I present the theoretical backbone of the thesis, considering: collaboration, context, and work. Taken together these set of literatures prove useful when considering MCNs from a perspective which centralises the activity of those that are participant members of MCNs. In particular attention is drawn to the nature of wicked problems, leadership and authority (Grint, 2005) and the question is raised of how to account for collaborative advantage (Huxham and Vangen, 2004). Considered

together they draw our attention to the actual *work* or practice which informs MCN organising.

In chapter five, I introduce the methodological framing of the research. I describe the paradigmatic assumptions which were made and informed by hermeneutic theorising. I explain my decision to use ethnography, aiming to justify my research strategy, whilst explaining some of the limitations.

In chapter six, I move to describe the actual doing, that is, the method. I discuss how the study was planned, executed and taken forward. I outline the ethical and organisational hurdles required to gain access to the sites. I present an overview of MCN sites, participants, and data sources. I close with a consideration of my analysis and data presentation.

In chapter seven, I outline my first research iteration. I describe how during this early stage, inter-related methodological and empirical difficulties emerged. I describe how I struggled to account for: the different roles that I was ascribed by each MCN; the sense of the confusion the participants demonstrated in describing what a MCN was or what it was for; and the difficulty with which they located the impact that their activity had had on healthcare delivery. In particular, in 2 of the MCNs participants reported a general frustration over the seeming discrepancy between what the *potential* of the group was imagined to be against the *actuality* of their achievements. The question emerged, why would this difference exist?

Chapter eight thus moves to consider a function of MCNs. Drawing out the foundational importance of *uncertainty* and *suffering*, the heuristic of *morals-in-practice* is introduced: a dialogic relationship between *ethics* and *scientific evidence* which merges in *moral action*. This organising frame allows me to consider each MCN's differing clinical subject matters or conditions, whilst maintaining a view that similar contextual factors are transferrable, such as the pressure to ensure *clinical governance*. Against this backdrop the MCN thus become understood as a forum to consider the related debates around practice, at the patient and population level.

In chapter nine, I move to consider another function of the MCN to provide a forum to deal the *wicked problems* which occur in health and social services. In considering Grint's (2005) work which highlights *leadership* and *authority*, I consider how these MCNs conform to his suggested model. Further, I move beyond this, to consider what would be the necessary dynamics to tackle wicked problems. Drawing on the hermeneutic concepts of *alterity* and *openness*, I suggest that these capture the structural and dispositional elements necessary to mobilise the unstable nature of language or *logos*, the aim, *transcendent* or creative responses necessary to tackle wicked problems.

In chapter ten, I return to the central question: '*why would practitioners voluntarily choose to organise themselves in this way?*' Returning to hermeneutic theorising, I begin by assuming that MCNs are an *answer* to a set of social *questions* or dilemmas (Grondin, 1995). Through my consideration of morals-in-practice and wicked problems inherent in the work undertaken by MCN members, I attempted to partially capture these questions. In this chapter, I go further in an attempt to understand how the MCN could possibly be understood as an organising answer to these questions. Constructed around a shared yet differently understood clinical subject matters or *Sachen*, I suggest that the MCN can be understood with reference to an ideal type – the *hermeneutic community*. Finally, I return to consider the implications of this move, for our understanding of the form, function and impact of MCNs.

CHAPTER 2: THE POLITICAL AND POLICY CONTEXT

2.1 INTRODUCTION

Managed Clinical Networks (MCNs) were introduced into Scottish NHS policy in 1998 (Acute Services Review). MCNs were heralded as an organisational means with which to tackle institutional difficulties as varied as: difficulties in patient movement within and between sectors; inter-professional cross-boundary rivalry; human resource shortages and legal constraints on working practice. MCNs were suggested as an organisational model with the potential to ameliorate many of the functional and service issues faced by a modern health service.

In the intervening decade, MCNs moved from a peripheral organisational concept to central Scottish NHS strategy. MCNs have therefore been an attractive concept for policy-makers, who have raised the MCN organisational profile and MCNs now exist for clinical conditions (e.g. diabetes); service specialities (e.g. neurosurgery); clinical specialities (e.g. endocrinology); and across sectors, in the form of Managed Care Networks (e.g. dementia). The push towards breaking down the boundaries between professions, services and sectors harmonized with the wider political agenda has allowed a relatively rapid rise in the profile and establishment of MCN forms of organising.

In this chapter the MCN model will be placed within the relevant political and policy context. The aim is to provide an insight into how the MCN model was initially conceived and has since developed. Placed within these broader healthcare concerns the MCN model is argued to be responding and evolving to wider changes in health service development.

2.2 WHAT IS AN MCN?

MCNs are broadly networks of healthcare professionals, who come together to do *work*. Such *work* can be centred on clinical conditions, service specialities, clinical speciality, and across service sectors. Defined in policy as: *'linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board*

boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland' (MEL (1999) 10). The MCN model aimed to loosen structural boundaries enabling services and planning to occur between professions (for example different medical specialities on different sites), services (e.g. between hospital and community care providers) and more recently, sectors (e.g. between Health, Social Services or Education) through Managed Care Networks.

The underlying purpose of the MCN model was to make services more flexible, responsive and effective. Taking as its central tenets flexibility and patient-centred planning, policy provided the necessary political approval and governance mechanisms to establish MCNs bridging traditional geographic areas, healthcare providers and professional groups. Whereas prior to MCN policy practitioners may have informally organised themselves into clinical networks, the introduction of the policy now provided a base for formal, organisational recognition. This created networks which would have previously struggled to gain financial or managerial permissions to operate. Thus, MCNs were intended to enable the construction of structures and operations which were designed around the patient as they moved along their healthcare journey. MCNs were based on pre-existing health networks and informal professional relationships, thereby harnessing the creative positive ethos of collegial working, whilst providing the managerial structures to legitimise and formalise network forms of working: MCNs were to make more informally constituted groups into 'real' organisations.

MCNs did not however, develop in an historical vacuum and to understand how they evolved in policy I briefly the context from which they emerged.

2.3 SCOTTISH NHS CONTEXT

In 1998 The Scotland Act devolved certain powers to the recently convened Scottish Parliament based in Edinburgh. The Act outlined those powers 'reserved' by the UK Parliament and by a process of elimination those that were not specified were taken over by the newly named Scottish Executive. One of these responsibilities was for the running of the Scottish National Health Service. Until 1998, decisions regarding healthcare had been largely centralised in Westminster, with resultant healthcare

policy being relatively uniform across Great Britain and Northern Ireland. However, with devolution, a fragmentation of policy directions became possible and the duly appointed Labour Executive initiated a new policy trajectory for Scottish healthcare (Greer, 2004).

Beginning with a piece of pre-devolution health policy, the 1997 *Designed to Care*, the new UK Labour Government laid out their intention for Scottish healthcare. Their stated aim was to de-layer healthcare bureaucracy, increase collaboration and use planning which was more patient centred. Openly declaring the intention to move away from the Conservative *internal market* model, where commissioning was competitively and contractually managed, the policy document emphasised a health service founded on efficiency and quality, underlined with a belief in fairness and partnership. As a result Acute Trusts (the operational arm of hospital service provision) were reduced in number and Primary Care was given a higher profile and encouraged to increase linkages across sectors (Social Service and Education) via the newly formed GP-led Local Health Care Co-operatives (LHCCs). The aim was to underline the shift towards a new cultural attitude of collaboration and partnership.

After devolution, *Our National Health: A plan for action, a plan for change* released in 2000, argued even more strongly for movement away from the fragmentation of commissioning rounds. The plan was to synthesise many of the previous health plans and was described as a '*signpost on the way to a healthier Scotland*'. The emphasis was to be towards quality of care and services wrapped around patient journeys in a *whole system* approach. As part of this, the claim was that bureaucracy would be reduced, by creating 15 unified HBs to form a single, local and accountable health system in each area. The Trusts were still to have operational control of service delivery but their Chief Executives and Chairs were now to sit on the NHS Board as opposed to separately.

The Trusts however, did not have long to exist and 3 years later in the white paper *Partnership for Care* they were abolished, removing the last remnant of the purchaser-provider split which had been the dominant health policy of Conservative Government from the early 1990s. In line with the emphasis on localised community service provision, LHCCs were reconfigured to become Community Health

Partnerships (CHPs) with enhanced levels of responsibility for local service redesign and service integration. Together these moves were suggestive of a policy desire for a more integrative structural model for the Scottish NHS. Policy was emphasising a move away from centralised control towards a more localised focus. This trajectory was also underlined in *Delivering for Health* (2005) which once again stressed the need for locally provided, high quality, integrated care especially in light of the changes needed to mirror the requirements of a healthier, yet ageing population, rapid changes in health technologies, and the greater emphasis on public health and personal health responsibilities.

In May 2007, the Scottish National Party won the Scottish Parliamentary Election and took over as a minority government. Their first major piece of health policy was *Better Health, Better Care: Action Plan* published in 2007. Strongly emphasising the commitment to moving even further away from market oriented models, housing the NHS firmly within the public sector, the document opens with an emphasis on the relationship between services and patients: [the] ‘*vision is based on a shift from the current position where we see people as “patients” or “service users”, to a new ethos for health in Scotland that sees the Scottish people and the staff of the NHS as partners, or co owners, in the NHS. I want us to move to a more mutual NHS where partners have real involvement, representation and a voice that is heard*’ [2007:iv]. This is referred to as *mutuality* and places patient-practitioner collaboration central to policy thinking.

From the above, we see a policy emphasis of patient-centeredness, collaboration and localisation. Services are to be provided consistently across Scotland, evolve and develop around patient needs as opposed to structures, are to be delivered close to the patients’ locality, and will be provided by teams of professionals and practitioners who will work harmoniously together. Behind this there is also the hint of a structural metaphor, whereby the macro health system is conceptualised as comprising of multiple micro inter-linking systems. Further, this structural thinking suggests that these inter-related systems are potentially mappable and can be therefore be made, through re-design, to integrate, enabling less restricted patient flow (McNulty, 2002; Woods, 2002).

Moving on from broad considerations of Scottish health policy, attention now turns to more specific MCN policy: tracking the evolution of the organisational concept from tentatively considered solution to strategic policy centrality.

2.3 SCOTTISH MCN POLICY

Calman-Hine Report (1995)

‘Clinical networks’ initially appeared in the Department of Health (DoH) Calman-Hine report on English cancer services (1995). The report recommended a new structural arrangement for cancer services *‘based on a network of expertise in cancer care reaching from primary care through Cancer Units in district hospitals to Cancer Centres...this network of care is intended to deliver a uniform standard of high quality care to all patients.’* (p.7). The report goes on to state that *‘the network is one of proficiency and not of buildings’* (p.8). This suggests that it will be medical expertise and not location that is the focus of design.

This report argued for cancer services as being speciality focussed, linkages spanning from localised, generic provision through to specialised tertiary services. Using *networks* as a way of describing the pathway mapping of providers along the patient’s (potential) journey, this was seen as central to redesign which enabled equitable access to high quality care. It was an explicit strategic piece of service design, which viewed services as being inter-linked.

Acute Service Review Report (1998)

In Scotland the first mention of the MCN as a concept was the Acute Services Review (1998) chaired by Sir David Carter, the Chief Medical Officer. The Review was set up in the aftermath of a winter flu epidemic in 1995-1996, which created significant disruption in NHS service delivery. The Review’s remit was to examine Acute Services to consider preparatory strategic and operational planning which could be put in place to mitigate any similar future scenarios and was related to the recently published policy document *‘Designed to Care: renewing the NHS in Scotland’*. The Review intended to *‘encourage, develop and harness thinking about the services it provides, catalyse the process of beneficial change, and facilitate the continuing*

development of a climate of professional and public opinion in which change can take place'(p.7). Equity, access and clinical effectiveness were seen as the crucial factors in driving the development of high quality, sustainable patient services within a coherent and integrated national NHS.

The Review was guided by two principles '*service organisation should be led by patient need, and that while standards of service provision may be determined and audited nationally, how best to meet these standards should be decided locally*' (p.7). The Review strove to tackle differences in equity, access, quality and sustainability and whilst cautioning that structural change did not guarantee equity and quality of care, identified two forms of organisational intervention or '*models of service delivery*' which might of potential benefit.

The first was the *hub and spoke* model: a hierarchically aligned specialist *hub*, usually based at a tertiary hospital centre, linked to District General Hospital (DGH) *spokes*. This term was used to conceptualise the ties which exists between members of a clinical speciality over multiple hospital sites, as differentiated from cross-speciality relationships within one site. It was noted that the hierarchical nature of this model was potentially problematic, as it implied a super-ordinate (hub) and subordinate (spoke) relationship between the sites. However, the example of neuroscience was shown to successfully partner the 4 specialist centres with non-specialist hospitals to provide local, general neurological and specialist outpatient services at these local DGH sites. There was also noted to be a lack of primary care involvement in existing networks since the model was predominantly concerned with operations at the tertiary level, although it was noted that this model could be cascaded down to refer to a hub DGH with community based spokes. For those working in the DGH a concern was raised as to whether centralisation ('*rationalisation*' into '*super hospitals*' p.23) at the hub would result in a reduction in specialist provision at the spokes. The Review assured that centralisation was not the premise on which they were operating.

The second structural suggestion was to build on pre-existing informal clinical networks. This was hoped to help accommodate the rise in medical sub-specialisation, allowing co-operation across sites when patient populations proved too small to sustain adequate expertise on every site. The emphasis was to be on '*connection and*

partnership rather than isolation and self sufficiency, on distribution of resources rather than centralisation, and on maximising the benefits for all patients rather than a fortunate few’ (p. 23). The Review highlighted that much of the power and influence would lie at the interstices of the ‘*net*’, in the form of knowledge or resource, that is, where one network connects with a new network through interpersonal interactions. Doctors were seen as the key collegiate resource, albeit allied health professionals and nursing were seen as important. Characterised as a ‘*virtual service organisation*’ (p. 24), the implication was that the clinical network would provide a seamless chain of care across interconnected professionals and/or services, which may not be coterminous with existing Health Board (HB) or institutional boundaries. The model was to be dynamic and responsive, changing as relationships and medicine advances, however, this was not to imply a ‘*non-organisation*’, ‘*loose woolly*’ construct or ‘*free for all*’ without authority, responsibilities or ability to exert control but was to adhere to standards of clinical practice, governance and ethics. It was to be managed. To underline this move to organisational formalisation the model was named the ‘Managed Clinical Network’ (MCN).

In stark contrast to its previously cautionary tone regarding structural change and outcome, the Review Board goes on to declare: ‘*The Review sees the development of managed clinical networks as the most important strategic issue for acute services in the NHS in Scotland*’ (p.24). Further, it goes on to state that this form of networking allows ‘*the best basis for equitable, rational and sustainable acute services, are flexible and capable of evolution and allow greater emphasis to be placed on service performance and effectiveness*’ (p.24).

The Review goes on to describe two examples, the Scottish Cancer Network and Integrated Regional Vascular Services (IRVS). Similar to the model proposed in the English Calman-Hine report, the Cancer Network was structurally formed as a hybrid of a hub and spoke model (5 central sites and related units) and a clinical network. Highlighted for its ability to consider strategic resource issues, the network as a collective was seen to be driving forward funding priorities, unlike the orthodox model of decisions and planning taken by one hospital site. The IRVS on the other hand, was formed in response to what was perceived as a background of unacceptable

variations of availability and quality of care, duplication of equipment and failure to meet standards. Carrying out a population audit, a 'critical mass' of 500,000 patients was calculated as being needed to sustain an IRVS, this equated to 6 IRVSs across Scotland, with the configuration of those regions below the necessary clinical population yet to be decided. The MCN aim was: '*not about creating additional structures or committees, but [is] about working differently and getting things done*' (p.24). It can therefore be understood both as a bureaucratic organisational form and also an active organising entity.

Although the Review did recognise that introducing this new model would present new challenges to cultures and attitudes, on the whole these issues appeared to be downplayed. Of the issues it did raise, these included: a requirement for a degree of flexibility and developmental change amongst the senior workforce, as they would be expected to become more mobile as they worked across different sites; the need for new electronic information systems to back-up remote consultations; staff would be allied not only to an MCN (potentially more than one) but also their employer NHS governance system (such as the HB or Trust), the mechanics of how this would work would need to be resolved; new protocols would need to be developed for service delivery by whom and where; and strategic planners need to define and manage regional and national networks for some specialist services. But once again the Review ends with a predictive policy positioning of the MCN as key to HB planning and Trust implementation.

MEL (1999) 10

As a result of the Acute Services Review recommendations, a formal Management Executive Letter (MEL) was issued titled '*Introduction of Managed Clinical Networks within the NHS in Scotland*' outlining in detail the concept of the MCN. Whilst re-iterating much of the Acute Services Review report, the MEL moved extended the initial reports scope by tackling the particular organisational problems which would emerge as a result of cross-boundary working and further outlining the core principles to be adhered to by any MCN.

The main organisational issues identified were concerned with clinical governance, accountability and employment performance standards. To ensure a line of

accountability, MCNs were to be formally approved by any relevant HBs and Trusts through the local Health Improvement Plans; members of the MCNs were to remain under the clinical governance auspices of their respective Boards and Trusts; and performance standards would continue to be managed through normal employment contracts. In essence the MCN was to be an organisation that was to be ‘virtual’, allowing cross boundary working without the need for major structural re-design.

The MCN concept was further formed around certain key principles, aligned to the policy ethos of *Designed to Care* and the *Acute Services Review* outlined in Table 2.1. The MEL therefore outlined an organisation that had no clear governance responsibility or accountability power over its members and yet was also, tasked with creating standards, encouraging and devising evidence based practice, and educating and training those in the network. The activities to be undertaken by a MCN were left vague, allowing localised and professional responsiveness to the object of focus (whether this is a clinical condition, service or speciality). However, there was also a clear bureaucratic element with requirement for annual reports, audits of activity, information policies, and evidence of value for money. It seemed from the outset the policy was asking for the MCN to undertake more traditionally understood organisational functions, whilst at the same time tackling more clinically based service issues. This focus on both practice and managerial activity is central to the day-to-day functioning of MCNs.

HDL (2002) 69

In September 2002, a new Health Department Letter (HDL) was issued under the title ‘*Promoting the Development of Managed Clinical Networks in NHSScotland*’. The document’s aim was to reiterate the Executive’s commitment to the MCN as a concept, viewed as it was as a flexible and adaptable organisational form; arguably evidenced in the array of clinical policy documents which had utilised the model as a strategic way forwardⁱ. As if to underline the model’s increased policy profile, MCNs for Diabetes and Coronary Heart Disease (CHD)/Stroke were made mandatory for each HB area and were in the process of being established for these health priorities, cancer services having already gone some way to re-organising itself in this way. However, the HDL noted that although there was an increased activity in this form of

Table 2.1: Core Principles adapted from MEL (1999) 10

Core Principle	Action/Requirement
Network Management	Identified person with overall network responsibility, potentially a Clinical Lead, Clinical Manager and other. Production of a freely, available annual report for HB and public
Structure	Identifying the points at which the service is to be delivered and the connections between them
Clinical and service improvements	Clear statement outlining what patients can expect
Evidence Base	Documented use of available evidence-base (e.g. SIGN) and commitment to evidence-base expansion through R&D
Membership	Multi-disciplinary, multi-professional and patient representation
Information	Clear policy on information dissemination to patients and nature of that information. Highlighting special role of primary care in leading patient through system
Collective agreement	Professionals must indicate willingness to practice in accordance to evidence base and principles governing Network
Quality Assurance	Programme acceptable to the Clinical Standards Board for ensuring consistency of standards and quality of treatment across all MCNs
Education/training	To facilitate exchanges between those working in different sectors. Develop affiliations with universities, Colleges and the Scottish Council for Postgraduate Medical and Dental Education (SCPMDE)
Audit	All members produce audit data to required standards and participate in open review
Continuous Professional Development (CPD)	Include arrangements to circulate staff which could improve patient access and enable maintenance of professional skills. A programme of CPD for every member and a mechanism to ensure the programme is followed,
Value for Money	Evidence that the Network is generating better value for money

organising and there was much information, generic lessons were difficult to capture so the document went on to try and collate some of these findings.

Starting internally at the *core* the HDL stressed the importance of a small key team of people who would be initially involved in driving the MCN forward: the Network Manager and Clinical Lead. The Clinical Lead needed to have a range of skills: clinical background, managerial experience and project management skills. However, funding available for the time intensive start-up stage was limited and was to mainly fund the post of Network Manager. The HDL stressed that over time the Network Manager was likely to become a generic resource shared over multiple MCNs. For non-core team members, workforce planning had to be considered. It would be necessary to consider the implications of cross-boundary working in terms of training needs, skills mix and changes to contracts, whilst being mindful of the imminent European Working Time regulations (maximum hours that an employee can work) and the New Deal for Junior Doctors. Cross boundary working would not only require new ways of contractually managing employment but more fundamentally would also require new ways of thinking about work.

MCNs were typologically distinguished by geographic coverage: local, within one HB area; regional, across HB areas; and national, where the service or disease was so rare or specialised the clinical population justified a nationally provided service. Responding to the differing population and clinical needs of patient groups was seen as central to deciding the structural-geographic design of the MCN. However, the policy also suggested that what had begun as a health oriented model, might have utility beyond the bounds of the NHS, especially when considering meeting the holistic needs of patient populations with chronic conditions (e.g. learning disability, dementia, mental health). The cross-boundary, integrated working ethos was suggested as potentially having a place across not only profession and service but also sector.

In the period since the publication of the policy document MEL (1999) 10, other concepts were identified as in need of specific consideration and inclusion in MCN thinking. They included: greater recruitment and involvement of patients within

MCNs; introduction of MCN quality assurance programmes; design and agreement of clinical governance; greater linkage and consideration of wider service planning; greater inclusion of social care partners; a heightened focus on information and technology evolution and provision; agreement on workforce arrangements and evaluation; and consideration and location of funding sources.

Public and patient involvement in healthcare planning and delivery was increasingly salient as the agenda of self-care gained political prominence. *Patient-centeredness* (the notion that health services would design themselves around the needs and system journey of the patient) was a key concept in local and national strategy. Patients became highlighted as central to the development and monitoring process of the MCN, involved in all stages of MCN creation and maintenance. Their involvement required specific mechanisms to be created within each MCN to enable patients to fully participate in MCN activity.

The over-arching metaphorical view was of a holistic healthcare system working in harmony with all of its constituent parts. The MCN become an integral part of the local health plan. MCNs were not to become disconnected or isolated in their development and had to provide opportunities for strategic link-up with the HB. It was imagined that the MCN would be centrally involved in the development and oversight of any local planning dealing with their particular condition or service. Defined as a group of clinical experts, the MCN was embedded within the umbrella of pre-existing managerial and accountability structures. Funding arrangements were related to MCNs geographic coverage. For local networks, the local organisation (i.e. the HB or Trust) would retain responsibility for funding, accounting and support cost. Regionally, financial operations would be in line with that proposed in the regional planning policy. Nationally, a small amount of funding had been made available via the National Services Division (NSD) for the additional administrative co-ordination costs. In creating these financial and managerial linkages, a move was made towards creating MCNs as systems with externally monitored governance frameworks.

This desire for accountability was further extended by the Clinical Standards Board for Scotland (CSBS), an organisation tasked with ensuring quality in services. They had devised a Quality Assurance protocol which each MCN would use to devise its

own set of standards against which they had to measure their performance, reviewed on a 3 year cycle. Drawing on experience in the pilot Dumfries and Galloway CHD, any clinically untoward event occurring in services provided by the MCN was to be recorded as a critical incident by the Clinical Lead and forwarded to the Clinical Governance Committees of any relevant bodies (e.g. professional, institutional).

With boundary crossing integral to the aims of MCNs, Information Technology (IT) was seen as of central concern. Integrated clinical information systems were perceived as providing: accurate and timely information; connecting patients with their carers; promoting professional education and clinical guideline implementation; and facilitating patient tracking for audit purposes. As the patient moved through the system, so should all relevant information regarding their clinical presentation. Governance issues over sharing and storage of information would need to be tackled.

From this, the MCN policy is seen to have moved on from stating its core principles into evaluating lessons learnt. Accountability, governance and integration with existing managerial and financial structures are now central concerns as the MCN as an organisational form is encouraged to embed within mainstream health, creating increasingly formalised external linkages.

HDL (2007) 21

In *Delivering for Health* there was a note that the MCN model would have to be reviewed in light of the increasing policy emphasis on locally provided, integrated care serving a changing demographic (i.e. an ageing population), with the '*balance of care*' being moved from acute settings to community based care. The HDL (2007) 21 document thus strongly focuses on stakeholders' inclusion, relationships and the external connections made across service settings.

Considering the core principles some notable amendments were made. The overarching discourse of *whole systems* was now transferred into the structuring of service delivery. Services were based on *mapping the journey of care*, the tracking and subsequent re-engineering (McNulty, 2002) of patients' pathways. MCNs were now expected to be involved in this core activity and to specify how they linked into planning bodies' attempts in achieving this form of structural account. This more

active engagement with strategy and planning was to be outlined within an annual work plan, setting out the responsibilities for service delivery, service improvement and where possible quantified benefits for service users and their families. MCNs were now tasked with different knowledge concerns, instead of being committed to extending the evidence base in a broad sense, a move towards improving services through locally relevant audit and research was linked to the development of planning and change activity. MCNs were to be central to providing an action-oriented expertise for their localised populations, *practice* became therefore, more broadly defined. Practice no longer just referred to the traditional micro practitioner-patient interactions, but instead widened to include macro level inter-service linkages and service planning (practitioner-population).

However, along with this strong emphasis on service planning and delivery, there was still an expectation of managerial activities to be undertaken by the MCN, such as annual reports, governance structures, accountability chains and the creation of processes to meaningfully recruit and involve service users. These organisational and managerial elements formally required the MCN to interact with governing bodies, created an array of responsibilities and activities to be undertaken by MCN members. There was a tension in focus, between practice and managerial activity. This increase in responsibilities and roles will later be shown to have real resource implications for MCN members. The HDL goes on to introduce another layer of organisational complexity: the '*Managed Care Network*'.

Following on from the idea of cross-sector working in HDL (2002) 69 and in line with the general policy emphasis on partnership working, the new term Managed Care Network was introduced. Reflecting the move away from a purely clinical focus to include the aims and objectives of other sectors, such as Local Authorities, Education and the Voluntary Sector, the name allowed an acknowledgement of not only strictly medical concerns but social implications as well. To enable joint working, new tools would be required to bridge differences in systems, governance and organisational culture: performance measurement focussing on key outcomes and improvement targets via *Joint Performance Information and Assessment Framework* (JPIAF); *Single Shared Assessments* for incorporating common data standards and information-sharing; *National Training Framework for Care Management*, ensuring professionals

understood their roles and responsibilities, providing service users/patients with *‘the right inputs from the right professionals at the right time’* (p.2). Performance and shared governance requiring an ever increasing tool-kit of managerial products with which MCN members were to familiarise themselves enabling a *‘whole systems’* approach.

Closer working relationships with bodies external to the MCN were also required. Firstly the Community Health Partnerships (CHPs), accountable for the planning and delivery of all primary and community based services and for the integration of primary and secondary services in their area. Secondly, the Health Board (HB) with overall responsibility for the health and health service of its geographic population. Considering CHPs first, it was noted, whereas MCNs may focus on condition specific provision within a community, for the CHP the focus is on the community as a whole. Within any HB area, the MCN may have to engage and manage relationships with more than one CHP, each with localised priorities and strategies of operation.

With regard to the HB, the possibility of MCNs negotiating responsibility for specific service delivery and quality improvement was proposed. In order to focus on delineated pieces of work, such as referral pathways, treatment protocols, clinical audit and provision of information for service users and carers MCNs may have to become increasingly embedded within existing HB structures. This would involve tighter structural and reporting ties to ensure accountability and governance checks, with MCN being aligned, for example, being managed by a HB Division. It is worth highlighting, that these types of structural change have the potential of creating a reversion to traditional lines of managerial accountability, as HB requested activities are likely to be associated with greater monitoring of MCN work flow.

Internally, an emphasis on the roles and responsibilities of key MCN figures was developing. The Lead Clinician was seen as the key figure. They would span boundaries (professional, service and sectorial) and have specific skills and managerial style which would facilitate this type of working. Although it was stated that this individual was not necessarily a doctor, clinical authority and collegial respect was a necessity; the collective had to follow a leader who had little formal power to lead. Demeanour was fundamentally important, with a democratic,

consensual leadership style required. The individual needed to be able to negotiate in an unbiased way all views. The ethos of impartiality and being independent of sides was seen as fundamental to promoting a collective atmosphere of trust and collaboration. Alternatively, the 'Network Manager' was to ensure functional effectiveness and that tangible progress was made in '*developing equitable, high quality, clinically effective services*' p.5. Their role was viewed as especially important once the MCN had moved past the developmental bedding-in stage. As a resource they could be shared across MCNs, for example updating websites and further developing the MCN's Patient Focus and Public Involvement (PFPI), enhancing a cross-MCN view and information flow. Together this core team were to manage the bureaucratic requirements of a formal organisation whilst also encouraging the membership to undertake clinical and care activities without any structural power to do so.

Overall, the MCN was conceptualised as being central to public service reform, reform which took a holistic view of health. Bound up with principles of personalised/user focus, quality and innovation, efficiency and productivity, integration, and accountability, the MCN was seen as reflecting an increasing emphasis on multi-agency collaborations to deliver complex needs and raising public expectations. The HDL stated that '*whole system*' change (across service and sector) was unlikely to be achieved by tweaking at the traditional institutional hierarchies but alternatively MCNs could be used as '*planning fora*' for their relevant disease or topic by fully integrating them into local, regional and national planning structures. However, the increasing level of system complexity which the MCN model had to tackle was not without implication. The MCN concept was increasingly mirroring those health service policies and strategies articulated in the wider Scottish health service policy arena in a micro-arena.

2.5 CLINICAL NETWORKS BEYOND SCOTLAND

Whilst MCNs are specifically a Scottish policy construction, clinical networks based on similar principles and purposes have emerged in NHS England, for example the Calman-Hine Report (1995). However, more specifically the MCN definition as outlined in the Scottish MEL and HDLs have made their way across the border

reported via professional journals (Edwards, 2003; Thomas, 2005) being re-defined by practitioners to take account of their national healthcare policy context (Addicott and Ferlie, 2007; Spencer and Cropper, 2004). Later, I will introduce some research undertaken in English MCNs, therefore at this point, it is worth noting some of the differences in healthcare context which may go some way to illuminating why MCNs have remained relatively undefined in English policy.

The English policy agenda is centred round competition and performance targets. This is based on the assumption that quality, effectiveness and efficiency will be improved within a pseudo-market context and that there should be measurable targets, such as waiting times which can be used as a proxy for service quality measurement. For example, this can be illustrated in a simple example based around the policy emphasis on patient choice, the idea that patients should be able to choose between different healthcare providers. The stated aim is to improve access to services and to improve quality by providing competition. This aim has been made operational through the utilisation of a *Choose and Book* system, whereby the patient uses a drop-down menu to choose when, where and by whom they will be seen, that is which hospital they will be referred to. Choose and Book is an example of policy which has been designed to create direct competition between alternative providers (i.e. hospitals) to attract patients to their services.

From this observation a fundamental difference can be seen between the Scottish and English systems. In Scotland the policy move has been towards co-operation, shared resource and softening of organisational and professional silos. Amidst this policy agenda the conceptualisation of the MCN stressing inter-linkages would appear to fit well. However, in England where the main policy emphasis is to encourage provider competition for access and flow of resources, it would seem unlikely that MCNs would be as readily adoptable.

So, although clinical networks have emerged they have not achieved the same level of policy prominence that MCNs have in Scotland. Whilst Scottish policy definitions have been mobilised by practitioners to justify their local networking activities, the motivating factors for inception and the context (financial, organisational and political) in which clinical networks operate have significant differences.

2.6 CONCLUSION

MCNs were viewed as an organisational form which could tackle many of the institutional blockages created around *place* of medical care delivery (for example, around hospital or HB boundaries); *transfer of patients* (for example, between community and hospital or between HBs) and *professional silos* (that is, little evidence of cross discipline or speciality work). Within Scotland, MCNs were viewed as a formalised method of combating some of the typical organisational problems associated with the traditional healthcare structures (e.g. referrals being lost between services and sectors; duplication of effort; multiple practitioners involved in one patient with little cross communication; fragmentation of care and confusion for the patient).

As policy articulation and focus has evolved so too has the expectation and demand on this organisational form. The MCN has evolved from the rather simple idea of formalising pre-existing clinical relationships, into a sophisticated worked-up vision of an organisational body with clear lines of accountability, governance and outcome. As Scottish healthcare policy moved from models of competition to collaboration the MCN emphasis on collegiate working fitted well with this ethos. Policy thus encouraged the use of the MCN model as part of the strategic move towards flattened hierarchies, reduced bureaucratic layers, and services built around the patient.

The MCN model was an attempt to create formal networks around clinical conditions, service specialities, clinical specialities and across service sectors as opposed to traditional organisational structures (e.g. primary/secondary/tertiary, professional and disciplinary, and buildings). MCNs became an organisational answer with which to deal with service fragmentation as the language of *whole systems* took hold, MCNs were hoped to be developed as a vehicle to establish the necessary multi-organisational linkages.

The MCN model has developed within a changing healthcare policy context, being shaped by and helping to shape many of the Scottish healthcare debates. For example, the increased emphasis on personal healthcare responsibility has been stressed through MCN patient and public involvement, focus on longer-term

conditions and patient demography change has been represented by local and regional MCNs operating for these issues (e.g. dementia, learning disability, mental health, CHD/Stroke), and the emphasis on primary care is reflected in the MCNs mandate to develop CHP linkages.

What the MCN model has been required to undertake by policy, has meant that in many ways there has been an overly high expectation of what one organisational form can achieve. The list of tasks to be undertaken by MCNs includes both bureaucratic and practice activities: the first, to justify and establish wider managerial accreditation; the second, related to the mobilisation of clinical expertise. This arguably over-extended view of what MCNs must functionally undertake is not without resource implications for its members and will later be implicated in how MCN impact has been understood.

An understanding of MCNs' work involves an appreciation of the relevant policy, as certain forms of MCN managerial activity have been mandated. In later chapters, I will consider how these bureaucratically framed activities are related to other forms MCN work. Before reaching this however, I consider how networks generally and MCNs particularly have been understood by other authors.

CHAPTER 3: WHAT DO WE KNOW ABOUT MCNS AND THE WORK THEY DO?

3.1 INTRODUCTION

As shown in the previous chapter, MCNs moved from a peripheral concept to being part of a central policy organisational direction. Faced as they were with changes in population health, life expectancy, technology and workforce planning, NHS planners and those delivering services had to consider novel means to providing services to clinical conditions. MCNs were suggested as means to create novel structures spanning boundaries within Health and other sectorial divides.

The issue became how to successfully translate this policy into practice. Questions around form (what is it?), function (what does it do?) and impact (what has it achieved?) became central for understanding this form of organising. With a remit to evidence ‘*value for money*’, it became imperative that MCNs were able to be defined, located and evaluated and research sought to answer these questions with reference to social and organisational theory on the one hand and empirical and experiential findings on the other.

In this chapter I provide an overview of the current literature on MCNs. I consider: definitions of form which have been drawn from wider network literatures; present factors which have been identified as central for MCN functional success; and identify any reported impact of MCN organising.

3.2 FORM: WHAT IS A MCN?

Attempts to define and categorise MCNs have often been founded on simple structural definitions.

linked groups of health professionals and organisations from primary, secondary and tertiary care, working in a co-ordinated manner, unconstrained by existing professional and Health Board boundaries, to ensure equitable provision of high quality clinically effective services throughout Scotland. (MEL (1999) 10)

In addition to the above MEL 1999(10) definition, the most commonly used working definition of MCNs is from Baker and Lorimer (2000). They state:

Linked groups of health professionals and organisations working in a coordinated way that is not constrained by existing organisational or professional boundaries to ensure equitable provision of high quality clinical care [Baker and Lorimer, 2000:321]

In both definitions groups of professionals and organisations are to be linked to other professionals and organisations. Although, it is not clear from the above what the content of the inter-group transaction will be, informational, resource or capability, the outcome of these new linkages is to be the provision of high quality care. There is no mention of how this will occur. There appears an implicit assumption that by changing structure, effort will be co-ordinated and institutional or disciplinary constraints will be removed.

This structural definition of MCNs resonates with the theoretical descriptions of Structural Network Analysis (SNA). In SNA a *network* is understood as: *ties* linking different *nodes*. A node can be used to represent a person, place or organisation. SNA models a network by mapping each component node with its corresponding ties to create a visual representation of the underlying structure of the network (Scott, 1991; Wasserman and Faust, 1994).

In so much as SNA is centrally concerned with visual mapping of structure, it is limited in what it can say about social meaning or function within a network. Similarly MCN definitions of professional groups (nodes) linked (tied) to other professional groups (nodes) struggles to move beyond the merely descriptive. Whilst this may prove unproblematic in SNA research as it is not an analytical aim, for MCN literatures it creates difficulties in so much as the theoretical description is over-inclusive i.e. it describes any network or any social relationship. Further, it means MCNs cannot be distinguished from any other form of multi-service network (Hudson, 2007).

SNA theory is concerned with the *centrality* of a node (a node has greater centrality the more ties that node has to other nodes in the network), the *density* of ties (number of potential ties between members/nodes compared actual ties), *cliques* (high density groups), *structural holes*

(sparsely tied gaps between cliques), and *brokerage* (individuals can exploit structural holes to move between cliques forming relationships and controlling the passage of information).

Brokerage is reminiscent of the MCN role of *boundary spanner* (Goodwin *et al*, 2003; Hamilton *et al*, 2005) or healthcare networks *animateur* (Cropper *et al*, 2002; Ferlie and Pettigrew, 1996). This is an individual who moves beyond their normal group to create links across the boundary demarcations between different discipline, service or sector silos. That is, brokerage across structural holes. This individual, often the Clinical Lead, is argued as imperative to the MCNs overall success with Baker (2002:5) stating:

To be effective in managing clinical issues and clinicians, it is clear that MCNs will need some direct clinician involvement in management. It could be argued that MCNs have been misnamed and should be called CMNs –clinically managed networks

The MCN definition however, moves beyond the purely structural SNA account, as a nexus of linkages between sparsely linked groupings, describing the necessary interpersonal skills and roles of the boundary spanner. The boundary spanner acts as the spearhead to draw in members to the group, relying on *soft coercion*, they appeal to shared professional values in order to engage colleagues in quality improvement (Sheaff *et al*, 2003).

Tasked with directing the group via collegiate respect as opposed to traditional managerial influence (i.e. contracts), leadership style is described as inclusive, facilitative and consensual (Goodwin *et al*, 2003) or flexible, egalitarian and based on persuasion, enthusiasm and example (Guthrie *et al*, 2003). The boundary spanner is both pivotal in establishing the new MCN linkages and in encouraging ongoing development and participation. The boundary spanner needs a specific mix of professional, social and psychological parameters to be successful the extent to which this is possible is not discussed.

Complexity as classificatory

Whilst providing some sense of the structural composition of MCNs, as noted by Hudson (2007) in and of itself there is little in the above to identify that which makes MCNs different from any other form of collaborative (or networked) form of organising. He suggests moving beyond the basic acceptance that all networks are intrinsically defined in their creation of

linkages across structures, specifically in the case of MCNs, these will be linkages which may be new and have previously been difficult to organisationally justify the formation of. Instead Hudson suggests utilising the degree of complexity intrinsic within a network as a taxonomic account of MCNs.

Starting at the most simple level, the integrated care pathway, a structured means of developing and implementing local care protocols based on evidence based clinical guidelines the network is formed around a single condition. He increases complexity by considering Managed Clinical Networks which operate solely within the healthcare context, whilst allowing for work to occur across traditional professional and service boundaries. Finally, the Managed Care Network is considered the highest degree of complexity. For him, the Managed Care Network, whilst having a similar operational focus as the Managed Clinical Networks, involves more socially complex conditions resulting in working relationships with a broad range of partners operating out with health. Hudson argues that what *'this escalation builds up to is a concern with not so much a single condition or even the 'whole patient' but in fact the 'whole person'* [2007:4].

Whilst it could be argued that the integrated care pathway is more akin to a planning and service re-configuration tool, used as it commonly is to track patients along a service journey helping to identify linkages which need to be created or strengthened, the emphasis on increasing complexity within the MCN model may be a useful one. Hudson's assumption appears to be that if there is institutional differentiation between cliques at a macro level, this will impact on the complexity of the issues and challenges faced within the network. The Managed Clinical Network whilst having potentially as many nodes (professional and service) and connections between nodes, is still a simpler configuration due to operating solely within health, with the sectorial divide arguably creating inherent additional complexity.

Lateralality

Lateral organization capability, in that different functions are coordinated without communicating through the hierarchy. People in different functions communicate directly with each other, rather than through their respective managers. [Galbraith 1994:5]

Table 3.1: Adapted from Guthrie *et al* (2003): A typology of networks and authority within networks

A typology of networks	Forms of authority within networks
Individualistic – individual or organisation develop an association of affiliates to achieve a certain task, with relationship determined by contracts	Contract – contribution derives from the terms of the exchange between parties. Its strength lies in the predetermined life of the contract, the motivation to perform up to expectations and the expectation that planning assumptions will be acted on. Its weakness is behaviour that is reduced to the common denominator and the difficulty of changing circumstances and effecting alternatives without due cost.
Hierarchical – a defined organisational core (e.g. management and advisory groups) with authority to regulate the work of its members	Command - the law of sovereign body is delivered through a succession of superior and subordinate authority. Command lies in the effectiveness of control and accountability. Weaknesses are related to rigidity and conservatism in the face of changing environments.
Enclave – flat structure, close-knit group with high level of social cohesion and equality among members with high levels of trust and commitment	Communion/Collegial – an appeal to common values and creeds. Legitimacy for actions lies in consistency with the understandings, protocols and guiding values of shared frame of reference. Its strength lies in guidelines afforded by its shared values through different environment. Weakness lies in its insularity and inability to adapt.

The horizontal operation of MCNs is also regularly highlighted as a defining characteristic (Wall and Boggust, 2003; Brooks and Greenley, 2006). This lateral structure is echoed in Goodwin *et al*'s (2003) classification of generic networks. Drawing on Durkhemian typology

they identify a two by two matrix which describes 3 network forms referred to as *individualistic*, *enclave* and *hierarchical*. The fourth category (*isolate*) refers to an individual placed between networks and not embedded within any particular network and therefore is not relevant when considering networks.

Guthrie *et al* (2003) mapped these three network forms onto associated types of authority (Table 3.1). From this it appears the ideology of the MCN as an organising form with equitable status, authority and power (collegiality) amongst group members appears to concur with Goodwin *et al's* (2003) structural account of the *enclave*, a highly cohesive group with no obvious governing core controlling decisions and actions. MCNs would be contrasted to common *hierarchical* (vertical) healthcare structures, where modes of accountability and control are related to command managerial styles. However, in their evaluation of a Tayside Diabetes MCN Guthrie *et al* (2003) found a more complicated blend than these 'ideal types' would suggest. Whilst quality improvement and service change were seen as a function of the professional enclave and authority was generally collegiate in composition, the MCN was also found to be hierarchical in relation to other healthcare accountability structures and overall governance.

Structural description is central to definitions of MCN form. MCN form can be thought of as linkages between different groups across traditional barriers, which create flatter organisations led by individual/s that can move between disparate groupings allowing new structural configurations to emerge; the complexity of which increases as these linkages are created across macro-institutional boundaries. In a later chapter, I will return to ask whether structure is the only means by which to consider the question *what is an MCN?*

3.3 FUNCTION: WHAT ARE MCNS FOR?

Turning to function, the question is now asked is *what are MCNs for?* What are practitioners and managers trying to achieve in crossing boundaries and creating linkages? Additionally why, if as Hudson (2007) suggests, moving across sector boundaries increases organisational complexity, would policy encourage the establishment of Managed Care Networks? Baker (2006) puts it thus:

The idea that a single hospital can provide all the facilities necessary for its catchment area is no longer tenable.

The implication appears to be that as there have been changes in healthcare demand, traditional models of care centred on acute services are no longer feasible. Whether the reason for this lack of tenability is financial, resource, skills or population led is unclear, although all seem likely to be involved.

Drivers for healthcare change

A classic example illustrating this systemic mix would come from the policy on the treatment and care of Type II Diabetes, a condition which has in recent years seen rapid increases in clinical numbers (for the period January 1998-June 2005 a 67% increase in Type II diabetes Guthrie *et al*, 2003: 16). This has resulted in much of the long-term care needs of people with diabetes being transferred into a primary care and GP setting. For Type II Diabetes, the sheer volume of patient numbers and chronic (long-term) nature of the condition has resulted in the acute service being unable to cope with added demand.

This increased reliance on primary care may be due in part to a *diseconomy of scale*, where beyond a certain level of output organisational systems demonstrate lower productivity and an increase in average cost (Acute Service Review, 1998; Posnett, 1999). However, it is unlikely that the decision to re-configure services has been founded purely on cost. That is, changes in population lifestyle have increased the clinical presentation of diabetes this in turn creating the need to re-design delivery to deal with an increase in real numbers.

These changes occur against a backdrop of increasing demand for sub-specialisation and expertise for clinical conditions, especially those requiring high technical ability. The argument is that increased volume of activity (clinical contact time or *experience*) improves clinical outcome. Whilst the definitive relationship between volume of activity and clinical outcome is perhaps contested (Acute Services Review, 1998; NHS Centre for Reviews and Dissemination, 1997), the general move in clinical practice and education has been to move towards greater degrees of specialisation. This has resulted in a smaller pool of professionals who can provide certain forms of treatment. Added to this the '*tyranny of distance*' (Acute Services Review, 1998:17) created by the geographical and population spread across Scotland, this has meant that practitioners, managers and policy makers have

needed to consider novel ways of sharing expertise over partner hospitals and HBs to ensure equitable access to and provision of care.

Against this backdrop, MCNs can be seen as a structural response to these population, geography and resource issues. MCNs could allow for the creation of novel structural linkages which would allow local solutions designed and driven by local practitioners and managers. MCNs have been mobilised for a diversity of healthcare challenges, such as high volume (diabetes) or low volume clinical conditions (home parenteral nutritional); conditions highly focussed on social (addictions) or techno-medical (cleft-lip and palate) interventions; or groups centred on specialism (neurology) or discipline (endocrinology). MCNs are a structure which can function around the specific, ground-level concerns of the MCN members.

Managed clinical networks (MCNs) offer a new and potentially revitalising way of considering and delivering clinical services within the NHS. If they are widely adopted, there is likely to be a quiet revolution in healthcare that will result in patients and clinicians acting as the main drivers for change and the principal arbiters on how finite resources are used in local healthcare systems. In the recent past, there have been wholesale changes within the NHS. To ordinary clinicians these changes have sometimes appeared arbitrary; often, reorganisation has seemed to be for its own sake or for the sake of political dogma.

[Baker, 2002: 2]

This emphasis on practitioner led organising is seen as a potential strength of MCN, local knowledge creating local solutions (Livingston and Woods, 2003). In some ways the counterpoint of more typically managerial perspectives which put the stress on administrative direction and financial accountability, MCNs are instead viewed as a collective of local experts unravelling those issues salient within the local context they work in. The assumption is that local agents are knowledgeable about the organisational systems they operate within and thus embedded within tacit systemic knowledge, they can access local resources and information to create solutions that are better suited to their particular circumstances.

The degree to which this is an accurate assumption is not clear. Addicott and Ferlie (2007) describe their research in 5 cancer clinical networks operating in London. Concerned with the

degree to which MCNs act as counter-point to managerialist power relations, they argue that a model of *bounded pluralism* can be used to understand negotiations within the cancer networks. Although power is seen as being held in the hands of dominant medical groups, these medical groups are not homogeneous. They operate with different agendas and therefore did not appear to be interested in achieving consensus and collaboration but instead overall dominance within the cancer network.

They suggest that Dahl's (1958, 1961, 1986) traditional sociological model of pluralism is not supported with its assumption that action and response is primarily based on consensus. Nor do they find full support for the extended *plural-elite* model (Hazan, 2001), as once again it stresses that elite groups (e.g. doctors) work towards consensus. This model also proposes that elites will maintain their relatively autonomous status, but Addicott and Ferlie found evidence of coalitions between disparate groups in an attempt to take control of decision-making.

Further they argue that unlike the New Labour rhetoric which stresses bottom-up, shared decision-making, the cancer networks is instead heavily dominated by top-down policy controls. The example of externally-driven policy focussing on the centralisation of cancer services was found to have resonance with structural theories of power, concerned as this theory is with agenda setting. Additionally externally imposed governance and audit drivers were seen as being damaging to long-standing clinical relationships.

It is worth noting that there may be some discrepancy with what Addicott and Ferlie term managed clinical networks when compared with those which operating in Scotland. As discussed in the previous chapter there is no comparable policy related to MCNs in England, albeit there is policy on cancer and diabetes networks. Also all of their research case sites are structured as hub-and-spoke models, which is only one of the potential configurations of the MCN model. However, their work does suggest that any assumption that decision-making power is simply handed over to localised MCN members or that MCN members simply act benignly to achieve consensus is somewhat questionable.

Silos and tribes

Hunter (1996) proposed that healthcare professionals tend to become highly cohesive within their disciplinary bounds, becoming what he refers to as tribes (1996). Tribes may exist for

nursing, medicine or within the allied health professions. The inward thinking tendency of these groups, that is to be primarily concerned with their own particular disciplinary interests and needs, has led to statements that healthcare practitioners operate in silos (Baker and Wright, 2006) and the challenge for managers is how to direct these strongly tied groups to work beyond their professional bounds and self-interests. Having too localised a focus is also not viewed favourably. In terms of wider corporate loyalty, loyalty to the individual's profession can be seen to come before considerations of the employing organisation (Hunter, 1996) and is viewed as counterproductive for improvements in healthcare quality.

Professionals tend to show allegiances to professional groups and departmental groupings such as their ward rather than to their hospital or its management. Poor interactions between such groups are currently spoken of as evidence of the 'silo culture' of the NHS that may be a feature of clinical micro-systems in a dysfunctional macro-system. [Baker and Wright, 2006:561]

MCNs with their emphasis on multi-disciplinarity are one way of widening the network of inter and intra-professional relationships. MCNs also encourage a more organisationally systemic view moving concerns beyond the traditional boundaries of a local hospital or HB. As the boundary spanner creates new linkages, these new nodal relationships are arguably breaking down and re-drawing the structural demarcations of group membership and affiliation.

Why this would be beneficial appears to rest on an assumption that MCNs are arenas for knowledge management and organisational learning. In aiming to bring together disparate groups, it is suggested that this will nurture *shared best practice* moving across the traditional boundaries of service and profession which would have hindered this sort of interaction previously (Lugon, 2003; Goodwin (2003). In doing so, the MCN becomes *per se* a forum which breaks down professional knowledge silos.

Addicott, McGivern and Ferlie (2006) found that for their 5 cancer case sites, only 1 had begun to develop an education and training strategy. Even within this site however the training element was still uni-professional, in that it occurred solely within Nursing. Whilst the other 4 sites had in fact been in operation significantly longer, for these sites it appeared

that focussing on structural issues of service configuration and key national targets for waiting times were their priority. From this work anyway it does appear that education and training were not holistically central to MCN operations and strategy. However, it may be that informal modes of learning may be taking place by virtue of simply being in contact with those from other disciplines and professions.

Whilst this may be the reality of how learning and information sharing occurs, it is still unclear as to how collaborative approaches can actually be achieved. Indeed much of the commentary from practitioners and managers who have attempted cross boundary working has tended to focus on the significant difficulties in this way of organising. MCNs with lateral structures are, for example, at odds with the traditional lines of accountability and reporting creating administrative issues (Highley, 2004; Spencer and Cropper, 2004). Being inherently multi-disciplinary MCNs require a degree of coherence amongst members to agree goals, which is not often easy to achieve (Hamilton *et al*, 2005; Smith, 2003). In fact as Klijn (2007:268) notes on networks generally, as networks are drawn from members of disparate groups they are not guided by uniform, shared goals thus much of the decision and co-operation process is '*goal seeking rather than goal setting*'. In addition, specific information technology is often required to ensure communication and information sharing can occur between partners (Burnett *et al*, 2005). All of which means MCN can take a amount of time to '*bed-in*' or establish themselves (Hamilton *et al*, 2005). Added to the emphasis on the skills and credibility of the MCN Lead (Spencer and Cropper, 2004) which, in turn, creates issues for succession and sustainability should this pivotal individual move on (Guthrie *et al*, 2003).

This provides caution for accepting the early optimism around MCNs. It may be that primary function of the MCN to break down boundaries is not that straightforward to achieve. It does not seem that education and training have been centrally positioned in cancer network operations, and further it appears that if the strategies are enacted they are at best, only partially realised. It does not follow that in adopting this unorthodox working method anything will be added other than re-configuration of structural arrangements. As Bate (2000) warns networks have the potential to be fads, with no evidence that they might work any better than a well-managed hierarchy. Indeed if as Guthrie *et al* (2003) suggest professional enclaves are likely to risk being inward looking, having as they do historically less established relationships with managers and patients, it may be that instead of combating

silo working, MCNs simply replace one form of silo for another. If this is the case, it becomes important to consider what is the actual function of MCNs?

Function

Much of the MCN literature appears to be underpinned by the implicit question of how to make a MCN function better. However, this does seem to skip over the more fundamental question as to what *function* refers to. In asking how to make something function better, there seems to be an implicit assumption that MCNs have a desirable function. However what this desirable function may be does not appear to be clear. At present this seems to have been implicitly answered by stating that working across boundaries is simply a good thing. And yet on closer inspection, this method of organising seems to have consistently resulted in the creation of new, yet nevertheless, significant additional difficulties for professionals and organisations.

3.4 IMPACT: WHAT HAVE MCNS ACHIEVED?

A final question remains outstanding, what have MCNs been shown to add? If MCNs can be seen to have achieved significant impact to healthcare delivery and design, it may be that questions of structure and function become somewhat secondary. If the MCN form can empirically evidence the value pay-off for the effort and time necessary to create a functioning group, the above concerns whilst remaining theoretically interesting are perhaps not for practitioners saliently so.

Context and method

This question quickly runs into difficulties which are methodological, highlighting the inherent problem of evaluating change within a complex context. The issue is this. Whilst it is theoretically justifiable to construct (reify) the MCN as an organisational '*thing*' which can thus be detached from the organisational context in which it operates, this type of enquiry proves very hard to carry out. For example, if the research focus is MCN related changes in practice over time (i.e. what was practice before the MCN came into being versus what was practice after the MCN came into being?) the challenge becomes how to control for the impact of simultaneous contextual change (e.g. changes in policy, Health Board re-configuration).

Time series data cannot provide strong causal evidence that quality improvement (QI) is due to MCN activity because the qualitative data indicates that there was no neat 'intervention' at a single-time point to test. [Guthrie et al, 2003:14]

Designed around representational assumptions which have a tendency to reify the object, the attempt to measure impact often falls foul of simultaneous changes within organisational horizon. That is, during the period of time that the MCN is existence there will be simultaneous changes to policy, codes of practice, clinical evidence, staffing, all of which work in a dynamic way to impact on change.

Broadly evaluations of impact can become stymied by several related issues: the MCN cannot be removed from its context to be evaluated in isolation; interventions cannot be attributed to the MCN as an organisational object solely; and interventions undertaken by MCNs do not occur at one-time point. Whilst it may be possible to attribute causal changes to a MCN, it is difficult to do this with any certainty. That said, attempts have been made to evaluate localised MCNs in order to try to identify change which can be attributed to particular MCN's operations. In particular MCNS for Diabetes and Coronary Heart Disease have received attention.

Beginning with Tayside Diabetes MCN, founder Prof Andrew Morris described how their network IT system (initially DARTS, now replaced by SCI-DC and rolled out nationally) allows every relevant health professional access to all of a patients test results and scans. Whilst the IT system predates the labelling of the network as a MCN, the MCN has been able to provide baseline data for diabetes care audit which can be used to improve care across the network. As Prof Morris states:

'We are not the diabetes police, but if a practice or clinic is struggling we work with them in a non-judgmental way. A nurse, GP, consultant or network manager would go out and offer advice. It is a safety net for any practices which feel they have particular issues'. (Lewis, 2003:32).

No doubt in practical terms the ability to locate areas where practice can be improved, will help to improve longer term quality and provide support for those practitioners or practices

that are in need of additional resources. This should arguably improve the experience and care of patients. MCN Clinical Lead, Dr Alistair Emslie-Smith goes on to say,

‘And our ability to monitor and audit has demonstrated that we are delivering better care. We can show we are screening more patients for eye disease and at a population level carrying out better routine monitoring of haemoglobin and blood pressure.’ (Lewis, 2003: 33)

It seems that hard clinical measures can be shown to be impacted on by MCN operations or, more accurately, activities undertaken within the work programme of the MCN.

These findings were extended by an evaluation carried out by Guthrie *et al*, 2003 of the same Diabetes MCN. Data was extracted from SCI-DC for the period between January 1998-May 2005 for selected measures of clinical process and outcome for adult Tayside residents aged 16 and over with Type I and Type II diabetes. These measures were of: Glycated Haemoglobin (GHB), Cholesterol, Creatinine and blood pressure and whether retinal examinations had been undertaken. Compared to Scottish and English means, Tayside was performing above average on all measures. It is important to note much of the initial improvements occurred before the MCN was officially labelled as such and was operating as a voluntary clinical network. This suggests that the formal managerial activities required by policy were not necessary to make meaningful clinical change in this HB.

Hamilton *et al*, 2005 evaluated a cardiac MCN in Dumfries and Galloway. Impact was evaluated via the clinical data of 202 patients aged less than 76 years admitted to hospital with a confirmed myocardial infarction (MI) one-year pre and one-year post the establishment of the network. The main outcome measures were quality of care indicators that the MCN was aiming to target through its network protocols. These care indicators related to 13 detailed protocols of related care, which provided 16 clinical indices. Of this only 2 areas showed statistically significant improvement, immediate administration of aspirin in the community and pain to needle time (thrombolysis). MCN operations did not have any significant economic implications.

Guthrie *et al* (2009) carried out a comparative case study of 4 MCNs. They sampled as follows: 1 Diabetes MCN established before policy mandate; 1 Diabetes MCN established

after policy mandate; 1 Coronary Heart Disease MCN established before policy mandate; and 1 Coronary Heart Disease MCN established after policy mandate. Using both qualitative and quantitative data, professional participants strongly attached intangible impacts to the relationship of inter-professional and inter-organisational activity which helped to establish a collaborative professional enclave. Tangible changes were related to changes in professional practice and wider service improvements; however, these were less strongly attributed to MCNs *per se* due to wider contextual practice and policy change.

It seems that whilst MCNs do appear to impact on health service design and delivery it is often a difficult task to wholly attribute these outcomes to the MCN and its activities. Contextual changes in policy both at national and local level create a dynamic environment which changes organisational direction and practice priorities. Those outcomes which can be attributed and measured as being the sole outputs of the MCN are in their turn, often fairly circumscribed. Whilst not denying the possibility that these changes may not occur at all if the MCN were not there to steer change, it cannot take away from the impression that the promise of wholesale change brought on by structural change, has not been realised. It does appear that some clarity around what is achieved by MCN working is still outstanding.

3.5 WHY ORGANISE AS A MCN?

It seems that there are some outstanding issues in attempting to understand - what MCNs are, what are they for and what they have achieved. In light of this ambiguity, another question emerges – *why do practitioners and managers voluntarily organise themselves into MCNs?* What could it be that draws individuals together to work in what appears to be a very time intensive and personnel costly way? Whilst the question of why to organise as a MCN has not been the central question of any piece empirical MCN research, there have been many pieces of work which have considered potential benefits which may be forthcoming from MCN organising (see Table 3.2). It seems feasible to suggest that these benefits (outcome) may act as the motivation for this type of collective organising (input).

The benefits suggested tend to be centralised around improvements to patient care. In breaking down boundaries, services are suggested to become more equitable, more accessible and less likely to suffer from duplication of provision. Concerned with service accountability, MCNs are conceived to be flexible, dynamic and able to lead on evolution and change.

Table 3.2: Suggested benefits of MCNs

MCN Benefits	Reference
<ul style="list-style-type: none"> • Potential for seamless patient care, integrating care across existing professional and healthcare boundaries, making service provision more equitable for patients • Agree care protocols and pathways across the network area • Diversity of professional contributions • Multi-professional and multisite working, preventing duplication of effort and resources • Teamwork and collaboration, flexibility and dynamism, evolution and change 	Brooks and Greenley (2006)
<ul style="list-style-type: none"> • Promoting a focus on patient access to and experience of care • Identifying and sharing scarce existing resources-e.g. specialist medical and clinical practitioners, • Enabling release of, or joint investments for, scarce or costly resources • Reducing barriers to the coordinated provision of services • Providing a means of accounting for service performance across health care organisation 	Cropper, Hopper and Spencer (2002)
<ul style="list-style-type: none"> • Improve access to and quality of service • Seamless care across the primary, secondary and tertiary interface 	Baker and Wright (2006)
<ul style="list-style-type: none"> • Better access to services and more effective services • Improved coordination between services • Consistent advice • Better care and prevention 	Baker and Lorimer (2000)
<ul style="list-style-type: none"> • Potential for seamless patient care; integrated care across existing professional and health-care boundaries; and prevention of duplication of effort and resources with agreed professional care contributions • More equitable service provision for patients • Multiprofessional and multisite working • Teamwork and collaboration, flexibility and dynamism, evolution and change 	Wall and Boggust (2003)
<ul style="list-style-type: none"> • Integration across different sectors ensuring collaboration between different groups • Flexibility in services they offer • Effective utilisation of resources • Foster innovation and new ways of working • Can engage a whole health community in planning and delivery of a service • Can facilitate patient involvement • Pooling of knowledge and resources 	Lugon (2003)
<ul style="list-style-type: none"> • Make more efficient use of staff and reduce professional and organisational boundaries • Share good practice • Put the patient at the centre of care and improve access to care 	Goodwin (2003)
<ul style="list-style-type: none"> • Make better use of scarce resources (expertise) and rationalise the procurement of expensive equipment • Reduce inequalities and improve access to care • Enable the sharing of workload and resources • Enable clinical governance and audit across health care organisations, sustaining high quality local services • Standardise care in accordance with evidence based guidelines • Stimulate innovation • Encourage specialisation, providing opportunities for clinical training and CPD 	Livingston and Woods (2003)

MCNs are argued to nurture shared learning, create adherence to clinical guidance and develop professional competencies and specialisation.

Whilst all of these benefits are desirable for improving the quality of service design and delivery, they are merely potential suggestions of what might occur with organising in this way. Whether these benefits can actually be shown to occur is, of course, another matter. Indeed, in considering impact, it may be that, contrary to what is implied, empirically MCNs are more likely to struggle to evidence benefit. Nor does there appear to be any explanation as to why these benefits should occur by organising in a MCN. There seems to be a simply an assumption that by organising in a multidisciplinary and multiprofessional way, these benefits will be forthcoming. Why or how organising in a multidisciplinary way leads to these positive results, does not seem to be considered.

It seems that whilst we are likely to assume that practitioners and managers perceive benefit in voluntarily organising in this way, otherwise why do it, it is not particularly clear if the proposed benefits actually exist. Nor is it possible to say with any certainty, that these suggested benefits are actually experienced as the benefits of MCNs by MCN members. It may be that what MCN members experience as the benefit of organising in this way, has of yet to be uncovered. In not framing the question, to consider directly why MCN members voluntarily organise in this way, it may be that these benefits or motivators have not as yet emerged.

3.6 CONCLUSION

From the above it can be seen that certain fundamental questions still remain to be more fully explored: what are MCNs, what are MCNs for and what is the impact of MCNs?

Whilst attempts have been made to define MCNs, these have been founded on structural explanations – links between groups. Whilst perhaps useful for description, these definitions are not in themselves very useful for either complex classification or for understanding of social process. It may be that there are other ways of considering the question – what is the form MCNs? However, of more concern is the fact that function has often become equated to a structural response: the function of MCNs is to create linkages (ties) between silos (clique).

This tendency to mobilise structure and function interchangeably becomes theoretical tautology: a MCN's form is linkages between groups; its function is to link between groups. In this, for all intents and purposes, function and form implode into one concept. Add this to the other common practice of asking how to make a MCN function better without considering its function *per se*, it does appear that the question - what is the function of the MCN? - has not been adequately addressed. Also, there does not seem to be any clear indication of what MCNs have achieved. Whether this question is stymied by methodology or is in reality an indication of the fairly circumscribed results of MCNs is not clear. It does however suggest that there is a need to ask again - what is the impact of a MCN?

Taking these themes together it becomes not unreasonable to ask, if it is unclear what a MCN is, what a MCN is for and what a MCN achieves – why would practitioners and managers in non-prioritised health conditions voluntarily organise in this way? This question does not appear to have been adequately centralised when considering MCNs. Whilst it is possible to suggest that proposed MCN benefits may suggest reasons for organising in this way, the degree to which these benefits are empirically borne out is not clear. It may be that in focussing in on the motivation for joining together as a MCN, new ways of considering form, function and impact will emerge.

4.1 INTRODUCTION

In the previous chapter the literature on MCNs was shown to have many structural themes. Much of this research has highlighted the importance of boundaries, linkages and those individuals who act to broker relations between distinct groupings. However, I have suggested that whilst this structural perspective provides a means to engage with certain elements of MCNs, it does have certain limitations. In particular, a basic outstanding question remains: *why would practitioners and managers voluntarily choose to organise themselves in this way?* In this chapter I present some literatures which may be of use when considering this.

Beginning with an overview of collaborative forms of working, I consider the psychological and social barriers which seem to be inherent in this type of organising (Huxham and Vangen, 2004). Turning then to the context of health service work, I discuss the relationship between wicked problems, leadership and authority (Grint, 2005). Finally, I propose that it may be useful to consider the MCN with reference to *work*. MCN work is understood as being joint activity centred on a shared clinical subject matter, or *Sache*. I suggest that through the analytic lens of work, some understanding of why practitioners and managers voluntarily organise in this way may emerge.

I see the MCN as the work that's done. It's not the meeting. But you need to get to the meeting in order to, I'm here and I'm interested and I need to be part of this.

(Addictions, Interview 12)

4.2 THE IMPORTANCE OF COLLABORATION

As networked forms of organising have increased, they have helped to bring together professional bodies who previously have difficulty justifying working together, in particular managers and clinicians over health board boundaries or practitioners across sectorial boundaries. As a result the question of collaborative effectiveness has arisen, that is, can disparate disciplinary groups with different understanding and experiences work together effectively?

Discussion on collaboration is often underpinned by theoretical concepts inherited from psychological studies of teams (Mohrman, Cohen and Mohrman, 1995; Poulton and West, 1993). These tend to assume the need and desirability of shared understanding in order that goals can be agreed and taken forward. This shared understanding arguably allow participants' to predict the behaviours of others, letting them move forward in tasks without having to constantly monitor progress. This is seen to avoid duplication, inefficiency and wasted resources. As a result, implementation is thought to become smoother with the team works in a happier, more harmonious mode. This generally results in a reduction in intra-team conflict (Hinds and Weisband, 2003).

Team members can take action without having to check what other team members are doing because they have reached a common understanding of the team's needs. Such independent action enables the team to work like finely tuned machines in which members are acting independently but contribute to the good of the team. [Hinds and Weisband, 2003:22]

From this perspective, clear, unambiguous goals are of central importance (Poulton and West, 1993) in order that each member can contribute to the goal and challenge the team to make progress towards that goal (Katzenbach and Smith, 1993). Interpretative barriers, which thwart the team reaching a shared understanding in order to establish and ultimately attain the agreed goal, are something which has to be '*dealt with*' (Dougherty, 1992: 195).

It is assumed that different interpretative schemas or cultures operate. Through mutual contact these schemas merge to create shared assumptions about reality, defining what the relevant issues are and how these issues should be made sense of (Weick, 1995). It seems that through this sense-making process, a shared understanding becomes possible. As a result of this shared understanding, it is implied that collective consensus emerges and this resultant homogeneity removes the pre-existing interpretative barriers. All of this, presumably being of ultimate benefit to the team.

Taking a more organisationally situated and culturally oriented view of the team; the team can be alternatively understood as a *community of practice* (Wenger, 1998). In the community of practice tacitly held rituals, norms and activities underpin daily activity. This

shared knowledge of ‘*how things are done around here*’ allows the steady rhythm of routine and goal oriented work.

In both theoretical views there seems to be an assumption that regular collaborative, contact results in shared goals, identities and understanding. However, this vision of easy going, shared understanding does not empirically appear to be borne out (Huxham and Vangen, 2004; Huxham and Vangen, 2005).

Drawing on over a decade’s action research on collaboration, Huxham (Huxham and Vangen (2004) argues that collaborations are inherently problematic. Complex cross boundary teams frequently suffer from what is referred to as *collaborative inertia*. This is commonly experienced as: the sensation of having common aims but not being able to agree on them; resource battles; suspicion and lack of trust; being pulled in multiple directions at once; wider systemic change causing friction; leadership and followership tensions; and leaders being thwarted in their attempts to move things on. This leads the authors to somewhat bleakly conclude: ‘Don’t work collaboratively unless you have to’ (2004:200).

If collaborations struggle to identify common goals, leadership is problematic, and social conflict is common, Huxham and Vangen (2004) also identify what they entitle *collaborative advantage*. They explain it thus:

This captures the synergy argument: to gain real advantage from collaboration, something has to be achieved that could not have been achieved by any one of the organizations acting alone. This concept provides a useful “guiding light” for the purpose of collaboration. [Huxham and Vangen, 2005: 191]

It seems that collaborative endeavours are not necessarily as simple to take forward as would seem to be suggested by research into teams. Collaborations are often reported to be fraught with difficulties, however, this is balanced against the suggestion that at least potentially, collaborations may have a synergistic pay off. The concept of collaborative advantage may be helpful to consider as a possible means to explain why professionals engage in what appears an inherently risky form of joint organisational action. Having the possibility to achieve collaborative advantage does not speak, however, to why this type of synergy may necessary.

4.3 THE IMPORTANCE OF PROBLEMS

If, as Huxham has suggested collaboration is not a straight forward endeavour, the question becomes why would collaborative advantage be sought? I suggest that to consider the desirability of collaborative advantage, it may be of use to consider the type of problems faced by MCN members in their work context. To do this, I consider the relationship between *wicked problems*, *leadership* and *authority* (Grint, 2005).

Problems and Leadership

Rittel and Webber (1973) identified 2 types of problem: *tame* and *wicked*. Tame problems are complicated but resolvable. They have usually been experienced before so have relatively low uncertainty, with standard processes to deal with them. Examples from Grint (2005) would include: timetabling a railway, building a nuclear plant, training an army, planned heart surgery or wage negotiations. He argues, whilst the circumstances may be fraught, the activities themselves have steps which are relatively prescribed and predictable.

Wicked problems on the other hand, are complex, intractable and without a completion point, solutions tending to generate new problems. There is no right or wrong answer to these issues, there are however better or worse solutions. Uncertainty is high and asking questions is central to shaping and understanding the problem. Examples include: developing a transport system, energy, industrial relations, defence strategy or developing a health system.

Grint (2005) identifies a third category of problem which he calls *critical*. This is what would be thought of as a 'crisis'. The problem appears self-evident, there is little time for contemplation and there has to be an appearance of certainty in the decision made. Examples of this can be drawn from military, political and economic crises, such as the Cuban Missile Crisis or stock market crashes.

Grint (2005) goes on to identify certain types of leadership which are more commonly associated with each form of problem. Tame problems have *Managers* utilising as they do process oriented solutions. Wicked problems have *Leaders* who utilise questioning and facilitation as a means to evolving the problem.

management is the equivalent of déjà vu (seen this before), whereas leadership is the equivalent of vu jade (never seen this before). (Grint, 2005: 1472)

Finally, critical problems have *Commanders* who provide answers to be obeyed. The authority on which each leadership is enacted is also important.

Authority and Compliance

Grint presents Etzioni (1964) typology of *Coercive*, *Calculative* and *Normative* Compliance. Coercive or physical power is related to total institutions such as armies or prisons. Calculative Compliance is related to rational institutions such as companies. Normative Compliance is related to institutions or organizations based on shared values, such as clubs and professional societies. He goes on to map these on to authority (see Nye's 2004 *soft* and *hard* power) and problems, arguing that the Commander deals with critical problems utilising coercive compliance. The Manager deals with tame problems utilising calculative compliance. Finally, the Leader utilises normative compliance to deal with wicked problems.

Table 4.1: Based on Grint (2005): Wicked Problems, Leadership, Interaction and Authority

Problem	Leadership	Form of interaction	Authority
Tame	Management	Organise Process	Calculative
Wicked	Leadership	Ask Questions	Normative
Critical	Command	Provide Answers	Coercive

Grint does not suggesting there is any possible objective assessment of each problem type with concomitant appropriate related response – Type A problem requiring Type A Leadership, however, he suggests is that the context as framed (Wicked, Tame or Critical Problem) allows a mapping of the appropriateness of the chosen leadership role (Leader, Manager, Commander) and their operational style in which to gain compliance (Normative, Calculative or Coercive). The ‘event’ will will be contested and framed differently by different factions. Each faction will see different leadership styles and modes of authority as appropriate depending on how they have constructed the problem. Thus, how any problem is constructed will require different forms of authority to be mobilised

In short, the book is never closed but permanently open to contestation, just as reviews of, say, Winston Churchill, are never finally agreed but always open to different renderings and potential inversions. (Grint, 2005:1471)

MCNs and problems

How though does this help us with understanding MCNs? MCNs operate within a health service context, in which the problems faced are defined in the main as tame, managed routines (ranging from Human Resources hiring and firing to planned caesarean sections) or wicked (such as introducing a SIGN Guideline into practice, improving the health of the nation or improving mortality rates in deprived areas). Unlike tame problems where routines or protocols can be made into efficient, effective solutions, we have seen wicked problems are uncertain and intractable, having with no end point, with only better or worse solutions. Wicked problems do not need Managers whose authority rests in their position within a contractual hierarchy. Instead they require Leadership which is collaborative and ideological, drawing out questions and debate. Followers grant authority to and comply with the power of the Leader due to perceived shared values and ideas. This clearly resonates with MCN policy discourse, underpinning MCN ethos and the role of boundary spanner.

But further wicked problems are also understood as imperative, intractable and unanswerable through routine process. To respond to a wicked problem requires leaders who can open up debate and dialogue to find new ways of responding. Their aim is to unpick, to create novelty. It may be that this is why collaborative advantage is sought. Collaborative advantage may be understood as a description of the synergy needed to respond to wicked problems.

4.4 THE IMPORTANCE OF WORK

Challenges faced across different MCN sites are unlikely to be the same or are even understood similarly within any one site, yet shared activity occurs in all, under the name of the MCN. As any MCN shared undertaking is unlikely to be uniformly understood, it is useful to consider how we can helpfully capture what the focus of the MCN is. If as I have suggested that MCNs may be faced by wicked problems and that collaborative advantage may be sought to respond to these, it is reasonable to ask what is the wicked problem a

wicked problem of? To provide a theoretical means by which we consider this question I consider *work*.

Work occupies a substantial proportion of most people's lives and has often been taken as a symbol of personal value: work provides status, economic reward, a demonstration of religious faith and a means to realize self-potential. But work also embodies the opposite evaluations: labour can be back-breaking and mentally incapacitating; labour camps are punishment centres; work is a punishment for original sin and something which we would all rather avoid. [Grint, 2005:1]

Keith Grint opens his 3rd edition *The Sociology of Work* (2005) with the above quote. In these words the ambiguous nature of work becomes visible. A nature which he argues is not essentially located in a universalist character but instead is constructed in a dance of numerous themes including economics, hierarchy, morality and technology. Simultaneously coded as both a positive and negative experience, work from this perspective becomes fragmented, temporally located and multiply interpreted by those participants involved. For Grint, what counts as *work*, what counts as *inevitable* or what counts as *rational behaviour* is not located within the object itself but within the social relations and interpretative processes which actively construct and reconstruct the phenomenon. Work in this framing is not a unitary essence but is constructed, multiple and contested.

Within Sociology there has been a long theoretical engagement with work. For my present purposes, I draw attention to the recurrent themes of: work having been repeatedly understood as simultaneously free expression and forced activity; the division of labour; and the difficulties faced in defining work in any objective way.

The relation of pain and work is not a recent theme. Grint (2005) provides several philological examples which capture this tension within historical linguistics. In Greek there was no general word for work but instead 3 particular ones: *ponos*, meaning painful activity; *ergon*, meaning task (military or agricultural), and *techne*, meaning technique. In Latin until the 16th century, work was separated into *oevrer*, meaning a work of art (yet derived from the Latin word *operarus*, meaning a man of pain or affliction), whilst labourer, to plough, comes from *labor*. These two words tended with time to be replaced by the single word *travailler*, to

work. This is drawn from the Latin word *tripaliare*, meaning to torture using a tri-pronged instrument (Godelier, 1980). It seems that *work* in its linguistic nature at least, is viewed both as expressive and repressive – art and technique counter-balanced with painful activity.

This tension is also found in the classic works of Marx, Weber and Durkheim. For Marx (1969), whilst work or *labour* was essentially the housing of *capital* excess, it was also what differentiated humans from animals. This ability, to produce their own means of subsistence through the capitalist labour exchange (i.e. workers being paid less for their labour than the value of their produced product) resulted not only in an *exploitation* of the labouring classes, but also via lack of control by the producer over the product, *alienation*. Whilst work was thus the means through which humanity demonstrated the ability for self expression (i.e. their separation from animals), due to the economic and technological constraints of the capitalist labour process, resulted instead in a reduction of humanity. It seems that work whilst potentially liberating, is corrupted by the capitalist system thus becoming alienating. In particular, alienation is related to the removal of producer from product; the further the worker is from the outcome of their work, the more alienated they will be.

Durkheim (1933) considered the increasing sub-specialisation of labour in his *The Division of Labour*. Whilst the current thinking of the time was that society was on the verge of imminent collapse due to increased division of labour and urbanisation of life, Durkheim took an alternative view arguing that only through collective solidarity and morality could the necessary foundations for individual freedom be found, within a pluralism of difference. He argued that ethical individualism was the key to progress and this would come from the increasing division of labour. He went on to suggest that as society moved into a different form of social cohesion, from *mechanical solidarity* (homogeneity due to similar work and experiences) to *organic solidarity* (heterogeneity brought on by division of labour) that there would be a transitional process which would result in an *anomic form* – or meaninglessness – of work. That is, as workers became deskilled by the manifest forms of factory work, the meaningless of their discrete operations would increasingly separate them from the end product or the consumers of these products. Work thus would become a meaningless activity with no sense of moral coherence. Durkheim did note that without concomitant opportunities to achieve newly constructed goals and meanings of work, anomie would prevail. It seems that in work there is a social importance to develop coherent localised morals and meanings.

Finally, Weber (1976) stressed the centrality of symbolic and material *rationality* within contemporary society. As science began to draw attention to means not ends, thinking became concerned with cost-benefit and efficiency calculations, leading to the rise of *bureaucracy*. Bureaucracy operated on *legitimacy*, a basis of procedures which could be judged as correct or otherwise and *rationality*, principles of expert knowledge and calculability. Weber limited the reach of bureaucracy to a form where legal rational administration is necessary, not as a universal whole. He also foresaw potential distortions, in particular where red tape and sectional control emphasised hierarchical control at the expense of the interests of the whole. Weber stressed status as the means by which groups could place claim to social action. Whilst for Marx it was class which determined the advantages of some over others, for Weber whilst related to class, status was not uni-directionally related i.e. your status was not just a result of your class. This suggests that high status, professional groups are able to control social action.

These classic discourses underpin contemporary sociological and organisational engagements with work but do not attempt to define what is work *per se*. When we do attempt to do this we often struggle to move past a reliance on economics as a delineator of work from non-work. For example, consider housework and unemployment. Whilst a housewife may be undertaking between 57-100 hours of labour in the house (Walker and Woods, 1976; Berk and Berk, 1979; Leghorn and Parker, 1981), it is unpaid and therefore is not defined 'work'. The unemployed may undertake voluntary activities but again due to the lack of economic transaction, this activity does not define them as in the labour market or in work. The assumption that an economic transaction is the pre-ordinate means through which work is defined, whilst no doubt being problematical empirically, as the example of housewife and the volunteer demonstrate, does not, however, stop it being one of its intuitive defining characteristics.

This highlights the more general difficulty faced in attempting to define work *per se*. For example, if we use economics as a defining characteristic of work, is all that is not paid for, non-work or leisure? If so should we classify shopping, ironing, parenting as leisure or non-work? Admittedly, like work, it is something we have to do, may be something we often prefer not to do, we may even refer to it as work, but we do not get paid for it, so if economics is necessary it cannot be work. Further, whilst sport is the leisure (unpaid) activity of the many, it is the work (paid) of the few. This suggests that the activity *per se*, cannot

appear sufficient to define work. Further, we may be at work, but does it necessarily follow that once there, we actually work? It seems that activity, place and economics are implicated in work, but that no one strict definition is likely to be possible, as there will always be exceptions to the rule. Along with Grint (2005), I suggest that to define work in any strict definitional way, is to deny the constructed and ambiguous nature of work, work is not objective, nor permanent, but is instead social activities which we construe as work embodied in social organising.

Mats Alvesson (2002) argues for increased ethnographic engagement which is sensitised to work. That is, the occupational activity which is undertaken within an organisational setting. This would admittedly seem to be a somewhat trite observation in that at first glance managerial study would appear to be concerned if not with work *per se*, at least fundamentally with the work place. However, this is perhaps where the subtlety lies – considering work itself and its related meanings, is not the same thing as considering how or where work is done. Nor is understanding work merely reducible to activity, but is instead activity framed within a network of social and moral meanings which are individually and collectively constructed. Thus research sensitised to work centralises activities undertaken and the moral and social understandings of those participating in these shared activities. Thus focussing in on work, the MCN will become understood less as an organisational structure, and more as an organising form that allows certain the activities to be undertaken. This being the case, my attention becomes engaged how to understand work in a theoretically delineated way.

4.5 THE IMPORTANCE OF SACHEN

As a means to understand work, I introduce the concept of *Sachen* or subject matters. The *Sachen* is a philosophical concept which emerges from Husserl (1913) and allows the consideration of non-real objects. For my current purposes this non-real object is the shared clinical condition which draws practitioners and managers together to do work.

Husserl argued that what is understood as the reality of an object is rather the grouping of appearances as if they were of one object, this is known as the subject matter or *Sachen*. The implication is that there is no essential object, but instead an illusion of essence created by an appearance of continuity. This insight underpins Phenomenology. Davey (2006) provides the

example of landscape: different artistic approaches to landscape painting, over time, become historically constituted as the genre of 'landscape'. The object of 'landscape' does not exist but is an ideal constructed from a cluster of evolving perspectives.

Sachen are understood as not having an essence but are drawn instead from different theoretical and empirical understandings constituting an appearance of unity. Stable definitions become more readily seen as temporally located, historically linked to differing configurations of meaning, these meanings related to activity. Thus as the Sachen is revisited, each interpretative iteration and action embodiment changes how the subject matter is presently understood. Our interpretative process enables the re-visiting and re-configuration of previous understandings, re-writing our historical, pre-understandings whilst also impacting on our yet-to-come future understandings (Gadamer, 1960). The Sachen is the focus of our attention, debate and contestation but is by no means an objective entity with an essential core.

Sachen has much in common with the concept of the epistemic object (Rheinenberger, 1997) which is drawn from history and philosophy of science. These objects are described by Miettinen and Vakkunen (2005:438) as:

not things with fixed qualities but rather are open-ended projections oriented to something that does not yet exist, or to what we do not yet know for sure. For this reason, they are also generators of new conceptions and solutions and can be regarded as a central source of innovation and reorientation in societal practices.

Miettinen and Vakkunen (2005) turn to the epistemic object as a means to understand the means by which activity changes. They suggest that understanding of the world is not situated within any one consciousness but is instead rooted within the constant interaction between individuals and the world of objectified cultural artefacts (Vygotsky, 1986). Drawing on Wartofsky (1987) they differentiate between three forms of artefact. The primary refers to tools and related bodily skills directly used in production; the secondary, for preserving and transmitting skills in the production and use of primary artefacts; and of more interest the tertiary artefact, which are abstracted from their direct representational function and constitute a domain in which free construction is possible. This representation of

possibilities goes beyond the present actuality, serving thus as tools for imagining and proposing alternatives.

Attention to the Sache thus suggests a potential means with which to examine the MCN, as a collection of activity centred round shared clinical subject matters - condition, service. The Sache is thus not understood as a discrete goal or task, but as the subject matter towards which the goal or task is directed. MCN members participate in debate, conflict and construct non-essential subject matter, which like the epistemic object or tertiary artefact can be imaginary, forward constructed and feeding back into actual practice. The Sache is understood as inter-dependent and participatory, with associated activity being situated, meaningful and creative. The Sache is worked: a production of the construction and reconstruction of the players involved within the environment, technologies and economies (social and moral) in which they operate. As Grint (2005:2) puts it, work *'does not just happen but has to be brought off'*.

4.6 CONCLUSION

In this chapter I have moved away from a structural description of the MCN, purely as a means to creating linkages between different groups. Instead I have begun to consider the question: *why would a practitioner want to join an MCN?*

I suggest that to answer this question a consideration of work may prove fruitful. To consider work, MCN activities are understood as being focussed around shared clinical subject matters. Sachens drawing interested individuals together to tackle the wicked problems associated with their condition or service. Wicked problems arguably require facilitative leadership and need novel, creative answers. These creative answers can be thought of as collaborative advantage.

From this perspective the MCN become functionally understood as a response to the inherent intractability and uncertainty of much of the work faced. MCN members join in order to deal with these problems. MCNs require particular skill sets which encourage collaborative engagement and discussion, to respond creatively to the issues faced by practitioners and managers in their everyday work. If so the MCN becomes understood as high status clinicians and managers mobilising a means of work organising which nurtures the possibility

of creative, social expression in the workplace. This intriguingly suggests that the MCN model may be an empirical demonstration of an attempt to reduce anomie and alienation in work.

In the following chapter, I turn to my methodology. I present the underlying assumptions made in the fieldwork and how this impacts on honing in on the work carried out within MCNs.

5.1 INTRODUCTION

In the preceding chapters, I have outlined the policy background to the emergence of MCNs, have discussed the structural framings which have tended to underpin much of the understanding of MCNs and have presented alternative literatures which may prove of use when considering the *work* of MCNs. I have suggested that as a means of considering MCNs, it may be of interest to focus on work, that is, the activity which is carried out on the ground-level by MCN members. By concentrating on work, my aim is to allow analysis of the MCN as an organising form to emerge.

In this chapter I will concentrate on the methodology I used. I will explain concepts that I have used drawn from the philosophical traditions of phenomenology and hermeneutics. I will discuss how these choices were made to justify my research strategy, ethnography whilst also discussing the difficulties which are inherent within these choices.

5.2 THE DANGERS OF TAKEN-FOR-GRANTED

Understanding an organisation as *a thing* is not necessarily a bad thing. This type of thinking allows certain types of research to be undertaken straightforwardly. Representational ontology in the social sciences – the assumption of thing-ness or reifying the form - is commonly linked with positivist/neo-positivist epistemology, which in its purest form, assumes that *a priori* hypothetico-deductive forms of knowing are both possible and methodologically desirable. That is, knowledge exists before us and it can be uncovered by using specific, repeatable and delineated steps allowing us to judge the veracity of an argument. Causal, acontextual argument is thus the aim, ultimately allowing for the creation of universal Laws.

Drawing on natural science, reality is treated as existing outwith our knowing and knowledge of this reality can be both captured and understood with recourse to scientific methodology. Science as understood in its methodologically tightest sense is centred on objectivity (the attempted containment of observer influence), reliability (the degree to which the results can be replicated over time, place and person) and validity (the degree to which the results can be taken as a true representation of the object of enquiry). The concern with objectivity is also

central to modernist social science, concerned as it is with foundationalist macro accounts of social reality, for example, Structuralism, Functionalism, Marxism.

Representationalism has an internal coherence on how we understand reality (ontology) and knowledge (epistemology). Its theoretical linkages allow us to take certain things for granted. Whilst for the sake of brevity this move appears helpful (we can assume we know what to do and how to do it) it does mean that it becomes increasingly difficult to question this chain of inter-dependent assumptions at any point. At a basic level, this style of methodology affects our design and research results. Critically, however, it also impacts on the interpretation of the meaning of the research questions themselves.

Thus, by beginning with this representational premise, perhaps unwittingly the MCN becomes not only imbued with a causal agency, but also inherits a central metaphysical assumption, that you can remove the MCN from the context it operates in, to measure it or understand it – it can stand alone and detached. The result is questions of form, function and impact typically framed as: *what is a MCN, what is a MCNs function and what is a MCNs impact?* With answers tending to link form to structural conceptualisations (what is *it*?); function associated to understanding how to make the MCN work more effectively (what does *it* do and how do we make *it* do it better?); and impact becomes an evaluation of hard, measurable clinical outcomes and outputs which are viewed as desirably quantifiable (what has *it* achieved?). Questions such as how the MCN is understood by members, what the social function of this way of organising is or consideration of wider indices of impact become less immediately relevant.

It is these last constructions on questions of form, function and impact I am more concerned with. I begin from an alternative set of premises, borrowing broadly from the Interpretivist philosophies of phenomenology and hermeneutics. Phenomenology offers a different understanding of objects from the representational. Following Husserl (1900-1901, 1913) phenomena are not seen as essential and causal but as a non-essential grouping of appearances, as if they were of one object. There is not an object at the root of appearances or behind appearances, but more the artifice of a coherent whole. Hermeneutics is concerned with interpretation. Interpretation is viewed as a profoundly participatory event forever oscillating between experience and understanding. Drawing on Gadamer (1960,) reality becomes understood as expressed in this on-going participation. Reality is expressed and

understood through language, yet is always beyond what language can fully express. That is, we always know more than we can say and there is always more to say.

Starting from this alternate set of assumptions, the understanding of the MCN as a representational thing is rejected and thus the related epistemological and methodological claims are also decoupled. Instead the assumption is that reality and knowledge are underpinned by a constructed and contextual dialogical process, that it is our participation through language which is of interest and the resultant methodology is thus concerned with inter-subjective interaction and iteration. This different set of methodological concerns allows me to re-visit form, function and impact to consider what impact this new way of thinking will have on answering these questions.

These choices are of course not without implication. In the following sections I will further draw out the details of my methodological assumptions to discuss what these implications may be. To do this I consider paradigms; the methodological position of the thesis; the limitations and benefits of this methodological stance; the research questions to be answered; the research strategy employed. In the following chapter, I go on to present the methods; the analytic process; and the presentation of the data.

5.3 RESEARCH PARADIGM

In this section I outline my methodology. I have attempted to work within a relatively coherent paradigmatic framework, through which my research choices and assumptions can be tracked and assessed for their justifiability. I begin with discussing the ontological and epistemological premises which underpin the study, so that this may act as a theoretical entry into the actual design and practical undertakings of the fieldwork.

Paradigms

A *paradigm* is understood as a short hand for the underlying ontological, epistemological and methodological claims of the research. It is hoped that there will be a degree of coherence between these differing considerations and that choices made can be justifiably linked. Denzin and Lincoln define a paradigm as simply: “*a basic set of beliefs that guide action*” (2005:22) which support “*the researcher’s epistemological, ontological and methodological premises*”. However, it would be fair to say that paradigms are not set in stone, demonstrating

a high degree of intra-paradigmatic variability. They are probably more appropriately seen as heuristic devices; a stereotypical presentation of the types of reality, knowledge and methodological claims which are conveniently grouped together for gross identification.

Paradigms which tend to cluster are referred to as a *paradigmatic family* (a heuristic of heuristics). An example of this would be Interpretivism; a family arguably including members from critical studies, hermeneutics, phenomenology, queer theory, action research and feminism utilising methodologies such as, ethnography, narrative and performance and arts-based inquiry. Although the function of the paradigm is to act almost as a short-hand into the philosophical underpinnings of a piece of research, as with any heuristic much of the debate and difference between the positions is concealed. However, that said for Interpretivism at least, there does appear to be at least a commonly agreed rejection of the utility and indeed possibility of the representational ontology and objectivist epistemology implicated within natural science methodology (Bryman and Bell, 2007).

In beginning with a different paradigmatic starting point, it is necessary to outline what the implications are. For positivist/neo-positivist informed research, it is often assumed there is little ontological and epistemological consideration or debate as these philosophical questions are seeming almost a given (Sechrest & Sidani, 1995) and that, somewhat condescendingly, the quandary of choosing between qualitative (words) or quantitative (numbers) method, equates to full methodological consideration (Guba & Lincoln, 2005). Housed as it is in an assumed representational reality, it becomes understandable that positivist methodology is focussed on objective empirical engagement; issues of reliability, validity and causality become of central concern. Methodology in this framing becomes a highly rigorous endeavour of attaining the closest approximation of objective *Truth* - Truth which is accessible via methodological rigour and is foundational to any object of interest. Qualitative methods with their inherent interpretivist relativism and subjectivity, can be seen from this perspective as almost sloppy in their lack of ensured replicability and objectivity.

However, for interpretive and language based pieces of research there is recognition that there has to be a more critical consideration of the work's positioning. That is, what does the research claim as the nature of reality, what is the nature of knowledge and how knowledge is accumulated, what is the quality criteria to assess a piece of research, what are the values and ethics underpinning the research, where does the researcher position themselves with regard

to the research and what is the researcher's training (Guba & Lincoln, 2005). To understand the paradigmatic coherence of any piece of research, the reader must consider multiple factors in assessing the work's internal consistency.

Heidegger

Ontology is the philosophical discipline which considers the nature of reality. Heidegger (1927, trans. Macquarrie and Robinson, 1962) fundamentally reconfigured this line of enquiry through his phenomenological account of *Dasein* (being, being-in-the-world). *Dasein* is the conceptual capture to the most fundamental ontological question, what is the nature of being? Heidegger answered that whilst never being able to conceive or construct reality, reality is still known to us in its temporal revelation. Reality emerges and manifests and unlike in metaphysical accounts is never understood as outside us, but is of us. We are not separate from reality in a subject-object relationship; this dichotomy collapses. Instead reality is us and we are reality. For Heidegger we are literally *thrown* into reality creating an interesting twist on Descartes aphorism - We are, therefore, I am - our subjectivity becomes known to us through our primary intersubjective engagement. In our *thrownness* we are immediately participating in reality. The question of *Dasein* being understandable apart from our participation becomes nonsense, falsely drawing a separation between the subject (enquirer - us) and the object (that which is enquired of - reality). We can never in this understanding of reality not be implicated in reality as our participation is creative and sustaining of reality.

What this means is that representationalist assumptions (that the MCN can be understood outwith contextual participation) can be disposed of whilst still being able to say something about the ontology of the MCN. Questions of whether there is such a thing as an essential MCN becomes redundant as the MCN is unable to stand outwith the historical and social context in which it is situated. Indeed Heidegger argues that reality is *that which shows itself in itself, the manifest*, (1927, trans. Macquarrie and Robinson, 1962:51) and tied to the historical-cultural. For present purposes, participation (or work done) reveals the MCN through those who are being the MCN and is simultaneously understood as being temporally-culturally situated and manifest. The MCN can be analysed through the lens of work (participation), viewed as a revealing the temporally located MCN.

Hermeneutics

Time and language and their role in the construction and maintenance of social reality are central to the interpretative paradigm. Concerned as it is with meaning, interpretative perspectives concern themselves with how language is understood, shared and translated socially and culturally. These concerns fall within the auspices of *Hermeneutics*, the name given to the philosophical school (cluster) dealing with the theory of interpretation. Referring to the work of Hans-Georg Gadamer (in *Truth and Method*, 1960) and his consideration of the text, the interpreter and the interpretation, I outline how this alongside the central concern with the *internal word* (Grondin, 1995) directs my enquiry and analysis. Finally, I turn to the work of Clifford Geertz (1973, 1983) to show how these types of premises have been mobilised in his anthropological fieldwork.

Philosophical hermeneutics does not constitute a 'philosophical position' but a philosophical dis-position. It is a practice of disposing or orienting oneself toward the other and the different with the consequence of experiencing a dis-positioning of one's initial expectancies. (Davey, 2006:xvi)

5.4 GADAMER

In *Truth and Method* (1960) Gadamer raises the importance of the dialogue between the text and the interpreter. From this fusion, interpretation arises, allowing an understanding of the phenomenon under consideration to emerge. This phenomenon can be historical, aesthetic or in the present case, social. In the following these inter-related concepts will be explained. Gadamer also argues from an ontological view, with interpretation being the ongoing oscillation between experience and knowledge, our participation in this being reality.

The Text

For Gadamer the text has certain key features which must be present: authority, information and truth. *Authority* refers simply to the superior knowledge (knowledge not currently held by the reader) within a text which subsequently has something to teach the reader. *Information* implies that this superior knowledge is in some way meaningful and informative for the reader. *Truth* must also be contained within a text. This is not a foundationalist or essentialist claim, referring to the Truth, but is truth as understood in relation to the structured

universality of the question and answer of any interpretative endeavour (Grondin, 1995:108). As the text poses a question, so do we answer; and as we pose a question, so does the text provide an answer. Gadamer is most interested in the content of the text - the actual text - as opposed to the context of construction (whether this is authorial psychology or history). Gadamer assumes that text can speak to us directly as *Thou*. That is, the text has agency with which to call to us directly. The text is also unitary, the individual words, sentences, paragraphs and chapters all add together to convey an overall meaning. To understand the text a fusion must occur between the parts and the whole, the tracking back and forth between the two known as the *hermeneutic circle*. The cornerstone to understanding complex text can be seen to be this part-whole tracking process.

The Interpreter

Gadamer's construction of the ontological status of the interpreter is influenced by his predecessor Heidegger's conception of *Dasein* (being). That is, we, as humans, have a temporal existence that our being is *thrown* into; in this we differ from physical objects in that they merely exist, whereas we have *lives*. The main implication is that for any given interpreter their individual, subjectivity is temporally constructed and historically constituted by an inherited *tradition* whether social or cultural. This is contrasted with ahistorical processes, responses or psychological attributes which would be independent of whatever era we were born in. Tradition is not about choice or selectivity but is an a priori set of social conditions which we are within. For example, as female, white and Scottish, I will never know the experience of being a male in 19th century Rajasthan. The historical-cultural constitution of religion, class, work, education, gender and language that differentiates us will make it a challenge to fully understand the other's social and cultural dimensions.

The implication is that any interpreter comes to a text from a substantive position; value-free observation is rejected as a possibility. Gadamer argues that the interpreter's mind (consciousness) is formed by historical tradition, which he titled the *forestructure* of understanding. This holds that there has to be something in our minds for understanding to occur at all. That which is already present is referred to as *prejudices*, the historically inherited set of ideas and beliefs or pre-suppositions. Prejudice used in this theoretical context does not include the normative connotations we would normally associate with our everyday use of the word. Prejudices are understood as those sub-conscious, tacit forms of knowing which

underpin that which is consciously known, but which are also accessible and transformative of our conscious knowing. For me to understand the male from 19th century Rajasthan, it will only ever be an understanding which is filtered by my prejudices of being white, female and Scottish.

The Interpretation

Understanding is seen as the *fusion* of text and interpreter. For Gadamer it is our deployment of our inherited tradition upon the subject matter under consideration that allows understanding of its meaning. Through projection of our preconceptions, that is our forestructure of understanding, we can throw certain meanings onto our subject matter, as it in turns speaks to us via its content. Our prejudices allow us to enter the *hermeneutic circle* that is the part-whole tracking of the text, through which understanding is achieved. Gadamer calls this the *fusion of horizons* and is also temporally constituted with past horizons meeting with present horizons (e.g. the South Sea Bubble read in conjunction with the current 'Credit Crunch' bubble). He further argues that incorrect interpretation will be thrown up by the hermeneutic circle as proposition and text meet in disjuncture. All interpretation will be generative, as past and present fusions meet to create new dialogically constructed readings, explaining why classic texts are constantly reinvigorated through new interpretations and fusions. It is thus that no original, pure past meaning is accessible as the present horizon will render such attempt impossible. Finally, Gadamer holds that interpretation has ontological status; we as humans do not choose to interpret, it is instead simply part of who we are.

Interius verbatim

Within this hermeneutic tradition there is a concern with the *interius verbatim* or *interior word* (Grondin, 1995). That is, that language does not exist as understood in the propositional accounts of classic analytical philosophy, that is, understandable with reference to relations of logic. But is instead forever in a state of *beyond itself*, striving to articulate which is always beyond articulation. Captured language is never the full story, written forms may lull us into false security that full understanding is possible but that which is captured in signs is only ever some of that which is able to be articulated. For the hermeneutist, language is instead constantly unfolding in an attitude of striving toward a momentary sense of truth; understood as the structural relationship between question and answer. Linked to the context and the

motivations in which it emerges, truth is always an incomplete response to an unarticulated urgency.

Behind every manifestation that calls for understanding, something else is going on which can only be alluded to by the words or the traces it leaves behind. (Grondin, 1995:x)

This sensitivity to context does not however necessarily lead to a fixation with relativist or historicist claims i.e. that we are never able to comprehend the other differentiated as we are by culture or time. Instead this awareness aims to awaken us to the shared nature of truth, extending to a dimension which exceeds the motivations of the speakers and points to tensions which they may not be aware. A dimension which is nevertheless present in the space between the *finitude* of what can be said and what remains behind what is said. Existing not in any psychological or social realm but inherent in the becoming of the *word* as a *Sachen*; hermeneutic interpretation is the art of bringing out what *becoming* may fill that space.

Whenever interpretation occurs, something emerges, and this something is identical neither with the subject matter nor with the register into which the subject-matter is to be transposed. (Iser, 2000:105)

Thus, centrally our activities can be viewed as the answers we activate to our unarticulated questions. Whilst we may not have the capacity with which to draw out fully what it is troublesome, attractive or curious, in our participation with bringing forth answers, the capacity to interpret the pattern of the underlying question arguably becomes possible.

5.5 THICK DESCRIPTION

Anthropology has a concern with the *other*. Those who are perceived as different to *us* in some way (e.g. gender relations, religion, kinship structures). Anthropology is about understanding *difference* or *alterity*. At a most basic level, the discipline is concerned with understanding ‘*another way of life from the native point of view*’ (Spradley, 1980:3). Inverting the typically viewed power relationship between researcher (ethnographer) and

participant (native), Spradley argues that the ethnographer makes no claim to *study people* but instead seeks to *learn from people*. As a discipline Anthropology is centred on the meaning of rituals, symbols and cultural forms, creating a Social Science with distinctly Humanist sensitivities. Concerned as it is with interpretative practice, there is a general acknowledgement that the role of the researcher is centrally important in both the understanding of a culture and also in the construction of a culture through the narrative in which it is transmitted, that is in reporting a culture, the act of textual creation both binds the culture holistically and creates the illusion that here is such a thing as culture *per se* (Clifford and Marcus, 1986).

This balance between realist demand (the need to report cultural ‘fact’ and not just make it up) and interpretative impact (the influence of the researcher to what is reported as fact) is acknowledged in the hermeneutically influenced fieldwork of Clifford Geertz (Sherratt, 2006). Rejecting as he does culture as a function of purely economic or pragmatic concern, he argues that as a science Anthropology is concerned with semiotics (the study of signals) and not universal laws. He holds that: ‘*societies like lives contain their own interpretations. One only has to learn how to gain access to them*’ [1973:453]. He proposes *thick description* as a means to achieving this. Thick description is the attempt by the anthropologist to uncover the meaning behind or beyond empirical data (known as *thin description*). This meaning does not necessarily have to be the meaning which would be drawn by those undertaking the activities.

For Geertz meaning occurs in symbolic systems. These symbolic systems are in response to underlying social questions (e.g. How to raise children well? How to find a good partner? How to make a living? How to remain safe?), the answers to which, will be culturally varied. How to unpick the interius verbatim dialectic requires interpretation moving from the data (symbol, text) to understanding. Geertz does this by treating *social action as text*, (Sherratt, 2006) allowing entrance into the hermeneutic circle: partial, individual experiences oscillating to a greater understanding of the collective, whole. Any interpretation is not though static. Instead it comes from the active dialogue between the interpreter and text (social act, symbol). Geertz’s anthropologic understanding is a tri-part inter-relation between: the object itself (event, act, text); the process of engagement (detailed observation); and the creation of a new text (the anthropologist’s version of events, not the participants’ version of what is going on). His new text though does not however make any claim to be the Truth, but

is instead *Sachen* – the illusion of an illusory fixed whole formed from the patterned parts. Whilst thin description should be relatively reliable over researchers, as it will present data which attempts to standardise multiple observations into a prototypical observation. Thick description alternatively will be dependent on the interpretative art and theoretical discipline of the individual.

In this last observation the similarities between Geertz's thick description and Gadamerian hermeneutics can be seen: the fore-structure of understanding brought by the interpreter and the *interius verbatim* of the text fusing to create new interpretative truths. Treating the social realm as text, Geertz's interpretative stance goes beyond a strongly realist cultural account based on function or structure, instead aiming to encounter anew the situated and contextual. Moving beyond any claim to present a fully representational account of the native view, Geertz instead merges empirically derived data with theoretical insight to create new readings of his cultural texts, echoing Gadamer for whom the interpreter both honours the text, whilst creating anew the interpretation. Whilst Gadamer has been criticised for traditionalism by Habermas, (for discussion see Davey, 2008), and Geertz for holism (for discussion see Shaerrat, 2006), as Davey (2007) has argued hermeneutic fusion is far from static, our ongoing interpretative participation in differing horizons continually recombining the part-whole relationship anew.

Openness

Davey (2007) argues that central to this dynamism is our *openness* to the other. Openness is not to be confused as a convenient cover for *will to power* epistemological tactics, truth being colonised by imposed views (Nietzsche trans. Kaufmann, 1968; Koezler, 1996) but is rather a positionality which is centrally disruptive. As language or the *logos* (word) is assumed to be speculative (having meaning which is behind and beyond itself) this non-propositional linguistic finitude, leaves space for infinite interpretative re-configuration. Further openness is centrally a position of vulnerability, our engagement with the other always risking new understandings of self. Davey stresses that fundamental to openness, is the recognition of our mutual ethical affinity. Thus for transformation to occur, there is a reflexive requirement for the recognition of our intrinsic affiliation to the other. Self is thus forever at transformative risk through our dialogic contact with otherness, the self becomes known to us through how

others know us. Our investment in the other must as a result, go beyond liberal indifference, as we are co-dependent on the other for new meanings of *self*.

only in my openness to the difference of the other, can I as a hermeneutic subject gain a consciousness of my own difference and difficulty. Only because the other sees me differently, can I come to see myself differently. (Davey, 2007:7)

Openness allows the space in which new understandings can emerge, where fusion occurs. In allowing myself to be open to the other, my prejudices (fore-structures of understanding) can be brought to conscious self-awareness and be understood anew. Openness is not ethically distant (through my participation with the other my engagement with their welfare is centralised), nor is it a methodological trick (the self has to maintain a position of vulnerability for creative, interpretative effect).

Openness to the other requires a particular refinement: the skill of being critically distant while remaining involved, attentive, and caring. (Davey 2007: xvi)

From the section above, it can be taken that my research is primarily interpretative. Whilst I will report data which could be housed within a realist study (thin description), I will organise, understand and explain the data using hermeneutically inspired interpretation (thick description). This means I may argue for interpretations which may not be commonly available to those undertaking the activity and which they would not normally draw on to make sense of what they are doing. Instead I necessarily draw on my own experiences and knowledge to make hermeneutic sense. *Centrally, I am assuming that the MCN can be understood as an interius verbatim, that is, an organising answer to work related questions.* Finally whilst the analysis will become fundamentally closed in terms of the final reporting, due to the speculative ontology of the logos, this by no means suggests that the holism of the text or indeed analytic themes is anything other than transitory.

There are very few golden rules and certainly no magic formulae for cutting through to Truth – if indeed there is any single monolithic truth, which is not typically the case. Human beings are complex, ambivalent, inconsistent creatures; not even the brightest and best organised of us lives in a sharp-edged world where we have all

consciously and consistently sorted out our attitudes and beliefs on all conceivable subjects. It is a mistake to assume that there is a pristine Platonic reality under the muddle of our public utterances to which really sharp research tools can cut unerringly through. Underneath the mess of language lie a mess of thought and a tangle of behaviour. If our research tools cannot recognise ambivalence and inconsistency as real and important, they will not help us to a very profound understanding of human thoughts and behaviour.

(Hedge, 1985 quoted in Crang and Cook, 2007:14)

5.6 RESEARCH STRATEGY

In this section I describe my research strategy, ethnography. I will explain what is involved in ethnographic research and highlight both the benefits and limitations that are associated with using this type of methodology. The aim of this section is to provide the steps which I used to justify the relationship between my informing philosophy and the actions I carried out to complete the fieldwork – to outline the movement from theory to practice.

Ethnography

Ethnography is a strange concept both referring to itself as a written piece (the research product) and the writing of itself (the research process) (Van Maanen, 1988). Ethnography is, it seems both verb and noun simultaneously, referring to loosely-coupled activities headed under one signifier umbrella. Lofland describes ethnography as:

sprawling, diffuse, undefined and diverse. As a research genre, it appears (relative to other domains of social science) organizationally and technologically the most personalized and primitive. [74:24].

Yet even in light of this ethnography has become a recognised methodology, spreading beyond the bounds of its traditional association with anthropology, to many other social sciences such as, sociology and geography. Briefly, ethnography is predominantly qualitative in method and is concerned with human ways of being human. Using observation, interviews and artefacts, the ethnographer fundamentally aims to understand *what is going on here?*

Whether they are interested in rituals, economies, families or work, the ethnographer aims to bring forth and understand the localised understanding of those participating.

Traditionally this would be through the use of participant-observation, where the ethnographer would eat, sleep and live with the group to aid understanding through taking part in their daily lives. Over time this requirement for full immersion has reduced, especially outwith the discipline of anthropology, due to a variety of practical limiting factors, such as access (e.g. social groups may only meet once or twice a week), expertise (e.g. you would not be allowed to participate in surgery unless you are a surgeon) or risk (e.g. studies of IRA members do not require participation with terrorist activity). These disciplinary and temporal changes in expectation alert us to the fact that there may be a high degree of variability in ethnographic process and product. I will consider both.

Ethnography as process

Whilst stating that ethnography is housed in the interpretative paradigm, there needs to be some clarity on ethnography as a process and how this relates to methodology, in particular the issue of the researcher must be considered. There is accepted within ethnography a central observer who brings their own perspectives and to a lesser or greater degree is involved with the action. This being so, the question we must ask is how can we be assured that an ethnography is not merely the reporting of an individual who sees the world in a rather odd way? Is it in fact possible to judge that the reported analysis has any credence or are we caught in an epistemological forced choice between objective Truth or subjective truths?

In the following I consider this highly important methodological concern for assessing ethnographic quality. I consider the issue of the plausibility and paradox, infinite regress, provide an overview of the hermeneutic perspectives by which interpretative research can be justified and highlight those issues which are peculiar to ethnography.

Plausibility and paradox

Hermeneutics holds that amongst subjectivity there is still the possibility of objectivity (Davey, 2007). That is, patterns can emerge and findings be drawn which are transferable across time and place. This claim is not the same as those made for generalisability, in that there is no claim to universalism or law-like status. Instead emerging interpretations may prove of more or less analytic use in new contexts, that is they may be transferable. It is

important though to explain how there can be a claim for this relatively soft objectivity, when there is an admission of a subjective self, that is, a self created by a mix of individual history, experience and learning.

In Heidegger's (1927, trans. Verlag, 1962) *Dasein* there is recognition of a shared (human) being which allows mutual understanding to rest upon. This *unity of man* is a theme which plays throughout anthropology (Barnard, 2000), with an assumed hierarchy of basic needs and functions (Maslow, 1943) which are common across peoples. Yet as Geertz highlights (1973: 43):

the notion that the essence of what it means to be human is most clearly revealed in those features of human culture that are universal rather than those that are distinctive to this people or that, is a paradigm that we are not necessarily obliged to share.

So whilst we may agree that there is something distinctively human about human beings, we do not necessarily have to claim that this human-ness is exactly the same across humans. This leaves us to account for human same-ness and difference.

Turning to the concept of *interius verbatim* (Grondin, 1995), it is possible to suggest that whilst humanity may face similar questions (e.g. how to parent, where to find food, how to make sense of our place in the universe), how different people answer these questions are infinitely varied. The *interior word* suggests that at this level at least, we are comprehensible to one another. We can understand our shared ecological, social and cultural dilemmas, whilst staying remaining free to be differentiated based on our solutions. Importantly, that we are at the very least understandable in the questions we pose, gives us entrance to understanding one another. For example, whilst I may not have a kinship structure which follows the same cultural rules as yours, I do, however, recognise in your kinship structure you are saying something about the social relations of family.

Interpretation rests on a very basic human sense of what it is to be human and as judges we can assess the *plausibility* of an argument. This is not an appeal to the normative – that we agree or disagree with a statement's ethical status - but that simply an interpretation makes

some form of human sense. Our attention on the *interius verbatim* leads us to ask what the underlying question is. What is this individual or collective responding to or in dialogue with through their actions? In making our interpretation, we draw together the act and context to try to make reasonable sense of the event. For example, whilst we may personally disagree with female genital mutilation, we may indeed think it is barbaric; still it seem possible to understand genital mutilation in a variety of ways - as an abuse of inter-gender power, a claim to intra-gender hierarchy, a ritual of liminality moving from girl to woman, a spiritual act of female solidarity, a medical abhorrence or as a form of sexual cleanliness – each perspective housing a degree of interpretative plausibility.

Whilst the *interius verbatim* may provide us with a structure to see action as an interpretative answer to possible foundational questions, it does little to enable us to assess truth. That is, which of the proposed arguments to explain genital mutilation is True? Is there in fact one True argument or can we only decide which of these arguments is more or less true than the others? From the above we can have a sense that whilst each of these arguments is plausible, they are also all paradoxically correct. Whilst we understand each of the analysis holds truth, we simultaneously appreciate that there is an internal conflict with holding all to be true. There appears to be a tension in holding that genital mutilation is a collective act of faith whilst also simultaneously arguing it is a personal physical catastrophe. However, this is the nature of interpretative paradox, that we can simultaneously understand dialectically opposing arguments to be true (Poole and Van de Ven, 1989).

In holding differing interpretations as simultaneously true, we must still be able to judge between them. Following on from the example above, if I were to suggest that genital mutilation was an act of labour organising this would perhaps seem at face value less plausible and more difficult to sustain as an argument. Of course, this interpretation may well become more plausible if I was able to link the activity to the sex trade. The issue here though is not whether one argument appears at face value more readily acceptable but that all require a degree of evidential support for a judgment to be made at all. Plausibility requires not only a degree of human sensibleness but must be linked to supporting evidence.

Infinite regress

Why evidence becomes important is due to the following question - why should my subjectivity not be taken as so subjective, as to make my interpretation only a personal

narrative? Or, put another way, how can the reader begin to accept my interpretation as anything more reliable than I turned up one day and decided rather idiosyncratically what was going on? This very tricky methodological question emerges due to an argument of Logic known as the *infinite regress*. Basically, as I attempt to justify my argument to you, I become locked in a chain which argues backwards, eventually locating itself in an assumed underpinning position I simply take to be true. What I assume to be true, of course, may not be and therefore my whole argument becomes suspect.

The infinite regress is thus a very real problem for any form of interpretative methodology. To try to tackle it I return to plausibility where two potential methodological issues emerge which may reassure. The first is that there is a provision of empirical evidence. This evidence should provide a structure which allows the evaluation of the narrative interpretation. If for example I wish to state that genital mutilation is carried out to make women fly, the reader would be rightly interested to know how that could be. If I could link my interpretation to discussions of witchcraft by participants this would provide me with relevant field empirical data or evidence. The second would rest on whether I could draw on the work of other researchers and theorists. If for example, I drew on the theoretical work of Duerr and his view of beings who sit on the boundary and flying being a form of distinguishing ‘otherness’ (1985) the reader may become more convinced. My interpretation would not stand alone but become embedded in both data and theory.

However, there is also a less methodologically inclined response to the infinite regress and that draws us back to the ontological Dasein. Heidegger (1962) argued that our being or reality is a shared one. We are thrown into a reality which comes before us and after us. As such our subjectivity emerges only from inter-subjectivity. The infinite regress in these terms is impossible. I cannot *de novo* create an interpretation which is wholly subjective, for my subjectivity has emerged only from that which is my social and cultural pre-horizon (Gadamer, 1960). Whilst the infinite regress may suggest the epistemological possibility of my creating an interpretation which no other person could make, Dasein’s ontological position suggests I can only rest my interpretation on an interpretation that some other person has made and will make. Further Gadamer’s (1960) assertion is that the hermeneutic circle’s tracking back and forth between part-whole will ‘*throw up*’ interpretation which is incongruent, resulting in a re-visiting of plausibility.

Concern of the infinite regress argues from a different set of philosophical concerns. Stemming from the epistemological perspective that knowledge is separate from being, not only can knowledge be more or less good but I can also create knowledge anew in my mind. However, in taking an ontological stance, that we are part of being with language coming before and after us, it becomes difficult to sustain the idea that our interpretations can ever be more than part of conversational participation. It also means that there is no reason to locate a non-assumed proposition (axiom) underlying our interpretative chain, as judgement of our interpretations rely on evidential and human plausibility, not argumentation based in philosophical logic.

Ethnography as product

Considering ethnography understood as research output, Clifford and Marcus (1986) have demonstrated that ethnography as a written product is as much a textually stylistic piece, as it is a realist record. Indeed they argue that a literary reading of classic ethnographies provide a clear view of changing tastes in terms of literary tropes, authorial stance and narrative structure.

Presenting the typical styles of ethnography Van Maanen (1998) differentiates between 3 narrative ideal types. The *Realist Tale* presents the experiential authority of a single, detached voice. This is a common style amongst the doctoral dissertation where the student has to demonstrate that firstly, they carried out the fieldwork and secondly, that they are now an expert in that area. Next is the *Confessional Tale*, no longer is there a position of authorial competence but an ethos of all too human blundering, contingency and serendipity. In this the author balances between convincing the reader that the text is useful and factual and is not mere interpretative whim, whilst providing an acknowledgement of the subjective context of the piece. Finally, the *Impressionist Tale* is characterised by dramatic recall. Recounted in roughly the order of occurrence, the aim is to draw the reader into the unfamiliar world to allow some form of imaginative re-living of the field experience, letting the reader see, feel, hear and touch the cultural environment in which the ethnographer roamed. Van Maanen reminds us however that within any one ethnographic piece there may be any mix of these stylistic elements.

This apparent variability in literary technical specificity and output highlights the importance of clarity when assessing ethnographic work. As theoretical tastes have changed over time, the degree to which an interpretative author claims to present certainty have weakened, this in turn impacting on presentation style and analytic tendencies. This has resulted in changes in

the means by which research quality can be assessed. It thus becomes reasonable to ask of interpretative research, how is it possible to judge or evaluate ethnography as a convincing piece of research.

As ethnography may sit anywhere on a methodological spectrum which ranges from realist to literary inclinations this creates difficulties in creating standardised means by which to assess quality. As Van Maanen notes (1998) when assessing the merit of the Impressionist Tale versus a Realist Tale, this can often become less about the correctness of the data and more about whether the tale is attractive, interesting and coherent. He states that assessment of the Impressionist piece can thus be centred on questions such as, does it hang together well, does it seem true, and ultimately, is it a good story? This observation alerts us to the possibility that when assessing output, how the work is presented may also require coherence with the inquiry's philosophical claims. For example, for this ethnography which claims hermeneutical underpinnings, it would seem questionable that a wholly Realist Tale presentation would be appropriate.

Limitations of ethnography

It can be seen that ethnography is a process and product which houses a particular collection of claims about reality and knowledge. As with any such set of claims, it is open to critique, the main being housed in the ramifications of the infinite regress. Whilst theoretically it might be possible to argue that the infinite regress is a particular line of argument which hermeneutics can reject, it is still hard to rid oneself of the sense of disquiet it raises. Quite simply, we have no way of evaluating the truth of ethnographic claim.

In addition, we could quite reasonably suggest that ethnography, centred as it is, on activity and meaning is little more than description, description which has been noted to be as much influenced by literary genre as by data. Further, concerned as ethnography is with language, it will clearly struggle to make any hard claims about causality (that X causes Y). Taking these together, the instrumental usefulness of ethnographic findings becomes distinctly questionable.

At best then, ethnography must be viewed in the same way as all methodologies, as providing a partial means to examine certain phenomenon. Whilst it has the strength of providing a sensitised means by which to view participants' every day experiences (e.g. work, family

relationships, cultural activities), it is simultaneously limited in the hard conclusions that we can draw.

5.7 RESEARCH QUESTIONS AND AIM

From the preceding discussion it can be seen that the present research houses itself in a particular set of paradigmatic assumptions. Language is centralised and reality is constructed through participation. Social activity is assumed to be a response to underlying questions – the *interius verbatim*. From this, I assume that MCNs are an organising answer to a set of work related questions and thus the activities and understandings of the MCN participants becomes of increased salience.

The aim of this piece of research is thus to try and locate the *interius verbatim*, that is, that which the MCN is the answer to. To do this, I first describe work as carried out in the MCN (thin description). I then attempt to go beyond that which may be readily accessible to the MCN members themselves, an interpretative step implicated as necessary in both Gadamer's (1960) fusion of horizons and Geertz's (1963; 1973) thick description, to ask:

Why do health and social care practitioners and managers organise themselves in MCNs?

In an attempt to be able to draw some partial conclusions to this question, I use the related guiding questions:

Form - what is an MCN?

Function - what does a MCN do?

Impact – what does a MCN achieve?

Through use of an interpretative ethnographic methodology, I mobilise work as an analytic lens to consider these questions. In this next chapter, I set out to describe how I went about this.

6.1 INTRODUCTION

In this chapter I look at the operational elements of the research. I present the steps that were necessarily taken to gain access to the various MCN groups, providing descriptions of these groups and their participants. I discuss the type and means by which the data was collected to provide an overview of who I spoke to and where I carried out the fieldwork. Ethnographic studies can use any number of methods, that is, the tools used to collect data. In the present study I use the qualitative methods of interview, observation and documentary analysis. These are commonly used in ethnography as a means to elicit understanding and meaning from participants on the activities of interest. Finally I discuss the analysis process and describe how the data will be presented in the later chapters.

6.2 ETHICAL APPROVAL

NHS: Ethics

Any piece of research which is proposed to be carried out in the UK National Health Service must go through a NHS ethical review. This review process is carried out through the National Research Ethics Service (<http://www.nres.npsa.nhs.uk/>), a centralised web system whereby an online form is completed and submitted to an Ethics Committee for review. The form itself consists of 71 questions and 25 pages, designed on the universalistic principles of informed consent, confidentiality and protection from harm. I was also required to provide the following supporting documentation applications for site-specific permissions (N=1), information sheets (N=5), age and context appropriate consent forms (N=9), introduction letters (N=4), Sponsorship form and Indemnity sign-off. This process requires a high degree of specificity in research design and possible outcomes. After protracted negotiations between March and August 2008 the research was granted NHS ethical permissions.

It is also worth noting that my initial application for ethical review was rejected by the Scotland A Research Committee. Their opinion was that the proposal was not categorised as research and as such did not fall under their review remit. The committee was suggested that I seek access permissions via localised HB governance mechanisms. Whilst I initially followed these suggestions, once in the field I became uncomfortable that I did not have full ethical review and decided to re-apply to another NHS ethics committee.

As part of this application process, I had to attend in person a Fife and Forth Valley NHS Ethics Committee to be interviewed and defend the ethical implications of my work. This meeting lasted for over 1 hour and I was questioned by a range of health professionals about such issues as: how I would remove my influence within research sites and how I would avoid changing things (I responded that I made no such claim to be able to do this and assumed instead I would change things by virtue of being there); my ethical justification for taking practitioners' time away from clinical duties (I responded that clinicians were involved in many activities in addition to frontline clinical duties and that I had an ethical duty to provide any information or help I could to help them be effective in these activities); and how I could control for junior staff being coerced into participating when they did not want to (I admitted that this was a thorny issue and I could not guarantee to counter this but that I was very aware I had to be vigilant for it).

NHS and Local Authority: Additional permissions

In addition to the NHS ethics process, the research was also reviewed by the other following bodies:

- Clinical Governance (a department dealing predominantly with quality of health care and its provision) or Clinical Effectiveness (dealing with service evaluation and review) in each Health Board (N=6)
- NHS Multi-Research and Development (MRAD) centre who negotiated on my behalf with 6 Health Boards
- 7 Local Authority permission systems
- 2 NHS Caldicott Guardians

All of these organisational checks and counter-checks were mobilised as gate-keeping mechanisms to ensure that I fully understood my ethical responsibilities, a research duty of care I had agreed to maintain for the safeguarding of my participants and the wider institutions.

University of St. Andrews: Ethics

In addition to the NHS ethics review I also had to undertake an academic institutional ethical review process. The internal committee within the School of Management, University of St.

Andrews passed my application on 28th April 2008 granting me permission to undertake my research.

In total, the time taken to transit through all of the appropriate ethical and governance systems was just under a year: from completion of the first draft of the NHS Ethics Form to the final Caldicott Guardian sign-off. This was no doubt in part due to the complexity of the study located as it was over multiple Health Boards, having sister sectors to consult with, and finally, prolonged debate over the necessity of ethical review for this form of methodology.

6.3 CHOOSING THE MCNS

My initial selection criterion was for MCNs which dealt with non-prioritised clinical condition. This decision was made as a comparative piece of research was already being undertaken in Scotland looking at the difference between voluntary and policy mandated MCNs for the priority conditions Coronary Heart Disease (CHD) and Diabetes (begun in 2002). I decided that MCNs for non-priority conditions in Scotland were therefore comparatively under researched. Unlike priority conditions (CHD, Diabetes and Cancer), non-priority condition MCNs were not mandated by policy and had thus emerged wholly voluntarily.

During a web-based scoping exercise of non-prioritised and voluntary MCNs that were in operation in Scotland during 2007/8 it quickly became apparent that MCNs could be chosen (sampled) by multiple different contextual factors, any of which may impinge on network work organising and everyday practice. These factors included, but are not limited to: patient population size (uncommon conditions versus relatively common conditions); organisational form (lateral versus hierarchical structures); network focus (organisational versus clinical); geographical capture (within or between Health Board areas); and sectorial spread (within Health or across Health and other sectors, such as Education, Social Services and Voluntary Organisations).

The nature of the clinical populations served by the MCNs also varied greatly. To illustrate this diversity consider the following MCNs: cleft, lip and palate; disorders of sexual differentiation; mental health; dementia; forensic mental health; addictions; orthodontics; parenteral nutrition and learning disabilities. Often being the sole operational MCN for their

highly disparate clinical conditions and dealing with widely differing population numbers, this made these criteria increasingly difficult to use a case-matched sampling strategy. That is, trying to get 2 or more MCNs which shared similar attributes e.g. clinical population size and clinical condition, to draw out the distinctive features between the MCNs.

Given the limited number of MCNs that could be studied my strategy was reduced to one simple assumption: that there are institutional differences between service sectors (Health and Local Authority) and that, therefore MCNs will be different depending on whether they operate solely within Health or across Health/Local Authority Boundaries. I aimed to recruit one Managed Clinical Network (an MCN which operates purely within Health) and one Managed Care Network (an MCN which operates between Health and partner sectors, such as Local Authorities, Voluntary sector).

Selection and recruitment of MCNs

Initially 5 potential MCNs were identified. These included MCNs for paediatric disorders of sexual differentiation (DSDs), forensic mental health, learning disability, dementia, and addictions.

Of these, two MCNs (learning disability and forensic mental health) were not included in the study. The decision to exclude one was due to a combination of operational considerations (too far to travel to meaningfully engage) and not replying to repeated e-mail contacts. The second site explicitly decided not to participate.

This left three potential MCNs - Addictions, Dementia and Disorders of Sexual Differentiation (DSDs) - all three were showing a high degree of responsiveness to researcher approach and a willingness to participate. As a result, a purely pragmatic decision was made to proceed with recruiting all three MCNs, this was made to ensure redundancy should one MCN decide to withdraw during early negotiations.

I decided to create redundancy for the following reason. Within each MCN every individual was given the right to refuse consent for observation. In practical terms this meant that whilst I may have seemingly successfully negotiated a MCN's collective agreement to participate in MCN observations, there was still the potential for one MCN member to refuse consent to be

observed. If this happened, this would have made the observational aspect of the study unviable and thus the MCN would have been unable to participate. In the event, all 3 MCNs collectively and individually provided their consent to participate.

6.4 ACCESSING THE MCNS

To access each MCN there was a process of gaining consent for collective and individual participation.

Informed consent

Each MCN was initially approached for consent to participate as a collective in the manner outlined below.

Addictions

Addictions had initially contacted one of my Supervisors for preliminary discussion on the possibility of collaborative research. At this point there was still some uncertainty as to whether the work required by the MCN would be of a more quantitative or qualitative design, but I was invited to attend in case the latter was a more desirable method.

Having established that the MCN may be interested in my research involvement and that there may be some potential overlap in perspective, I formally approached the MCN Clinical Lead by letter. This was followed up by a face-to-face meeting to introduce myself and to allay any concerns around the researcher being on site to observe and sensitivities regarding research duties of care for the MCN participants, such as confidentiality of data, quotes being identifiable and inappropriate disclosure of MCN business.

After this, the MCN was provided with a letter outlining the research which could be distributed to members. This was discussed by the MCN core membership as to whether they as a group would be interested in participating. Before the decision was finally made, I personally attended a section of the executive MCN meeting to introduce myself and to answer any questions or concerns they may have. Once having gained the MCN collective approval, my first observation took place in the June 2008.

Dementia

The Dementia MCN was suggested as a possible site to approach by a member of the relevant Health Board (HB) MCN Office. This office deals with the day to day management of all MCNs operating within their HB area. The contact details of the Lead Clinician were provided and initial contact was made via introductory letter. This was followed up by a telephone discussion outlining the parameters of the study.

The detail of the proposed research was taken by the Lead Clinician to be discussed by the members at an MCN executive meeting. It was at this point, the issue of partner members (i.e. Local Authority) approvals was raised. Through the assistance of one member of the MCN, the relevant bodies were contacted and approvals were granted to involve their staff. As a result Local Authority approvals were also sought for the other sites.

I was invited to attend a meeting to explain the research verbally to the group and respond to any questions or concerns. This meeting was in August 2008 and approval was subsequently granted.

Disorders of Sexual Differentiation (DSDs)

I had previously worked in this MCN as an Audit and Network Co-ordinator/Psychology Research Assistant. Initial contacts were therefore more informal due to the Clinical Lead's personal relationship with me. However, the same formal protocol of providing the research outline for full distribution to the core MCN membership (those members who attend the MCN executive meeting) and attending a meeting where questions could be asked of the process, was still adhered to. The first observation of the DSD MCN was carried out May 2008.

Anonymity

Due to the highly specialised nature of the MCNs involved, the maintenance of MCN anonymity was particularly problematic. It was likely that should anyone desire to identify the MCNs involved, this could happen quite easily. In recruiting *each* MCN, the concern with anonymity was made explicit. Each site was fully aware of this difficulty and thus had the

opportunity to cease participation. All MCNs agreed to participate on the grounds that MCN anonymity could not be ensured.

6.5 A COMPARISON OF THE MCNS

To provide for ease of comparison the tables below outline the three MCNs compared by the service descriptions (Table 6.1) and by MCN design (Table 6.2). As can be seen the MCNs differ in: clinical condition, clinical population, frequency of condition, service level provider, sector involvement, geographic coverage and activities carried out by the MCN. This would appear to be in accordance with the scoping exercise which showed that MCNs varied greatly in terms of form and function. Thus whilst I recruited these MCNs simply by virtue of them being for non-prioritised conditions and operating within health and between health and other sectors, there was by no means any attempt at extensive purposive sampling, the tables show that the MCNs differed on a wide variety of factors.

Table 6.1: service description of 3 MCN sites

	Clinical Condition	Population served	Condition Frequency	Health Service Level
Addictions	Addictions	Adult	Common	Secondary
Dementia	Dementia	Older Adult	Common	Secondary
DSDs	Genital	Children	Uncommon	Tertiary

Table 6.2: comparative description of 3 MCN sites

	MCN Type	Membership Composition	Geographic coverage	Type of MCN Forum
Addictions	Care Network	Health	>1 Health Board	Executive
Dementia	Care Network	Health, Social, Voluntary Sector	1 Health Board	Executive
DSDs	Clinical Network	Health	Scotland	Executive Clinical

Differences between the MCNs

The MCNs differed on their geographical organisation, representing a local, regional and national MCN; one operating within one Health Board area, one across multiple HB areas and one, Scotland-wide.

All three MCNs operated as an Executive Group, organised in a typical committee meeting structure (e.g. sitting around a conference table; papers to be discussed having already been circulated; minutes; and agenda). One of the MCNs also met as a multi-disciplinary team (MDTs) in tertiary level hospital clinics; I had previously worked with this MCN both managerially and clinically. It is worth highlighting that although the forum of MCN activity is categorised as executive (i.e. formal meetings) and/or clinical (i.e. clinics), this category only refers to that MCN collective activity which was observable. It is of little doubt that there was MCN activity occurring in less structured settings, via e-mail, telephone calls, and chance discussions in other settings however systematic gathering this type of data was beyond the scope of the present study.

Each group had a variety of medical and non-medical professional members with two Managed Care Networks claiming members from outwith the health sector (e.g. Local Authority, Voluntary). It is interesting to note that whilst the Addictions MCN utilised the title Managed Care Network they were observed as only having membership only drawn from the health sector, creating in affect an empirical 3rd category: a Managed Care Network operating solely with Health partners.

All MCNs were led by a medically trained Consultant (high status doctor). The MCNs varied on how many Consultants were in each MCN and the degree to which they came from the same disciplinary background. Addictions had a number of Consultants but all from the same discipline, Psychiatry. Dementia, was centred on one Consultant (two other Consultants were members of this MCN but did not regularly attend during the fieldwork period although this appeared to be changing at the tail end of the observations). DSDs, had a number of Consultants but from a range of different medical disciplines.

The MCNs therefore varied in a number of different ways: structurally, functionally and professionally. Whilst these differences were by no means created intentionally, the

differences did allow me to draw out thematic similarities and differences. This in turn enabled me to consider my research questions from a variety of perspectives, allowing me to understand how work was thus impacted on by organising.

6.6 DATA COLLECTION

I collected a variety of different data types, using interview, observation, documentary analysis, field notes and writing an ethnographic journal. I describe them below.

Interviews

I carried out 30 interviews. A breakdown of the demographics is provided in Table 6.3 below. Initially I had intended to use a semi-structured interview schedule covering issues, such as the structure, function, impact and roles of the MCN. These questions were informed by the traditional, organisational MCN literatures as outlined previously – asking about form, function and impact. However, it quickly became apparent that many of the issues that were being observed *in vivo* were not adequately covered by a prescribed topic guide, so a more fluid interview process was used. This method allowed a much more *naturalistic* dialogic interaction between researcher and participant, with the participant often leading the discussion to wider professional and service issues which would not be, for the researcher, obviously related to MCNs, but for which the relevance was seemingly clear for the participant.

All individuals who attended the MCN executive meetings were approached to take part in interviews. A total of 30 consented to participate: Addictions = 12; Dementia = 8; Disorders of Sexual Differentiation = 10. Table 6.3 shows the breakdown of interviewees by broad discipline; 50% coming from a medical background.

Observations

I carried out 25 observations. These took place in executive meetings, clinics, educational seminars, conferences and in participants' clinical work areas. Whilst these observations were mainly non-participant, as I will discuss in the next chapter, in some instances this broke down and MCN members invited me to take a more active role.

Table 6.3: Interviews by MCN participants by discipline and professional background

	Addictions	Dementia	DSDs	Professional Background	Total
Psychiatrist	5	2	0	Medical	7
Surgeon	0	0	5	Medical	5
Physician	0	0	3	Medical	3
Clinical Services Manager	4	3	0	Non-Medical	7
Administrator	0	1	1	Non-Medical	2
Lay Member	0	1	0	Non-Medical	1
Psychologist	2	0	1	Non-Medical	3
Pharmacist	1	0	0	Non-Medical	1
Allied Health	0	1	0	Non-Medical	1
Total	12	8	10		30

The breakdown of observations is presented below in Table 6.4. As executive meetings only occur every 3 to 4 months, this reduced the number of possible of observations over a year. An attempt to mitigate this obvious limitation was by having multiple MCN sites, by observing other MCN activities and by interviewing participants. Although it would have been desirable to carry out clinical observations in all of the MCNs, ethical and organisational constraints meant that this was not possible other than at the DSDs MCN site. For this MCN, observations were carried out in three clinic sites, Aberdeen, Edinburgh and Glasgow.

During meetings and clinics, minutes were taken of the discussions, so that a partial record of the 'live' order of events and conversation could be made. On five occasions an audio recording was made of a meeting but the quality of the recording proved too poor for usage. A written record was also made to note environmental issues, such as seating arrangements, room decor, room layout and artefacts present (used or unused) to contextualise the setting.

Table 6.4: Breakdown of observations

	Addictions	Dementia	DSDs	Other	Total
Executive Meeting	5	5	4	0	14
Clinic	0	0	7	0	7
Other (conferences, education seminars)	1	0	2	1	4
Total	5	3	13	1	25

Documents

I was given access to MCN e-mail correspondence, with any related attachments (including for example, policy documents, local research findings, service audits, clinical statistics and adverts for public meetings and events), minutes of meetings and agenda, websites, annual reports, business plans, practitioner operational guidance and, relevant strategic policy. This documentation was used to help make sense of much of the discussion of the MCN members, providing much of the contextual background to their clinical and strategic concerns.

Ethnographic journal and photographs

I kept an ethnographic journal to record impressions of events observed and any questions which may have arisen from these events. This proved invaluable for trying to track the theoretical and interpretative development of the ethnographic process, allowing my *present* self to engage with my *past* understandings. My journal recording style developed over time and as the interviewing process became less structured, so did the journal entries. I found it personally interesting to observe that as I became more confident in the interpretative process, the influence of events occurring outside what would traditionally be classed the field, became much more present in the journal and there was clearly a more entwined engagement between my personal and professional life.

I also took digital pictures of some of the health service sites to record the variety of premises that the members of the MCNs worked in. This helped me gain a sense of the difference in environment and working conditions of the MCN members. At the extremities these ranged

from the ultra-modern, hotel-esque, new build acute hospital to community service premises that were damp, roofed with barb wire and positioned behind graffiti covered high rise flats.

6.7 THE VALUE OF OBSERVATION

During my initial data collection period I began to suspect that my *a priori* theoretical framings or literature-induced structural assumptions ran the risk of limiting my empirical investigation. No doubt any theoretical lens or prior understanding will both enable and hinder data capture and analysis, but in the present case my observational data was drawing attention to the strong possibility that these MCN literature derived framings were *missing the point* in some way. Observations interacted with interview data as a means to validate the relevance of the questions I was asking.

Observation proved invaluable in opening up the framing of the research by highlighting areas of MCN work which would have remained beyond sight had the design been solely based on artefact (minutes of meetings, organisational charts, policy documents) or interview (guided by a topic guide). Data elicited from minutes of meetings is in the main devoid of any processual or contextual information and semi-structured questions directed as they would have been by the MCN literature, ran the risk of focussing the research attention purely on the bureaucratic element of MCNs. The use of documentary analysis and interview alone would have provided an impoverished view of what mattered to the participants within their respective MCNs.

Hermeneutic thinking however draws our attention to the importance of attempting to understand the unspoken question and answer structuring behind and within dialogic interaction, the *interius verbatim* can often more readily present in the postures, expressions and silences between words. Ethnographic observation acted not only to bring into question the assumption of the adequacy of the structural and functional perspectives underpinning much of MCN research but also accessed the unfolding nature of the context, allowing a positionality of openness to the other to direct interpretation. Without the input of observation, I would strongly suspect that my findings would have struggled to make sense of the ethnographic question *what is going on here?*

6.8 ANALYSING THE DATA

Due to the various data types an iterative and multi-staged process of analysis was used. I frequently moved between data and literature, aiming to allow the data to drive my theoretical sense-making.

Interviews

There was one telephone interview for which written notes were taken. Face-to-face interviews were audio recorded (N=29). All participants gave consent for their interviews to be recorded. Of these N=28 were transcribed. Each recording was sent to a professional transcribing service to be produced as Word files.

These interview Word documents (and any other documentary data) were imported into the QSR NVivo8 software package to facilitate storing and organising the data. The NVivo8 package allows an iterative interaction with the data and also has the software capacity to allow embryonic interpretations to be attached to transcripts and to the audio recording itself. A thematic analysis was undertaken to broadly capture the issues which were of importance to participants, this analytic process also allowing for a more general re-familiarisation to the data.

Observations

The observational data was more difficult to deal with in a programmatic way. Whilst the observational data that been typed up in Word format was easily transported and analysed utilising the same methods as with the interview transcripts, in the main, observational data served a different interpretative purpose. Firstly, the observations provided me with broad contextual understanding of the localised MCNs and secondly, they presented specific incidents which illustrated more wide ranging themes.

Observations served to open further questions in need of answer. As I tried to work out why practitioners and managers organised themselves in MCNs, it was of use to see them doing different activities which could lead me to ask ‘why are they doing that?’ and ‘why are they relating to one another in that way?’ The observational data moved beyond the more readily captured linguistic and cognitive interview data to allow me to access moods, emotions and

sensory data. Accessing in-house jokes and rituals was clearly of added benefit when it came to understanding what was important to MCN members, but would not necessarily have been reported in MCN literatures. All of this helped to make more analytic sense of the interview data as I became more in-tune with the MCNs taken-for-granted interactional contexts.

Hermeneutic iteration

Through my focus on *work* I became increasingly more aware of what was or was not important to MCN members. As I began to appreciate the concerns of my participants, the analysis began to hone in on these themes so that they could be theoretically developed. The initial interview and observational data can be thus thought of as akin to Geertz's thin description (1973, 1983) inductively creating themes which participants should recognise as being of importance to them and which can be reported by directly drawing on recorded quotes, whereas the analytic interpretation can thus be understandable as thick description.

The data analysis was thus multi-staged, continuing throughout the whole of the fieldwork. Interview and observational data were coded for themes. The interview themes were compared against the observational themes for discrepancies and similarities. These comparisons were then used to return to the field to inform further interviews and observations. This cycle was repeated many times. In addition to this, I repeatedly attempted to locate literatures which may help to understand what the data was saying. Overall, this process describes the hermeneutic research cycle, where experience and understanding, continually impact and interact with one another in ongoing iterative cycles.

Hermeneutic iteration refers not only to the conversation between data streams (e.g. interview and observation) but is also a conversation between the data and theory. That is, analysis is not only in reference to the data and themes per se, but also is concurrently considering how these findings can be explained. Underpinning this process is the assumption that social activity is an answer to an as yet unidentified set of social questions - *interius verbatim*. This back and forth between data and literature is akin to Gadamer's (1960) fusion of horizons process and was carried out throughout the whole of the research, the aim to move beyond more realist data to create interpretative understanding and explanation. This analytic process can only be thought of as being finished at the end process of write-up, where the final verbal

construction of the thesis *per se* eventually locks down the analysis in temporary hermeneutic closure.

6.9 PRESENTATION OF FINDINGS

The presentation of the findings reflects the variety of data forms and complexity of the thematic inter-relations.

Firstly, considering that which could be understood as thin description, I provide interview and observational data. The interview data is of relevant quotes which are seen as informing or strengthening analysis. It clearly records the number of interview and the MCN it is drawn from. All quotes are presented in italics. Observations are clearly presented in text boxes. It reports those events which are seen as important to particular MCN developments or theoretical themes. Again, it is clearly indicated which MCN it refers to.

Chapter 7 provides predominantly thin description, interview and observational data. It also though provides a description of a transition point in the methodology and whilst the positioning of this chapter perhaps sits clumsily with regards to timeline, it is included to provide a more genuine account of the stages in the research. It records my initial forays into the field where I admittedly did not have a very clear sense of what I was doing or what I was being told. Yet this stage proved to be a vitally important developmental stage in my understanding and is presented to allow a more accurate record of the types of questions which informed my later methodology, data collection and analysis. In placing this chapter here I do though recognise that it provides the reader some challenge in relation to narrative line.

Moving on to Chapters 8 and 9 it was necessary to organise in a way that draws together relevant literatures and data. This style of presentation was used to allow the reader some entrance into the contexts of the MCNs in order, to provide a theoretical context for assessment of the *plausibility* of the interpretations made.

In Chapter 8, I organise these themes in an analytic heuristic of work, *morals-in-practice*. Centred round the *Sachen*, shared clinical subject matters, this constructed organising frame,

has the dual aim of allowing the inter-relatedness of data themes to become visible, whilst also helping the reader to compare similarities across MCN contexts.

It is worth noting at this point that as the discussion is centred on the Sachen, shared clinical subject matters, the content may make at times for uncomfortable reading. It is not my intention to create difficulties for the reader but is presented to give an account of the work in relation to these Sachen. It must be borne in mind that the data presented represents conversations which are normalised and frame the work undertaken within these MCN contexts.

In Chapter 9, I use wicked problems as a way into MCN work and contrast the different MCNs through leadership, authority and relevant hermeneutic concepts. Again, this tack allows an interpretative organising frame for the data, whilst allowing the differences between the MCNs to become visible.

In the final Chapter, I return to the question of the *interius verbatim*, mobilising it as an analytic. In Chapter 10, I thus make the final interpretative move towards thick description, considering how the hermeneutic iteration of data and theory can help to answer why practitioners and managers voluntarily organise themselves in this way.

Thus as the analysis is understood as moving between data and theory – experience and understanding – this is reflected in the presentation of the findings. To do this it has been necessary to attempt to construct the narrative in an unfolding hermeneutic iterative style, layering theoretical and empirical evidence. Whilst granted this means the presentation style is challenging and somewhat unorthodox, this organisation style has been adopted deliberately. My aim is to at least partially, capture and inform the reader of the range of competing challenges and pressures which face MCN members in their every day work.

CHAPTER 7: MCNS AND EARLY FINDINGS

7.1 INTRODUCTION

In this chapter I describe the first iteration of the research. Outlining my relatively naive, initial attempts at trying to understand: *What is a MCN?* (form) *What is a MCN for?* (function) and *What is the impact of the MCN?*, I provide an outline of the early stages of my data collection and analytical thinking. I do this I present a basic outline of the MCNs, describe my early engagement with the MCN members and consider how my previous working experience impacted on these early findings. This early stage acted as a scoping exercise helping me develop a sense of the MCN activities and participants, whilst simultaneously the MCN members developed a sense of me, the researcher.

By presenting these first tentative steps, this chapter also goes some way to showing a personal micro hermeneutic process – as I tried to make sense of the relationship between the data I was collecting (experience) and the research strategy (understanding) I was using. Through this it became clear that my more tightly structured approach to interviewing had difficulties in reconciling what I was observing, yet it seemed to me that what I was observing was of importance to understanding MCNs. These early findings forced me to return to my methodological assumptions, so that I could be clearer on how I could theoretically understand and explain the relationship between what I was doing and what I was finding.

At this point of the research, it would be fair to say that my informing methodology was very under-developed however I report this stage, as not only did it provide data which was in need of further exploration and explanation, it also served a vital developmental function by raising certain methodological issues which needed to be resolved. Thus this early stage provided themes in need of further consideration, whilst also serving as a transitional point where I moved away from a method-led research process to a more methodologically informed piece of work.

7.2 THE RESEARCHER

In any piece of qualitative work, it is important to consider the knowledge and expectations that the researcher has on beginning a piece of research. In the following I will be explicit

about the assumptions I carried with me into the sites and also, outline of my own professional history which may be relevant.

As discussed in chapter 3, much of the literature on MCNs is underpinned with structural and representational assumptions of form. The linked investigations of function and impact were commonly framed as questions round how to make MCNs function more effectively and efficiently, with impact considered through evaluations of hard measurable outcomes. I carried these ideas into the field.

Thus it would be fair to say that on entering the sites I had a relatively tight unproblematised interpretation of the meaning implied in questions of form, function and impact. For form, I assumed I could draw out data simply by asking - *what is it?* - an ontological question which to my mind was already answered with recourse to a structural mode. Unconsciously asking - *what does a MCN do?* - was already framed as the first step in improving functionality for instrumental end. To understand impact, I assumed I merely had to ask - *what difference has the MCN made?* In all of this, I had a fairly firm idea of the issues that were potentially important, with the questions to be asked stemming from an assumed structural understanding of MCNs. This unquestioned reification therefore dictated the meaning of the research questions, these in their turn allowing a straightforward linear analysis of the MCN and its actions. At this point in my research the importance of work, had not emerged as an analytical device.

That is not to suggest that these assumptions are indefensible or of use for certain research questions, but, with time their usage did create some interesting tensions, inviting re-examination of my 'taken-for-granted' theorising. In particular, I struggled to account and reconcile the apparent difference in what I was being told about the MCN and what I was observing within the MCN. It was clear that during this stage of the research I was assuming that MCNs could be considered separately from the context from which they emerged.

With the luxury of hindsight, I now suspect these early confusions are a necessary and unavoidable stage of ethnographic data sensitisation in which the researcher underscores their social naivety by asking questions which for those within a context emphasises their outsider status. Perhaps, at this stage the researcher is more politely tolerated than actively engaged. The researcher hopes, of course, to ultimately, traverse this stage of miscomprehension (or

‘missing the point’) to form a more in tune, if still at best, partial understanding of the concerns of those acting within their local worlds.

It is worth noting however, even at this early stage I was not a total outsider. I had been employed within the NHS in various roles, including a Nursing Assistant, a Clinical and Research Psychology Assistant, a Research and Development Officer and as a MCN Co-ordinator. It was in this last role that I was employed within one of my MCN sites. I was therefore to some extent acculturated to this healthcare context and had firsthand experience of a variety of clinical, research and managerial roles within it. This no doubt impacted on what I was shown, understood and was analytically attracted to. Previous experience no doubt both helps and hinders the ethnographic process, for example, it helped me access to highly sensitive clinical encounters but hindered me by making certain issues so obvious that I struggled to see their analytic importance. It also of course means I could also hold no methodological claim to entering the field blankly (Glaser, 1992).

7.3 THE MCN SITES

Turning to the sites themselves, I provide a comprehensive outline of each, to provide some necessary depth to their individual descriptions. The following is an overview of each MCN’s HB coverage, clinical condition, clinical population, professional membership, structure and main collective activity. This descriptive data is drawn from HB and MCN websites, interviews and MCN documents.

Addictions

Based over multiple Health Board areas the Addictions Managed Care Network was established in 2002/2003 and covers a geographical spread which is typical of the Scottish population in general, including a high mix of urban and rural settlements. The population clusters ranged from villages with approximately 100 inhabitants, through modest towns of 10 to 18,000, to a city with a population of over 140,000. The MCN core membership is drawn from the Health Service, although there is no bar on members from out with Health joining. The regular attendees include: 5 Psychiatrists, 2 Clinical Psychologists, 4 Clinical Service Managers (1 acting up) and 1 Pharmacist (rotating). Together they provide the addictions service for a total population of over 1,000,000. The clinical population is predominantly problematic users of opiates (e.g. heroin) and/or benzodiazepines (e.g.

Valium, Temezepam) and is estimated to be approximately 1 in 50 of the population aged between 15 and 54.

The Addictions MCN meets as an executive group. These meetings are held quarterly. The meetings are held, on a rotational basis, at each of the members HB sites. Travelling time to a meeting can be between 1-2 hours dependent on the arranged site and meetings usually run to two hours. Administrative support for minutes has recently been agreed via a gentleman's agreement and is provided by the respective host Health Board. The Chair of the group changed during the observation period. With the establishment of a new Chair, a period of organisational re-structuring began.

Dementia

Established in 2005, the Dementia Managed Care Network was based within one Health Board area, the Health Board being sub-divided into multiple Community Health Partnerships (CHPs) covering both rural and urban communities. The geographic population of the area is around 400,000 with an estimated clinical incidence rising from 1 in 1400 of people aged 40-64 years, to 1 in 6 at 80+ years. This equates to a clinical population estimated at around 5,600 people. Services are delivered in secondary care hospital placements, private and Local Authority care homes and individuals' own homes.

This MCN has executive meetings approximately every 3 months, held in a central city NHS base. There are regular information up-dates sent out by e-mail in the intervening months. Travelling time to meetings is approximately one hour for those out with the city and meetings usually run to 2 hours. Regular attendees of the meetings represent a wide mix of institutional partners, including Alzheimer's Scotland, Clinical Service Managers from the 3 CHPs, Psychiatrists of Old Age, Nurses, Allied Health Professionals and Lay members.

Within the MCN, the core team is centred on the Clinical Lead and a designated Project Worker, who between them co-ordinate the running of the MCN. The Project Worker carries out much of the actual activity done on behalf of the MCN, collating reports, chasing up MCN members to do agreed tasks and publicising the MCNs activities to relevant groups.

Disorders of Sexual Differentiation (DSDs)

Formed in 2002, the DSDs MCN is recognised by the Scottish NHS National Services Division as a National Managed Clinical Network (2006). Core membership is exclusively drawn from the 3 Scottish NHS tertiary paediatric hospitals and together they provide a Scotland-wide service for children with DSDs. DSDs are a cluster of conditions which affect the development of internal and external sexual organs and which in the most extreme cases may result in ambiguous genitalia at birth. Birth prevalence rates and the estimated number of children and young people in Scottish population for DSDs are shown in Table 7.1. From this it can be seen these conditions are very rare, however, these conditions require high-end technical expertise to diagnose and treat these very complex children.

Table 7.1: Adapted from Ahmed *et al* (2004): Prevalence and incidence of DSDs in children Scotland

	Birth prevalence	New cases per yr in Scotland	Number of patients < 20yr
Congenital Adrenal Hyperplasia (CAH) - 21 hydroxylase	1 in 14000	3	64
CAH - others	1 in 20000	<1	10
Androgen Insensitivity Syndrome (AIS)	1 in 40000	<1	24
Gonadal dysgenesis	1 in 100000	<1	10
True hermaphroditism	1 in 100000	<1	10
Other	1 in 100000	<1	10
Total		Approx 8	Approx 128

This MCN differs from the other two sites in that it is split into two separate forms of activity: clinical and executive. The clinical work is provided by a Multidisciplinary Team (MDT) and is organised over the three tertiary paediatric children's hospital sites, with approximately 10 clinics in total held per year. The decision-making team comprises of Consultant-level physicians (paediatric endocrinologists, geneticists, neonatologists),

surgeons (paediatric urologists, paediatric surgeons, adult gynaecologists and paediatric and adult plastic surgeons), paediatric clinical psychologists; and biochemists (clinical and non-clinical). Experienced paediatric endocrine nurses and a MCN administrator also attend.

Clinics are fully booked (between 6-8 cases). The case outline is initially presented by an endocrine or surgical registrar to the MDT as a whole. This occurs before the child (if present) is actually examined by two or three members of the team. In one clinic, the examination can be viewed remotely via live camera feed by the rest of the team located in a separate room. Core members of the MDT frequently travel out with their hospital site to attend the MCN clinics in other hospitals.

I had been able to gain ethical permission to observe the MDT clinic by ensuring the provision of information sheets and consent forms to clinic patients (children and young people) and their parents. Information sheets were designed to be age appropriate and were sent out by the MCN Administrator to protect patient confidentiality (i.e. names and addresses). I attended the DSD clinic and approached parents and patients so that I could respond to any questions or concerns they may have about the research. If they were satisfied with my explanations, consent to observe the clinic was sought. It was stressed that I was not there to collect patient data, but observe the working interactions amongst the staff.

The executive meeting provides a forum to consider the organisational running of the MCN. These meetings occur 3 times a year and are organised before one of the site clinics as many of the MDT are also members of the Executive committee. The meeting is also transmitted over telemedicine (a live video transfer link, predominantly used for clinical case review) which means those in other paediatric hospitals can attend without the need to travel large distances. The MCN has a dedicated administrator who takes minutes and is responsible for their distribution. There are approximately 14 members on the executive committee including two lay representatives. Some of the regular activities undertaken by this group include production of a newsletter, development of a clinical register to record cases and production of patient information sheets.

The MCN sites thus differed on a number of variables: professional and organisational membership, HB coverage, clinical population, clinical condition and form of meetings to highlight just a few.

7.4 ACCESS - WHO ARE YOU?

Turning to the fieldwork itself, it quickly became apparent that on all sites there was an implicitly agreed, if somewhat fluid, collective MCN boundary. Members clearly identified themselves as being part of their respective MCN group centred on their clinical condition/s. Although there was recognition that there were internal differences, members varying on many different categories (place of work, speciality, HB, sector for example), there was also appeared an implicit demarcation of who was a MCN member and who was not. Being an 'outsider' how I was perceived and categorised was of interest and varied in each locale.

Addictions

The Addictions MCN site had approached one of my supervisors to undertake some form of organisational evaluation with them. After some discussion, they settled on a more qualitative and reflective form of engagement (i.e. me). At one of the first meetings to fully negotiate site access, I was openly invited to come and observe '*their death*'. For these respondents at least, it provided some indication as to the current perceived level of MCN function, however, as they were also actively looking outward for external engagement [possible help?], this also suggested that there may be some underlying motivation for the MCN to continue.

Initially, I had hoped to observe clinical interactions between patients and professionals, as was happening at the DSD MCN, the aim being to track how MCN policy and planning was interpreted and enacted at the micro, clinical level if at all. However, as observations within clinics meant that I would have access to patients' personal medical information, this proved infeasible. The stumbling block was centred on clinical governance concerns of gaining patient consent.

Institutionally, it was decided that patients should have the right to agree or not agree to my accessing their clinical information. As clinics were on a week turn around, from clinic list being drawn up to actual clinical meeting, this element of the project became logistically impractical. As there was realistically no time to mail out information, give patients the opportunity to consider taking part, deal with any questions which may arise and get consent forms posted back, this part of the study was removed.

However, this somewhat protracted and at times, this heated debate (with an individual in the Clinical Governance department and ultimately, with the HB Medical Director) appeared to go some way to building credibility with the MCN leaders who acted to verify my tenacity to the wider group. This did not however remove the need to build relationships with individual group members.

As I was a new person within this MCN without any meaningful social history, there appeared little confusion as to what my role was – *ethnographic researcher*. On negotiating access to the MCN had explained that I would be observing, taking notes and interviewing any of the MCN members who would be willing to participate. During meetings I sat taking notes, silently watching and apart from the occasional request to stop taking notes [this often seeming to be more a test of control by group members and a demonstration of trustworthiness on my part since I could have subsequently written up all their comments without their knowledge], my presence was initially accepted as external non-participant observer.

With time and personal contact, however, the relationship with this MCN evolved as group members began to identify me as a potential resource of expert knowledge on MCNs. I was re-labelled as '*our observer*' [Addictions, Observation 6]. Subsequent to the data collection period, I was invited to participate in 2 MCN meetings more actively to provide advice and expertise on MCNs. In this site, therefore I appeared to move from initially being classified as an MCN observer, to latterly becoming re-classified as a MCN participant.

Dementia

The Dementia MCN was different from the other 2 MCNs in that access involved a truly cold call. As a potential field site they had been identified via a third party HB manager. Again, a prolonged institutional access negotiation was undertaken. This was made more complex as this MCN also had multiple Local Authority partners; each of which had to be approached for individual permissions, resulting in considerable e-mail traffic. However, unlike the Addictions MCN, the management of this process was undertaken by a group member who although a very engaged MCN member, proved not to be a person at the hierarchical core of the MCN.

At the initial stages, it proved extremely difficult to engage the core team members to discuss engagement with the MCN. I suggested travelling to meet with those leading the MCN however my multiple requests for a face-to-face meeting were rebuffed. Eventually negotiations for access were held by telephone. The suggestion of any potential observation of clinical practice, was treated with a degree of suspicion and in the end, this request was not pressed. This apparent coolness may possibly have been the result of my introduction being managerially suggested. It is quite possible that this created a perceived role for me as an evaluator of MCN work [managerial spy?]. However, it is also feasible that it was simply due to a lack of available time.

Whilst many of individuals in this site were helpful, open and interested, as a collective there was no attempt to engage the researcher in any active way. Unlike in the Addictions MCN where they appeared to view me latterly as a potential participant resource, within the Dementia MCN I distinctly felt like a non-group member, never truly moving beyond the role of passive *observer*.

[After my fieldwork was completed, I fed back to the group my initial findings. After this, I did perceive the stand-offish attitude by the MCN members as appearing to thaw. Where previously there had been little interest in my research and I had felt held with a degree of suspicion, the presentation appeared to loosen interactions and acted to simulate an engaged discussion about my data. This was experienced as the only time I moved beyond a passive observer role.]

DSDs

Considering the DSD MCN, where I had previously worked, the MCN members readily accepted my presence. Negotiations to enter the site were relatively informal, with little apparent concern of me observing their clinical or managerial practices. MCN members' reactions to my return were generally of welcome and curiosity of where I had been and how I was. One of the participants commenting '*we're never getting rid of you are we?*' (DSDs, Observation 1). The general mood was the reception of a returning colleague.

However, with regards to my, as yet undefined role, more collective consideration as of *what I was up to* was apparent. With regard to my current *research*, there was a basic level of interest in what I actively writing down and commenting on. Individuals attempted to

surreptitiously read my observational notes, but as these were anonymised and were written as real-time minutes of MCN events as they unfolded, interest in what I was writing appeared to quickly wane and members quickly sought other means by which to classify my purposes.

Members appeared to actively attempt to categorise me in a variety of ways. For example: as handy technological helper when the ICT systems wouldn't work [a task in my previous role that I would have been called on to do], as a mouth piece to feedback to policy makers [my central funding possibly appearing to act as a bridge to government decision-makers], becoming a NHS manager to act as go between for clinicians and bureaucratic process [my knowledge of both 'languages' – i.e. managerial and clinical – apparently seen as a translational resource]; and as a 'mole' within NHS QIS (NHS Quality Improvement Scotland) to help meaningful data collection [it was suggested that I get a job at NHS QIS so that I could act as a possible mediator for demands perceived by clinicians as unreasonable or unfeasible – the balance between the constraints of clinical working and the need for meaningful data collection and output]. As I resisted or rejected these role classifications, the MCN members eventually seemed to settle on engaging me in discussions with regard to our previous shared clinical and research activities. I was engaged in discussions on qualitative findings amongst the client group and my opinion sought on the adequacy of certain psychological services.

This categorisation seemed to provide a degree of resolution for the group, allowing them to dually respond to me in my *old* role as *psychological researcher and clinician*, whilst accepting my *new*, ambiguous [and apparently incomprehensible] role as *ethnographic researcher*. For this group, they seemed to eventually settle on explicitly understanding and engaging me both as a returning MCN participant, whilst implicitly acknowledging but not really engaging with my new role as a MCN observer.

Researcher role

From the above rose one of my first of several methodological concerns. In Yin's (2003) typical account of case study, the researcher is left as a relatively unproblematic object: the objectivity of the researcher as data collector is assumed and their roles and identity are seen as stable, consistent across time and place. However, as can be seen in the above 3 sites, this was not my experience. In each place, I was categorised differently by the site participants, with them ascribing roles they felt comfortable with and these roles changing with time and

exposure. Rather simplistically and in contrast to traditional one-way subject (researcher) examines object (site) case study, my role can be seen as being moved along the participant-observer continuum as the members of each site sought to make as much sense of me, as I was of them. My identity was actively being constructed by each MCN site according to their perceived needs, my perceived resources and the myriad of other contextual decision-making factors which may have been in play, such as trust, likeability, time, shared history. I, as researcher, was not proving to be objectively essential but a social construction.

In and of itself my changing role may not appear to be of any particular concern but over time the untenable nature of claim that the researcher was constant over time and space, created a sense of discomfort. I began to wonder, if this basic methodological premise was proving suspect, which other of my assumptions might also prove to be? Questions began to nag, such as, if my methodological status was becoming increasingly unsustainable as transferable across sites, that is, as they all constructed *me* differently, perhaps my assumption that MCN-ness was comparable across sites was also problematic?

7.5 FORM – WHAT ARE WE?

My initial attempts to try and conceptualise MCNs were also admittedly relatively simplistic enquiries asking on questioning ‘*what is a MCN?*’ This line of questioning tended to result in two different thematic clusters: organisational and organising.

The first cluster drew heavily on organisational metaphors: organic, evolutionary, systemic or even, watch-like. At a very basic level, respondents appeared to be intuitively articulating the MCN either in terms of what are in management literatures understood as traditional structural, mechanical metaphors. These metaphors of *organisation* seem to have transferred into healthcare settings and are being used by practitioners to articulate understandings of form.

the original model we had, the descriptive model was one of gears in your car you know, although perhaps the gears of a watch might be more appropriate. Some are different sizes, they're all necessary in the watch for the watch to work, if one doesn't work the whole watch doesn't work. But they're all different sizes, it may be that the small cog over here actually doesn't physically contact the large cog over here but it

does influence it through some other pathway. And at times the teeth of the cog are together and in some sort of interface, but once they've interacted they move on you know, and these seem to be the best sort of models that we could have. But then they would come round again and re-interface and they had to continuously do this in order to ...in order to get the whole thing to work. (Dementia, Interview 3)

The second cluster drew more heavily on inter-personal relationships and histories, respondents seeming to interpret softer, social interactions as somehow being related to what MCNs are. Interestingly, the respondents who used these types of interpretations tended to draw heavily on their own professional epistemologies to make sense of and articulate their interpretations. For example, psychiatrists drew on broad personality typologies and a psychologist used a genealogical tool from systemic, family therapy to illustrate inter-linkages. These interpretative schemas therefore appeared to be heavily influenced by theory derived from professional practice.

I think it's a part of human nature, you know I believe, okay I'm a Psychiatrist and I can talk to you about personalities for the rest of the afternoon but I believe that there are two types of people. The can do and the can't do. (Addictions, Interview 7)

Added to this my own initial conceptualisations of what an MCN was it would be fair to say at this point I was somewhat struggling to find any focus from which to navigate through a worrying array of potential theoretical lenses to understand what the MCN was, if anything. Each of the theoretical and empirically-provided lenses was experienced as momentarily illuminating and attractive, but quickly dissolved when a new perspective was offered through which to view the MCN. I was left with the worrying situation that we were all wrong in our descriptions or more theoretically concerning, how to account for us all being right. However, it did not appear that I was alone in struggling to articulate what MCNs were.

I kind of feel really terrible for saying that, because I do know what it's about, and that's really contradictory I know, but I know it's about bringing people together, I know it's about sharing best practise, I know it's about looking at how we can develop the service without it being duplicated. I know all these things, but for me I still feel there is that kind of not knowing bit which doesn't....(Dementia, Interview 6)

It is a great sense of frustration to me because I feel that it (MCN) has a future potential but I feel if I try to ... I'm seen as bossy and domineering, what do you want; I think it needs somebody from outside to ask the questions because I think people would think if I said it, it would be like...I think the moment has gone to do it if I was gonna do it. (Dementia, Interview 2)

Further, each of the positions whilst appearing justifiable in terms of wider theory or from the professional positions of the respondent appeared to have little to offer in terms of the activities that I was actually observing. It seemed that something was fundamentally wrong with how I was viewing the MCN, but at this point I was simply at a loss to know what it was.

7.6 FUNCTION - WHAT ARE WE HERE TO DO?

It also did not take long to realise that something very confusing was happening in MCNs: members seemed to struggle to articulate what they were for. If I had expected a straight answer to *what do MCNs do?* I was quickly disavowed of any such pretension. In two of the sites at least, there seemed to be a fairly global scratching of heads when asked to articulate what the function of the MCNs was.

Sometimes we don't have a clear direction where this is going. I say look try and get things defined. One of the things they come up with in the other meeting is, promises, promises, promises and I mentioned it to one of my action groups and say well we are given all these promises but at some point here we are going to have to define who is going to implement the promise, they don't have anybody tied down to the promise. It's all fine saying we'll do this, we'll do that, we'll promise this, we'll promise the next thing, you've got to pin down to saying that's the guy that's making the promise, it's him or her we've got to see, that's their responsibility. But I feel here as well, I am not locking anything down, it's all laid out, you've got to start at some point locking things down to the responsibilities of organisations, groups or specific people. (Dementia, Interview 1)

I feel that there should be a plan and there should be a systematic approach, if you're going off to see ... what's the purpose? What would we take from that and because NAME is far removed from it she can't keep a tab on that. (Dementia, Interview 2)

Alternatively, there was a tension between whether MCN discussions should be round national strategy and steering. For some participants this defined function, for others it was activities which were more directed towards patients. My observations in meetings suggested that discussions round strategy, did not appear to be of much collective interest.

The MCN, where do I see their remit? I see it very much as a steering, their bringing in the policies, looking at what's going on nationally and as my membership round the table it's to see what's going on in other areas as best practice. (Dementia, Interview 4)

I think at times the MCN discussions are around about the patient, I think it's a bit more removed from the patient. And we quite often have strategic discussions, and I think the thing, if I'm being absolutely honest, I really don't like is when, you know, we have the sessions about oh well, this is happening here and that's not very good, and we're all quite derogatory. You think well rather than moaning about it, what are we going to do to make it better? (Dementia, Interview 6)

Interestingly, the members of 2 of the MCNs seemed to be of the opinion that this was something specific to their MCN, and that perhaps, their individual grouping alone struggled for some sense of coherence. They provided examples of other MCNs who they perceived as having got it right, a noted Diabetes MCN seeming to be the popularly chosen *gold standard of MCNs*.

Our experience though with the diabetes managed clinical network there, they've had a lot of money put into diabetes. But the way in which the diabetes network was set up was slightly differently, it began as a research group who was specifically looking at audit, so when they started with their DARTS data base it was specifically set up with that as the core function. So the other stuff grew round that so in some ways that's why they're ahead of the game where as sometimes when you look at the MCN's it's almost like you know, the things you shall achieve are so diverse and so wide. (Dementia, Interview 5)

Reasons for this lack of collectively defined purpose was variously linked for example, to historical phases where different activities were the focus (such as developing a clinical psychology service, writing up a response for the HB strategy, devising a business plan); differences in clinical conditions, services and access to resources when compared to other MCNs perceived as successful; changes in policy focus; personality clashes within the MCN; lack of authority of MCN members to make decisions; general grumbling about MCN leadership; and lack of time/commitment of certain individuals. My question became: were these MCNs really that ineffective? Was members' down-beat assessment a true reflection of their collaborative attempts? And further, were their reported stumbling blocks something explicit to their own particular MCN, to all MCNs or networks more generally?

There was a lot of energy and clarity and focus when we're preparing the bid for SEAT and we designed the business plan, there was a lot of animated discussions and, but I think because it was instigated for the potential of getting money and I mean we didn't get that, I think there was a deflation going on and an anti-climax of some sort. I don't think we've ever recovered from that, process, we suddenly realised okay where are we going now, you know we had a reason to live, where are we going now and the whole idea seems to be very reactive to what was happening out there. (Addictions, Interview 7)

Our MCN is interesting because everyone has different understandings of what it does and doesn't do. I guess there's a difference between what it should be and what it is. I think my understanding is it's a group of clinicians that get together and talk about things that could be at the moment. (Addictions, Interview 5)

There are people that are within that group that I think are there because they're ticking a box, are not interested in the wider remit and there are some people there who I think should be much closer to us than they are, much more visible and you know, pro-active within the steering group and it's not happening. And that's, there's political games being played, put it that way that are very frustrating and I find myself stuck in the middle of these games sometimes and I find that very, very difficult to deal with....Yes power struggles and, yes power struggles, and some personalities though, just some

personality stuff but I think that again is around power and position. (Dementia, Interview 5)

As discussed previously Huxham and Vangen (2004), argue that *collaborative inertia* is fairly typical of collaborative endeavours. They highlight that the common experiences of this type of working includes: lack of shared goals and aims, resource tensions and interpersonal strife and leadership and followership tensions. It seemed that the MCN participants' frustrations and lack of definition might not be a factor specific to MCNs but could be a more widely experienced set of issues, expected to commonly occur in any type of collaborative form.

Collaborative inertia, captures what happens very frequently in practice: the output from a collaborative arrangement is negligible, the rate of output is extremely slow, or stories of pain and hard grind are integral to successes achieved. (Huxham and Vangen, 2004:191)

And yet, the DSDs MCN appeared not to be suffering the same degree of observable or reported frustration and lack of focus. It seemed there was something specific in their collective which was acting to alleviate this sense of confusion that was reported in the other two sites. The question I was left with was what could this be?

7.7 IMPACT – WHAT HAVE WE ACHIEVED?

Unsurprisingly, considering the above, when it came to actual impact, there was again a lack of definiteness. Just as MCN members struggled to articulate what they were there to do, they also had difficulty in saying what they done. As Guthrie *et al* (2009) had found, my respondents oscillated between tangibles (establishing a new psychology service (Box 7.1), impacting on HB strategy, carrying out audit and education in other sector settings) and intangibles (passing on knowledge, learning from other disciplines). It seemed that for MCN members it was the tangible, hard pieces of output that were thought of as being of more value. As they struggled in interviews to capture these *things*, they appeared to become more disheartened with their efforts.

The Dementia Strategy for instance which has been led by NHS Tayside contains all of the elements that the MCN considered to be priority elements and no other

elements you know. So I mean, I think that we have been very influential and it would suggest that we have skill mix or otherwise. I mean we have got a lot of the right people involved in the MCN because you know we've now got a plan which we can take forward no matter what organisational changes there might be. (Dementia, Interview 3)

This often led to a conversation about what the MCN should or could achieve, captured in the idea of *potential* - the sense that the possibilities of what a MCN could achieve as a collective group, was greater than the constituent parts. This vision had sometimes led to blue skies thinking, where hopes of joint centres of care had been mooted or *critical mass* achieved in population numbers to trial care packages and treatments were discussed (Addictions Interview1, 4 and 7). There seemed assumed behind much of the thinking of why MCNs were a good idea that a collective could achieve more.

Box 7.1: Addictions - Clinical Psychology Service

The Addictions MCN provided the forum to share Clinical Psychology Services across the member HBs. Grade B Consultant had been employed and was instrumental in developing and growing service provision across the whole of the MCN.

Going back to your question about 'where does the MCN figure in this?' We are all striving to provide the best Addictions services that we can and I suppose we do that individually within our given areas but obviously there is a principle behind the MCN is that there are areas of that work that we can probably do better collectively. (Addictions, Interview 10)

The main aim of the MCN is to improve services for people living with dementia by bringing together people with different skills and knowledge based around dementia, bringing everyone together, sharing what's going on, looking at what's good in one area and then perhaps looking at well that's worked here, let's have a look in another area and see how we can use that, adapt it, whatever and it's about highlighting gaps, and there's lots of them let's be honest and looking to see how we can perhaps fill that gap and is there any ways we can change the way they're worked to actually fill that gap. (Dementia, Interview 5)

I'm employed directly by Tayside under a gentlemen's agreement from three heads of psychology service. So I'm funded entirely by Tayside, but Tayside has agreed that I would work across the MCN to set up psychology services. So there was nothing there apart from a couple of trainees who basically been landed. So when I arrived, I was told find out what is needed, and sort it out. So that's what I've done. I've found out what's needed and I've tried to sort it out. I've developed the pathway which takes account of the paucity of resources of clinical psychologists and tries to maximise the use of skill mix in other professions across the health boards. (Addictions, Interview 2)

However potential was often quickly balanced with *actual* achievement, with participants quickly returning to considering tangibles. Tangibles seemed to be the measure by which participants assessed whether the MCN had in fact achieved its potential. Rather frustratingly for members, their own self-evaluation of MCN outputs, tended to be assessed negatively. Potential was unachieved and tangible output was perceived as relatively low.

Moving the network on from being the kind of [special interest group] brains trust if you want to think about it in that way into actually being an engine for changing, improvement I think that's been, you know that's been the, the disappointment. So we made bids for that but you know we're unsuccessful so I think, that's been a pity in that and that's limited the potential value. (Addictions, Interview 1)

The question thus remained, why bother? Simply, why when it took so much time and effort to be a member of an MCN, would you keep going when by your own assessment you felt the MCN hadn't done very much? MCN members themselves seemed to grapple with this question. Oddly, the only reason that appeared to be put forward was a rather circular appeal to potential: although the MCN hadn't achieved potential, potential was still there to be achieved and that was as good as a reason as any to keep going.

7.8 REVISITING FORM, FUNCTION AND IMPACT

As has been hinted at, all of these early findings left me some outstanding questions. How should the MCN be conceptualised? There seemed to be issues in the representational assumptions I was making of myself as researcher, what if this was also causing problems in

my conception of the MCN? Was I looking at the *what is it* question in the wrong way? Why didn't MCN members know what they were here to do? Could the participants simply be underestimating their activity in their zeal for hard outcome? If impact was as limited as the MCN membership would have it, what was the point in this way of organising? If these groups were indeed maintained on what appeared little more than hope of a brighter future, shouldn't they just pack up and go home? And yet they didn't, so I began to wonder quite simply *why were they doing it?*

At this point I began to consider more closely what was it about the DSD MCN that was different? For the DSD MCN whilst similar activities were undertaken in the executive meetings, considering policy, quality indicators and patient information and education, there did not appear to be the same level of frustration amongst the members as to overall MCN focus. It appeared that whilst there was an overlap amongst all of the MCNs in the type of work carried out in the MCN executive meetings, there appeared to be something different about this group which made it relatively upbeat when compared to the other sites.

There were several issues which potentially could be stopping them from reporting the general negativity and confusion reported by the other groups: membership, geographic coverage, clinical population size, leadership style to name a few. But it struck me that the most glaring difference was that this MCN carried out direct and collective *clinical work* in the form of MDT clinics. It appeared that the act of doing joint, clinical work, might be defining the function of the DSD MCN – providing quality care for children; the additional tasks undertaken in the executive group meetings only being seen as an add-on to their core clinical work.

It seemed that whilst all of the 3 MCNs were constituted by active practitioner' and operational managers, the DSD MCN differed in that the direct clinical work was carried out under the MCN, as collective MCN work. In the Addictions and Dementia MCNs, whilst some individuals may work together clinically or operationally, this was not part of their designated MCN's function but was instead part of their HB contractual duties.

This raised an intriguing possibility. Perhaps the collectively perceived lack of *doing* in the other sites was the blockage in the system? My observations began to hone in on the

presentations of the MCN members as they discussed activity topics (in all sites), and a pattern began to emerge: members were unenthusiastic about activities which were perceived as managerial (e.g. annual reports, meetings with accountability structures, creating patient leaflets) and excited when clinical service improvement activities were discussed (e.g. training and support of front-line staff; locating funding for core staff; sharing helpful organisational information).

However, returning to the policy documents the requirement to undertake both forms of activity was clearly marked and underlined quite directly in the title of the organisational form: *Managed clinical/care Network*. MCN participants were expected to do bureaucratic work in the name of the MCN. Added to this, it was becoming apparent during observations that the sheer volume of soft social activity that was undertaken in MCN meetings was grossly underestimated by members within the interviews (e.g. sharing information, suggesting and working on potential pieces of joint working, discussing policy changes and funding streams). Change to services (tangibles) appeared to be the only outcome factors worthy of reporting. Taken together, this raised a real query over the structural and functional focus of the MCN as a *one stop shop* meeting, where MCN members tried to do *everything* (managerial and network activities) in 1-2 hours per annual quarter. Simply the blockage to valued *doing* may have been sheer lack of time.

You do it with other professionals because they're of course more on an equal footing and they kind of understand your language.... I mean the carers say "oh you go too fast and we don't know what you're talking about, you know and therefore you should all slow down and ... and go at our pace." Now I mean supposing, supposing I was a plumber you know and I went to their house you know would they say "wait a minute you know, you're going ... I can't follow what you're doing, just slow down and explain everything," you know I mean would they do that? No, they wouldn't you know they would think that plumber, you know that's that they do, they want in, they want to get the job done and they want to get onto the next job. Well you know this was our job and there's only a certain amount of time and we have to get through that work. (Dementia, Interview 3)

All of this left me with a quandary, how could I account for these observations of everyday, social interactions, within a theoretical framework which assumed the MCN was a

representational form? How could I look at doing, if I had unconsciously conceived of the MCN as an object? My answer was to return to the policy and consider an alternative mode to conceptualising the MCN as an historically, politically constructed set of permissions for organising. That is, that the MCN did not exist as a thing, with an essence or with any assumption of comparable form, but was a product of the policy discourses which gave practitioners the green light to organise themselves to do certain forms of activity. The policy had granted clinicians the means by which they could formalise pre-existing informal networks, begin new networks and transit some of the structural and financial boundaries which would have previously been very difficult to justify (e.g. a surgeon regularly attending clinics in another tertiary hospital or a psychiatrist meeting quarterly with clinical managers in a different HB). It became plausible that although pay-off for this political support was that the MCN had to carry out certain ascribed managerial tasks (annual reports, agendas, minutes, patient involvement), for MCN members perhaps the motivating factor was centrally framed around practice (in its narrow sense patient-practitioner and its wider sense practitioner-population). If so, the focus would become those practice issues which seemed to matter to practitioners and managers.

I was thus beginning to assume that the MCN did have a function. And that practitioners and managers had been given permission by policy to carry out this function. Therefore the MCN was becoming understood as an organising response to some, as yet undefined, set of issues. I suspected that these issues were housed in the practice or work of MCN members.

7.9 CONCLUSIONS - THE ITERATIVE RESEARCH PROCESS

From the above it becomes apparent that some significant issues were arising from the assumptions that I had taken into the field. The implicit designation of the MCN as a stable, representational form created difficulty in capturing the lived reality of MCN work which I was observing during executive meetings and clinics – because the unit of analysis was drawn to organisational forms and not the process of organising. The interview questions, structured as they were around assumptions taken from the MCN literatures, appeared increasingly inadequate to draw out the nuances of MCN members' experiences and concerns. Along with the apparent break-down in a stable researcher role and identity, I began to seriously suspect that many of the philosophical assumptions I had taken into the field were proving unworkable.

It had become necessary to re-visit the methodological underpinnings of the research in order to provide space for an account of MCNs which made no assumptions of ontological stability, *a priori* theorised comparative concerns or assumed researcher equivalence. Whilst allowing certain aspects of the MCN to become highly visible, my structural lens was also undoubtedly acting to obscure a significant proportion of potentially relevant data – I was *missing the point*. What became necessary was a perspective which allowed a more dialogic account of MCNs as a phenomenon, constructed from the policy discourses and made *real* in the narratives, actions and interactions of those organising in this way.

At this point I re-visited my methodology, in particular hermeneutic theorising as a means to try and liberate myself from reifying the MCN, allowing instead the MCN to be understood through a focus on the *work* undertaken in each site. My methodology became much more considered, this allowing me to go forward with the research and analysis. This iterative step whilst uncomfortable and challenging was necessary both for my personal academic development but also to help me feel more confident in the justifiability of the research design, analysis and output. Once done, I was free to move on to explore *work* in a more explicit way, attempting to understand each of the MCNs through the practice undertaken.

8.1 INTRODUCTION

As I have shown I found that traditional methodological and theoretical premises did not help me to adequately understand the MCNs. Conceptualised as organisational or bureaucratic form, MCN studies had presumed that structural and functional aspects were the focus of enquiry. Thus these studies used methods which were not unreasonably directed towards gathering data which answered questions informed by these premises. However, the essentialist claims which lurked beneath this type of theorising quickly became challenging and difficult to reconcile with what I was actually observing in the field. I found my attention being increasingly drawn to the activity or *work* of the MCN members.

In this chapter then I begin to consider the MCN members' work or *practice*. The definition of practice is wide (HDL (2007)21), it includes activity which is not only occurring at the level of practitioner-patient interactions, but also practitioner-population. In drawing attention to work, the aim is to consider whether MCNs can be conceptualised as an organising response to the challenges which arise in everyday clinical life. If so, voluntary MCNs, at least, can become understood less as an organisational thing and more as an organising response.

In order to examine work more broadly in relation to wider contextual challenges faced by MCN members, I introduce an organising heuristic *morals-in-practice*. Introducing some basic literatures on ethics and evidence, I suggest that there is no purist mobilisation of either sources of knowledge instead ethics and evidence operate in tandem, helping practitioners to respond to issues of *suffering* and *uncertainty*. The meeting of these two differing epistemological traditions are partially held in repose in *morals*, which creates for practitioners an imperative for intervention. That is, morals are put into action, or *practice*.

I will present data which illustrates practice from the level of the practitioner-patient to the systemic view of practitioner-population. I move between the clinical encounter, to attempts to deal with service gaps. In all of this the practitioner is the basic unit of analysis and from this perspective, I aim to illustrate the MCNs are inherently linked to the competing practice demands of the shared clinical subject matter or *Sachen*. By illustrating a few of the

complexes of practice, I am simply suggesting that MCNs can be viewed as an organising response to the challenges of work.

8.2 WORKING WITH DILEMMA

Few, if any, in clinical practice is immune to dilemma. Drawing on my own experiences working in Learning Disabilities (as a Nursing Assistant and Clinical Psychology Assistant) these can range from the rather mild concerns of, should sexual education be provided to adults with a measured mental age of 5 and who exhibit sexualised behaviours, indeed are sexual relations even acceptable amongst a learning disabled population? Through to more thorny issues such as, should women with learning disabilities be given contraception without their knowledge and informed consent, or what do we do if pregnancy occurs in this population, or rape is reported?

Clinicians are often faced with making these types of dilemma and have to make decisions, frequently without the luxury of experience to draw upon. Unprepared and unanticipated, these are decisions which must be made up close and personal, often irreversible once enacted. The luxury for ethical debate is often temporally divorced from the event and evidence rarely provides a relevant, to-hand, randomised control study.

These types of experiences often prove well beyond the realm of natural science, the biochemical, anatomical or physiological. Scientific papers based on replicability, reliability and validity, struggle to tackle the fluidity of the social world. Social Science theory, modernist or post-modernist, provides little guidance on what to do when faced with actual suffering - to know power is present or being abused, does not of itself give us strength to act when faced with it. Awareness of our self as theoretically incoherent, fragmented and constructed through discourse, may help make sense of decisions after the fact, but perhaps provides little help in directing our actions. Ethics does little better, universal principles are hard to live by and the sense making after the fact, whilst perhaps cathartic, does not help in the moment of dilemma.

Much of the time there are no definitive answers from which to draw, instead our actions, underpinned by uncertainty exist in a realm of best guess. Knowledge is uncertain, yet suffering is evident. Drawing on a mix of perceptions (sound and vision), religious belief,

upbringing, ethics, disciplinary training, emotion and empathy, practitioners attempt to make sense of what they encounter. In all cases, action and non-action are decisions which have to be lived with.

This chapter is thus about this very thorny element, the dilemmas of MCN work, ethics, and evidence. By considering how this intermingling happens in the *real world*, I am attempting to illuminate that which is so tacitly understood, yet ignored or perhaps made safe with attempts at objective packaging – that suffering and uncertainty are central to practice.

Ethics and suffering

The nature of work within any clinical setting is embedded within an ethical framework which finds a historical horizon stretching back to the Hippocratic Oath believed to have been written in the 4th century BC, albeit with outstanding question marks over authorship (see Box 8.1). In its words it is possible to draw some resonance with our present day concerns, issues of, religious diversity; intra-disciplinarity and transmission of knowledge, evidence based practice, issues of professional commitment, demarcation, protectionism and censure for misconduct, dilemmas on the sanctity of life, censure for patient-professional relationships, and the intrinsically deontological caveat of *Do No Harm*.

The Hippocratic Oath is not presented here to make any naive interpretative claim of undiluted transmission of ethical standards or concerns over the interceding millennia, indeed even how the seemingly easily comprehensible, *Do No Harm* has changed meaning over time (Jonsen, 2000). Nor is it presented to argue any conscious presence within modern-day practitioners' daily working lives. Instead I present it merely to direct our attention to the intimate link between medical (and more broadly clinical) practice and questions of ethics. Issues of individual *right decorum*, that is the deportment and attitude of the practitioner, and related *right action* as professionally, socially and politically defined, have been core to healthcare practice. These combined *right behaviours* have been central concern of medicine, having been re-visited and re-constructed repeatedly (Jonsen, 2000).

Just as *right behaviours* were central to historical clinical debate, the same concerns are as likely to be present in our modern age concerned with, to name but a few issues, increasing life expectancy via forms of technological interventionism, genetic screening for congenital.

Box 8.1: Hippocratic Oath - translation by North (2002)

I swear by Apollo, Asclepius, Hygieia and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment, the following Oath.

To consider dear to me, as my parents, him who taught me this art; to live in common with him and, if necessary, to share my goods with him; To look upon his children as my own brothers, to teach them this art.

I will prescribe regimens for the good of my patients according to my ability and my judgment and never do harm to anyone.

I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan; and similarly I will not give a woman a pessary to cause an abortion.

But I will preserve the purity of my life and my arts.

I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by practitioners, specialists in this art.

In every house where I come I will enter only for the good of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves.

All that may come to my knowledge in the exercise of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal.

If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.

anomalies in vitro, financial-health benefit balance sheets for prescribing, stem cell research, changes to systemic care delivery as a result of lifestyle changes within the population, and more fundamentally changes to definitions of *health* and *health care* (Svenaeus, 2000).

Our understanding of ethical dilemmas are often theoretically conceptualised as occurring, what I will call, *distance-far*, that is from an assumed objective positionality, whether experienced collectively or individually. Ethical dilemmas are generally not analysed as occurring subjectively (or more poignantly emotionally). In this framing there appears an enlightenment concern with the superiority of rationality, generalisability over personal experience and the need for analytic separation which necessitates emotional detachment. Perhaps the theoretical aim is to counter any claims of radical subjectivity, the fear that we are reduced to ethical *sui generis* for lack of objective foundation from which to measure, for

instance ‘good’ or ‘truth’. On the empirical level, there appears a suspicion that professional over-involvement, will result in emotionality clouding the understanding and utilisation of scientifically derived knowledge, muddled as we become within a fog of affect. Distance-far is concerned with application of ethical principles detached from the event *per se*.

Starting from the furthest *distance-far* point, we find politicised debate. Often disseminated via media spin and made tangible within healthcare policy, such as, should there be penalties in provision for those whose lifestyles contribute to their conditions (obesity, smoking, alcohol consumption) or should under-16s receive contraceptives without parental consent? Moving in closer to actual healthcare delivery, the debate becomes more professionally grounded, for example metamorphosing into questions of where service funding should be directed e.g. Heart disease and smoking. Arguably non-smokers, have a more virtuous disease state, aetiologically out with the control of the patient; the second, perhaps more a result of lack of personal responsibility – who should get the transplant? However, in both these examples, the debate occurs at the level of population. As we move in closer to actual practitioner-patient interactions, we begin to encounter different modes of distance-far.

Now if you go along to the Scottish Government, Scottish Executive or whatever you know they will say “we have improved community care therefore er, people with dementia are staying in the community,” and you all think well that’s just bollocks you know. You know you haven’t done, you know this, but they will have signed a letter saying community care will be improved and passed it on therefore it’s done, you know that’s how they think. But if you, if you’re dealing with someone who you know is at home and you can’t get a Home Help for a month, you know, then you’ll know whether that’s accurate or not you know. (Dementia, Interview 3)

Moving in, the next level of distance-far positioning, is bound up in the role of the theoretical Biomedical Ethicist. The Biomedical Ethicist will professionally debate the pros and cons of clinical action often using ethical universals, ethical principles which may be helpful but are not necessarily deterministically followed through. A clinical case will be provided and debate occurs as to whether the right course of action was undertaken with regard to prescribed logical, ethical premises. In absolute terms action will be evaluated ethically. However, as Arthur Kleinman astutely points out, for these ethical theorists, *actual* tangible

patient suffering is rarely encountered (Kleinman, 1995; Kleinman, 2006); they professionally have the luxury of distance-far ethics.

I also have a thing with the carers groups, there's one started, carers and partners in long term care who have passed away and we meet every so often and go for a bit of lunch. We are looking to develop that further i.e. start going to the theatre. I like the theatre, again it's not very nice going on your own, or a concert, and it's not the same. And then holidays... (Dementia, Interview 1)

What of the practitioners who encounter ethical dilemma in their practice, how are these lived tensions professionally understood? It appears that even when what has been subjectively experienced, distance-far is often still maintained; discussion reduced to clinical case study. As one General Practitioner colleague, in a moment of self-reflection noted, '*Oh! we talk in the third person*'. It seems that linguistic grammar and professional ritual both work to maintain professional objectivity, perhaps simultaneously maintaining a safe, psychological distance for the individual professional. Ethics even at the practitioner-patient level appears to be constructed as distance-far, objective phenomena, clinically, without subjective impact. And yet in Kleinman's distinction above and the quote below there appears a separation between the ethicist and the practitioner, the ethics debate and the clinical actuality. The suggestions becomes that distance-far ethics is not all there is to say, Kleinman highlighting as he does *suffering*.

Participant: Well, they're UCT year 5 so it's not the babies that come in that are completely enthusiastic and they're going to heal the planet (laughing).

AD: (laughing).

Participant: By the time I get them they're, they're ...

AD: A bit jaded?

Participant: ... they're not going to heal the planet. Erm, so that, that's usually a session every week and then you've got this problem basically learning curriculum in Glasgow and I'm a facilitator for that and I do a session of that a week for ten weeks at the, at the university here and that's really nice because it's a very structured way of teaching and it's cognitive stuff, it's not clinical stuff, it's not hands on stuff, but you give them a sort of scenario and they have to work out what's wrong and you role play the patient or the patient's relative or whatever and go through it and ... I like it,

we always hit the ethical and social dimensions which of course are most interesting.
(DSDs, Interview 2)

Suffering is central to practitioner-patient relations; patients seek help for that which they suffer from. This may be couched in biomedical, social or psychological terms; but suffering does not occur distance-far. Suffering is instead *distance-near*, it occurs at the micro operational level of the practitioners' daily work. I read in the paper about a new day service being established for older people and skip over the details (distance-far) for the practitioner who has faced the daily loneliness and isolation of the early stage dementia patient and fought for improved service provision, the victory is tangible (distance-near). Ethics can be understood as occurring from a distant far objective level via politics, population or third person theoretic, or alternatively distance-near, understood as personalised, emotive forms and where *suffering* is implicitly taken as central to the interaction (Kleinman, 1995; Kleinman, 2006). The type of suffering that practitioners are daily and frequently confronted with is exemplified in the following words of a carer participant.

And when I went home that night I felt I had left NAME, and from that point I was quite suicidal, I actually thought about it. I've done it. I can't do any more. But then I thought to myself no, that would be letting NAME down and I have to fight it.
(Dementia, Interview 1)

It is *distance-near* that I am interested in. In turning to suffering I assume that the translation of a deontological framework which directs professional behaviour is not a straightforward affair and is necessarily merged with the lived interpretations, as healthcare practitioners daily come into contact with very human hopes, desires and needs within the dialogic practitioner-patient space. Distance-near is messy, subjectively and inter-subjectively constructed, debated and contested and is operated in daily practice. The experience of suffering is core to distance-near ethics is central to further conceptualising the social function of MCNs.

Evidence and uncertainty

Before it became a movement, or a cause, evidence-based medicine (EBM) was a kind of cognitive itch: a troublesome doubt that follows from the realizations that humans

are fallible, that scientific knowledge increases and that medical decisions sometimes have very high stakes. If you make a mistake, your patient might die. Less ominous, even if they do not die, patients are often paying for physicians' services, either through taxes or by putting cash on the barrel in one way or another. Failure to know what one is doing then becomes a kind of rip-off or scam. These realizations tend to focus the attention of most clinicians. (Goodman, 2003 p. 1)

Beginning in the 1980s in Canada, the idea of *evidence based medicine* emerged. In simple terms it was centred on the belief that clinical decisions should be rationally made and founded on the best available information for any particular issue, the overall aim to improve practice. As an empirical reality it has many problems, psychological as well as systemic. However, challenges aside the idea has infiltrated clinical practice quite successfully and practitioners seem in broad terms at least, to agree with the premise that more knowledge is a good thing and aim to be, at the very least, evidence informed (Nutley, Walter and Davies, 2003). Evidence, and the quality thereof, thus becomes vitally important.

To gauge the quality of the information, its veracity and validity is predicated on methodological reliability. Research results relevant to particular questions are placed upon a hierarchy with respect to underlying design rigour. This ranges from the case studies/case reports at the weakest level, through case control studies, cohort studies, randomized control trials, systematic reviews; to the evidential pinnacle, the meta-analysis. The aim being to allow an objective assessment of research claims by consideration of its positioning on the pyramid. The understanding being the higher the positioning on the pyramid, the more weight can be placed on the related findings – the higher up the pyramid the further we are from the mess of subjectivity. Ultimately, objective comparison should be possible between disparate pieces of research going some way to clarifying the 'gold (star) standard' of clinical care and treatment is. Drawing on replicability and validity, this natural science methodology provides a systematised key to information evaluation and decision-making, the goal for scientific knowledge to be used to provide a definitive answer to inform action. However as noted above, the model has some problems. It assumes that one, the practitioner is a rational, objective being who is able to make statistically sophisticated judgements between multiple and often conflicting forms of information. Two, that they have the will (and time) to do so.

Three and perhaps more immediately relevant for our purposes, that the information needed is available.

It is surely a great criticism of our profession that we have not organised a critical summary, by specialty or subspecialty, adapted periodically, of all relevant randomized controlled trial. (A. Cochrane, 1979)

Whilst there may be some question as to how this figure was actually calculated, the alleged percentage of practice which is evidence-based at the high quality or gold standard level stands at around 10-25% (Goodman, 2003). If Goodman's figure is accurate we are left with accounting for non-gold standard evidence based practice at 75-90%.

'[I'm] giving an opinion without letting them know I have no idea what I'm doing'
(DSDs, Observation 9)

'Participant *[on being asked about the typicality of the above statement in an open forum]: No, I think people might say these things, I've actually heard people saying similar things in the past but maybe not in such a wide audience. I think it's a sharing of those feelings or not feelings, share of information is new but as you say, it's okay to say, I don't know and it's okay to ask other people what they think and they might say, we don't know. But knowing they didn't know either is helpful.'* (DSDs, Interview 4)

'AD: *Because I mean, part like the whole evidence based medical practice thing is that you kind of go to the evidence, the answer there and you bring it out, that's it, everything is wonderful. But in reality...*

Participant: ... The evidence isn't there.

AD: *Yeah.*

Participant: The evidence isn't particularly good, and most of the evidence is based on people's opinion, saying 'well I do it and it works so it must be okay.' (DSDs, Interview 3)

'Well, the paediatric bit, a few differences of opinion about some very minor issues, well, some people regarded them as major, but the beauty of evidence based

medicine, you have to go look at the evidence. The difficulty then is the evidence is not necessarily there. The level of everybody's expert opinion, then you're going back to the experts and think about what's best.' (DSDs, Interview 7)

If it is the case that there is often no definitive evidence, this suggests that *uncertainty* becomes a central notion to practice. Evidence runs out or is simply not there, but clinical action must continue. Practitioners must function without having a robust RCT evidence base to draw from, at times left only with informed best guessing. If evidential uncertainty is common, it would be reasonable to ask what other premises practitioners actually use to make their decisions.

Anyway, so what we do is very much discussing that lack of evidence with everybody else. The problem has been where the patient goes through your summary, the patient goes to see another person and the other person is in different clinics, and you may get slightly different opinions. So I think by getting us all in one room I think that's helpful. (DSDs, Interview 1)

If you're going to act on evidence, then the evidence is building all the time. There are numerous areas in which knowledge or evidence reaches its limit and then you have to go on what... (DSDs, Interview 4)

it is a reality that interactions of a patient is an approximation of what you know of as best practice, working out how much can you do without to get more people seen. So you get consciously aware of that but in an ideal world you would give x, then you're asked to do y, y is hopefully safe but it's certainly not what you would wish and it's not what you would hope the patient had come to have an expectation to expect. (Dementia, Interview 6)

Morals-in-practice

I have argued that within practice decisions, considerations of ethics and evidence are central. Implicated in these are the further concepts of suffering and uncertainty. Central to this is an acceptance that *complete objective knowledge (ethical or scientific) is always lacking* and as

a result practitioners must use whatever is close-to-hand to inform and justify their action, oscillating continually between these imperfect guiding sources.

It's also the learning element that is also very useful is on the surgical side, is other specialties because for individual patients, we would confer with a surgeon, with one surgeon and we would hear back from them and surgeons very much make their own decisions about surgery. What's really fascinating, I think is hearing the surgeons discussing surgery and the options and hearing their uncertainties. You see, that's a whole new thing. It's a wider experience than we've had before because it's more been a one to one thing and then, naturally a surgeon will have a surgical preference what operation they might do or when they might do it or how they manage things and some might behave more autonomously than others and from a clinician's point of view, I think we've probably always would share things but there's much more of an open invitation to do so at any moment. From a surgical point of view, I think DSD has really broken down barriers, hugely. (DSDs, Interview 4)

In the following sections I illustrate this dialogue occurring within the MCN sites. Through the use of the *morals-in-practice* organising frame, I demonstrate the epistemological dynamism through which practitioners attempt to meaningfully inform their actions. In and of themselves these practice decisions may be of interest, but for present purposes their salience moves beyond the single patient. Instead what we begin to see is individually and collectively formed morals-in-practice becoming constitutive of and constituted by the MCN – services, clinical policy and national guidance not only influencing, but becoming influenced by, MCN work.

8.3 ADDICTIONS: METHADONE - CONSTRUCTING A SERVICE

We've got protocols and procedures, how we prescribe our methadone and we've got, guidelines on how to do alcohol work and things like if someone steals from a pharmacy do we discharge them, and what are the processes we go through. And most of what we do is very contentious and there is no right answer so we have a defined rule set that we can try and work to so we have, if not correct method of practice but consistency of practice, that's what we would aim for. (Addictions, Interview 5)

Methadone is the pharmacological treatment of choice for users of opiates, generally heroin. Methadone is green in colour and although available in sugar-free varieties, it is generally prescribed in its non-sugar free version, which whilst associated with significant dental decay, is arguably more acceptable (palatable) to patients (Information provided by Addictions, Interview 11). It is used as substitute for individuals who are being supported to end their opiate addiction and forms a central plank in the Scottish policy on drug harm-reduction (*McClelland Report* (1986); Scottish Office (1994); *Drugs in Scotland Meeting the Challenge*). The underlying assumption appears to be that the methadone will enable the addicted individual to combat the physical craving associated with withdrawal, whilst creating a psychological window enabling users to increase their chances of successfully becoming opiate free.

At this point, there seems little which would cause any great degree of concern regarding the possible use of methadone and a straight forward outsider reading would be that, any treatment which can support the patient stop the cycle of addiction must be good. However, observation and interview quickly illustrated that this was not the case and that in fact for the MCN members, the mechanics of prescribing methadone was fundamentally important and that their respective positions were not answerable merely in terms of best clinical evidence or bioethics but the inter-relationship of the two.

Central to this rather lively treatment debate appeared to be contested interpretations of *Do No Harm*. However, the mere straight-forward identification of this ethical underpinning proved inadequate to explore the impact this deontological statement had on MCN functioning. Whilst all were experts in their field and drew on the latest research findings within their respective disciplines and clinical field, this did not in of itself equate to the same readings or conclusions of these findings. There was not only different interpretations of the meaning of the same results but mobilisation of fundamentally 'different' interpretative, professional models; neurobiological, psychological, sociological, occupational to name but a few. Whilst the mobilisation of scientific evidence was readily alluded to by respondents in interviews, there seemed to be a general reticence amongst MCN members to collectively debate the evidence they were individually drawing upon.

It appeared that *objective* evidence at the most basic level housed internal contestations. This was demonstrated in the lack of coherence and replication of services and treatments across the various HB areas. Simply if there was an agreed *gold standard* of care, delivery modes created from the same evidential underpinning may be expected to fairly coherent and consistent across the patch – they weren't. Neither the ethics of *Do No Harm*, nor scientific evidence for addictions taken in isolation appeared adequate to understand clinical action. Could morals-in-practice prove of any use as an interpretative schema?

Methadone and morals-in-practice

For some clinicians, the potential neuro-pharmacological risk associated with methadone prescription could not be adequately predicted and thus prescribing was an act done with a high degree of caution. The scientific evidence from animal studies on neurotoxicity was sufficiently concerning for these practitioners to question whether their prescribed treatments would be doing more damage to the patient than non-prescribing. For these clinicians the issue of *Do No Harm* was seen to be focussed at an individual level, protecting the patient from further potential neurological assault related to prescribed regimens, scientific evidence providing a relative contraindication warning.

For other clinicians however, their concern when prescribing methadone was apparently to stabilise the patient as quickly as possible. The aim to harness the patient's subjective request for help as soon as was organisationally feasible, thereby exploiting a perceived window of psychological (will) opportunity. The therapeutic aim not only to allow the individual world of the patient to be rapidly anchored (drug users are often described as 'chaotic'), but further acting as a protective factor for society in a wider sense. Evidence for this was marshalled from published rates of drug-related offending (Scottish Executive (2004) *Reconviction following drug treatment and testing orders*), concomitant child protection issues (Scottish Government (2008) *The Road to Recovery*), and incidence rates of Blood Borne Viruses via intravenous drug use (Scottish Executive (2006) *Hepatitis C Action Plan for Scotland*). *Do No Harm* was associated with stabilising the patient quickly and wider societal considerations.

I don't think that overall giving people more drugs is a particularly good idea, but it really, really works to stabilise people for long enough to get them engaged to do the psychological way. So I buy that. (Addictions, Interview 2)

No doubt these archetypal extremes are artificial, with most participants oscillating between the two outlier positions. However, throughout the MCN, members did appear to grapple with the prescribing relative to *Do No Harm*: that is, did *Do No Harm* refer to the individual or did it include society more generally?

Participants themselves did not appear to recognise an underlying usage of *Do No Harm* as an interpretative device, instead framing their debates with regard to their evidence base e.g. research, treatment protocols, care packages and service planning. However, the content of their discussion, seemingly without solution by appeal to evidence, appeared to rest on each individual's moral, distance-near inter-mingling of ethics and evidence: evidence mobilised to justify particular readings of *Do No Harm*.

There are huge differences huge differences in philosophy that you wouldn't get in diabetes or anything else. No one has the hard and fast answers. (Addictions, Interview 8)

Of itself, this observation would not appear to be of any great relevance to the MCN, as at this level of presentation it seems to be little more than an example of where abstracted ethical interpretation engages with contested clinical knowledge: an interesting example perhaps of when evidence is not forthcoming and ethics does not even delineate its scope. However, due to the imperative for action inherent in distance-near suffering, ethical debate and scientific evidence quickly merge to attempt to deal with uncertainty. This point of merging, becomes translated into action. The local organisational world can thus become understood as an embodied representation of these dilemmas, enacted as they are in practice. For Addictions, clinical debate becomes action with regard to issue of the threshold for prescribing methadone.

Methadone prescribing thresholds

Methadone can be prescribed using different prescribing regimes, some participants referred to this as a '*prescribing philosophy*'. Prescribing regimes refer to the interplay between the timeline of commencing treatment, the dosage of treatment, and the rate by which treatment increases. For those who are more cautious regarding the impact at the individual level, they

would tend to use a high (or higher) threshold prescribing regimen. For those who are interested in stabilising the patient as quickly as possible, a lower regime will be used. Each of these thresholds will be explained in greater detail information provided by one of the MCN members (Information from Addictions, Interview 8).

For patients who enter a service which uses a high threshold *prescribing philosophy* prescribing will be after a prolonged referral to waiting time (approximately 12 weeks). The individual enters a period of pharmacological assessment known as '*tolerance testing*'. For tolerance testing, the individual will be asked about how much opiate they are using and the amount of methadone to be prescribed will be dependent on this number. The initial prescription level will often be a conservative estimate based on this reported amount to minimise adverse effects due to overdose (i.e. being prescribed over their tolerance level). The individual must remain in the clinic for several hours so that signs and symptoms of withdrawal can be monitored. If withdrawal symptoms are present another therapeutic dose will be administered. This process is repeated the next day. By the end of this process the tolerance level is clinically gauged and a prescription is written for the month. Prescriptions are generally taken on site at chemist premises. This is in itself a ethically contested practice, with issues of *anonymity* (the methadone is sometimes taken at the pharmacy counter in full view of any passing public), *trust* (the individual is fundamentally not trusted not to abuse their prescription e.g. trading it on the black market) and *responsibility* (observation by pharmacist of the patient is structured within a paternalistic dyad) are entangled with this practice. Before prescribing there is usually an intensive psychiatric/ psychological assessment, which added to long referral-to-treat waiting times, makes for a high drop-out rate.

For those using low threshold prescribing, an individual self-reporting an opiate problem can be prescribed methadone relatively quickly. Once an individual self-refers, they will be given an appointment for a clinic within 6 weeks. The individual will be unlikely to have had a full assessment when they begin treatment and will go through a '*rapid titration*' pharmaceutical process to find an appropriate dosage. They will be started on a prescription at a much lower dosage (approx. 20 mls, max. 40 mls). This is given to take away and self-administer for 3 days and the dosage is upped by 10 mls. This is repeated in another 3 days and so on, until the appropriate therapeutic dose is reached. This form of prescribing is normally referred to as '*harm reduction*' and was the focus of a major central government policy push (Scottish

Office, 1994). This form of prescribing has increased uptake of the service considerably, one participant believed the service had gone from 800 patients to 1300 patients being treated (Addictions Interview 8). The publically reported impact on health service funding in a low threshold prescribing area in the MCN was debated in a local newspaper (30/12/08). It was reported that the total amount of methadone prescribed had increased from 16.5 million units in 2006/2007 to 26.1 million units for the year 2007/2008, attributing to a rise in cost from £248,000 to £486,000.

if you looked at it in another way, then you'd be saying for every pound spent on addictions, there would be sixteen pounds saved. Another way of saying it is that addiction is costing you and me two and a half thousand pounds a year. Em, so there'd be a large number of people who are be coughing up two and a half thousand pounds, who would say 'line them up and shoot them'. (Addictions Interview 8)

*Basically philosophies which are, probably you would call very low threshold approaches to prescribing. What that means is your view is that the treatment of drug dependency is to get people on methadone. So you believe that it trumps everything and that's what you need to do. So you go about making sure that your services are set up in a certain way, that anyone can get methadone if you think they have a drug problem. Now, the question is what are the checks and balances you have in there? If you make services so low threshold, what will happen is a lot of people who are not opiate dependent will be put on methadone. Is that a **good** thing? Well, some ah, some people would say, 'well, yes it is, because they'll not die of opiate overdose', although they might, of course. Other people and I'm certainly one of these would say, 'that's serious overkill'. The reason for methadone, which is a great treatment, is so vilified by the public, is because all the wrong people get put on it and get put on it the wrong way ... (Addictions, Interview 4)*

Implications of different prescribing philosophies

From the above quote, ethical considerations are used to assess evidence. *Good* is used as an evaluation and the impact of methadone prescribing on the individual (versus societal considerations of *Do No Harm*) is considered. More importantly though, it becomes apparent that these discussions are not left at the level of ethereal debate but that provision is

actualised on the different moral understandings of the individuals involved. The result is very differently designed and delivered clinical services. For example, in sheer throughput of patients alone, services have to cater for large differences in referral numbers and treatment expectations. Across the 3 different MCN areas sites operate different models of service delivery ranging from walk-in, drop-in services staffed for quick assessment and pharmacological delivery of a rapid titration service, to others which are more geared toward the assessment and provision of psycho-social support. What is delivered on the ground and how it is accessed, can look very different depending on the focus of *Do No Harm* and whilst presumably the same evidence base is available to all, what evidence is mobilised and how it is interpreted can vary widely.

This crucially, impacts on what is possible for the MCN to agree and deliver. Policy provided the justification to construct the MCN as an entity which could provide a mechanism through which certain bureaucratic and clinical functions could be carried out. For example, within this particular Addictions MCN there was a desire for clinical governance and prescribing protocols to be shared and a degree of concordance reached as to practice across the 3 Health Board areas. Motivation for this, variously understood as creating a ‘critical mass’ or adequate sample to allow clinically meaningful research and audit to be undertaken of interventions undertaken (Addictions, Interview 1, 4, 7) and more prosaically to allow patients to cross HB boundaries without any disruptions to their treatment packages (Addictions Interview 4). However, if as has been suggested this is no longer a straight forward task of delineating services based on best evidence or with reference to ethical dictate, but instead becomes embroiled with morals-in-practice, the degree to which collective coherence can be achieved and rolled out across the piece becomes increasingly challenging.

In Scotland, it's quite hard to do, to do work on a scale that you're going to need getting your teeth into. The only places in Scotland that can are Edinburgh and Glasgow, so that's to do with population size. The MCN actually in substance misuse, drugs and alcohol, bring together three areas which are actually representative of Scotland. [MCN HBs] are much more like Scotland than either Edinburgh or Glasgow are. So we have a population which is much more reflective of the Scottish population. You know, large county towns, rural hinterland, x heavy industry, blah, blah, blah. You have that. You have an overall population of about 1

million people. So that's comparable with the two other big conurbations. You, you have, you know, a range of different relationships between health boards and local authorities. The opportunity to really look at practice across that, if you were able to take that just as an experiment, which is still kind of where we were coming from, is amazing actually. You, you know you've got 20 percent of the Scottish population. You could bring together some uniformity around treatment, you could look at outcomes, you could look at methods and models of delivery and all that. (Addiction, Interview 4)

Further considering the Addictions MCN, in quantitatively measured (yes it did/no it did not achieve) audit terms it would appear the MCN has failed in its undertaking to create shared prescribing protocols, an aim inherent in its stated governance requirements. However, this audit framing fails to appreciate the moral complexity and importance of the debates underpinning MCN activity and continuity. For this MCN at least, the evaluative observation that the MCN has failed in its creation of shared clinical protocols and clinical governance, appears to ignore the highly contentious nature of this biomedical practice debate. Further, in failing to recognise the central importance of ethics and evidence to practice, simplistic forms of audit not only underestimate the contested nature of healthcare, but also act to nullify that which is of greatest distance-near, moral importance within the local, clinical world.

Alternatively by widening our analytic lenses to include the moral nexus, where ethics and evidence merge, our evaluations may gain a partial understanding of why certain seemingly straight forward bureaucratically anticipated activities are not achieved. Each clinician's practice does not arise solely from an objective bank of scientific knowledge, nor is it neatly based on an objective ethical absolute translated uncorrupted into the real world. Further, the dialogue between evidence and ethics does not stand apart from the MCN but is in fact central to its construction and potentiality. What the MCN can or cannot achieve is illuminated by considering what is fundamentally important and therefore, contested to those organising themselves in this way. Furthermore, that individuals choose to organise themselves in this way may become more readily understandable in that the MCN may be providing a space which allow morals-in-practice to become reflected upon collectively.

However, it would be fair to ask is there not something unique about Addictions which means this relationship between evidence and ethics is somehow specific to this clinical condition?

Perhaps, this clinical group is related to a particular social class, lifestyle or psycho-social functioning which is not that relevant to other populations. Perhaps morals-in-practice are a peculiarity specific to this MCN and as a conceptual framing will prove little use elsewhere.

8.4 DEMENTIA: MOVING OUT OF THE HOSPITAL

the figures you know you can go round and round with figures but I mean there's 72,000 people over 65 in Tayside and if you talk about some degree of dementia err there's probably about 10%, so it's about 7,000 people you know. Now the number of cases of bowel cancer in Scotland last year was 5,200 I think so HB is one eleventh of the population. So you know if you look at the profile of bowel cancer and what they do for it and you look at the number of people you know there are probably eleven times as many, more than eleven times as many, you know in Scotland but you know does it have the same profile? Well not really you know. (Dementia, Interview 3)

Dementia is a common condition, which year on year is increasing in real numbers. As healthcare improves lifespan, more elderly are surviving to exhibit signs of significant cognitive decline. Unlike the previous two cases healthcare has little to offer on the biomedical front, pharmacological treatments being few and of low efficacy. Services are designed to involve a complexity of cross sector partners, both in helping to maintain an individual within their home and ultimately in ensuring quality care is provided within institutional settings. This central biomedical impotency will be indicated within the morals-in-practice exhibited within this MCN; going some way to helping understand this groups activity as it grapples with trying to organise services much of which falls outwith healthcare organisational control.

I mean concentrating on vascular problems in middle age, may be a benefit but the primary benefit is not to reduce dementia it's to reduce heart attacks and strokes and such like, which means people will live longer and therefore have more chance of developing dementia. So you know the problems of dementia are problems of success not problems of failure, you know if ... if the Government hadn't made people live as long and be as well educated and so on they wouldn't have this problem. (Dementia, Interview 3)

I think the document was called 'The Rising Time' and that was in the mid-seventies, we've identified at least since then, there is a particular issue with what are called baby boomers, but you're right, it's a year on year gradual increase which has perhaps been slightly exaggerated by improved medical treatments. Perhaps more people surviving in terms of dementia, more people surviving in terms of treatment, but the basic demographics have been known for a long time. I can show diagrams of population trends that go back to the start of, not last century, the start of the twentieth century and it's been a fairly steady process through that century.
(Dementia, Interview 6)

The daily management of patients has also been impacted by a change in healthcare delivery. Across the UK over the last 2 decades there has been a sustained effort to reduce the number of hospital beds, shorten length of hospital admission and place care closer to home. This policy push filtered down into local strategies and operations, resulting in an exodus of patients from the hospitals into community settings, with changes to roles and responsibilities of staff.

Along with the teams being set up, obviously we had quite a lot of continuing care beds and clearly the move was towards care in the community. So we've closed, well, closed or changed, moved resources from having something like 120 odd continuing, well not just continuing care, but 120 odd beds to, we now have only 67 beds, and we have no continuing care. Because as part of the strategy we believed that people don't need to spend the rest of their life in hospital unless there is a real health need, and quite often that was not the case. (Dementia, Interview 6)

With time, the focus has been less on getting patients out and more on keeping patients from going in. In its current policy incarnation this drive is referred to as *Shifting the Balance of Care* (Better Health, Better Care, 2007), but in essence the aim is to keep those patient groups who do not need in-patient health service care in their own homes with services to be provided for them there. In order for this to be achieved different providers are being urged to work together as *partners* (creating cross service strategies and planning) or ideally *integrate*, working together (through single shared assessments, being members of MDTs, having care managers).

Shifting the Balance of Care (SBC) describes changes at different levels across health and care systems – all of which are intended to bring about better health outcomes for people, provide services which reduce health inequalities; promote independence and are quicker, more personal and closer to home. This means we need to develop clinical and care pathways that may involve shifting location, shifting responsibility; and identifying individuals earlier who might benefit from support that might sustain their independence and avoid adverse events or illness. This means we are shifting: towards prevention, who delivers care and location of services.’ (Scottish Government, www.shiftingthebalance.scot.nhs.uk/)

For an MCN that deals predominately with frail elderly, this has meant that the services that work closest on a daily basis with this client group are often outwith the NHS, such as the Local Authority or private care homes. Although, there are still some wards which cater for people with dementia and challenging behaviour in community hospitals and/or district generals, the bed numbers are few. An elderly person with challenging behaviour may come in for in-patient care, but unlike previously, where a patient with behavioural issues may be admitted to longer-stay care wards, the aim is now for medical or rehabilitation referrals to be dealt with quickly and the individual discharged to home as soon as is feasible.

she'd be sitting in the house and she would get up and be shouting at somebody. Once I went in the hallway and she was walking down the hallway and standing just shouting at the glass reflection. (Dementia, Interview 1)

However many of the behaviours that those with moderate to significant dementia exhibit are highly challenging, and can at their worst involve violent outbursts. Whereas previously, these individuals would have been cared for in a long-stay hospital facility, often on a locked-ward to prevent wandering, often this person is now maintained at home or in a privately run care home. For one participant who had previously worked on the wards and subsequently moved out into the community, this raised significant issues to do with risk for an elderly person with dementia remaining at home. Whereas previously in the hospital the environment had been controllable, the patient monitored 24/7 in a community setting they had had to learn to give back control and responsibility to the individual.

I think that, as nurses in institutions settings, and I'm being quite generalist here, we tended to not let people take decisions about their own risk, we make them for them. It's easy for us, we can lock the door. We can say this is a locked unit and we're locking the door because we believe it's in the best interests of everyone in it, everyone on the ward. Whereas in the community, you're in someone's house, and it's not for me to tell them to lock the door. You can suggest things, you can work with them for different things. I guess it's kind of hard to verbalise, but I think that's probably the biggest thing, the biggest part of my whole practise that changed was my approach to risk. (Dementia, Interview 6)

It could be argued that in an institutional setting the patient is safe from harm, but the cost is liberty and freedom to choose; a tension that this participant was all too aware of, going on to say.

I don't know if these are the right words, but taken for granted that a dementia unit would be locked, but without any real thought about the fact that you were restricting people's freedom and liberty. Not everybody that was in the ward was actually detained under the Mental Health Act; and really that's the only way you should have the door locked; but it was done out of the best interests for the largest group of people. So if three people needed the door locked, it meant it had to be locked for everybody. (Dementia, Interview 6)

As care changed in the setting it was delivered in, the dilemmas changed with it. The above participant gave one example of a lady who wanted to cook chips and the lengths that staff went to manage risk of fire against providing her with the freedom to do this. For example providing an enclosed fryer with a timer, placing it beside a window, making sure not much cooking oil was in the house, and having a fire blanket.

The implication is that different interpretations of *Do No Harm* and risk are linked to the environment in which they occurred. The hospital there was some level of blanket control which minimised risk perhaps at the cost of some individuals' personal liberty. In the community risk has to be managed to maximise an individual's liberty. In the first *Do No Harm* appears defined as no physical harm, whilst in the second it appears related to *Do No Harm* to an individual's right to freedom and choice.

What do you do when there is no cure?

For dementia there is little curative medicine to be done: no (semi) magic bullet of methadone or high-tech surgical technique. At best clinicians can hope to slow the progression of the disease or help to alleviate behaviours which are seen as problematic.

A lot of conditions if you think about what are now called long term chronic conditions in people of acknowledging, there's a lot of medicine, medicines for heart failure, things like arthritis, there's a lot of things out with the psychiatrics here that are not cured. But you're right it is nice, even depression can be cured...I think you reset your goals if you think about it, you've got a disorder that you're not going to cure outright, you probably play games with yourself without realising, if you have a rate of progression and you slow on that rate of progression and you've helped cure, whatever, something. If you have a behaviour which is causing immense distress to the person and to others and you bring that under control, you have cured that behaviour temporarily (Dementia Interview 8)

However, these treatments are not without their moral difficulties. For example, whilst the use of anti-psychotics may be questionable, quite simply docile patients are easier to manage. For those working for disruptive and violent patients, there is the need to try and manage what can be frightening and potentially dangerous behaviours towards staff and other residents.

Participant: It's rapidly changing, the Scottish Government is against the use of anti-psychotic drugs for people with dementia, so there should be changes. But again there's an attitude amongst medical staff, this is the way we've always done it. Now I went to a lecture of Clive Ballard's at the University in Glasgow

AD: Is Clive a psychiatrist?

Participant: He's a professor of psychiatry based down in England and he'd done a study on use of anti-psychotic drugs and he done over 165 patients and some were placebos and some were that, and at the end of the three year study I think it was, most of the ones who were on the anti-psychotic drugs were dead, it actually killed them.

AD: Right, okay.

Participant: And I told the nursing home that this lecture was coming off and they got six tickets, and four of them went through, and after the lecture I spoke to one of them and said how did you like that. She said no, I didn't like the lecture, she said we've got to use these drugs. So it's drilled into these nurses that they've got to use these drugs to control the patient.

AD: Did they say why they have to use the drugs?

Participant: To basically control people, that was the mental health nurse.

AD: Yes, because I mean the kind of underlying theme that I am getting from that is the actual sedation is quite a good thing for the staff.

Participant: It's easier when the person is sat there quiet and not bothering anybody. But they are sitting there dying. But the thing is, if you think of the behavioural problems, there's things you can't do, like say come on lets go for a walk, take them away and put them in another room, go and sit in another room, there's things you could do like that. Well again you could take them away. You might need to play it differently, like a 6 foot 6 patient couldn't be, needs a secure ward, but for someone half that size, cussing and swearing and what not, and lashing out but surely she could be moved from one place to another to quieten her down.(Dementia, Interview 1)

However, from the above quote there comes the uncomfortable suggestion that certain medications are used as: 'well Clive [Ballard] described it as a social cosh' (Dementia Interview 1). It seems that albeit the scientific evidence appears to show that these medications are related to early death, it seems that their use is more readily assumed as pragmatically necessary, being less questioned within certain environments. In this case, it may be that the apparent control of the institution is creating assumed unsafe behaviours.

I raised the concerns about using drugs on people with dementia from different departments but there's nobody really pinpointed to say right okay we'll have to seriously look at this because, you see they are too ready to reach for the prescription pad nowadays I find and in days gone by you went to the doctor and he says look do this, do that, do that, and sometimes you didn't get a prescription. Now you go to the doctor, he's got his pad written, and people going into surgery, they expect to come out of that surgery with a prescription. (Dementia, Interview 1)

As *Shifting the Balance of Care* has aimed to maintain people in their own homes or moved them into private and Local Authority care facilities, the burden of care has now fallen on family members or care staff. This has had a knock-on effect, with carers frequently showing signs of having adversely affected mental and physical health. For members of this MCN it became a central piece of their focus to help train up members of care staff to deal with dementia patients.

similarly you know if you go into a care home and you say right now what ... what do you think you need here? I mean, look this person you know they've been on drugs for ages and they haven't improved and you know your staff are running around and they're afraid to go near them, you know 'what do you think you need?' And they will say, 'aahh well you know ...' they'll say training, and you say 'well is that all you need?' And they'll think 'no, no it's not, actually what we need are you know more specialists input on a regular basis, people who can come along and advise, not a Doctor you know who' ... by and large Doctors don't see people you know face to face as much as other groups of staff 'but you know someone who will maybe come in and say well let's observe that person over the course of a whole day'. You know and I'm not going to do a time and motion study. I'm going to sit and watch the patient and see what they're doing, see what you do you know and at the end of the day we'll feed all this back and so on and so on.' (Dementia, Interview 3)

This work involved carrying out audit and an education package throughout a number of care homes. The project was well received and findings suggested that the project had made a difference to ground level care staff.

we've got the number of care homes participating in the care home education forum, said that you know dementia's up twenty percent from last year to this year. But my huge [unclear] with that is I could go out and educate all these people, the difference it would actually make on the ground, what would they do with that knowledge, what difference would it make to people who care for them I have no idea. (Dementia, Interview 5).

In this, the embodiment of morals-in-practice can be seen. As changes have occurred in policy and care has changed setting, how ethical absolutes have been translated has been interpreted anew, with novel dilemmas and challenges coming to the fore. As staff have experienced requests for assistance to support others' practice, the focus of their output has moved towards action, the MCN becoming the space where those closely allied to distance-near moral experience, can operate to improve the lot of their patients and carers.

And that I think is ... is you know one of the advantages of the MCN is that it's not all managers sitting round you know looking at their officers saying "well I could allocate this and I'll take that. You know there are coal face workers there you know people with eon's of experience of dealing with folk with dementia. (Dementia, Interview 3)

It seems then that morals-in-practice may also be a useful framing for those dealing with understanding the work carried out around common biological conditions which have the potential to affect every one of us. However, it may be that the lack of technical and high-end medical interventions affects how practitioners construct their work; the lack of viable treatments in secondary care distinguishing them from tertiary care services.

8.5 DISORDERS OF SEXUAL DIFFERENTIATION (DSD): TO CUT OR NOT TO CUT?

Participant: when I started doing this work you had to have a 10cm vagina, now ... isn't everybody only 10cm? Does it not change from the minute it's born and surely not, but that, that was the kind of measures of a functional vagina (laughing).

AD: And you had to measure it? You actually had to measure it?

Participant: People did, yes...and we got this length of vagina and, you know, maybe got that once and then it all shrivelled up and fell out or something like that.

AD: (laughing).

Participant: People are not unreasonable to say 'look I don't think this is ever going to be all that good,' they'll take it on the chin and they'll deal with it because that ... do you know what I mean, that ... the difference between 'well we must make this person look 'normal' as opposed to ...' oh, I don't know, erm what's the best we can hope to achieve.' (DSDs, Interview 2)

DSDs are a potentially fraught arena for outsiders and new incomers (parents, families, children and young adults). The above quote demonstrates how rapidly an outsider becomes bombarded with concepts, images and language that are not of the normal, everyday. The sexually explicit language raises a sense of social discomfort; talk of genitals being generally outside the realm of everyday, public speech. The knowledge that children are born without an identifiable gender is often a challenging new idea. Further this raises the very real question, how can the decision be reached on which gender category to ascribe a baby, a category which will forever more an impact on that individual's life. In blunt terms, this may mean come down to practitioners making the forced choice between - whether it is better to be an infertile female or a male with a penis which may not be sexually functional?

However before we turn consider the basis from which these type of decisions are made, I shall take a small detour into how evidence is contested and constructed at the micro level, a small example of how practice continues even in the absence of knowledge.

Making a penis grow

As I have noted I was previously employed within this MCN (2004-2005). The example in Box 8.2 comes from observations done prior to the time designated as *fieldwork*. I point this out merely to highlight the longevity of this particular discussion occurring over years, exemplifying practice embedded within highly ambiguous science.

This observational anecdote is presented as some background as to the assumptions I had made about baby's penis size due to this experience. I had formed the (uninformed) opinion that paediatric surgeons like bigger penises to work on: bigger penises providing more tissue and more room for surgical manoeuvre. I suspect that when what you have to work on isn't normally that much to begin with, size really does matter. Granted, in the above story my assumption of size might have been based more on my lack of prior knowledge, than what was clinically perceivable: I may have been wrong and what I took to be rather small, was, clinically speaking, rather large or these babies may indeed have had very small penises. Which raises the question, how small is small?

Today, almost all children will be raised according to their genetic sex but sometimes the anatomical variation is so different from the genetic sex, so that a prime example on that, this wouldn't be debatable. It would be somebody with total androgen simply

because they would be girls. So they're not going to present, but sometimes you can have extreme partial androgynies, it would be very difficult anatomically to raise a child as a male. (DSDs, Interview 4)

Box 8.2: DSDs - Hypospadias surgery

Having observed operations for hypospadias, it appeared to me, a lay person, a fascinatingly, fiddly job. On the table had been 3 baby boys (12-18 months old) with varying clinical severity, surgically worked on back to back. Their penile length I assume varied to a professional eye but from my perspective all seemed fairly tiny; being babies, I figured, that was to be expected. The babies were anaesthetised in the arms of their parents, wheeled into theatre on a trolley, had iodine swabbed onto their penis and the cutting quickly began. The surgeon seemed to peel the layers of skin slice by slice, a bit like an onion I remember thinking, until a buccal (skin graft) could be transplanted; stitched into place. There was a lot of blood and from the vivid memory of my aching legs, a lot of standing. The surgeon had to maintain his 'on task' concentration for several hours, his hands and mind working full out on the job at hand. Although there was a general jovial, calm amongst the team: surgeon, surgical nurses and anaesthetist, it didn't seem far from my mind that what was a routine op could quite rapidly and unexpectedly become an emergency. The clinical session, the 3 operations lasted just over 3 hours and that was frankly more than enough for my calves and mind, so after the lunch break, I did not return.

Micropenis is a condition where the penis is significantly reduced, statistically 2.5 standard deviations below the median size for age. It is frequently associated with hypospadias. Hypospadias is a condition where the hole for urination (meatus) is in the wrong place. The severity of the condition depends on how far down the shaft this hole is. There is a concern that severe hypospadias may impact on later ejaculation and thus, fertility. Micropenis therefore creates real challenges for surgeons undertaking hypospadias repair, as they are limited by the tissue they have to work with (to do skin grafts) and hampered, in very basic terms, by the size of their adult fingers in relation to the area they have to operate on. Size seems to be a very salient aspect when considered alongside clinical outcome. If the size of

the penis does have an effect on what is clinically achievable, it would not seem unreasonable to ask, is it clinically possible to make that which is smaller, bigger?

In the DSD clinic, this conversation was framed around discussions of potential pharmacological intervention, DHT (dihydrotestosterone) cream. DHT is a topical cream which is applied to the penis and arguably encourages penile growth. Over the time, that I had been involved with this group, this conversation topic has moved from patchy, initial queries into potential sourcing of the cream, to the present day, where there seems to be global usage of the cream by the MCN surgeons across the various paediatric hospital sites.

However, the scientific evidence for DHT is not strong and there is no robust clinical trial which the surgeons can draw upon to strengthen their treatment choices. This lack of robust (any?) evidence was highlighted by one of the physicians, who appeared to find much humour in the collective surgical view that they were relying on their clinical observation to argue for good outcomes for their patients (DSDs, Observation 5). Indeed some of the argument for this treatment seemed to be evidenced by little more than lack of clinical response, one surgeon stating *‘well you wonder have they actually put the stuff on at all?’* (DSDs, Observation 1).

The physician it had to be said was in a much more scientifically robust position; there had been was no clinical trial, no double blind and no replicable or valid study carried out – the information simply did not exist. This practice decision was based on expert clinical observation, albeit collectively undertaken by the surgeons. The surgeons it appeared had come to this practice conclusion based on a surgical need: bigger penises on which to work. Understandably, they wanted to improve the circumstances of their surgery in order to improve clinical outcomes, but they had little evidence for their treatment protocol other than, collective, perceptive faith or expert opinion which is at the bottom of the hierarchy of evidence. An answer would have been to design a double-blind RCT and the idea had been mooted amongst the group. However due to the bureaucratic research hurdles associated with trial design, there was little enthusiasm for the undertaking and they instead settled for waiting on someone else to do the research and in the meantime to live with the evidential ambiguity (DSDs, Observation 5).

It seems though that even here where there are clearly medically-based conditions, scientific evidence still reaches its limits, yet practice continues.

Consent for genital surgery

The above is presented as a rather clinically low importance observation around evidence and practice. It is used to highlight that even within the highly sub-specialised, ultra technical end of medicine, or the tertiary hospital, where anatomical and biochemical variables would presumably be more measurable, than when compared with conditions impacted on with social and psychological factors, evidence still runs out and practice still has to continue. Even here at the so-called cutting edge, surgeons are operating on collective expert opinion (faith), doing the best they can for their patients by attempting to improve their clinical odds. Indeed in the face of uncertainty, intelligent best guesses may often prove all that we can hope for. However, what if we return to that more central issue of gender alignment and deciding whether the child should have genital surgery; is intelligent guessing good enough?

I think it's a difference between looking after a little person, who can't speak for itself, and I can speak for them, with the best intentions and looking after a person who can speak for their selves, I think that's the big difference and I've not got any paediatric training except for the time I spent when I was a student, which I enjoyed, but more for the social aspect of it really. The clinical stuff is interesting because you just get different things than adults things, but within MCN I'm very interested in the lack of autonomy of a child, but that's quite alien to me, and particularly with things like the Adults with Incapacity Act and the Mental Health Act, you ignore somebody's wishes at your peril, adult medicine, and your registration's on the line if you override that person's autonomy. But that's not the same for kids.' (DSDs, Interview 2)

Returning to the concept of distance-near, the central uncertainty of evidence becomes much closer to the actual event of decision-making within the face-to-face clinical interaction. This appears to heighten treatment decisions moral salience for practitioners. Observing a clinic, the patient case discussion is seen to oscillate between highly technical discussions, regarding hormone levels, biochemical assays, surgical techniques and internal scans; and consent to

treat, anonymity, disclosure, parental and societal norms, *Do No Harm* and collective MCN moral identity (See Box 8. 3).

There have always been important psychological issues and ethical issues. What has evolved with time, prior to the MCN setting up, but obviously it's always evolving over time, is input from adult patients or adults who are affected with children and their reaction to what happened to them early on, particularly on the surgical side and surgery's left much later now than it used to be before. So there has been a huge change in practice over time and I think that's all the more reason why you want in some ways a clinical support network, I mean of professionals, so the patients get support as well, plus the professionals get support from each other.' (DSDs, Interview 4)

Box 8.3: DSDs – clinical cases

A case would be opened through a presentation by a registrar doctor. The presentation would provide clinical data such as: endocrine functioning levels, laparoscopic video, ultrasound findings. This presentation would serve as a focus for clinicians to discuss their relative specialities to the wider group. The presentation would end with an opening to discuss clinical management.

Case management would often cover issues such as current and future sexual function, family support, knowledge and dynamics, disclosure of age appropriate medical information, service transition preparation, cultural impact on clinical adherence and clinical treatment implications.

2 to 3 MCN members would meet with the patient and their family/carers to deliver the collectively agreed clinical care package.

This is perhaps best captured by the collective decision within the DSDs MCN not to carry out cosmetic (or aesthetic) surgery on children with CAH or AIS. The moral argument runs something like this: we *know* that some of those who have undergone these forms of surgical intervention have *come to harm* (whether psychological, sexual or physiological) but we *don't know* if *doing nothing does harm*; so we will *do nothing*, as it might *not do harm*. In this argument there is a clear inter-mingling of ethics (harm) and evidence (knowing), both interplaying with the other: evidence of clinical outcome merged with *Do No Harm*.

'Participant: we do tend to want to make things normal, people want normal, and you know you have also got this, we are here to try and make things better, that's what we do. Paediatric surgeons for example in particular, we are there to reconstruct things, that's your bread and butter, that's why you came into to do. So if you think 'oh actually yeah I can probably do this', then the parents say 'I well I'd really like, I want a child who looks normal', there is a big pressure to do that operation.

AD: I suppose when I was meaning acceptability, I actually meant further down the line, previously maybe you know if function or appearance is your only outcome, whereas you know, 30 years down the line, you know my clitoris doesn't work properly.

Participant: Exactly, yes....That's the balance isn't it? Between, it's the balance between what is going to get you through school without you getting abused and called a freak and called the girl with the penis, and between you know being an adult who is very unhappy with their sexual function. You know, where they might have gone through school perfectly happy and grown up perfectly happy, but found out they were not that happy later on, or, you know, is that worse than going through school miserable and being thought of as a freak, and then ending up with. If you have the psychological ability to actually form a relationship, you haven't been completely damaged by school and adolescence, then you might be able to have a satisfactory sexual relationship.

AD: So, I mean that's a minefield.

Participant: Absolutely, that's why there is no right answer.' (DSDs, Interview 3)

Box 8. 4: DSDs - genital normalisation

A young CAH patient was seen in one of the DSD MCN clinics. The parents requested that the child undergo clitoral reduction surgery. The surgeon was unwilling to do this as there was no functional reason.

The parents asked to be and were referred to another DSD clinic. Their request for clitoral reduction was refused here also.

The parents were provided with clinical contacts in England should they wish to pursue normalising surgery.

AD: Do you think, I mean in some ways that you have actually kind of got an agreed sense of "do no harm"?

Participant: We do. I think, we have certainly evolved a view in Scotland that surgery should only be operating when there is definite proof that it is going to be of benefit, so I think that has evolved, and I think that's a view that isn't just in Scotland, I know it is spreading, it is around in other places, Liverpool have the same general view now. There are places that don't have that view, but because they take the view that they think they can fix it.

AD: Do you think there is anything to fix?

Participant: Well.

AD: Is that, you know.

Participant: Well, they think they can cosmetically improve it.

AD: Yeah.

Participant: Or normalise the anatomy, or whatever you want to call it.

AD: And is your kind of stance that unless there is some real functional reason to do it then?

Participant: Yes, and not just functional. I think functional potential. I think there are elements, you know issues where, if you've got a child with a huge clitoris, you know in the of the world that we live in up here, if you live in a pretty small village or a small town, if you have got a child with a huge clitoris, you are basically are limited to what, you can't, you would struggle to find a babysitter because you would have to tell them if you change the nappy, don't worry about the fact if you see a penis, she is a girl. And basically she says guess what I did the other day, you know, it gets around pretty quick. So I think that, I think, you know parents come to me and we go through all the discussions blah, blah, blah, we do all that sort of thing, they say we appreciate all the risks, but, we really want our child to have a smaller clitoris, because we think.

AD: The stigma associated.

Participant: Yeah, potentially, but I think that's difficult to argue with, as long as they know the risks and. When a child comes to you as an adolescent, or she comes to you when she is 25, why did you do this to me? I think as long as you can say well look, this is the discussion we had, this was the arguments, your parents felt and agreed that growing up like that, in that environment, because they wouldn't know what it was like, because it would have been sorted by then.

AD: Because in some ways, I mean, part of.

Participant: I think that's one of the reasons why clinical photos are used, I'm not a massive fan of those, but I think in that situation, having a set of clinical photos before you do anything is useful, so if somebody comes back to you in 25 years, why on earth did you do this to me, you can say this is what you looked like before. Somebody I think that tends to be quite persuasive and saying actually, it may not be great but I can see why.' (DSDs, Interview 3)

'It is, it is, most of the problems I have had apart from one, have been parents wanting me to do more than I have wanted to do, I don't have a lot of golden rules, but I never try to persuade people to have an operation, I don't go out to persuade parents against their better judgement to have an operation. But in DSD most of the time when there has been a conflict it has been parents wanting to do more than I was comfortable doing, and that's usually around clitoral reduction and genital reconstruction in females.' (DSDs, Interview 3)

We quickly find ourselves in the terrain of morals-in-practice, the above logic underpinning no less than a national service decision: the decision that cosmetic genital surgery will not be carried out in Scotland in children below the age of consent. How this plays out is observed in clinicians collectively supporting one another to stand by their decision to refuse surgery, often in the face of quite distraught and determined parents who desire surgery to make their child look more anatomically normal. At first appraisal, this would seem of more distance-near relevance for surgeons, as it is they who actually wield the knives, however, as clinic appointments are designed so that physicians and surgeons meet parents as a core medical team, often with a psychologist or geneticist as an added level of specialist expertise, to all intents and purposes this moral decision was enacted by all members of the MCN.

This is not to say that morals-in-practice were always collectively shared. Indeed Box 8.5 shows a situation where a surgeon quite obviously chose to demonstrate their own morals-in-practice, albeit it could be argued in doing so they removed the patient's choice. Nor are they fixed in time. Over the course of the clinic observations, both the ethical and the evidential were re-visited many times as practitioners regularly sought any additional or new information which may have proved relevant. So for example the discussion on cosmetic (or normalising) surgery was re-visited frequently in order to elicit any new perspectives or evidence, whilst also seeming also to act to collectively reassure MCN members of their

decision. Whilst the outcome of discussion for patients was clinical case management, for the collective it was also round the dilemma of their Sachen.

Box 8.5: DSDs – Individual morals-in-practice

A patient with was found to have gonadal tissue which was of genetic interest.

A heated discussion was held as to whether it was ethical to do surgical biopsy to remove a sample of this tissue. The benefits would be increased knowledge, the costs potential assault to fertility.

The decision was effectively made by a surgeon who informed the parent they *'would not do this to their own child'*.

In the main though and undoubtedly due to this paucity of definitive answers, the conversation often served to self-justify and strengthen the moral position and identity of the group. Other national and paediatric services, where cosmetic genital surgery was still undertaken were spoken of somewhat disparagingly, relations between surgeons and physicians stereotyped as separate and bounded, surgeons portrayed as gung-ho and physicians and patients as being *'left to pick up the pieces'* (DSDs, Interview, 2). An example of how very wrong things can go was illustrated in a conference presentation by a (surgical) gynaecologist. The presentation was on the use of, until relatively recently, a once-popular technique for extending a shortened vaginal pouch, the use of rectal tissue as a graft. Unfortunately after this intervention women were affected horribly, left with a continual foul odour emanating from their vagina, along with an associated unpleasant discharge. This long-serving surgeon, suggesting her reserved opinion came with age and experience, and through her descriptions of personal exposure to (distance-near) suffering, was now strongly advocating non-surgical, non-invasive interventions, such as vaginal dilatation (stretching the vaginal cavity tissue by insertion of increasingly sized dildos) (DSDs, Observation 9).

[On discussing the above presentation] *And she was, I felt it was quite interesting, because that is someone who has been doing it for years, and has been through the gamut of things and decided after her own experiences that operation isn't any good, and that's a very honest view of it I think.* (DSDs, Interview 3)

Another participant vividly outlined the problem of carrying out surgery too early on a child. The physical issue of stenosis (tissue becoming scarred and rigid) notwithstanding, it is uncomfortable imagining having to think about carrying out the necessary vaginal dilatation to ensure post-operative surgical success on a female child.

‘AD: I mean I suppose it’s, it’s almost kind of, you know, like I suppose in, in a naïve sense it’s like well, okay, you get this child who’s a baby and the little girl’s got CAH and we do a bit of making neat and all of that, you know, you do all that, erm we try and do some labial reconstruction, we messed about with that, we have umpteen problems with stenosis, we have scar tissue, we have all of these ...

Participant: We can’t do those procedures I don’t think on an infant without fluffing about with them all the time after and it’s not nice for mummies to put things into a little girl’s vagina, or for daddies, and it might be the daddy that’s looking after, and it doesn’t really matter, it would matter what gender the carer was ... not appropriate.

AD: Yeah, so I mean in terms of that, that’s because of the pouch ... to stretch the ...

Participant: So who’s going to do that?

AD: So in ... the thing is then if you kind of leave that child alone, essentially leave that child alone and you see them then at what 15 or ... is the ...?

Participant: She can speak for herself.’ (DSDs, Interview 2)

Interestingly, these examples were provided by the MCN surgeons themselves, appearing to function as a means to distance themselves from what they appeared to perceive as over-zealous surgical practices. This *othering* (the use of others to become reflexively aware of self) appeared to function as a means to strengthen MCN internal bonds and collective identity. It seemed, in this case at least, surgeons found closer affiliation with their MCN physician colleagues. The relations between different medical disciplines, and to a certain extent, non-medical disciplines, such as Clinical Psychology, were seen as being collegial and respectful. Whilst each clinician brought their own expert specialism to the cases, ultimately the MCN was united in their attitude towards non-clinically indicated surgery.

‘AD: Yeah, in terms of your ... now, your girls that you are seeing, do you get any girls that come through that have had nothing done to them?

Participant: No, because that's been a relatively recent thing, NAME was very instrumental in the European consensus and changing name to Disorders of Sexual Differentiation and they recommended that you shouldn't have surgery in infancy or CH for example but you'll still find a surgeon that'll do it, you know, and the parents will go around until they get somebody to see you.

AD: Yeah. So, so I mean the thing is in terms of kind of ... are you, do you expect then because of the guidance and what they've done that, you know, like the next say ten years you'll start to see girls coming through.

Participant: Yes, I expect there will be more but it will be a European wide thing, it's not just a Scottish thing, and a lot of it comes from the adult pressure groups I think, I think a lot of it comes from there, and if we're honest we'd maybe stop looking at 10cm vaginas and think 'well, what sort of a sex life do these people have?' Answer 'Crap!' Why is that? Because you've screwed them up. So a bit of a move away in the medical literature which was very focussed on the appearance and the length and the position things, to 'is this woman or man happy with themselves?' (DSDs, Interview 2)

No facts and fictional others

In the above discussion on the DSD MCN I have provided some examples on knowledge construction and morals-in-practice. In the first, I have provided a simple example of practice based on localised, expert opinion. The lack of evidence-based practice not due to motivational or access issues but more profoundly due to simple lack of evidence. Nevertheless even within this evidential context practice still continued. In my second example, I have attempted to show how ethics and evidence merge in the nexus of morals-in-practice, each case was considered not just for its medical issues but also in terms of the wider psychological and social factors. This not merely affecting decisions and actions at the patient service level but also at the level of populations and national service design and delivery. Further, the use of *others'* morals-in-practice is mobilised to secure collective DSD MCN internal identity, challenging any notion that professional disciplinarity is the main form of categorisation for MCN members.

Participant: You want to make the right decision for the individual. So you hope that you'll make decision that they won't feel unhappy with later. Unhappy with meaning

they feel they should have been the other gender or unhappy with meaning they don't have enough, but the anatomy does not allow them to function successfully or it impairs their function, in particular in terms of sexual function.

AD: *So it sounds that it hits you in a personal responsibility level?*

Participant: Yes. You can imagine if that's difficult and there's no right answer, that sharing that decision making can be supportive. (DSDs, Interview 4)

It seems that morals-in-practice is also a useful framing at this tertiary level of healthcare. I have shown that as a way of considering the realities of practice, morals-in-practice draws our attention not just to the evidential or ethical but the merging of these two separate modes of decision-making in *morals*. Further from this position it is possible to see how our morals are activated into action or practice which ranges from the individual practitioner-patient level to practitioner-population (service) level.

8.6 CLINICAL GOVERNANCE

The thing that has changed over the years though is clinical governance. So whereas people before might have been quite happy to say, well, this is the way I do things, it's a bit like the gender assignment earlier on. There's probably no right answer but just knowing that it's not always the same individual that's making the decision. Knowing that other professionals think that's a reasonable decision. I would expect the same is true for surgery, where there's not a lot of evidence about the best operation or the best timing for the operation. Then having a consensus from your colleagues about what's reasonable is good for clinical governance. (DSDs, Interview 4)

In the previous section the focus has been on healthcare practice. In this section I widen the net of morals-in-practice to consider how as a collective the MCN group must deal with the wider political forces and healthcare discourses within which they are embedded. MCN members, as practitioners are not immune to the external pressures which guide clinical practice and organisational accountability. Whilst the MCN can be understood as a space which allows the subject matter or clinical object, to become the central focus, the MCN should not be understood as a hermeneutically sealed horizon (Gadamer, 1960). That is, the boundaries and interpretation of the subject matter are always engaged with policy

influences. The MCN, whilst being a dialogic space where the subject matter can be innovated, is also centrally participation with the wider actualisation of healthcare work. In this section those wider political, social and professional influences are considered in the form of clinical governance.

Infamous beginnings

At the end of the 1990s and start of the 2000s the UK NHS was rocked by a series of high profile healthcare cases, cases which were to change the perception of healthcare practitioners and their practice forever. Culminating in 3 Public Inquiries the cases created questions around clinical governance, the internal mechanisms embedded to scrutinise clinical practice and ensure clinical quality. The cases were the: Bristol Babies; the GP serial killer Harold Shipman; and the Royal Liverpool Children's Hospital, Alder Hey, organs scandal. They are outlined below.

The *Public Inquiry into children's heart surgery at the Bristol Royal Infirmary (BRI) 1984-1995* (2001) estimated that in a third of all paediatric cardiac cases at BRI, children received less than adequate care. The Inquiry also found that in the period between 1991 and 1995, 30-35 more children under the age of 1 died after open-heart surgery in Bristol than would have been expected in a well functioning paediatric cardiac unit. The Inquiry suggested that individual agents were not singly accountable but that a lack of leadership, communication and teamwork had conspired with badly designed service delivery and lack of internal accountability mechanisms, to place power in the hands of a 'club culture'. Further, as the wider national NHS context placed paediatrics as a low priority client group, the local NHS organisations had also not placed an emphasis on children's services, thereby not routinely monitoring clinical quality and outcomes, in this case resulting in tragic consequences.

On January 31st 2000, Harold Fredrick Shipman a General Practitioner was convicted at Preston Crown Court of murdering 15 of his patients whilst practicing at Market Street, Hyde, near Manchester. In the subsequent Public Inquiry the ruling found him responsible for unlawful killing in a further 215 cases, with a high degree of suspicion in a further 45 cases. Dr Shipman was a popular GP and was also a very successful serial killer. His murder career had spanned over 2 decades and took place in both group and singlehanded practices. The question became how he been able to operate so lethally unnoticed for so long?

Throughout his career as a general practitioner, Shipman enjoyed a high level of respect within the communities in which he worked. In Hyde, he was extremely popular with his patients, particularly his elderly patients, and was regarded by many as 'the best doctor in Hyde. (Taken from Public Inquiry, First Report: Summary, point 6)

In 2001, Alder Hey Children's Hospital, a paediatric tertiary centre in Liverpool became infamous. In a building in Myrtle Street, the hospital was found to be storing a mass of children's organs and tissue which had been harvested without parental knowledge or consent. Between 1988 - 1995 there had been a widespread practice and global policy to remove tissue from children who had died in the hospital. Whilst the intention was admittedly that these samples were to be used for research and teaching, the Public Inquiry found that *'the organs were largely ignored, with the consequence that there was a remorseless increase in the number of organs stored in containers.'* (point 1.4). Questions remained how *'custom and practice'*, that is, what we do around here, had somehow managed to bypass ethical and governance legislation concerning consent.

The practice of removing and retaining organs following post mortem examination has been widespread in hospitals around the country and is of long-standing. The medical profession justifies retention for the purpose of medical education and research. Their approach has been paternalistic in the belief that parents or relatives would not wish to know about retention of organs and the uses to which they are put. In some cases consent has not been obtained at all, in others consent forms have been signed but without the relatives fully understanding what was involved. In the current climate of frankness and openness it should no longer be possible for organs to be retained without the knowledge or consent of the parents or relatives. (Taken from Public Inquiry Report (2001): point 1.3)

These cases helped to ensure clinical governance became intrinsic to the design and delivery of any service provision. Medical practitioners, whom in particular, had been somewhat above reproach, were now rudely awakened to the possibility that their colleagues or indeed their own practice may be suspect. That *custom and practice* in Liverpool had normalised

practices which were ethically, medically or indeed purposefully questionable; that power relations between doctors and non-medical colleagues in Bristol had meant nurses were unable to question higher status doctors' decisions, a situation only exacerbated by poor information flow and lack of accountability; and that the absence of internal quality indicators and practice monitoring had allowed a serial killer to operate under the noses of his GP partners for decades, did not sit comfortably. Whilst these individual cases were situated within specific healthcare contexts, the issues they raised were not viewed as situational. That is, what had happened in these cases specially could be seen as potentially occurring generically elsewhere. The question was asked what could be done to prevent similar events happening elsewhere.

Clinical governance: defined in Scotland

In Scotland, clinical governance too became a central issue which required tackling. Linked to organisational accountability mechanisms, the focus was on: safety, quality and effectiveness of delivered clinical care (see Box 8.6 for NHS definition). Respective policymakers established new departments which dealt with: audit and quality (Clinical Resources and Audit Group, later Clinical Standards Board for Scotland, later NHS QIS - NHS Quality Improvement Scotland); and clinical guidance (SIGN – Scottish Intercollegiate Guidance Network). New methodologies, such as patient planning pathways, total quality management (TQM) and single shared assessments across services became more commonly utilised. Together these bodies and tools were to enable structured data collection and analysis of the available scientific evidence, legal and ethical guidance, in order to recommend national modes of practice and service delivery.

However, as much as the top level of governance was apparently dealt with in terms of policy and protocol, the transition to actual local practice and context was still problematic. Questions emerged as varied as: *how could SIGN guidelines be implemented? How could clinical effectiveness be compared over differing clinical services? What do we know about our clinical populations? How can a patient pathway be designed?* These apparently straightforward moves to improve accountability, safety and quality needed related practical systems to carry these objectives forward. For those practitioners and managers on the ground, the policy call to improvement of service, created a whole new set of organisational problems in need of tackling.

Box 8.6: NHS Scotland (2007) - clinical governance definition

Clinical Governance is how health services are held accountable for the safety, quality and effectiveness of clinical care delivered to patients.

Clinical governance is a statutory requirement of NHS Boards and is achieved by coordinating three interlinking strands of work:

- Robust national and local systems and structures that help identify, implement and report on quality improvement
- Quality improvement work involving health care staff, patients and the public
- Establishing a supportive, inclusive learning culture for improvement

sometimes you can push these things, sometimes things evolve and I guess it depends a little bit on your standard of working. Sometimes it's just a matter of saying the same thing again and again and a few times and then after a while it sinks in and people realise, so I think, for instance, you probably know this but in Glasgow, when I came here, every surgeon was doing a bit of surgery on genitalia, so one of my early gambits was to go and meet the surgeons and say this is what I am trying to develop and I need a couple of surgeons really to deal with, and that was the kind of initial thing where we tried to sort our own [unclear] before moving to other centres. And that worked. I am very grateful to the surgeons to think that way as well. The timing was good because it was the kind of time when Bristol Cardiac Surgery and all those kinds of things were happening in the background. So clinical governance was becoming an issue. So combined with that and that governance certainly combined with patient's expectations and so on, I thought it was a good time to say look we need to be thinking about how we do things. (DSDs, Interview 1)

For members in each of the MCNs, clinical governance was a central concern. The MCN form was viewed as possible clinical governance mechanism providing a space where internal systems for clinical audit and practice learning could be centralised amongst a group of experts in the field. These activities were seen as protective factors against potential healthcare negligence and also a way of enabling new systems to improve service quality. Sharing knowledge and experience allowed informal learning which extended professional competencies and capacities.

I want to see more about what's going on in other areas and that's one of the things I would want to see change. How could that be intertwined into the meeting, would it make the meeting so long that people just wouldn't turn up because they've got this you know, awful three hour or whatever meeting, I don't know, I don't know. I suppose you that, especially the kind of roles that you take, the shared learning element of being able to say 'well what is happening, you know what can I learn from you or is there an opportunity to be joined up working between us where we could share?', is a missed opportunity almost... during the conversations, you go along and it is not necessarily the most efficient way of getting that information. (Dementia, Interview 6)

For the MCN members the idea that each practitioner was held up to a collective degree of scrutiny provided a counterbalance to any individuals who may push the boundaries of their expertise or competencies. The MCN collective were able to debate the scientific evidence, ethical issues and political pressures on a specific topic to reach some form of consensus on the most appropriate form of service design and delivery, a lay theory of 'more heads are better than one' perhaps underpinning much of this governance thinking.

if this was a surgical MCN and we had, I don't know, the orthopaedic surgeons in HB 1, HB 2 and HB 3, we decided to have an MCN, you would have a condition, I don't what it might be. Rheumatoid arthritis of the big toe. Em, or hey, shoulder op, shoulder injury. I've got one, so let's make it a shoulder injury. You've a shoulder injury and what you will find is that as you say, clinical autonomy, the orthopaedic surgeon in Fife, is 65, wishes he could retire, but can't quite at this point and he was trained in the 1970s and his view is that what you do is an operation which they stopped doing in 1982 and that's what you get. In HB 1, you've got a bright button new guy, whose cutting edge, you know, doing all this stuff, academic and he's doing certain things which are real cutting edge, likely to get the best outcomes, quite intensive, quite expensive, whatever, and you'll have something in the middle in HB2. So you've got the same condition and you've got a range of treatment interventions. Now the purpose of an MCN it seems to me is to say, what's actually best practice? So what that MCN should be able to do is come to a consensus view about what the standard of treatment should be. So you sit down as real clinicians who are working

in evidence based practice. There will be in fact, probably a SIGN guideline that says for rheumatoid arthritis of the big toe, first option is this, second option is this and third option is this and what you're going to find is, when you then compare your local services protocols to an acceptable national standard, when you've got an orange guideline, actually one partner clearly falls short, another partner is pretty close and another partner is gold standard. There should be a consensus that that's the case. What this guy is really saying is, well, I'm clinically autonomous and I can do whatever the hell I want, because I'm autonomous. Now, the MCN can't allow that, so the MCN actually has to say well, with all due respect, if we set an MCN standard and you don't meet it, then we're going to be reporting that you're not meeting an MCN standard, because that's what should happen.(Addictions, Interview 3)

Whilst clinical debate and discussion may be assumed to occur automatically in healthcare, according to one participant the opposite was the case, at least for consultant psychiatrists. The MCN as a space to nurture this degree of openness was exception rather than the rule – albeit the ability of MCN participants to use this forum with the necessary hermeneutic vulnerability required varied amongst sites.

AD: To be able to go back to your health care and say...?

Participant: Yes, to say this is what we've all agreed and needed.

AD: And within Scotland, because this is just a sort of a [unclear] contesting but do consultant psychiatrists get together and do that type of work now?

Participant: No they completely avoid talking about very basic clinical things.

AD: Is that historical or...

Participant: Yes. (Addictions, Interview 5)

For the DSD MCN, with its MDT activity base, open sharing of clinical expertise and knowledge was highly evident, with each patient case being discussed from multiple physical, surgical and psychosocial perspectives. However, as members were often from differing disciplinary backgrounds, this may have proved less threatening for individual morals-in-practice. This attitude of collegial debate was also evident in the more

organisational activities of the DSD MCN, presumably as the clinically-acquired trust relationships are transferrable to the differing types of MCN activity.

I guess it is supporting two groups of people, one is the professionals and the other is the patients and I think the two things have to be taken together. obviously the ultimate aim is that you are improving the care of the children as they become adults and probably as adults, and that's a discussion which we are having at the moment, but so I guess the eventual aim is long term improvement and health, yes. But that's, the objective I guess is supporting patients and staff so that they can deliver better care. (DSDs, Interview 1)

This consensus was taken as a means with which to reassure local decision makers that the practitioners were in a position to speak from authority and accountability.

the development of clinical psychology is another example, so there's actually quite a few where I think is has helped internally to be able to say this is part of the kind of broader consensus. National guidance can fill that role as well, you know if you're doing a consensus, the kind of direction nationally and whatever. But I think also being able to do that on a kind of regional basis I think gives some reassurance to decision makers that, that Practitioners are you know, know what they're talking about. (Addictions, Interview 4)

The ethos of medicine has changed to a certain extent. People are much more critical of other people's results and things I think. People are much more aware of what's going on, people are much more happy to comment, you know. We have clinical meetings every month and one of the three teams has to present their morbidity and mortality and it can get quite heated sometimes, like why on earth did you do that. And particularly if you're working here where there's fifteen consultants then what you're doing is very much on show. People know when things aren't going well. Whereas if it was a much more smaller unit then I suppose other consultants don't have anything to do with anybody else's patients whereas we do a ward round and see everybody on a Saturday and Sunday morning. (DSDs, Interview 8)

It also meant that during perceived constant structural and organisational change, some degree of continuity could be maintained for practitioners and managers who were interested in their particular shared clinical subject matter, Sachen.

the history of service planning and development in HB, which tends to be that there's an organisation and you start developing a plan thinking that's what you need to see services for people with dementia develop over 5, 10, 15 years whatever. And then the organisation changes so rather than adopt the plan the new organisation wants to have their input into it, and we've changed from having a HB wide governing body to three separate area governing bodies to a governing body for older people and another one for mental health and then into the current four different bodies that we have.... but I certainly felt that there was a need to have some kind of body which could co-ordinate the sort of planning process, influence the strategy and be consistent enough as far as personnel were concerned to carry the ... the development over no matter what was going on at organisational level. (Dementia, Interview 3)

MCNs in this framing become a space where individual and collective morals-in-practice can be held up to scrutiny by local experts; thus becoming an internal HB mechanism for quality assurance around specific clinical conditions. MCN participants are able to learn, debate and discuss the central concerns related to their own particular Sachen, whilst accessing multiple professional views on the topic enabling a holistic overview to emerge which can be drawn on to inform further service design and delivery.

I think they come back to the clinical governance issues nowadays much harder and much more to the front and what was done in the past is no longer acceptable. The way patients were treated and were told what was going to be done and not had actually anything to do with it. But again I think because some of these cases are really quite rare there is much more of a feeling well, you've got another group of interested people that you can speak to so it's quite appropriate to speak to them and get people's opinions because if you don't see this type of cases too often then it's a lot easier for you, takes a lot of weight off your shoulders to be able to discuss them with like minded individuals who may have a little bit more experience than you in one particular area and could help you to justify what you're doing. (DSDs, Interview 8)

8.7 CONCLUSION

The aim in this chapter has been to illustrate certain elements of the work of the MCN, practice. Practice is defined broadly to encompass activities which range from practitioner-patient to practitioner-population interactions. Focussed in on the central suffering which practitioners face in the clinical encounter, I have shown that ethics and evidence are used as means to navigate the uncertainty which is faced in everyday work. In introducing the organising frame, morals-in-practice, the relationship with action comes into focus. These are not idle debates but are instead mobilised into real clinical and service decisions.

Ethics and evidence have been shown to have their limits: ethics, from a distance-far stance is removed from the lived realities of daily patient-practitioner interactions; and evidence has been shown to be uncertain. Alternatively in moving closer to the experience of care, awareness of distance-near ethics has brought the emotionality, empathy and suffering of daily practice, to the foreground. Faced with suffering and uncertainty practitioners and managers attempt to respond at the patient and service level.

Participant: If you talk to DSDs you get one opinion, if you go to London you will get another opinion, if you go to Paris you will get another opinion. So, the, the reason why there is so much discussion is that, in some ways it is about trying to give parents the confidence that the decisions that have been suggested to them, action that have been suggested are based on the best evidence that we have, but still nobody knows what the right answer is. And the right answer for one child isn't, the other problem is the right answer for one child isn't the right answer for another child. If you do an operation and it goes well and it is perfect and there aren't any problems, then that's the right decision. Do an operation and it's a disaster and they ended up being operated on again and again and again, then that's the wrong decision. But who is to say which is the right one and which is the wrong one?

AD: So in some ways then does kind of being in DSDs provide I suppose a personal reassurance for yourselves, well it's not just kind of you?

Participant: Yeah it does, it does help, it helps to make a decision knowing that you have made the decision, the decision you have made for your patient is based on robust discussion, with the best people who know most about it in Scotland.' (DSDs, Interview 3)

MCNs are thus beginning to be viewed as a forum where consideration of the shared clinical subject matter can be made. A space where the range of competing demands associated with the Sachen can be centralised and considered. Whether these be associated with clinical case management, issues of clinical effectiveness (DHT), developing clinical protocol (prescribing philosophies), agreeing or ensuring clinical governance, or taking forward relevant strategy.

In this next chapter I consider another means to consider work, the *wicked problem* (Rittel and Webber, 1973; Grint, 2005). To do this I draw out the differences in leadership and authority in each of the MCNs and ask go further to ask if MCNs are about solving problems, where could the necessary dynamic to achieve this be theoretically located?

CHAPTER 9: MCNS AND WICKED PROBLEMS

9.1 INTRODUCTION

In the previous chapter I introduced the organising heuristic *morals-in-practice*. Through this I argued for the importance of uncertainty and suffering as central to much of the work undertaken by MCN members. The MCN in this framing could be viewed as a forum where MCN members' shared similar concerns on their shared clinical subject matter, the Sachen, and worked together to deal with clinical governance issues. *Morals-in-practice* thus provided a framework to describe how clinical work created different service organising and debate. In considering the nexus of ethics and evidence, I suggested that action could thus be considered as a dialogue between two separate epistemologies, which whilst distinct, became mobilised together. From this the MCN could be understood as an arena where this process moved from the level of individual decision making to collective consideration.

In this chapter I turn to consider another possible function of the MCN, to deal with wicked problems (Rittel and Hottel, 1973). Wicked problems are intractable, unfolding and centrally important. Wicked problems require solutions which are beyond the typical, creative responses to testing challenges. These creative solutions inherit the action imperative inherent in *morals-in-practice*, even when the action is non-action this must still be a justifiable practice decision. This is especially true of wicked problems where responses can only be evaluated as being good or less good, but never completely right (Rittel and Hottel, 1973). From this perspective, practice is understood as forever in dialogue with context as wicked problems as both are simultaneously changing and being changed by the other. This framing provides a temporal backdrop to allow us to see how problems emerge and how practitioners and managers attempt to respond to them. As wicked problems inherently have no end point, they are understood as never having a definitive conclusion.

To consider the relationship between MCNs and wicked problems, I examine those differences in group organisation which may be implicated. Firstly, I present the styles of leadership and authority which Grint (2005) has suggested may be necessary for a group to tackle wicked problems. I then move to consider some of the theoretical dynamics which may explain the purpose of a well functioning MCN and how this purpose is achieved. This discussion is centred on the hermeneutic concepts of *transcendence*, *alterity* and the

speculative nature of the *logos*. Thus the aim of this chapter is to consider the empirical MCN data to answer the following questions: *what factors are implicated in MCNs responding to wicked problems, where is collaborative advantage located and to what degree do these MCN sites achieve potential?*

9.2 WICKED PROBLEMS

Wicked problems are problems which do not have simple, process managed solutions, instead being embedded in systemic inter-linkages and which can be understood through multiple perspectives. They are problems which in the unwrapping are found to house yet more problems. Wicked problems are considered highly intractable, such as, how to improve the health of the Scottish nation or how to reduce mortality in Glasgow? Inter-related issues are implicated such as housing, employment, poverty, educational opportunities, cultural and social influences. None of these single perspectives is arguably sufficient to answer these questions, but all of these perspectives may be necessary to consider. As an aid to understanding, I provide the following concrete illustration of a wicked problem which is relatively frequently experienced in health services.

[On the single shared assessment] It's clinically relevant data but in a sadly pointless form, it's a lot of repetition and a lot to be physically filled in on paper... the principle is accepted and even the folk who suffer most from it, the nursing staff, the social work colleagues are fully committed to making sense of it. But it can literally get in the way of whether someone accepts a new referral or not, to think of the time to see the patient and the time to do what seems a shame. And that's quite a common discussion, is to see whether people can pick up because of that. (Dementia, Interview 8)

So the GP's would say "the network will never work unless you take account of the fact that, you know primary care doesn't know what it's talking about and so we want you to deal with everything that's to do with primary care." And the acute hospital would say "well the network will never work unless you do something about the number of people with dementia who are in the acute wards and they've got to be taken out," you know. And you thought well you know although some of the desirables were really ... you know they would be beyond what anyone could possibly

deliver. It was very clear that what we had long suspected that the planning process for people with dementia was simply siloed, disjointed, you know with no clear understanding that a change in one aspect of care inevitably changed the need for service provision in another. (Dementia, Interview 3)

A centralised decision-making body recommends that Clinical Standards, a collectively agreed, expected minimum of service quality, must be created in order to create indices against which the actual quality performance of a health service's delivery can be measured. On paper this appears a fairly straight forward undertaking. However, to make this ideal into an actuality, I present a few of the systemic implications to be overcome.

Implementing organisational standards requires audit data against which to measure achievement. This requires agreement of what data should be collected by clinicians. Higher status clinicians need to convince their clinical colleagues that data collection is a worthwhile activity to undertake and that clinical standards are a performance measure of real world utility. Clinical staff must be identified who have the necessary technical knowledge to record the data. They in turn will have to manage this administrative task alongside their frontline duties (i.e. seeing patients). New members of staff may need to be recruited or current members of staff will have to be re-deployed to manage the data collection and analyse the data required. Human Resources will have to become involved in writing up contracts, advertising and interviewing for any newly created post/s. These staff will require adequate training to ensure they have the appropriate audit and analytic skills (and organisational induction training). A centralised administrator will need to ensure full data coverage across the participating areas of service, check compliance of data completion protocols, identify non-completers and put into operation systems to enhance compliance for those who need increased motivation or support to meet their input requirements. A first round of piloting data administration will likely uncover design issues, requiring data sheet re-configuration and addition or removal of certain variables to be collected. ICT will be involved for procurement, ordering and initial set up of systems for storage and analysis.

This is, of course, only a partial snap shot of the chain of events which occurs prior to the quality standards themselves being assessed. After this there is still further work to be carried out to close the gap between the clinical standard and what the actual services current operational level is. Therefore an intervention package has to be designed and mobilised,

requiring further collective buy-in, education, changes in practice, staff re-configuration. An evaluation of the intervention package's effectiveness has to be undertaken, locating any new issues to be tackled, resulting in yet another iteration of service re-design.

From the above it becomes clear that measuring service standards becomes an increasingly complex network of activities to be managed and undertaken, one issue spawning multiple tasks for multiple players. The additive effect of the individual tame steps becomes as a whole a wicked problem. Indeed the types of systemic organisational change that would be required for wholesale clinical audit and clinical standard improvements arguably necessitates widespread organisational cultural buy-in. This, in its turn, suggests another wicked problem: how to change organisational cultural?

Box 9.1: DSDs – ISD data

The Information and Statistic Department approached the MCN for buy-in to a new IT data service which would collect data which would be useful for clinical audit.

The proposed system had 7 screens of information to be completed.

The MCN declined to take part.

I would hope that always things are improving, I think that we've moved away, and you're talking about these kinds of changes can't happen, or I don't think they can happen, quickly. You know, we're talking about changes in whole cultures and practices of hospitals, which doesn't happen quickly. And what we did was that we won't have continuing care beds. So, where nurses got comfortable with, that person came to you because they needed to be with you, they never left until they died.

(Dementia, Interview 6)

Wicked problems and practice

Practitioners face externally mandated directions for their work. This often changes the nature of how wicked problems are constructed and tackled. For examples changes include: changes to central policy (through changes of Government or new thinking about service direction and evolution); the introduction of clinical guidance as new evidence becomes available; attempts to create patient pathways; and design of service delivery for populations, say older people. It is not difficult to imagine the complexity of each of these endeavours if

Box 9.2: Dementia - Mental Health Collaborative

The Mental Health Collaborative was tasked by the Scottish Government Health Department to ensure that HEAT targets were met for Dementia.

A representative for the collaborative presented the clinical data which was presently available and discussed what was required.

The current data suggested that there was a short fall between the estimated population for Tayside and the actual GP registered number.

Discussion was centred on what would occur should this 'hidden population' be located and how services which were already struggling would cope with an increase in numbers.

we consider the above example as an illustrative baseline. Add to this the inter-linkages between services, the magnitude of the organisation influences which need to be navigated becomes clear - this ever-changing complexity *per se* can become a wicked problem in need of creative solutions. One participant provided the following example of inter-dependent clinical targets.

Because the targets have not been thought through, I mean look at the HEAT targets that we have at the present time, we want to reduce anti-depressant medication, repeat prescribing of anti- depressant medication, fine, laudable, we want to reduce suicide, ah now let's think about this. We reduce antidepressant medication suicides are likely to go up aren't they, right okay so we've got a wee problem with those two.

We could increase ECT (laughing).

Increase ECT (laughing). We want to reduce people drinking, right okay but if we reduce, if we successfully reduce the target for anti-depressant medication, people will probably drink more because they'll use that as a self medicant and if they drink more, then the suicide rate's going to be affected because that's when get disinhibited and that's when they top themselves. So we've got three little targets there, you know that are all laudable as long as one's in this room, one's in that room and one's in another room but put them together and they become totally inter-dependent, in a way. So we might be successful with one target but it's going to have an impact on the others so we're never going to win it, so why set that as a target in the first place, I have a target. (Addictions, Interview 6)

The above quote suggests a change to one part of the clinical landscape does not occur in isolation but instead impacts on other clinical targets. The 3 wicked problems being tackled may have been framed as: how do we reduce drinking in Scotland? How do we reduce suicide? How do we reduce excessive antidepressant prescribing? But the implication is that rather than being understandable as discrete entities they are instead co-dependent.

These politically driven developments are also occurring in contexts where delivery has been driven often by peculiarities of individuals and claims to geographical identity. As shown with morals-in-practice the idiosyncratic interpretation of evidence and ethics does not necessarily remain at the level of the individual clinical decision-making but can become acted out in service design. Wicked problems are thus not universally constructed or understood in each HB locality, far less at the national level.

it's a kind of combination of these you know external, local, local decisions. I think now we've, we hear a lot of about you know postcode prescribing usually the term, it's usually postcode services and I think it's a recognition that that's not right and there should be equitable services across Scotland. But yes, so we, you know history does lead to there being patchworks of organising, you know there have been patchwork services. And I think that's less now than when I first came into post, in 1990. So there's less patchwork than there used to be but the history has still been bearing on, on what's, what's there and available for people. (Addictions, Interview 1)

There have also been many historical changes to disciplinary ritual (custom and practice), for example, the activities a consultant physician or surgeon remembers being expected to perform as a newly qualified doctor, may bear no resemblance to what activities are now seen as routine. Changes in legislation, such as the European Working Time Directive, also change professional working customs. These changes create new wicked problems, such as, how to train new staff on patient interaction or how to adequately resource wards?

as a consultant surgeon doing ward rounds from one bed to the next, I would stand until sister pulled the bed sheets down. You'd never make a move anywhere near the patient until the bed sheets had been turned down, the pyjama jacket was undone. Whereas now days you know, you just get on with it. (DSDs, interview 8)

Over time evidence moves on and this in turn has a knock-on effect on practice. The participant below highlights how medical specialities can disappear or be transformed with new aetiological or treatment discoveries. What would once be a taken for granted practice and disciplinary pathway disappears, taking along with it the now un-needed expertise in this area. As changes occur in the disciplinary pathways, new gaps in service appear, as clinical populations become visible and practice debates open up preferred methods of treatment. The wicked problem of service design and delivery must be tackled.

Participant: the whole field of medicine is constantly changing, there's constantly new specialties emerging and these are picked up or are redundant and that's an inevitable part and parcel of medical practice. For example, in haemangioma, haemangioma are managed by a whole variety of doctors in a variety of settings and you've got recently some big breakthrough, they're treating them with beta blockers, a relatively benign drug. And certainly that's changed the role, and now they are managed more medically than surgically and suddenly people have got to think in different ways and some specialties that might be dominant in the management of that condition, may no longer be the predominant speciality because the protocol is a drug related treatment.

AD: So like the thing with the stomach and the ulcers in the stomach.

Participant: Exactly. That's the whole thing. So the cosmetic practice continue to shift, the emphasis of treatment continued to shift and therefore there's an area that becomes a conflict for teams or specialties or has potential for conflict in specialties on who does what. So the whole focus continued to shift, but I think most people, you get some dinosaurs that are ...

AD: Entrenched.

Entrenched, Luddites and advocates of the functional silo but I think most people who have been around the block a bit and then modern thinking, just want to do what's best for the patients and not what's best for their particular speciality. (DSDs, Interview 6)

These changes are unpredictable and speak to the inherent both to the unfolding nature of wicked problems and the uncertainty of practice. As policy agendas change (e.g. moving

from policy which emphasises heroin users being prescribed methadone, on to how do we get heroin users on to a road to a drug free lifestyle), new evidence becomes available (e.g. psychotropic usage in the elderly) or indeed ethical catastrophes occur (e.g. the public enquiry into Mid-Staffordshire NHS Trust), wicked problems are continually evolving and form the background to which practice must respond.

That is, whilst practitioners and managers are tasked with responding to the needs of patients and service populations, responses which requires mundane, routine responses, such as setting up clinics, managing contact lists, delivering classed to students, this is not all there is. There are also novel questions which arise, such as: How do we provide psychology services across 3 Health Board areas for addictions? How we roll out adequate dementia training for staff in care homes? How can we ensure that any baby born with a DSD born anywhere in Scotland is medically supervised by expert professionals within 48 hours of birth (bearing in mind the particular geographical challenges of Scotland)? These questions are about identifying gaps in service and improving delivery by tackling these gaps. These are the localised, service-related wicked problems which were identified by the MCNs themselves.

Grint (2005) has suggested that the type of authority and leadership used to respond to wicked problems impacts on the likelihood of success, thus it is of interest to consider the type of leadership and authority demonstrated in each of the MCN sites. Are there any observable differences in the leadership in these MCNs, and how does this relate to tackling wicked problems?

9.3 LEADERSHIP AND AUTHORITY

To recap, Grint (2005) has suggested that there are 3 types of leadership which are implicated in dealing with problems. Briefly these are as follows. Critical (or crisis) problems rely on Command leadership with coercive authority. For these problems, answers are provided. This type of leadership is commonly associated with the military. For Tame problems, leadership is classed as Management. It relies on calculative (contractual) authority and is concerned with organising process. Finally for Wicked problems, Leadership is required. It relies on normative (group granted) authority and the leader encourages the opening up of questions i.e. opening up the wicked problem for collective consideration and debate.

If as suggested MCNs are involved in the tackling of wicked problems, it would seem that the type of leadership required would stress a normative approach, with the leader opening up questions and debate. This model would seem to suggest that the soft facilitative style implied in the MCN 'boundary spanner' (Goodwin *et al*, 2003; Hamilton *et al*, 2005). I will consider the MCNs in turn to discuss whether this leadership style appeared present.

Box 9.3: Addictions MCN – Leadership

During fieldwork the Chair of the Addictions MCN changed. The incumbent was the 3rd Chair that had led the MCN.

They began their term by requesting a vote of confidence to take over the role of Chair.

At this point, there had been difficulties in identifying the MCNs purpose and there was a general reported frustration as to the effectiveness of the group, with the possibility of the group disbanding. Therefore, the Chair outlined that the MCN was '*on probation for a year*'.

The MCN collective agreed to both the incumbent as Chair and the timeline for evaluation of the MCN.

It seems that in this first meeting, the Addictions MCN Chair (Box 9.2) acted in accordance with much of the issues that Grint (2005) suggests are necessary for dealing with wicked problems. The Chair asked for the collective permission to lead, thus requesting normative authority. They constructed the MCNs activity as a wicked problem *per se*, albeit one which had a timeline for collective consideration and resolution. This opening up of MCN operations (focus and structure) for consideration was met with collective agreement. In further meetings, these discussions served as the focus for the MCN meetings and eventually resulted in an agreed re-structuring of MCN activity to separate strategic MCN issues separately from different service-related wicked problems (e.g. IT, audit, clinical governance, operational management).

we're always going to be kind of limited, but the planning process is very much a case of you know you take your idea, you work it up, you do it to the nth degree, you then persuade the Board that it's a great idea and they say yes this is a no brainer and then nothing happens. I mean this is why people become very frustrated and

disillusioned you know, and this happens time after time after time (Dementia, Interview3)

Box 9.4: Dementia MCN - Leadership

The Chair of the Dementia MCN had been leading since the MCNs inception.

Meetings were highly structured, carried out around an agenda and discussion was tightly controlled. Argument was infrequent and the Chair took a central role in all discussions.

Meetings were often focussed on responding to externally-driven policy issues. There was little discussion on identification on service-level gaps or practitioner identified issues. Meetings had a formal atmosphere.

For the Dementia MCN, there remains a question as to whether this MCN was focussed on tackling specific dementia-related wicked problems or *Dementia* as a totality as a wicked problem. The meetings were more tightly controlled with little open, facilitated discussion on service gaps identified at ground level. Whilst much of the discussion was on the difficulties faced by practitioners as a result of externally driven changes and measures, these discussions tended not to be solution oriented but focussed rather on information sharing. The MCN meetings were centred on the Chair and this resulted in some reported discontentment amongst MCN members who felt their views were unrepresented.

Box 9.5: DSDs MCN – Leadership

During observations the DSD MCN Leadership changed. The outgoing MCN Lead was a clinical lead and had been instrumental to the creation of the group. They had actively encouraged the recruitment of members from relevant disciplines across the 3 paediatric hospitals.

Meetings whilst based on a meeting agenda were not strictly adhered to and service issues which had arisen in the clinic were often discussed.

The newly incumbent MCN Lead had been a long-term member of the MCN and was a respected lead clinician. Their leadership style had much in common with their predecessor, inclusive and relaxed. Meetings had a relatively informal atmosphere.

The DSD MCN Chairs were similar in that their leadership style was relatively informal and relaxed. Meetings whilst structured around an agenda which dealt with issues which were

related to MCN external relations and managerial issues, frequently wandered into discussions which were more clinically relevant. Both Leads appeared to be accepted by the MCN membership, with the first Chair especially recognised as being central to the development of the group. It seems that for both Chairs there was an agreement that they would be granted the authority to lead, that wicked problems were discussed and that meetings were relatively relaxed to allow open debate and consideration of these issues.

Over the MCNs there appears to be some difference in the style and topics of discussion. Within both the Addictions and DSDs MCN, the Chairs appeared to facilitate the opening up of debate, relying on authority granted from the group. Whilst these Chairs still clearly controlled meetings and led the agenda, discussion appeared relatively wide ranging. Topics considered were related to external policy or MCN strategic issues, but also considered service related issues. This meant that within these MCNs discussion could focus on wicked problems which were both operational and strategic.

The Dementia MCN appeared to differ in that there was a tighter adherence to the agenda. The agenda was predominantly concerned with issues which were external to the MCN, such as HEAT targets and Patient Pathways. Apart from the education of care home staff, the discussion did not relate to any service related wicked problems. The MCN Chair was central to all discussions and this appeared to cause some resentment amongst some MCN members. This brings into question the degree to which the Chair held normative authority. There also tended to be a down-beat evaluation of how much they could influence or change what was done.

the planning process is very much a case of you know you take your idea, you work it up, you do it to the nth degree, you then persuade the Board that it's a great idea and they say yes this is a no brainer and then nothing happens. I mean this is why people become very frustrated and disillusioned you know, and this happens time after time after time. Now the cynicism about the new body [Mental Health Collaborative] isn't that it's a new body per se but it's ... they should know all this before they come along, there's no point in coming along and saying "well you should have a strategy for dementia," and you say "well which version would you like?" You know, here's one that we've had from 1991 but we still want something's out of that, 18 years later." Here's one from 1998, we still want stuff out of that,

you know a lot of that I think you know is just ... is kind of lack of preparation.
(Dementia, Interview 3)

It seems that these MCNs differed in leadership style and authority, this appearing to relate to the focus of the groups and the issues they tried to tackle. For Addictions and DSDs, the MCN Chairs appeared to more closely resemble the leadership style associated with tackling Grint's (1950) wicked problems. Their authority tended to be normative and their leadership style facilitative and the issues they opened for consideration ranged from service related gaps to changes for policy and practice related to from HB and Health Department externally mandated changes. Alternatively, the Dementia MCN was led in a much more Managerial style, with the Chair having a tighter adherence to the agenda and taking a much more active role in directing discussions. Intriguingly, a participant from the Addictions MCN identified some of the limiting factors which may be associated with committee structure and ritual.

I forget who said it, where, how does it go, but committees are organisations where, highly intelligent, clever proposals taken down the back alley and quietly strangled, can't remember who said that but I think that's one of the functions of a committee. Yes that it can strangle things and I think it's not done in any malicious way, I think it's done by inactivity, yes gaining the belief that you can't do that... which is why subjects just keep going round, you know people saying the same things all the way round because there are a whole host of constraints in a committee setting and that's about saying stuff that could embarrass somebody or breaching a confidence, you know there's a lot interferes with the smooth running of an organisation. It's set up and tries to look like a mechanistic body but it's actually not, you know it's a bunch of people with their own agendas, whatever they might be sitting down trying to find a consensus, that's what a committee essentially is. There are ways of working a committee such that it can actually a consensus but a lot of work has to be done outside of it and that's exactly what happens in parliament, you know everybody meets up outside and has a chat and does a bit of horse dealing and then goes into the chamber and, oh wow we've got this issue. (Addictions, Interview 6)

The Dementia MCN also differed in that discussions, whilst centred on wicked problems, tended to be concentrated on wicked problems resulting from external mandate or policy. Discussion was mainly on issues of how to respond to pieces of strategy, such as meeting

HEAT targets. As a result, there was little debate on service-related operations. This type of discussion whilst providing solutions of a sort, tended to be at the planning or strategy level, which seems to have been perceived not to have been taken up by relevant bodies. Yet oddly even whilst much of the activity was strategic there still seemed amongst MCN members the identification for the need for more service directed solutions.

we know from you know lots of experience that there is no point in taking problems to managers, you know because they won't have the expertise you know at a clinical level to solve them. They may suggest solutions but they won't solve them for you. (Dementia, Interview3)

we've got services here that's got a three hundred percent rise in their referral rates and with no added resource to support that, you know no wonder staff are at breaking point, it's really, really sad but you hope, you know you keep hoping, I think when you worked with dementia long enough, you know you get sort of patted down on the head and then you get kind of, maybe this time, maybe this time so we'll wait and see where the strategy goes with this, please be some money applications. I think England got a huge whack of money, I mean it's not a lot for the fund there but it's something rather than nothing, we need somebody to give the staff on the ground a bit of a wee bit of a boost as well to say well something is going to change, you know I think that gives them a wee bit of, you know I think I could do something to, let's get together and look at this. Make a wee change but just now as way things are... (Dementia, Interview 5)

This observation for the desire for solutions raises another set of issues. Whilst Grint's model is perhaps equal to the task of describing different forms of leadership and authority which may be inherent in solving wicked problems, it does not help identify where the dynamic for tackling wicked problems may be located. It may be that whilst Grint's model is adequate to compare MCNs with regard to the differing types of leadership and authority style, it does not tell us why MCNs as a means of organising *per se* may be a feasible way of dealing with wicked problems. That is, what is it about MCNs that may make tackling wicked problems a possibility? It is to this I now turn.

9.4 ALTERITY AND OPENNESS

MCNs are structurally about difference or *alterity*. That is, bringing together different disciplines, sectors and services. As I have suggested, uncertainty can be seen as inherent within evidence and morals-in-practice. With this acknowledgment comes the question of how to deal with this uncertainty in order to ensure the best possible practice is followed. This raises the possibility that it may be necessary to seek out others to extend the boundaries of what individuals know and what is evidentially known. It may be that others simply know that which we do not and that in extending our contact to them we can not only encourage our learning but also help to ensure better governance.

The MCN forum can thus be understood as a place where individuals can reassure themselves that their individual practice is adequate. That to a certain extent their own personal professional anxieties and concerns are shared by others. In opening themselves up by sharing their private professional uncertainty, practitioners are able to cope with the ongoing stresses of daily, frequently isolated practice.

Participant: Yeah it does, probably it does yes, and it means that, you know when you are speaking to an endocrinologist or a geneticist or a paediatrician in DGH or whatever, they all know, everybody who is there knows your thoughts and knows the dilemma you know. And I think, I think it's the biggest change probably is it allows people to, people to vocalise their thoughts, you can say these are my issues with this, this is what I am struggling with, to make the decision. Because on this end, one hand I've got this decision to make and these problems, on the other hand I could do this and these are the potential problems. And I think having that discussion is useful, it helps to clarify it a bit in your own mind, how you are going to approach it with the parents as well.

AD: Does it also help the fact that other professionals kind of can say well we don't know the answer either?

Participant: It does yeah, it does and it means that you don't, because a lot of things you don't necessarily know the answer to, but you can speak to a whole lot of other people who don't know the answer as well, then at least then you don't think you are a complete loser, you think, you realise it's much more, the issue is one that everyone is struggling with. (DSDs, Interview 3)

There was a time when people didn't actually know much medicine at all because there wasn't very much to know and as time has gone on people have sub-specialised and you know, knowledge about disease has increased hugely and it's impossible to be au fait with absolutely everything that's going. I mean I don't know much about cardiology but then cardiologists don't know much about plastic surgery. So it's much more useful to have people who know what they're doing for their particular part of the puzzle than to have lots of different people who don't actually know an awful lot about anything, but know something about everything. (DSDs, Interview 8)

However, in addition to simply searching for reassurance, the above quote suggests that through increasing subspecialisation in clinical practice something more fundamental has also changed, the ability of an individual practitioner to work holistically or at least to the extent of being able to claim expert knowledge (the exception arguably being the General Practitioners). In the DSD MCN clinic, the forum provides an arena to recapture this whole – the patient or clinical condition as a totality, not merely discrete disciplinary slices.

Apart from anything else, you learn what other people can offer. You don't get many surprises but sometimes contributions, people come to the table with different experiences and different abilities and different kind of ways of thinking about things which makes big difference to the patient. But I think what has to, in order for managed clinical networks to be successful they have move from the ethereal, let's all sit round and talk about then do, to actually service and making sure that happens on the ground, make sure people are working in multidisciplinary kind of way, on the ground, there's joined up care for the patients. But for that to happen it requires specialists to be more open and less entrenched and less self interested. (DSDs, Interview 6)

However, this holistic capture is not only linked to practice at the patient level, but also extends to the population level of practice. In the executive function of the MCNs the sharing of knowledge across boundaries of service and discipline adds to wider service knowledge and shared direction.

it's a forum to take back work to be discussed amongst you know, many multi-disciplinary, multi-agency, voluntary carers, which we discuss along that kind of forum which you don't get anywhere else. I don't know where else you can take that kind of stuff. (Dementia, Interview 4)

learning from their experiences both in terms of clinical practice and organisation and things they've achieved within their setting that you know might be transferable to, to mine. So I think all of that has been ... for me been, been helpful, and I think it's also been helpful as I was saying earlier within NHS Tayside, to be able to say you know other specialists, in other regions, either share this view or take this view or whatever. So that, that has been, that has been, been useful, to me. (Addictions, Interview 1)

partnership working, co lobbying with organisations whether it be local authority, NHS, voluntary sector, private sector, taken all the skills and knowledge from these areas and hopefully working towards one goal. A specific goal that, you know, is for everybody's purpose. (Dementia, Interview 5)

From this, there is the suggestion that exposure to different perspectives provide something to each individual MCN member. As each expert provides their own specialist knowledge on the care of individual patients or their part of the clinical service, this knowledge is shared with every other MCN member, thereby increasing their knowledge. Further, as knowledge is shared, it becomes considered from a multitude of differing perspectives, each perspective adding to the understanding of the not only the individual patient, or service, but also the MCN's shared clinical condition *per se*. Through repeated discussions of the clinical condition, the MCN clinical subject matter (Sachen) is continually created and re-created. As a result, practitioners and managers can come to recognise that they individually and collectively rely on the expertise of other practitioners to ensure the quality of delivery, for the MCN, the clinical service, and individual and population practice.

there's always the different way of thinking and ... and at a clinical level you know if you're involving a social worker and a person in ... in dealing with some ill patient of yours then it can be valuable to get their different way of thinking on things and you can think well, I never thought of that, you know and then you can incorporate that,

you know after a few hundred people you incorporate that and say well maybe I should be thinking a bit differently about this. (Dementia, Interview 3)

Participant: But then by the same token she has an area of expertise that the others don't. She's the one that knows about periods, etc, etc, etc and hormones and all the rest of it, so I suppose part of the respect for each other may come from the fact that I don't do what NAME does, he knows about that, I don't. And maybe it's the same, oh NAME knows about plastic surgery, I don't, NAME knows about gynaecology, we don't, therefore she's the expert, therefore she's not a threat to us because she's bringing something else to the table, she's not trying to take my patch, I'm not trying to take her patch because I do my bit and she does her bit. So there's no rivalry.

AD: And so there's no competition so at the same time you're almost quite a co-operative group of folk.

Participant: Yeah, because we have to rely on each other. (DSDs, Interview 8)

In actively seeking difference, awareness of the different possible *horizons* of understanding occurs (Gadamer, 1960). Practitioners and managers become aware of how things are done in other services, HBs or disciplines. This goes some way to making the taken-for-granted less assumed and opens up new ways of doing and thinking.

I think that probably the difference with DSD is everyone is looking to be educated at the same time, in terms of there's very much an element of we are here to sort of get the best option, but we are also here to discuss it so we can all learn from this, and all have an opinion. (DSDs, Interview 3)

Indeed, for two participants they suggested the MCN debate could be widened even further by including ethical discussion and patient experiences. For these individuals the recognition that both the ethical and experiential is embedded within the nature of responsible practice, resulted in the recognition that there may be the need to recruit individuals who would specifically bring these forms of argumentation to the table.

But a huge issue can then, you know, what's the word, say basically that we discussed it at the clinic where everybody else was in agreement that this is what we should be doing, which I think is very useful and this is where the MDT, the clinical service

comes into its own, talking about huge ethical issues and moral issues, in some cases where we are saying as a group, this is what we think is the right thing to do, and these are experts in that area. You could say well maybe we need a couple of other people in this group. So perhaps you know if I had a wish list, the current people I would like to have who we are missing at the moment are primarily some form of ethicist. But we don't have a system of necessarily clinical ethics group really. We are just developing something here in Glasgow. And those people would just add an extra dimension to our discussions. We've got to be careful, we can't, I can imagine it would be a bit like you, talk for a while (laughing). (DSDs, Interview 1)

I think the idea of involving patients more in their care is really good, and I think you know a lot of people, I think that's a struggle for a lot of clinicians when people come in and say well I looked on the internet last night and it said that, that, that and that. And a lot of folk don't like that and I think they find it threatening and I think that's a transition thing and I think what we're looking at as the paradigm shift, from a paternalistic health service into an interactive health service.

dialogic

A dialogic health service, yes, and that's a struggle but I think also it's going in the right direction, so yes I mean there are positive changes that have taken place. I mean our knowledge of technology has improved dramatically and the knowledge of therapies has improved dramatically, we still can't match properly you know, we still do a lot of one size fits all type of approach. (Addictions, Interview 6)

The debate can occur as much geographically as disciplinarily, bringing together larger populations of patients and providers around their shared clinical subject matter. Indeed participants included international perspectives as being linked up to possible MCN interactions.

I think they [MCNs] help to facilitate. The interaction in different cities between different surgical and medical specialities anyway, but I think what they do is potentially improve that interaction across the whole country, which will be less of an issue for the big cities but may improve matters for people that are out of the cities in smaller hospitals. I don't think they've driven change in practice or change in care necessarily. I think they just facilitate an interaction. (DSDs, Interview 7)

These linkages can also directly benefit non-clinicians. The Addictions MCN in particular actively began to encourage operational managers to come together to share expertise and think about joint resource planning across HBs in a MCN sub-group.

I think the MCN potentially instigated a contact at this level. I think the contact we've had as team leaders was just really through probably other service initiatives. So it's the MCN that has initiated or instigated our integration with. I certainly see ways in which we could, certainly with HEALTH BOARD 1 and HEALTH BOARD 2, we could support each other in terms of staffing and staff development and just general induction and integration of staff across the MCN. (Addictions, Interview 12)

There's a managers forum but that's for managers so yes we meet infrequently I have to say as managers across Tayside, so that forum, I wouldn't say it's hugely successful, it's one of those things that goes in fits and starts so last time I met with the managers must have been about a year ago, following through management network. The ICP part of things where I meet other people from other areas as well. That came through the MCN, so if the MCN hadn't been there we would have had to do something ICP wise. (Dementia, Interview 4)

However, seeking out alterity or difference requires an acknowledgment that conflict and disagreement may, and frequently does, occur. This conflict does not need to be viewed as taking away from the working of the group, but can instead be viewed as adding to it. Different opinions and perspectives can thus be viewed positively, with debate and discussion being perceived as an enjoyable experience.

I think because it is recognised, everyone accepts now that if you are dealing with unusual and rare conditions, you shouldn't be doing it unless you have some experience of it, so I think people appreciate that they are getting a degree of experience that they wouldn't normally be getting, and that's seen as confidence. And I think, I think the other reason is we all kind of get on, I think that's really important, we do all seem to get on pretty well. There isn't any, very rarely a completely left-field opinion, sometimes people say well what about, have you thought about doing

this, but there isn't any, there's never any great hostilities, never anything other than this is another view, or whatever. And then when someone disagrees with your view, then it is presented, it is put in a manner that's okay I see and appreciate that is a different opinion, I hadn't thought of that, or I thought of that and this is why. So I think DSD has kind of evolved that way because it is inclusive, and people want to be, I think most people enjoy the discussion. (DSDs, Interview 3)

Just working with people and it's the nature of, it's a natural education system. I mean, I can think of, when I worked in a GP practice, I might get referred and someone who had very marked anxiety or fear of recurrence of cancer, breast cancer. Now I would have done the best I could given my training in that situation but I know that our clinicians within oncology can actually do a much better job because they're much more aware of what treatments are. They're much more aware of what happens to patients, so I think we learn from, it's a mutual learning thing. It's not a one way process. (Addictions, Interview 5)

Alterity though may result in unforeseen consequences – opening the self up to possible critique and re-evaluation of our position. In this there is an underlying recognition that in seeking out difference, there is the possibility that the self may be disrupted, questioned and interrogated. This is a vulnerable position to take.

Even with an evidence base there are levels of evidence as you all know, so you're consciously or unconsciously taking decision at the level of meta-analysis on a level of numerous RCTs or the level of one RCT or the level of a cohort study. And you're coming down and sometimes you're taking it at level of expert opinion, sometimes you were one of the experts, sometimes you weren't, sometimes you respect the expert, sometimes you don't. But it can still be given in evidence all the way down to something that's not much better, and you and a collection of colleagues discussing it, but to be fair usually better than you as an individual plucking it out of thin air and if nothing else the evidence base has suggested to us that we all have a duty to keep as up to date as possible. But I think we're trying to do anyway, but also to consciously keep in touch with colleagues as to the limits of our knowledge and sadly the debate about ethics and values is one that cannot happen in isolation, that is again probably one that's broader than medically based evidence, probably one that belongs in the

multi-disciplinary setting, so you can get the range of perspectives, which is when folk agree. But they're still constructive even when they don't, because usually you've got your decision to make and that won't go away, and you're better informed even if the debate has been inconclusive, even if there's a lot of disagreement. The biggest single problem to my mind is to miss an entire perspective, it might ultimately reject it or you might want to partially incorporate it, but to miss it completely seems to be where the problems start, comes from. Is what I think you are talking about if you go with purely evidence based paradigm then, and reject the values, you could have flawed decisions. The same in reverse if you go only with your view on the individual patient, and only the values and neglect the fact that there could have an impact of twenty other people, is a point of view that you can't consider doesn't feel realistic either. It's a balancing act. (Dementia, Interview 8)

What drew me into MCNs, is that it is a means of raising issues that are never raised unless you're there. I suppose, for each of the clinicians that are there I think their overriding motivation is improvement in patient care. Maybe some of it is a little bit defensive in that perhaps they don't want people making decisions that they think are ridiculous. So that might be their motivation. I think it's probably quite complex but I think in general there is quite a positive feel about the MCN, because I think they feel this is quite a good arena that we can influence what happens. (DSDs, Interview 5)

Alterity, or bringing together professional difference, can thus disrupt and challenge what we currently do. By exposing ourselves to others' opinions and knowledge, what we take-for-granted may become questionable thus provides the possibility of new, creative response. However, without a disposition of *openness* there is no realisation of that possibility. Openness refers to the allowing of the self to be vulnerable to having its own practice disrupted (Davey, 2006). It may be that we bring ourselves into contact with other opinions, but if we do not free ourselves to the potential of becoming questionable to ourselves, the dynamic for change is lost. Alterity therefore requires openness, understood as a reflexive stance, the confidence to admit to ignorance and an awareness of the limits of one's own knowing.

I can't see how anybody could defend their practice in modern clinical practice if they weren't open to using the looking for best practice, sharing problems, looking for solutions, I don't think I've got all the answers, I know I haven't. NAME'S much better at doing literature searches than I am so I don't have to bother...(laughing) (DSDs, Interview 2)

Probably before you might only have done that if you had an exceptionally difficult case, whereas now I might do that just, it wouldn't have to be an exceptionally difficult case, I might just want to clarify something or to discuss things. It's a much more open forum now. (DSDs, Interview 4)

In the Addictions MCN this was clearly illustrated in their struggle to tackle the governance issue of prescribing protocols. The participant below illustrates the inherent challenges of allowing oneself the possibility to be scrutinised. Whilst being hopeful of the possibility for change, they also acknowledge the outcome may ultimately be destructive.

This is going to be a really a very difficult conversation. So instead of sitting down and going right, let's have a difficult conversation, I think your prescribing is dangerous [laughs] or I think your prescribing is conservative, you know, back at you in spades. Instead of having that kind of discussion, what I've said is why don't we share all the documentation and as a starter, I said, here's mine. Here's my prescribing protocol. Have a look at it and see what you think and NAME has come back, you know, after a period with some different pieces of work from HEALTH BOARD. As I say, we're still waiting for something from HEALTH BOARD. Em, when that, when that all arrives, what I've then said is, we can then say, do we think that actually when we look at all these things that there's enough commonality here for us to do this exercise and to try and come to a point where we can agree something or should we not even bother. In a way, I'm pre-empting what you said. If this is just going to be destructive and if it is, then I don't think we should do it....This thing about prescribing. I've set that up, we'll see if it goes anywhere. Um, but do I really care what NAME's view is about prescribing? Not really. Do I care what NAME'S view is? Probably not really, actually. Em, er, I've seen one or two of their documents and actually they look quite good, so actually we can probably learn from how they've presented things and stuff like that. I think that's really helpful, em, but

actually if NAME was to say, well, actually I completely disagree with your philosophy of care. I would expect her to, actually, em, well, that's not going to change my practice. It's just going to help me be clear in my own mind that NAME'S not in the same place as I am when it comes to particular treatments, em. Now, that's about, you know, mutual respect and openness and honesty. We need to be able to have, sit down and have difficult conversations. (Addictions, Interview 4)

Taken together I am suggesting that the MCN can thus be understood as a forum which is structured on *alterity* or different perspectives. In bringing together different perspectives, there is not only a shared understanding of the contextual practice challenges suggested in *morals-in-practice* but also an acknowledgement of the possibility that practice can be disrupted via *openness* to the other. However, whilst suggesting that MCNs may function as a forum where practitioners' deal with the complex, challenging nature of their work and its wider context, it does not address how difference is related to wicked problems. To consider this I turn to *transcendence*, that is, the ability to move beyond what was there previously and the dynamic inherent in the *logos*.

9.5 TRANSCENDENCE AND LOGOS

The term *transcendence* has a long history in theological and philosophical thinking. It was traditionally associated with metaphysics, with reference to religious transformation. However, in Nietzsche there is a different aesthetical reading. In this transcendence becomes akin to novel, creation. It is understood as the moving beyond the orthodox, to the original. In Nietzsche's *Beyond Good and Evil* (1886), transcendence is thus understood as where man transcends the mundane. In *Thus Spoke Zarathustra* (1883-1885), it is in the creation of the *Urbemensch*, Man becoming super-man. In both texts though Nietzsche was concerned with breaking free of the routine or accepted, whether this be in artistic creation or in social evolution.

For present purposes, transcendence as a term is borrowed to put emphasis on this creative moving beyond. To bring to the fore the idea that the routine is challenged and something new emerges. Rittel and Hottel (2005) suggests that wicked problems are intractable, unanswerable and beyond the routine. If this is the case, this would suggest that novel, creative ways of responding are required. As we move from the managerial and the

processed, there is a requirement for more creative forms of doing and leadership becomes more about opening up these possibilities.

We'd have a lot more joint projects, a lot more joint thinking about things we'd be a bigger political force, it would be a source of strength for clinicians to say no, I, that's not acceptable, you need this to happen. Hopefully it would be access to funding and overall it would be something, because we are part of a larger group would make our patients' care better. (Addictions, Interview 3)

This need for creative solutions to wicked problems is in some part being externally driven by policy. I have suggested that as policy changes the context of practice, new wicked problems can emerge. As the following participant explains central policy is now moving from measures of simple output to outcomes, this creating the need for different responses.

An input, delivering detox. An output, more people are able to, get out, get access to detox. An outcome, people are off drugs. So, em there is now this single outcome agreements and all that. That's about the Scottish government saying. The reason that this has come forward, in my mind and I think it is very innovative, hugely innovative, but I think it's too innovative for public sector. I don't think we can do it, because I don't think we have the intellect to do it. You know, I don't think we have the rigour to be able to do it. I think we're used to going, look at all the things we're doing. We're doing lots of things. Oh, you want me to do more things, I can do more things, I can tick more boxes and they're saying, yeah, we don't want you to do that. What we want you to do is to deliver, so how many people are you going to have drug free at the end of the year? Are you going to achieve that? How many people are going to be back at work? Are you going to achieve that? How many people are bringing up their families properly and normalised into their communities? How are you going to achieve that? Em, instead of that we are counting, you know, people in services, activity. So we're very input orientated. The government has said Scotland is going to deliver a safer community, people who live longer, people who are wealthier, people, you know who are more satisfied with their communities, you know, and all that. And then the local system has got to start thinking, what does that mean for us then? (Addictions, Interview 4)

This necessary change to mindset requires the space in which new ideas can be formed and taken forward. The policy-permitted space which the MCN provides is such an arena where this type of activity and solution seeking can occur. MCN members each bring their own professional expertise and local knowledge able to identify and respond to gaps in service – to move beyond what is currently provided. They are on the look-out for opportunities to work together under the auspice of the MCN.

It is a question of spotting where the MCN might be productive and helpful. So I think it's really a case of, of spotting the opportunities for the MCN might be a useful vehicle, mechanism to get things achieved. So I think that means the kind of utility of the MCN actually depends on quite a number of external factors. So the MCN doesn't actually drive its own usefulness, you know its usefulness is the circumstances and how other things actually line up. (Addictions, Interview 1)

If you work as a clinician in services there's always something that you recognise that you can provide a better service for patients because you know the limitations of the service that you provide and also patients know those limitations of the services that are provided as well. I think that most clinicians want to offer a better service. I would think that most of them would see the MCN as a way of trying to improve things. I can't think that many people, I can't think what other motivation really would drive people to sit through what can be quite boring meetings sometimes. (DSDs, Interview 5)

There are certain things that you can be. I think there are certain things you need to keep the service running and there are other things that are very pro-active that would make things better but you don't have to do them. And it's getting more time to do those things and those more MCN and more kind of visionary, new developments which are the exciting good bits but harder to get the time and space to do them. (Addictions, Interview 3)

It seems that bringing together different disciplines, mobilising alterity, this can act to create new possibilities or transcend what was there before (See Box 9.6) However, whilst there appears a recognition amongst MCN members that they are attempting to

do this, look out for new ways of working, there is still the need for a theoretically account of how this change can occur. As previously stated, Hermeneutics is founded on an understanding of the *logos* which is inherently speculative or apropositional nature. Any word is theorised to house multiple meanings which can never fully be captured, it is always in a state of beyond itself. In bringing together multiple interpretations of the clinical subject matter, the instability inherent in meaning

Box 9.6: Addictions MCN - Information Technology

Within the Addictions MCN forum there was discussion over the need to improve IT systems for collecting clinical patient data.

Each member HB had data systems which were individual to each site.

The desire was to commission the development of a generic recording system which would allow population data to be created across all HB members. This would allow service and treatment efficacy comparisons to be made.

As one of the HBs was involved in the development of a bespoke package, other HB MCN members were invited to observe its development.

The timeline for this packages development was creating frustrations.

Each HB representative was clear that they were in need of better recording systems and that a shared system would be beneficial, however, the delays in delivery were making the likelihood of each HB developing separately more likely.

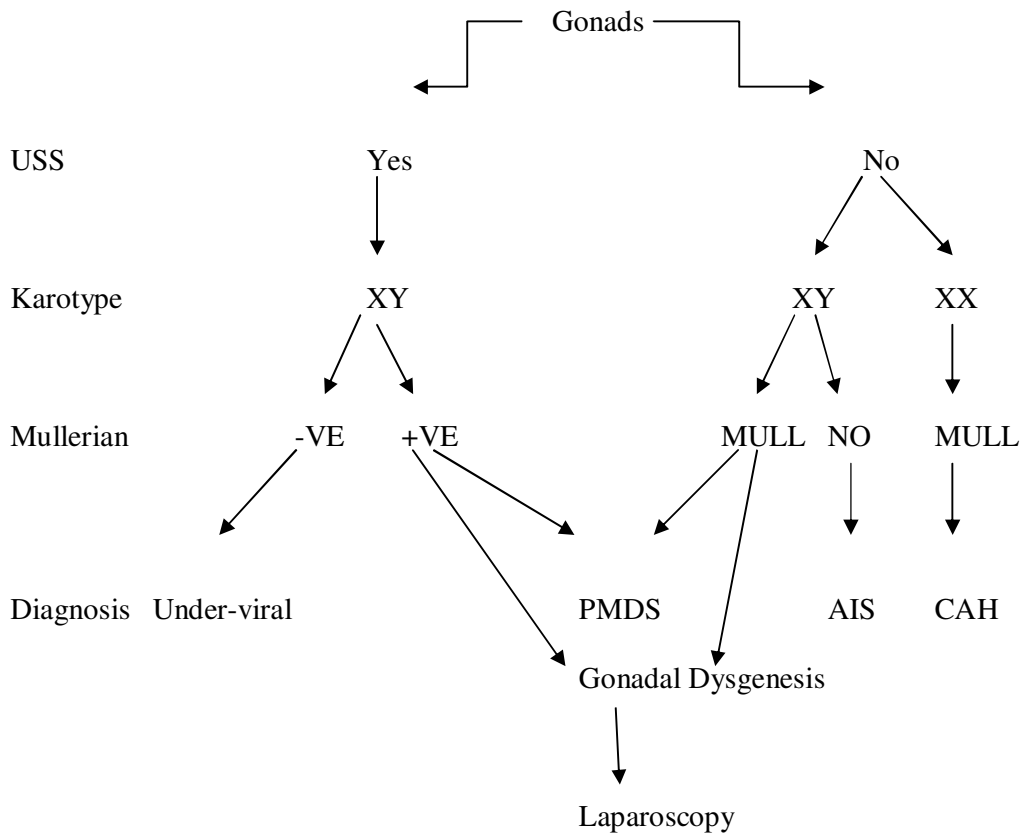
becomes visible and allows new configurations to occur, these in turn, re-defining our understanding and action in continual iterations. Simply put, as the MCN brings together difference, repeated discussion of the clinical subject matter, makes the understanding of this clinical subject matter, different.

9.6 CONCLUSIONS

Through a consideration of the wicked problems of practice, I am suggesting that the MCN can begin to be understood as a forum to create solutions. Inherent in the work faced by practitioners and managers is intractability, an ever unfolding state of problems' becoming.

Box 9.7: DSDs MCN – Laparoscope Clinical Protocol (02.06.08)

The following protocol was developed during a DSD MCN education meeting (lasting an hour). The stimulus for development was a Registrar's presentation of a clinical case. The protocol was the result of a brief discussion between a consultant physicians and surgeon.

**Clinical Protocol**

Unpalpable Gonad

Laparoscope

Palpable in groin

Laparoscope?

Inguinal + severe hypospadias

Laparoscope?

46XY + Mullerian

Laparoscope

These types of problems require novel approaches and solutions. They require leadership which is open and facilitative, so that the issues can be unpicked and conceived more holistically and responded to creatively.

To be able to respond creatively I am suggesting that the structural composition of the MCN is implicated. Central to MCNs function is the shared clinical subject matter, the disciplinary part understandings creating a holistic consideration of the clinical condition – Sachen. In

bringing together MCN practitioners and managers together they can collectively work on their shared clinical subject matter, whilst simultaneously centrally honouring their own and others disciplinary expertise.

There are other forums but for dementia this is a good one, yes there are other medical forums, yes there are other forums that try to link things up, but for dementia specifically this is a good one. (Dementia, Interview 8)

It is this discrete disciplinary expertise or alterity which is understood as dynamic within the MCN. As the limits of any individual's knowledge are reached and the inadequacies of a unitary professional understanding are exposed, the 'other' is sought to assist. It is our contact with the other, which allows us to tackle wicked problems creatively. The instability of language and its speculative nature create disruptions which theoretically provide the space for routines to be transcended. MCNs in this framing are thus centrally about transcending what was done before and indeed what is done now. Empirically practitioners and managers are aware of the gaps which exist in service; the MCN becomes the space in which new vision and direction can be created and nurtured in response to these gaps.

This is what I was that these group meetings, that is all about that change, and the thing is if a report comes out and its passed round different people and they read through it they might say yes okay I agree with that and it might change their attitudes and might change the way they provide services. Or they might come out flat 'we've always done it this way'. You see this is the thing there's an intransigent sets in where people say 'no, no we've always done it this way, this is the way it works. You've got to get rid of that. (Dementia, Interview 1)

Whilst I no means suggest that MCN members classify what they do in this way, by doing so, I am able to move beyond thin description to try to account for the interior verbatim – the why of organising. In accepting that health and social services are understood as being constantly faced with ongoing political, financial and practice change, there can be an understanding that within this flux practitioners and managers must still seek sense. From this MCNs can become viewed as an organising answer to deal with these ongoing challenges.

In the final chapter I consider how work aids understanding of the form, function and impact of MCNs. In considering morals-in-practice and wicked problems, I have attempted to draw out the challenges faced by practitioners and managers in their everyday work. I now go on to consider if work can tell us any indication as to the benefits of MCN organising. I create a theoretical ideal type - the hermeneutic community - to draw together those concepts which may be related to MCN functioning. I aim to consider the influence of alterity on the Sache to examine whether collaborative advantage can be accounted for. The hermeneutic community acts as a device which enables the MCN to be constructed as an organising which has the functional aspiration to achieve transcendent responses to wicked problems.

CHAPTER 10 – WHY ORGANISE AS A MCN?

10.1 INTRODUCTION

MCNs, or at very least these MCNs, appear not without their problems. MCNs, like other forms of collaborative working, seem to be prone to inertia (Huxham and Vangen, 2004). During interviews MCN participants reported internal group difficulties and external institutional pressures which created challenges to working in a collective way. They described MCN activities as lacking in clarity and focus or situations where MCN actions appeared so inter-dependent with other policy and organisational decisions, that members were left with a frustrating sense of lack of impetus. Participants appeared to struggle with identifying any tangible outcomes for their individual and collective effort. Nor did MCN participants seem to be able to clearly articulate what the MCN was and what it was for. Yet, they still chose to voluntarily organise in this way. This begged the question - why? – what did organising in a MCN provide MCN members?

In an attempt to answer this, I draw together my empirical findings. By recapping, I aim to construct a partial theoretical coherence against which to evaluate whether some modest, conditional conclusions can be drawn as to the reasons why practitioners and managers have organised themselves in MCNs. I start by re-visiting the suggested benefits of MCNs to consider whether there is evidence of these benefits in the MCNs studied. I go on to consider the nature and context of work, as implicated in the framework *morals-in-practice*. I suggest that MCNs can be viewed as a particular type of organising form, which I capture in a theoretical ideal type - the *hermeneutic community* – the purpose of which is to harness collaborative advantage or *potential*. I go on to reflect on the sites in relation to this suggested model. Finally, I conclude by returning to my research questions to consider what my findings have suggested for responding to them.

10.2 BENEFITS OF MCNS

In chapter 3, I presented the proposed benefits which may be forthcoming from organising in a MCN (see Table 3.2). I suggested that these benefits may be reasonably considered as possible motivators for collective organising. However, as these benefits were based on theoretical conjecture, as opposed to empirical evidence, it would now seem reasonable to consider whether these benefits were actually observable in the MCNs studied.

MCNs were argued to provide a means by which to promote and improve care for patients. In creating structures which moved across boundaries it was suggested that MCNs could help to create seamless and integrated patient care, with access to services being improved and more equitable. Care was to be standardised and evidence-based, whilst services became more flexible, dynamic and responsive. In challenging traditional boundaries and silos, multi-site and multi-professional working would occur, thus reducing service duplication and removing barriers to co-ordination. Scarce resources could be identified, purchased and shared (e.g. practitioners or equipment). Clinical audit and governance should become possible across the MCN feeding into service improvement cycles. MCNs would foster opportunities for clinical training and continuous professional development. They would provide a diversity of professional views, encouraging teamwork and collaboration, pooling knowledge and good practice, stimulating innovation and evolution. (See Table 3.2).

From the above, there is the suggestion that much of the work undertaken in a MCN would be delivery oriented. MCNs were arguably tasked with tackling access, equity and quality of care. Some empirical support for this came from the DSDs and Addictions MCNs. In Addictions, they had developed clinical psychology services across the MCN HB members (Box 7.1) and were attempting to create shared clinical prescribing protocols. They were also very keen to develop shared IT systems (Box 9.6) in order to carry out service audit across the 3 HB areas. In DSDs they had set up clinics (Box 8.3), had designed clinical referral pathways (Box 9.7) and were trying to tackle equity and speed of access to services across Scotland. These 2 MCNs also showed evidence of a diversity of views, fostering attempts at teamwork and collaboration. With discrete pieces of work, there were clear attempts to innovate and evolve services, moving beyond present delivery.

As much of the Dementia MCN visible activity tended to be less service oriented and more strategic and policy responsive, it was difficult to collect evidence of attempting to directly tackle care issues. The exception was involvement with the development of the Integrated Care Pathway (ICP). However, this work was not directed by the MCN, but was instead reported on to, the MCN. Further, as any work carried out by the MCN generally regularly fell to a cohort of MCN members and did not appear to be distributed amongst the wider MCN group, the degree to which collaboration occurred was hard to gauge.

In none of the 3 MCNs was there any evidence of attempts to reduce duplication, in the main because local services still continued in conjunction with MCN activity (e.g. addictions and dementia services were still organised and delivered in each LA and HB area). It also seemed that the likelihood of the MCN acting to reduce duplication was low. As MCNs have no budgetary or no executive decision making power, there was little opportunity for any of the MCNs leading on whole sale service redesign and change.

we can only control a certain amount, we are not an executive body and that ... we are not an executive body, you know we don't have budgetary control of anything and we don't have the ... you know a key manager who can say yes this service will change (Dementia, Interview 16)

Whilst shared best practice was discussed by participants as something they would like, again there was little direct evidence of this happening in MCN meetings. For Addictions and DSDs alternative forums were available via related conferences. In addition to the actual MDT clinics, the DSD MCN also hosted their own annual conference where at the end of the session, actual clinical cases were presented for wider discussion. Addictions was linked to CARES (Centre for Addictions Research and Education in Scotland) based at Ninewells Hospital, Dundee, which also held annual conferences. I am unaware of any similar forums for Dementia.

I think it wants to be operational, but it's getting stuck in the strategic stuff... and, I suppose what turns me off as well, is you then go to these strategic things to listen to the same things again, and you think that's the right place for it to be, the HEAT Target Meeting, that's the right place for these things. Okay it would be good for those that don't go to that to get an update, but I don't want to go round and round and just listen again. Or you just have an open session for people and say I've had an idea but how will I meet it? (Dementia, Interview 6)

I'd thought that the MCN would bring us sharing of best practice across areas, so that people trying something think, right, we maybe tried that before and not got anywhere, maybe it's because we're not doing it, maybe it's because we need to do it differently. The other thing I think it's a good benchmark, to know what kind of service are, we providing in comparison to Dundee and Perth, and are we miles

behind them. And if so, what do we need to do to catch up, kind of thing. (Dementia, Interview 5)

It seems that overall there is only modest support for elements of the benefits proposed in at least 2 of the MCNs. The question thus becomes, how can we account for these differences? To answer this I begin by assuming that MCNs are an organising response to a question or set of questions, as yet, perhaps, unarticulated (Geertz, 1973, 1983; Grondin, 1995). Assuming this, I return to consider the work undertaken by MCN members.

10.3 REVISITING MORALS-IN-PRACTICE

I have suggested that central to practice is *uncertainty*, whether considering evidence or ethics there is infrequently one, obvious answer. Instead, what is commonly found are contested ideas and theories. Any piece of scientific knowledge can plausibly be analysed to draw multiple theoretical conclusions and any ethical stance is likely to be understood in many different ways. However as has been pointed out, health and social care practice demands action, even when this may be the action of considered non-action. This I have referred to as morals-in-practice, the nexus where evidential and ethical reasoning merge and are translated into activity or *practice*.

I have suggested practice is not confined to the *practitioner-patient* unit of analysis, but also encompasses the *practitioner-population* interaction. These two levels of interaction are not discrete but inform and work in conjunction with each other. For example, having *distance-near* experiences of patient *suffering*, impacts and informs practitioner-population decisions to the extent that services may be configured and delivered differently (NB: even though policy context is held constant across these areas). Practice frequently occurs at the very edge of what is known, thus, decisions become as much based on a practitioner's or manager's ethical beliefs, as to available scientific evidence.

Against this background, I have suggested that the MCN provides a forum to consider and debate morals-in-practice and clinical governance, the MCN as collective whole providing a method of ensuing accountability of practice. In the DSD MCN this was demonstrated during group discussion of individual patients in the MDT clinic. Practitioner knowledge and experience of the Sachen was shared, ensuring that as much of the available evidence was

considered as possible whilst simultaneously opening each individual's practice to collective scrutiny. For Addictions, they were moving towards working on shared clinical protocols and development of shared clinical data systems. The Dementia MCN spent much of its time considering relevant strategy and policy to ensure that their collective responses provided the best evidence available, considered by resident experts in the field (e.g. the National Dementia Strategy).

Coming together with other MCN participants acts to allow scrutiny of not only own morals-in-practice in reference to other MCN members, but also aids further learning by exposure to evidence from colleagues who work within different disciplines or sectors. This allows the MCN participants individually and collectively to increase their generic competencies, whilst also acting as a monitor of professional self conduct. The activity of the MCN is about sharing professional knowledge and experience of a shared clinical subject matter in order to improve the quality of health service delivery and performance.

This ability to collectively access diverse streams of up-to-date information is especially important when changes in health care technologies continue apace. Whilst practitioners may arguably keep up to date with their specific professional competencies, it would be impossible for them to keep abreast of all changes in their disciplinary partners. The MCN provides an arena where any relevant new developments in practice, guidance or policy can be brought to the attention of colleagues working in the same field. For example, changes to funding streams impacting voluntary sector partner's provision for Dementia or potential centralised funding coming on stream for Addictions and how to successfully apply for it. The MCN allows these developments to be shared and considered. The outcome being improved learning, service development and service governance.

Finally by considering the MCN as a forum to deal and debate with morals-in-practice in a collective way, it may suggest why the membership of MCNs is predominantly high status experts. The MCN is not simply a training forum for in-house, professional disciplinary, but is more appropriately seen as a learning space for those who lead and create services for a shared clinical subject matter. These MCN members were heads of service, positions and roles which are ascribed overall responsibility for service design and delivery. At this level, the need and desire to be able to think out with the parameters of their own knowledge, geography or service in order to balance safety, quality and creativity becomes paramount;

the MCN drawing membership from highly skilled, experienced practitioners and manager provides a space for this type of learning and debate.

This function becomes important if as I have suggested clinical governance is central to the functioning of the MCN. Practitioners and managers use the MCN as a form of quality control. There appears recognition that the individual practitioner working in isolation is no longer a sustainable model of practice. Whereas historically a Consultant or GP would have been viewed as the hierarchical elite, separate and somewhat untouchable, this form of professional elitism, in the light of the tragedies related to Harold Shipman, Bristol Hospital and Alder Hey, has become suspect in modern health care. This is not to deny that within a MCN, the medical profession is still influential, however, there does appear to be a recognition that whilst a managerial leadership is necessary for certain forms of professional learning and organising i.e. internal professional line management, for the ethically and evidentially complex activities dealt with by MCN members, multiple perspectives help to provide a systemic, collective safeguard.

MCN members recognise that there are no simple answers to the dilemmas they face. The MCN forum thus allows discussion and debate on *what we don't know*, experts being able to admit to mutual ignorance in an attempt to provide the best care and service in the face of uncertainty. It is collectively understood that there is no quick and easy off the shelf answers to fix the issues faced, in this work context, uncertainty reigns. Thus the MCN members shared experience and understanding of morals-in-practice underpins their collective endeavour to deal with their shared clinical subject matter. Clinical governance is understood as a work horizon that is beyond the limits of any single individual professional or disciplinary understanding or experience. Against this backdrop, the MCN offers a social space where a form of quality safeguard can be embedded in the everyday work of those who have the responsibility to design and deliver services.

10.4 REVISITING WICKED PROBLEMS, ALTERITY AND TRANSCENDENCE

Much of the work that MCN members then deal with is fraught with uncertainty; there is seldom an off-the-shelf answer. Indeed, I have suggested that many of the issues faced by MCN members are classifiable as wicked problems, infinitely unfolding but of critical importance. Further as wicked problems are intractable and systemic, it becomes imperative that those attempting to tackle them utilise methods of engagement which are systemic and

fluid in order to deal with the ever changing demands of their continually evolving nature. Due to their complexity wicked problems quite simply require responses which are novel, routine responses are not being adequate to the task– if the question is wicked, there is a need for creative thinking and working which transcends the routine.

I have suggested that health and social care practice is a rather messy affair, with evidence and ethics mixing together in moral action. I have shown that inherent in morals-in-practice is not only the uncertainty with which practitioners and managers are faced, but also the sense of the subjective and collective importance that is imbued in these decisions, that is to say, these decisions are not made lightly or with the luxury of objective *distance-far*. Instead in the *distance-near* interaction, there is embedded the normative imperative *to do the right thing*. I have suggested that in governance terms, doing the right thing may mean opening individual practice to collective scrutiny and allowing the MCN group to act as a quality monitoring and continual professional development resource, however, in terms of wicked problems, I am suggesting that doing the ‘right thing’ may be the mobilisation of alterity *per se*. That is the bringing together of professionals from different disciplines, services and sectors.

It is often assumed that the tacit understandings that we share with our close professional and disciplinary colleagues underpins successful teamwork and collaboration (Dougherty, 1992; Poulton and West, 1993). For example, in much of the clinical occupations, positivist epistemologies hold sway, determining how knowledge is known and collected. These are taught to new students in their disciplinary training and form an unquestioned basis from which their work is carried out. So, for example, albeit a psychologist and an endocrinologist will have professionally distinct knowledge, they will also tend to have similar understandings about the nature of knowledge and the central importance of reliability and validity in uncovering objective facts. These assumptions can be taken-for-granted when carrying out a piece of joint work.

However, I have argued that it is not within similarity that creativity is located, but is instead theoretically accounted for in difference. In hermeneutic theorising, *transcendence*, moving beyond the orthodox, is possible due to the *speculative nature of the logos*. As the logos is apositional, that is in is never fully captured and always houses multiple meanings, it is vulnerable to disruption (Davey, 2006). That is as ideas are expressed in language they can

become disrupted by other ideas expressed in the language, thus new combinations can become birthed. This means that when I come into contact with those who are trained in a different discipline to me, it is the disruption of the meaning of words, concepts and underlying assumptions which opens the possibility to new ways of being. As language is always vulnerable to new combinations, when differing professional epistemologies come into contact with each other, they are open to the possibility of new ideas being created.

Whilst then MCN members share much, they also differ in how they understand their shared clinical subject matter, it is thus their professional, geographical and service differences which arguably make their shared endeavour dynamic. In bringing together different understandings of the clinical subject matter, the subject matter becomes understood and re-understood. Returning to the psychologist and endocrinologist example, it is not that the two professionals share an underlying understanding of the nature of knowledge but that their professional competencies, experience and understanding is different. It is in their diversity that new ways of being emerge. For example, the psychologist does not understand the hormonal underpinnings of congenital adrenal hyperplasia any more deeply than the endocrinologist understands theories of bereavement implicit in the birth of a disabled child. However, in bringing these two professionals together not only is knowledge potentially increased for both parties, but new ways of thinking and acting for any particular case is open to change: the physician begins to consider the psychological and the psychologist begins to consider the physiological. As the patient begins to be viewed differently by each professional individually and as the MCN collectively, the care and clinical activity which they receive begins to change as a result of this mix of different knowledge: the orthodox practice is thus transcended.

In the MCN executive functions the same thing occurs. For example, if we consider the MCN relationship between a psychiatrist and a dementia patient's lay family member – a relationship where power, authority and influence is traditionally understood as being held by the medical practitioner. During meetings issues which may appear of less service salience or interest to the psychiatrist, such as the age range attached to service access, become within this context reframed, moving from an individual patient's experience to a population consideration. The lay member repeatedly reports the difficulties they and others have experienced in accessing services for under-65 year old dementia patients, this somewhat arbitrary banding impacting in very real ways on the support, finance and service referral

they can receive for their family member. In doing so, the lay member puts this topic on the Agenda quite literally. Whilst dementia is admittedly uncommon in under-65s, it does occur and for the psychiatrist being faced with these experiential stories of service in a formal setting, moves the subject out of the realm of individual complaint to be recast as a clinical population issue. In this, the lay member's position of alleged inferiority in status is redrawn as language also gives them creative power. Intriguingly the lay member holds the possibility of impacting on future service design by simple virtue of presenting the issue and increasing its MCN salience. Again, viewed in this way different understanding and experience shared between alters, can transcend what was previously present.

You've spoken to someone who says you know "I hate going to this locus, because it's full of old people and I'm 20 years younger and even the carers are older than me what's the point in me going?" So you say "well what would you like?" and then you can go along and you can take that up and say "well this is what people are saying, we think that might be a good idea," and they say "oh well what about this and that?" and then you go back and ... and you can see someone else and say "well this is what we're planning and ... and would it work?" So you do get this generation of ideas and then you get a validation as well you know as you're going round from person to person. (Dementia, Interview 3)

Transcendence thus relies on alterity. Epistemologies which come together and clash create the possibility for new ways of seeing a problem, situation or current way of being. Enough is shared, in the form of morals-in-practice for practitioners and managers to work together with a level of mutual understanding, but it is the differences that distinguish them and which houses the creative tension to move beyond that which is orthodox. It seems that in referring back to *potential*, participants may have unwittingly been hinting at this hermeneutic framing – the potential for transcendence theoretically located in the speculative logos, drawn out through contact with the other. It seems that whilst being unable to theoretically articulate what potential refers to, participants appear to have however experienced the process in real life: a finding in keeping with the principle of hermeneutic realism. However, this does not answer why moving beyond what is currently present would be desirable or necessary.

To answer this we return to the nature of wicked problems. As knowledge changes, uncertainty remains, practitioners and managers are faced with ongoing pressures demanding that they have to respond to and with - technological advancements, quality mandates and financial restrictions – the overall aim to provide a safe, efficient and effective service. To do this, they must continually re-visit and re-understand the work they carry out; finding new ways of dealing with the issues they are faced with, to think creatively to respond to the changes in their context and their understanding of the clinical conditions. The work that the MCN deals is forever evolving, the MCN members responding to this with an on-going, embedded creativity which seeks to transcend today's understandings and experiences through collective engagement. The MCN thus understood is inherently a creative social space through the central mobilisation of alterity; the MCN responding to and creating a new the shared understanding and experience of the Sachen.

10.5 THE HERMENEUTIC COMMUNITY AND POTENTIAL

I have shown that participants put emphasis on the tension between *potential* and *actuality*, with tangible evidence of activity seemingly difficult to provide yet, the draw of potential seeming somehow to attract members to participate. I am now suggesting that potential can be theoretically accounted for in the speculative nature of the logos; as words come together from different professional epistemologies, they have the possibility of combining in unusual ways. This allows creative innovation to emerge. Potential in this framing becomes understood as recognition by participants of an underlying creative mechanism which, whilst they cannot explain, they are nevertheless aware of and attempt to articulate.

Put another way, in silos professionals are surrounded by similarly thinking and doing colleagues, understanding becomes learnt within the *community of practice* (Lave and Wenger, 1991), that is tacit knowledge framings which implicitly demonstrate '*how things are done around here*'. This is not to say that communities of practice will not tackle new activities or tasks, but that they already share a good deal of knowledge about how to tackle that issue and that issue is understood. For example, a group of surgeons may debate the best technique for a meatus (hole for urination) mobilisation, but they will be unlikely to disagree about what tools they need to use or have any need to explain the language they use to describe these techniques. However, when you add an endocrinologist to this discussion, whilst they may share the underlying medical terminology, the expert knowledge of surgical detail will be absent. If a psychologist is added into this discussion, the underlying medical

taken-for-granted need for surgery even becomes necessarily suspect and in need of explanation. From this, the possible disrupting effect of *alterity* can be imagined.

Taken together the above concepts – alterity and potential - we can re-construct our understanding of the MCN. The MCN becomes conceived of as a space which brings differing professional epistemologies together so that the assumptions behind the words used by differing groups become visible and in questioning these differences, practice is as a result, be disrupted. It is this disruption or *potential to disrupt* which allows the possibility of transcendent or creative responses. These concepts can be drawn together and captured in a constructed ideal type - the *hermeneutic community* – which I will define as - ‘*a forum where difference is purposefully drawn together, in order, that openness to the speculative nature of language can disrupt practice to achieve creative ends*’.

Why though would a hermeneutic community necessarily emerge? Again I draw attention to the nature of the issues to be dealt with, unfolding wicked problems. These particular problems are not resolvable in routine ways. These issues require novel approaches. There is thus a necessity to develop beyond what is taken-for-granted to do things differently. MCNs understood as hermeneutic community allow us to understand that they are an organising activity specifically for the purpose of going beyond the conventional to consider the creative – to release the potential.

Understanding MCNs as hermeneutic communities brings with it the suggestion that MCNs are a social space where creativity is at the forefront. Unlike traditional forms of organising which rely on hierarchy and embedding within established professional knowledge, the MCN is instead about mixing it up. The aim is to somehow capture the *Sachen* in a holistic form, whilst simultaneously acknowledging it can never be captured in any propositional way. As policy and evidential base for decision making is continually changing, the *Sachen* is therefore never stationary and is continually being reconstructed. Whilst then MCN members share much, they also differ in how they understand their shared clinical condition. Their professional, geographical and service differences are arguably what make their shared endeavour dynamic. In bringing together different understandings of the clinical subject matter, the subject matter becomes understood and re-understood. However the very real dilemmas of uncertainty and suffering still exist and practitioners and managers still have to actualise their individual and collective morals-in-practice. The MCN thus understood as a

hermeneutic community becomes the space where these challenges can be tackled in new ways.

10.6 REFLECTIONS ON THE MCNS

Drawing together the above discussion, I am suggesting that MCNs are thus founded on *alterity*. That part of a MCNs theoretical and empirical function is to bring together difference *per se*. The reason for bringing difference together is to mobilise the dynamic nature of the *logos*, language. This dynamism is achieved by *openness* to the other, which in turn allows new meanings and understandings to emerge, possibly creating *transcendence* or creative solutions. These creative solutions are required as the MCN practitioners' are faced with *wicked problems*, which in their intractability, cannot be responded to with straightforward managerial processes.

In the following, I use this set of theoretical assumptions to reflect on each of the MCNs to see if this helps to make sense of how each of the MCN functions. If, as I suggest, these concepts do provide an account to understand the function and functioning of MCNs, it should be possible to ascertain how these factors are actualised in each of the MCNs and to consider how, if at all, this impacts on each of the MCN sites.

Addictions MCN

Structurally the Addictions MCN was predominantly dominated by Psychiatrists. During fieldwork there was 5 Consultant Psychiatrists involved. This professional group had been the impetus for the setting up of the MCN and the Clinical Lead had always been drawn from this discipline. There had been 3 Clinical Leads to date. The relationships between the Psychiatrist across Health Boards were on the whole good, with some tensions between 2 co-located Psychiatrists and also some grumbling that 2 of the Psychiatrists formed an *old boy's network*. This suggestion appeared to be based on the length of time these two individuals had worked together.

Other MCN members were drawn from Operational Management (3), Clinical Psychology (2) and Pharmacy (1 regular attendee). 2 of the Operational Managers had recently become involved due to changes in post within their respective Health Boards. They were self-admittedly still finding their feet in their new posts but were on the whole fairly positive

about the idea of the MCN. This was in contrast to one of the preceding Operational Managers who was reported as being quite resistant to the activities of the MCN. The third Operational Manager had been in post for many years, was very experienced and had a reportedly long, fraught history with one of the Consultant Psychiatrists. The Clinical Psychologist had had their post created by the MCN, with the MCN seeking a joint funding package for a cross Health Board clinical psychology service. This had been on the whole very successful and this individual had gone some way to lobbying for the establishment of additional funding for Psychology service development. The other Clinical Psychologist was a long-term colleague of the first and was involved with national training. The Pharmacist was a regional manager and regularly fed back to pharmacy colleagues any relevant information.

From this, alterity appears fairly limited amongst medical colleagues, all having been drawn from Psychiatry. However, this surface level analysis was not borne out in the data. There was still a high degree of internally recognised alterity regarding the debate on *prescribing philosophy*. Whilst the other disciplines would not necessarily be centrally involved with this particular debate, they would be impacted on by this. Services have been shown to be designed and developed with reference to individual's morals-in-practice, and this in its turn would impinge on other related professional disciplines (e.g. through put for pharmacy and clinical psychology services). The most obvious demarcation in the Addictions MCN appeared to be between clinical and managerial MCN members. Non-medical MCN members were involved and often central to discussions and decisions on funding for the organisational elements of the MCN (questions of where to get funding, how to get funding, and what to get funding for) and areas of possible joint working (commissioning IT systems and joint in-patient bed provision).

There's areas that realistically we can share across the MCN HBs. There are those that for one reason or another, we can't. An example of can't is fairly early on, we had a discussion about in-patient beds, but not all in relation to detox, but longer term, in relation to residential rehab and that was to do with HB 1, they've got the beds in PLACE. Is this a resource that we could use across the three areas of the MCN and that might be a good MCN project. HB 2 are already contracted with HB 1 for I think it was two beds. So we had to bring that discussion back to our groups here and what we said it would be nice, but we're not in a position to do it because

we've spent a lot of energy and resources into developing community orientated services. We've got a detox service. Okay, we don't have residential rehab beds. We do have access to, or what we were negotiating at that time, was access to dedicated detox beds but for the numbers that we deal with on an annual basis, we can place these out of area. Not ideal and the other thing we had to take into account was geography as well, was for someone in HB 3 to access a bed in PLACE might not be. So what we have to conclude is, thanks, but we'll step out of this one because it's not a priority for HB 3 at this time. So we didn't waste time there, we didn't say, well, scratch our heads and take two or three months to think about this. We went up to PLACE, had a meeting across the MCN and said, yeah, this is not an issue that would be worth pursuing across the MCN. (Addictions, Interview 10)

Towards the end of the field work observation it appeared appreciation of other's knowledge was becoming more embedded, with the lack of personal interaction (i.e. not trusting each other enough to pick up the phone to directly to ask for advice/help) becoming a verbalised frustration for moving things forward. In particular, one of the new operational managers openly challenged the customary bureaucratic style of interacting. This, in addition, to the purposefully tackled difficult conversation on prescribing, may have been evidence of an increased move towards more open intra and inter-disciplinary dialogue.

As stated, there had been some long standing difficulties for this group with regard to what their purpose was and during the observation period the new Clinical Lead had put the MCN *on probation* for a year. Due to this perceived lack of direction, there had been a very frank discussion as to whether the MCN should be dissolved all together, with several members reporting they would be quite willing to cease meeting as a MCN. At this meeting, the new Clinical Lead proposed that they have a probationary period in which to achieve some goals and if in that time this was not forthcoming, the MCN would cease to be.

The Clinical Lead had been very proactive and interested in talking to me about my early findings, in particular the distinction between the bureaucratically enforced and the clinically relevant activities. These discussions acted as an impetus to re-configure the structure of the MCN with these two activity themes being separated. They developed a Strategic Group to deal with steering of the MCN. This was to draw membership from Drugs and Alcohol

strategic planning and approximately 8 sub-groups (e.g. Mortality (drug deaths) Group, Database e-Health Group, Clinical Guidance and Protocol Group, Audit and Evaluation Group, and Operational Working Group). The aim was to add some vitality back into the MCN via providing some visible and focussed 'doing'. This structural intervention was on last discussion with the Clinical Lead, proving successful and had resulted in the MCN still being operational after the probationary period.

It seems that for the Addictions MCN whilst there was difference intrinsic in the group, this alone did not prove adequate for the MCN to move forward. However, it could be argued that the clinical lead engaged with me as 'other' and that this perspective of the MCN went some way to bringing new ideas to the group on structure and function. Openness to the other was clearly not straightforward, yet moves towards discussing shared clinical protocols suggested that this might be changing. Further it did appear that those activities which were more closely aligned to the practice element of the Sachen were more functionally motivating and cohering. With time this MCN appeared to be moving to a new functional phase, where members were less concerned with the MCN as a wicked problem - how do we make the MCN work – to wicked problems associated with shared subject matter - what work does the MCN allow us to do?

Dementia

This was without doubt the most difficult MCN to engage with. I felt that I was treated with a high degree of suspicion and therefore could not build up the rapport and ease which I had with the other 2 MCNs. I suspect that this may have been due to fear that I was there to evaluate activity. Whilst this was distinctly uncomfortable for me as a researcher, it did provide a unique observational perspective in that I could watch how the MCN unfolded without any of my direct involvement, research findings or knowledge being added to the mix.

During fieldwork the Dementia MCN showed the greatest amount of professional diversity, members were drawn across health, social services and voluntary organisations. Hudson (2007) suggested that this type of inter-organisation working would be the most complex form of collaboration.

Participant: I think you know there's been a best value review recently and they did say that they recognise that dementia is different but weren't sure, you know, found what to do with it or anything like that. And I think that is the difficulty just now and I think with the NHS just now, with all the mental health collaborative, with all the chronic conditions collaborative and, if we put the HB Older People's Strategy you know, how all these things are fitted together now is...

AD: Anyone's guess?

Participant: Yes, it's complicated so if you start to bring in local authority stuff as well which is just as complex, that's really difficult. (Dementia, Interview 5)

Whilst there were many different disciplines represented from Health (Medicine, Nursing, Allied Health Professionals) and members drawn from other sectors; this group was on observation the most traditionally aligned to a hierarchical structure. The MCN Lead was a Consultant Psychiatrist who had been instrumental in developing the MCN and had been Lead since the MCNs inception. During the time of observation there was only one Psychiatrist in attendance-the MCN Lead. The Lead chaired all meetings and was very much in control of decision making. This caused some resentment from various MCN members, who viewed proceedings as slightly outwith their ability to influence.

Indeed my subjective emotional reaction having attended one of these meetings was generally one of depression. Much of the discussion generally re-visiting the topic of pieces of work which had been carried out in previous years for the Health Board and had had to be '*put in the bottom drawer*' as they were ignored. There was a distinct sense of the hopelessness around action. This was in contrast with the other 2 MCNs where meetings felt motivating (even if that proved to be short lived after the meeting). It was hard to tell if this was a result of the clinical condition, the MCN collective psychology or the MCN Lead's managerial style.

Another main topic of discussion was around the *Best Value Review* which was being carried out on MCNs in the HB area. The hope was that this would provide some clarity as to what the MCN was supposed to be concentrating on. This proved not to be the case and the review was perceived as causing a lot of preparatory work for not much return. The MCN was not evaluated, as the review struggled to find parameters by which to review MCNs and no feedback was given as to a way forward. The only outcome was that the MCN was to be

structurally linked within a new division. This to some extent later led to the downfall of the MCN.

The best value review was sort of, I waited with baited breath, and by the sounds of things it was just one huge disappointment and I've had some sort of initial feedback from both NAME and NAME and it's not what people thought it was going to be. Which is a disappointment because we thought we would maybe be reviewed and what's the form of the MCN, of that review, and that's not happened which is just a real shame. (Dementia, Interview 4)

Thus whilst the MCN members appeared relatively open to one another and there was a very high degree of alterity, closeness to the delivery planning of the Sachen was severed. The only exception to this was care staff training delivery which was talked with a high degree of enthusiasm by the MCN Lead. This work was carried out by the MCN Project Worker. The Project Worker was directly funded by the MCN and was available to carry out all of the work needed for the MCN, both bureaucratic and service-related. This meant that much of what was understood as the 'MCN' was carried out by this individual. However, when the MCN was re-structured post-MCN review, funding for this post was not continued and to all intents purposes the 'work' of the MCN ceased.

However, the Dementia MCN also raises an issue of interest which is not implicated in the theoretical concepts and that is, of hierarchy. During observations this MCN, was clearly led by one consultant psychiatrist. Whilst there was one other psychiatrist involved in the MCN, they did not regularly attend. This differed from the other 2 MCNs where there were multiple consultant grade Doctors (Psychiatrists, Physicians, Surgeons). To a certain extent the activation of the dynamism in alterity appeared to be related to perceived shared hierarchical status. Or alternatively, in the Dementia MCN there was no-one perceived as being of high enough medical status to challenge or question the MCN Lead. This may have created a blockage in the creative potentiality of the MCN. In addition the leadership style was more managerial and less facilitative – meetings were very much meetings and the agenda was strictly adhered to. Having a facilitative style, Grint (2005) has suggested is necessary when dealing with wicked problems, such as the intractability of a condition such as, dementia which relies on a multi-service response.

For this MCN it may be that the added complexity of cross collaboration working, along with a more traditionally committee style leadership and a lack of diversity within the medical discipline may have created difficulties engaging with service-related wicked problems.

DSDs

Due to my long standing relationship with the members, this proved to be the easiest of the 3 MCN sites to observe and interview. Many of the theoretical concepts were undoubtedly drawn from this MCN as I tried to make sense of the relative 'high motivation' amongst this MCN when compared to the others. This said, it should thus come as little surprise that the DSD MCN showed high alterity (disciplinary difference) and openness (willingness to have practice disrupted). However, it is perhaps their closeness to their relevant Sachen which differentiated them the most from the other MCNs.

This MCN carried out clinical work and much of their 'positive vibe' seemed to come from this activity. Each clinical case acted as a focus for shared debate on their respective clinical specialities, this acting as a learning forum. It also meant that the uncertainty and suffering of clinical practice was clearly shared, as participants navigated together their individual and collective morals-in-practice. For example, a very senior surgeon shared their anxieties over an operation where things had not gone well with the group. Having relied on ultrasound result, rather than experience, a potentially life threatening clinical event could have occurred. The individual was clearly disturbed by this and used the MCN collective space to share this distress.

However, whilst the clinical setting proved dynamic, in the executive arm of the MCN, the same apathy for bureaucracy was present. Considered alongside the multiple clinical and research demands, the desire to fill in paperwork and audit for external bodies such as NHS QIS, was not high. Even here it seemed that the further activity moved from the Sachen, the more enthusiasm waned. It may be that for all 3 MCNs members the desire to function at the distant-near end of the suffering spectrum was a motivator for action.

As an aside, it is perhaps suggestive that when the MCN Lead who first established the DSD MCN, was given the choice to establish another MCN they decided not to and instead opted

instead for a clinical network. The individual commented that the bureaucratic component of the MCN did not necessarily add anything to their activities or what they could achieve.

Overall

It seems then that for these MCNs at least there was a desire to be involved with works which was service related to the shared clinical subject matter, this type of activity being of most motivation for individuals (when compared with bureaucratic activities). This appeared related to wicked problems. Firstly, wicked problems had to be in some way made tamer. For example, the Dementia MCN seemed to be attempting to understand dementia in its totality, concentrating on steering and strategy, yet members seemed somewhat dissatisfied with this focus. Secondly, wicked problems needed to be closer tied to service related issues. For the Addictions MCN who had moved into a new phase they were separating different functions – strategic and operational, this was seen as being closer to practice.

Alterity was also implicated, yet strangely for the Dementia MCN which had the most variety, crossing over service boundaries, this seemed to be a hindrance. It may be that too many competing systems undergoing simultaneous change, made decision-making overly cumbersome. The DSDs MCN had the highest degree of variability within Health, constituted of predominantly consultant level (high status) doctors. For the clinical focus of this MCN this seemed to work well, enabling creative discussions and outputs to ‘fall out’ of contact.

you could be social work, you could be voluntary, you could be health, you know you should be looking at a body of skill not a body that is full of Reps. The difficulty with Reps is, is you say “right do you agree then?” And they say “oh yes well I agree but I’ve got to take it back to my constituency.” So you’re dealing with third parties all the time and then they go back to their constituencies and say “well I don’t really understand that because of course I wasn’t at the meeting so I can’t take a decision.” So you come back and they say “well we can’t take a decision, you have to understand we can’t take a decision.” And you think well what’s the point in coming then if you can’t take a decision, you know. (Dementia, Interview 3)

Leadership utilising a facilitative style such as in the Addictions and DSDs MCNs appeared to have a better fit to creative activity. The Dementia MCN appeared to be led in a more traditionally ‘Chaired’ style and this did not encourage the consideration of wicked problems.

It seems that alterity, leadership, the nature of the construction of the Sachen and related wicked problems are all important for MCNs to achieve hermeneutic potential and transcendence. In conclusion, the ideal type of hermeneutic community may prove of use empirical and theoretical use when thinking about MCN form and function.

10.7 CONSIDERING MCNs AND HERMENEUTIC COMMUNITIES

MCNs

In this thesis, I set out to answer several questions about MCNs. These questions were related to form, function and impact. To answer these, I suggested that work may be a useful lens. I have suggested that MCNs can be understood as an organising form – the hermeneutic community - where practitioners and managers come together to tackle the wicked problems associated with their particular Sachen.

I see the MCN as the work that’s done. It’s not the meeting. But you need to get to the meeting in order to, I’m here and I’m interested and I need to be part of this. Also, to learn, to get knowledge, information. (Addictions, Interview 12)

From this perspective the questions of MCN *form* and *function* become understandable as being framed within an *interius verbatim*, a question-answer relationship. That is, the MCN is an organising answer to various organisational health and social care questions – MCNs form and function are means by which to describe this organising answer. Form thus can be understood as the structural mobilisation of *alterity* round a shared Sachen and MCN function is to construct and re-construct the Sachen, to creatively tackling the related wicked problems which emerge due to this work. I suggest that the MCN, in ideal form and function, can thus be captured in the concept of the hermeneutic community – ‘*a forum where difference is purposefully drawn together, in order, that openness to the speculative nature of language can disrupt practice to achieve creative ends*’. Thus to consider the likely impact of a MCN, it is necessary to consider the practical and theoretical implications of the hermeneutic community.

Hermeneutic communities

In this section, I make some tentative suggestions as to what the implications of the hermeneutic community may be at both a practical and theoretical level.

Practice considerations

It is worth re-iterating that whilst MCNs have been seen as an attractive option, networked working is just not straightforward (Huxham and Vangen, 2004). In very real ways what an MCN can actually achieve is limited by personalities and sheer pragmatics. Quite simply practitioners and operational managers are busy people, with multiple demands on their time and multiple personal agendas. This means that they will differ in how much input and what priority they can place on that which is arguably an optional extra. To survive, the MCN model must be seen as providing something of value which could not be achieved without it.

I have suggested that the bureaucratic work elements of the MCN, such as production of annual reports and audit, did not hold much interest to MCN members. That instead those activities which were closer to practice, or practice identified service gaps, were of much greater motivation to members. Bearing in mind my suggestion of the centrality of the *Sachen* this would seem to make sense. That is, if MCN members are indeed drawn together to answer wicked problems which arise from their shared clinical condition, activities such as how to go about ensuring patients with Addictions have adequate Clinical Psychology input or how to up skill staff in care homes to resource them to deal with the highly challenging features of Dementia or quite simply how to provide DSD patients with a unified, multidisciplinary service, would intuitively seem more motivating than writing an annual report.

It may simply be that the bureaucratic demands placed on the MCN are too far removed from the practice *Sachen*. In fact, I could go further and suggest that these types of tasks are in fact the *Sachen* of management professionals *per se* and that is why they hold little or no interest for hands-on practitioners or operational managers who are necessarily client facing. From this perspective it becomes of interest to ask, what value, if any, do these bureaucratic demands add to the MCN? The startling answer may be none. Indeed it may be that these activities are undertaken purely as a result of the expectation that the MCN must undertake

certain managerial tasks, in order, to be seen to be managed. The outstanding question is of course, what types of activity should be undertaken by MCNs?

If we assume that the hermeneutic community is the underlying model of the MCN, the suggestion is that this organising form's value is attached to the potential for creative problem-solving. More particularly, creativity focussed on tackling empirically experienced patient and population clinical issues. The conclusion being that to make any impact creative responding to localized practice issues is the remit of the MCN and activity should be quite explicitly centred on this type of activity. That is, as a type of hermeneutic community, MCN members need not act as apologists for concentrating on their shared subject matter and what they achieve in limited, localised terms for their patients and populations. Hermeneutic communities are about mobilising difference to achieve meaningful change in behaviour, attitude, ideas, activity and services therefore this should be foremost in the minds of MCN members and policymakers, as they offer an ideal opportunity for creative responding to intractable issues.

An acceptance of the hermeneutic model also suggests certain features which are worthy of consideration when designing a MCN. For example, whilst difference is the dynamic by which the creative process occurs, empirically it must be borne in mind that too much difference is likely to be counter-productive, not least because action is required to be attached to the Sache. The political, economic and managerial boundaries which require to be crossed for say inter-sector networks may simply prove insurmountable for any other than top-level strategic and financial managers. To be collectively motivating social action should be perceived as client facing, i.e. it tackles real issues experienced by real patients. Drawing on morals-in-practice, the MCN members clearly had very real investments on improving service, the MCN was by no means perceived as an opportunity for idle debate. In order to make things happen, leadership must be about drawing out ideas and thinking creatively about problems faced, however, whether this is necessarily the responsibility of one individual or can become a micro-cultural attitude is moot. And this leads me to conclude, MCNs understood as hermeneutic communities are about a creative disposition to work. Central to this is the recognition that the Sache provides, and always will provide, challenges which need new ways of being considered and met.

Theoretical considerations

Turning to briefly consider wider theory, I consider what possible directions may prove fruitful when considering hermeneutic communities. Perhaps the most intriguing is the relationship that hermeneutic communities suggest for the evolution of work organising.

In these MCNs at least, we have some intriguing examples of modes of thinking or doing work, which challenges the traditional hierarchical organising within healthcare. The MCN provides empirical examples of professional status offering the opportunity to re-cast working practices and mobilise social action (Weber, 1976). Further, these collectives appear to be seeking meaning, *morals-in-practice* provide us examples of individual's ethics amongst a plurality of difference, in turn understandable, as a partial response to the anomie, emerging within the division of labour Durkheim (1933). Even within the general apathy towards bureaucratic activity, moving away as it does from client facing activity, we can find resonance with Marx's alienation, brought on as the producer is removed from the product (1969).

Taking this admittedly, very macro theoretical view it seems that the MCN as hermeneutic community may also be a type of organising form which has emerged to tackle the need for localised meaningfulness in work. MCN members come together to understand the Sache because there is shared need to construct moral coherence and resultant social action. This pull to coherence is suggested in my decision to refer to the model as a hermeneutic community. Central to hermeneutics is not only the idea that interpretation and understanding is an intrinsically human characteristic, but that the dialectic of part-whole is constantly in play. Whilst, sub-specialisation (division of labour) encourages the *part*, the need to understand the Sache as coherent *whole* draws MCN members together. That MCN membership is predominantly drawn from privileged high status practitioners and operational managers admittedly allows this actualisation of the hermeneutic circle to occur at all.

These suggestions thus add a new dimension to the basic model of hermeneutic communities. Whilst in practical terms there is the need to mobilise structure for creativity, a side effect of this creative process is the space for meaning-making about the work done. Those within the MCN are thus construction the new meanings for their Sache, but additionally they also have the social status to turn these new meanings into diffusible action. Therefore, the MCN

understood as hermeneutic community can demonstrate in very real ways, the construction of new ways of understanding and acting out the Sache.

Future research

Taken together all this suggests that the model of the hermeneutic community has much to offer both for MCN and network research. As I have previously shown, several areas appear to be of importance: whilst difference is imperative, this cannot be too much difference as this becomes stultifying; leadership needs to initially concentrate on drawing out ideas and debate, before moving to goal based process; any problems to be tackled, need to be located close to the Sachen, shared goals are only deemed motivating in their perceived close relationship to meaningful shared subject matters; time spent on bureaucratic tasks does not provide best value for this form of organising, concentrating as it does on managerial procedure and not creative potential; and overall the hermeneutic community must be understood as being about creativity *per se*, that is, creating the space for new meanings and social actions to be constructed; and finally, I suggest that my proposed hermeneutic community model provides a potential theoretical lens to be used to consider and compare any new organising contexts where networked or creative work is centralised.

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