



Tuke Institute
FROM HUMAN SCIENCE TO MEDICINE

Participative Medical Governance in the Delivery of Health-Effective Medical Services

Document ID: 1004-CD1.1

Title: Participative Medical Governance in the Delivery of Health-Effective Medical Services

Author: Dr. Rupert Whitaker

Purpose(s): Green paper; seed-paper

Audience(s): policy-makers; commissioners; senior medical administrators; ethicists; social, organisational, and behavioural scientists

Available from: www.tukeinstitute.org

Contact: www.tukeinstitute.org/contact

Copyright ©: the author 2010

Table of Contents

Summary	4
Introduction	5
What medical governance is	6
The need for participative medical governance (PMG)	9
Current problems with participative medical governance	11
Health-effective PMG	17
Finding a solution: Overview, principles, and standards	17
Defining and gathering information useful to medical governance	20
The system of information-collection	21
Assessment of the patient’s illness-related status	23
Assessment of clinician-performance	25
Assessment of the administrator’s performance	28
Translating good data into good governance	30
Structure	30
Process	32
Information-delivery	35
The act of governance	38
Critical analysis of the model	39
Testing the model against the findings of the Bristol Inquiry	39
1. Patient-centredness	40
2. Integration of services	41
3. Creating useful information of high quality for governance	43
4. Transparency and clear lines of accountability	44

CONSULTATION VERSION

5. Insight and honesty, with an ability to learn from errors	44
6. A culture of public service and collaboration	47
General Analysis	50
Consequences of this model of Participative Medical Governance	54
Acknowledgements	55
References	56

Summary

This paper puts forward a model of participative medical governance. It builds upon two other models being developed by the Tuke Institute: i) a model of biopsychosocial medical services framed by a personalised assessment of illness, which is used to bench-mark individual medical outcomes that focus above all on health-effectiveness—i.e., helping the ill to get well and stay well long-term; and (ii) a model of measurement that relies on scientifically validated methods to determine if and how a medical service is being health-effective, thereby ensuring a valid evidence-base for medical governance.

Medical governance is required to ensure that a medical service remains health-effective and delivers services first and foremost to the public rather than to its providers. This model of participative medical governance specifies a robust system by which the public can ensure that information on health-effectiveness is used to ensure quality of service and it relies on the public's participation at all gradations of service, from the patient and the family caring for the patient all the way out to national policy, in a horizontal framework. Importantly, this model provides the means by which to identify at an early stage the points where intervention is necessary with poorly performing clinicians and administrators, so as to protect the public's health and prevent malpractice.

The model provides tight feedback on the quality of service, which is likely to increase clinicians' morale when their performance is assessed as good and provide early motivation for all clinicians and administrators to address anything less. It promotes mutual knowledge-transfer between service-providers and service-users and ensures high transparency and accountability, preventing scapegoating while engendering a culture of professionalism and personal responsibility. Together, these aspects promote the repair of trust in and goodwill towards medical service-providers, which have been so badly damaged through the present medical culture that has led to excessive litigation and the need, in Britain, for government Inquiries over the recent years.

Many solutions to the problems of medical effectiveness fail to demonstrate that they—or the model they support—are fit for their intended purpose. For example, while such initiatives as the multi-billion-pound "Connecting for Health" programme are essential, they can not be health-effective (and therefore cost-effective) without building in a framework of health-effectiveness-measurement and of participative medical governance. This paper shows why. Many of the problems analysed here are typical of nationalised medical service-systems and the British National Health Service (NHS) is used as an exemplary problem to solve. The analysis is framed specifically in relation to the findings of the British Government's Bristol Inquiry, a high-water mark of problems in the NHS, the final report of which made a series of recommendations intended to be solutions to those problems. However, the report did not specify how its proposals

would deliver solutions to long-standing organisational and cultural obstacles; this paper fills that gap and proposes a system that has the scientific benefits of being evidentiary, coherent, practicable, and testable.

While the model provides a solution to the problem of medically and financially ineffective nationalised medical services, it is not aimed at solving the problems of the British National Health Service (NHS) *per se*: it is equally a model for American systems, for example, where there has been inadequate emphasis on medicine as a pro-social service rather than a pro-market opportunity. While elements of the model can be applied in commercial medicine, a partial implementation severely constrains the model's health-effectiveness: only a nationalised system is able to address comprehensively the illness-related needs of a given individual in the interests of that individual and the public as a whole. Additionally, the model discussed is equally and directly applicable to social medicine—that is, not just to 'health-care' but to 'social care' as well—and provides a common framework for solving common problems.

Introduction

Medicine is the practice of informed skills that are applicable to the healing of an individual's current illness and the prevention of future illness. In person-centred practice, medicine consists of whatever helps to heal illness¹ and brings that person as close as possible to health—i.e, a state of complete physical, mental, and social well-being, and not merely the absence of diseases (WHO, 1946). This definition is the basis of the Tuke Institute's definition of medicine as the "the service necessary to treat illness so as to maximise health long-term, not just the elimination of physical disease"².

The definition of medicine has varied throughout the social history of medicine, especially in the West, with its traditions of competition between the various medical professions such as herbalism, surgery, etc. (Porter, 1999). Too often, the focus on the patient's needs have been over-ridden by a focus on the practitioners' professional 'needs'. With the recent advent of the principle of evidence-based practice, the issue of health-effectiveness has re-emerged and we have moved on from problems of frank charlatanism to the problems of malfeasance and narcissism in practice, as seen in the evidence submitted to the Bristol Inquiry of the fatal, experimental surgery on children (Kennedy, 2001).

The emergence of the issue of health-effectiveness has occurred, then, through the evidence of its absence in an era demanding more than blind faith in clinicians. It has been evident that administrative malfeasance can be central to the failure to deliver health-effective medical services and it has been argued cogently (cf., Kennedy, 2001) that such an absence of health-effectiveness is due primarily to inadequate medical governance.

¹ i.e., any condition that causes mental or physical dysfunction, knowingly or unknowingly, to the person afflicted

² cf., www.tukeinstitute.org/values/values.html

What medical governance is

'Medical governance' refers to the regulation of the delivery of medical services through the specification of standards, the monitoring of medical practice in reference to these standards, and the use of sanctions in the instances where these standards have been breached³. Medical governance itself can be split into three domains of consideration⁴:

1. the design, development, and commissioning of services
2. the trained competence of providers—i.e., clinicians and administrators
3. the health-effectiveness of delivered services, which is largely related to the management of providers

The most common components of medical governance are outlined in Inset 1; further elements often cited are more actually values, such as transparency and accountability.

Inset 1: Elements of Medical Governance

1. audit of clinical performance, which may or may not include the audit of clinicians' performance
2. audit of administrative performance—often limited to gross financial performance and not to the audit of administrators' delivery-performance in a wider sense
3. risk-evaluation and -management
4. management of provider-competence, usually confined to clinicians and their technical knowledge as opposed to a wider competence; it also usually excludes administrators' competence. This may be through a variety of mechanisms including:
5. review of qualifications and history of training, sometimes according to job-task specifications
6. continuity in post-qualification training (sometimes called 'continuing education')
7. informing the design of medical services for optimal health-effectiveness
8. informing the commissioning of services (policy, administrative, and clinical processes) on the basis of the public's medical needs and in reference to the performance of current services

The utility of medical governance lies in the structured maintenance and improvement of medical service-standards through regulation of medical practice, but its intended purpose may not be reflected in actual behaviour: its purpose

³ In Britain, medical governance is often called 'clinical governance', although this suggests the exclusion of administrators and other non-clinical staff from the focus of governance—the term 'administrator' can include all functionaries designed to facilitate the delivery of services by clinicians, from government officials downwards. In the USA, a common term is 'healthcare quality assurance' although it has little to do with health but treatment of physical disease and its focus should not be quality *per se* but health-effectiveness, as the two are distinct. For these reasons, among others, the more neutral term of 'medical governance' is used here.

⁴ It is worth noting that these are broadly similar to those outlined in the Bristol Inquiry Final Report (Kennedy, 2001; p. 404); however, that Report specifies a top-down, administrative, and ideological solution with ideas that have not been systemically assessed for robustness. While I agree with Professor Sir Ian Kennedy's democratic values, a solution must both meet the needs of those who don't agree with such principles and still be fit for its purpose; consequently, I propose a bottom-up, public-centred solution using elements that have been tested elsewhere.

CONSULTATION VERSION

can vary from protecting the public's interests (i.e., health) to protecting the organisations' or clinician's interests (e.g., financial or reputational). Confusion between intention and actuality is common.

One reason for this confusion is due to the origins of medical governance in business governance, from which it borrowed many concepts, and it has developed a distinct purpose only slowly. As a consequence, it still suffers from a failure to base itself above all on pro-social rather than pro-market values. Some medical governors find the concept of social value quite novel since medical ethics was not included in their business-training, if they had any such training. In business-governance, the principle stakeholders are identified as the shareholders and directors, with only an implicit reference to the interests of the employees and the wider society. Its primary purpose is to protect the financial interests of the shareholders and directors through limited methods of accountability and transparency—and the limited value of these methods was seen in the collapse of WorldCom, Enron, and the Western financial disintegration of 2008 due to malfeasance of individual bankers and banking as an organisational system (cf., Erdman & Lundmann, 2002a, for other examples). The purpose of business-governance is to promote the primary value of economic strength. Increased regulation is resisted by those who believe it reduces competitiveness in the market—a fundamental tenet in itself—or who are simply ideologically opposed to it, and regulatory compliance is often claimed to be excessively costly; however, one must ask the question of whether the costs of efficient regulation outweigh the actual and potential costs of the global recession of 2009. In contrast to profit-driven enterprises, the social and financial costs and benefits of regulatory compliance in nationalised services (such as medicine in Britain or Canada) remain an area for analysis.

The distinction between medical and corporate governance should be obvious: corporate governance is to protect the financial interests of the shareholders whereas medical governance is to protect the medical interests of the people to whom services are provided. To protect both equally creates a conflict of interest in pro-social medical services. To protect the shareholders' financial interests above the public's medical interests is a dereliction of professional duty, even if the shareholders are the public, for medicine is in question, not co-operative money-making. While the protection of the public's financial interests is necessary, it is not sufficient to achieve the protection of the public's medical interests and so should be of secondary consideration. Thus, considerations of cost-care need to come after health-effectiveness and cost-effectiveness can not be reasonably demonstrated except within the framework of health-effectiveness.

An accepted foundation of democracy in Western societies is the welfare of the individual member of the public equal to or over that of the collective public, which underlies much of what is held commonly as a social contract in free societies; this contract is breached by the diminution of such a social value by pro-market interests impinging upon pro-social services, to the extent that confusion of purpose often occurs. In pro-social medical services, this confusion between pro-social and pro-market values is an ethical failure that is secondary to a more primary failure in knowing how to measure medical rather than just financial performance. In privatised medicine, on the other hand, there is no such conflict of interest in privatised medicine as there is no direct duty—beyond a minimal duty of professional care—to value the patients' medical interests over and above the provider's professional interests or the corporation's financial

CONSULTATION VERSION

interests (albeit that publicly valuing the patient is of use in public relations and gaining market-share). In this instance, the determinative factors of standards of practice are legal rather than moral, social, or regulatory and the primary proactive restraint lies in a fear of malpractice litigation. Whether the primacy of market values in medicine is considered morally right thus depends on whether a particular society values the protection of its citizens' health more greatly than the wealth of private individuals.

Another difference between business- and medical governance is the source, nature, and usage of information as to performance and effectiveness. In business-governance, the prevailing myth is: (1) that an 'efficient market' will provide adequate information such that the shareholder can rely on the judgements of professional investors; and (2) that financial accounts are the outcome by which to monitor business-directors' performance. However, imperfect accounting means imperfect governance and the complexity of conflicts of interest (as with the Arthur Andersen and Enron debacles) has shown this myth of the effectiveness of the efficient market to be of little value. In the USA, the Sarbanes-Oxley Act of 2002 brought some toothy (if incomplete) regulation into business-governance, in crisp contrast to the listless, laissez-faire approach that persists in Britain where the most that is required is that, if a company diverges from suggested guidelines, it must explain it in its company-report and the shareholders are then left to regulate the company's practice. That this is ineffective and imprudent was also shown by the nature of the 2009 financial crisis in Britain.

The nature of the information necessary for medical governance is far more diverse and complex than that required for business-governance. For the purposes of medical governance, it is not enough to study the financial status of a hospital or even measures of cleanliness and mortality rates, let alone put them into a crude rating system of 1-5 stars. The public's credibility in clinicians' and now administrators' authority has been rightly eroded and a demand for meaningful information is apparent: relying on administrators' judgements is not enough, especially where there are questions of competence in assessment and of conflicting financial versus social interests.

The conclusions that may be drawn from this brief overview is that medical governance is truly distinct from business-governance; that administrators need to be competent to understand the difference and ensure appropriate measures of performance are implemented; that medical governance applies primarily to pro-social medical services, as privatised medical services can justly defend their primary duty as being to their financial shareholders; and that a business-approach to medical governance is insufficient. It is also reasonable to suggest that medical governance should be concerned with monitoring the health-effectiveness of clinicians' and administrators' practice so as to ensure that patients' medical needs are met first and foremost.

The need for participative medical governance (PMG)

In Britain, there has been a number of governmental Inquiries into various aspects of medical practice and its practitioners, such as the Shipman (Smith, 2002-05), Alder Hey (Redfern et al, 2001), Kerr/Haslam (Pleming, 2005), and—most significantly—the Bristol Inquiry (Kennedy, 2001). As Britain's is the most salient, international example of professional medical services, it is used here as the point of reference.

In the Bristol Inquiry, there was an exhaustive assessment of the treatment of children receiving medical services for heart-disorders at the Bristol Royal Infirmary between 1984 and 1995. This Inquiry identified a coherent and self-maintaining system of problems that led to malpractice (cf. Inset 2). Because of these problems, about a third of the children who had open-heart surgery suffered and it was estimated that from 30 to over a 100 children died when they would not have done so with competent medical services. In this assessment, the essential need for some form of participative medical governance became evident.

Inset 2: Key Causes of Malpractice Identified by the Bristol Inquiry

1. a club-culture, with privileged status for physicians and administrators, resulting in:
 - a. a lack of transparency and accountability
 - b. a lack of insight and honesty among providers
 - c. an inability to learn from errors
 - d. imprudence about patient safety
 - e. a lack of managerial and clinical leadership
 - f. a punitive work-environment causing low morale and stagnation
2. a lack of patient-centred standards, causing:
 - a. disorganised and unintegrated services
 - b. incompetent team-work
 - c. an inability to work across professions and disciplines
 - d. inadequate services to the families of the patients
3. medical authoritarianism, causing:
 - a. the exclusion of patients from choices about their treatment
 - b. incompetent communication with patients and their proxies
 - c. unresponsiveness to complaints
4. a lack of methods to ensure clinician and administrator competence, causing:
 - a. lack of usable information on performance, medical outcomes, and signal events

CONSULTATION VERSION

The Inquiry's final report (Kennedy, 2001) contained a seminal and radical set of almost 200 recommendations for the overhaul of the delivery of nationalised medical services in Britain (cf. Inset 3); it is essential to note that the level of funding of the services was specified as not being a causative factor⁵. This report has not stopped further malpractice occurring, as has been seen in 2009 in the several hundred unnecessary deaths at the Stafford Hospital (BBC, 2009), despite current claims for public participation in medical services.

Inset 3: Key Solutions to Malpractice Identified by the Bristol Inquiry

1. a culture of public service and collaboration
 - a. specific, patient-centred standards for clinical service
 - b. transparency in services and their governance
 - c. a clear, single locus where patients can complain about service quality
 - d. the public must be at the centre of the design and implementation of services
 - e. the NHS and the public should be involved in selecting and establishing the criteria for selection of those to be trained as providers
2. integration of services:
 - a. integration of primary, acute, community, and specialist care for patients
 - b. integrated services for psychological medicine with links to external systems
 - c. funding of voluntary organisations for the work they provide to the NHS
3. better governance and regulation
 - a. clear lines of accountability
 - b. performance through audit:
 - i. with usable methods of performance-assessment and of feedback
 - ii. where performance data must be gathered as the by-product of clinical service
 - iii. a unitary approach to data collection
 - c. jobs assigned on the basis of competence, not status
 - d. service organisations able to deal with clinicians as employees, independently of the providers' professional bodies
 - e. equivalent terms of employment for clinical professions
 - f. co-ordinated governmental regulation of providers
4. better education of providers
 - a. training for providers in basic interpersonal skills, such as communication
 - b. trained competence for administrators in medical services
 - c. continuing medical education and revalidation for clinicians, administrators, and service units
 - d. joint training and common curricula between schools for medical professionals

⁵ An excellent review of the Bristol Inquiry may be found in Davies (2007; pp. 123-149).

Current problems with participative medical governance

A major conclusion from the Bristol Inquiry was that there needs to be ‘public participation’ in medicine, especially in its governance. This refers to a number of widely differing initiatives that involve the public in various aspects of medical services. It has a number of commonalities with initiatives in participative science in North America that are aimed at enhancing ‘knowledge transfer’ both to and (less often) from stakeholder-communities (Minkler and Wallerstein, 2008; Whitaker, 2009a) as well as with social movements to regulate governmental malfeasance, as with civil review boards of police action (Erdmann and Lundmann, 2002b; p.35). Such initiatives developed originally from post-liberation-politics of participatory democracy, devolved governance, empowerment, and political autonomy in the Americas, but they have also been misused for the business purposes of increasing providers’ public relations and promoting consumerism. These latter uses of public participation have had little relevance to the purpose of medicine *per se* or of participative medical governance.

Public participation has a history of over a quarter-century in Britain, although it has never been popular or effectively implemented (Hogg, 2007). In part-response to the British Inquiry, the British Department of Health issued a consultation document “A First Class Service” (DoH, 1998), the core component of which was medical governance. During the Bristol Inquiry and following the British NHS Plan of 2000, a duty was placed on the NHS by the Department of Health to involve patients and the public in the planning of clinical and community services, the development and consideration of changes in the way those services are provided, and in decisions to be made that affect how those services operate. This was enshrined in Section 11 of the Health and Social Care Act 2001 (UK) and guidance on best practice was published subsequently (DoH, 2003).

Despite such good intentions, there have been serious problems with the way in which public participation has occurred. Very little has focused on participative medical governance. The Department of Health guidance on strengthening accountability (DoH, 2003) focused on ideas and values, but not on methods, processes, or standards. The Department of Health declined to specify types of outcomes and methods and rejected calls to create even a template of a formally-structured mechanism by which to translate patients’ experiences into health-effective medical services; there has been repeated rhetoric from the British government about its not wanting to be prescriptive, of the importance of decentralisation, of empowering local providers, but this simply reflects a lack of knowledge as to how to achieve the results required. If a national government does not know this, it is not reasonable to presume that local providers with far fewer resources will somehow know. That such a refusal to specify the outcomes intended and the types of methods required is unintelligent is beyond question, as it set up the NHS to fail again and to lose further public trust. Medical administrators charged with the task of ensuring public participation have not had a clear remit, and so they have not understood the purpose of what they are to do, how they are to do it, what they are to achieve, or the competencies re-

CONSULTATION VERSION

quired of it. At best, governmental bureaucrats have developed lists of the most pressing issues for public participation without recognising that this provides further stimulus to boil a system already in turmoil by inducing change for appearances' sake: as that list of issues changes, so do the requirements for participation and there is a lack of accrual and continuity of knowledge.

In contrast to its stated wish to be non-prescriptive, the British Department of Health has made a variety of demands of medical providers to implement fully participative initiatives. Such demands have entailed representative democracy, which in a diverse Western society is virtually impossible to achieve or to measure and it causes problems relating to a number of issues, including those members of society who can not or will not use the dominant language of the nation in which they live; a belief in the interchangeability of experience between members of the public and between clinicians and the public; the funding of participants, which is difficult and not without ethical concerns about conflicts of interest; the prevention of misconduct by participants; the intrusion of single-issue agendas, including ideological prejudice or bias; and the political pressure from providers (notably physicians) to get their 'buy-in' because otherwise they will refuse to do the jobs they are paid to do.

In order to meet governmental requirements for public participation, administrators have fallen back on business-solutions and introduced methods from market-research and public relations, regardless of whether these methods are helpful in medicine. Without a clear understanding of what public participation is for, why it came about, and its scope, NHS administrators have reduced it to administrator-selected elements of the 'patient-experience', the 'patient-journey', 'patient-satisfaction', and 'patient-choice'. Some service-providers exhibit public participation through methods of opinion-gathering, including public meetings, formal consultation, satisfaction-surveys, patient-panels, and focus-groups; others—such as North London haemophilia services—have children's picnics. Few, if any, are aware that public participation was intended to focus on governance. This conceptual and moral failure is consistent with the practice of applying common administrative solutions across all situations regardless of context, where, for example, a leisure-facilities administrator can be put into the position of administering a medical service in the belief that administering a swimming-pool is the same as administering an emergency-medicine unit. It is evident that this ideology of context-independent administration does not work in medicine.

As a result, the idea of public participation in medical governance in the NHS has had various incarnations that continue to change in form and purpose while remaining ineffective. Consequently, public participation is reformulated or renamed regularly by governmental fiat, without public consultation, suggesting the actual respect in which it is held. In due course, it will likely probably be concluded that public participation does not work; the public will be frustrated, and public distrust and the default solutions of consumerism, then privatisation, will escalate for lack of more intelligent and effective responses. Participative medical governance is intended to solve these problems but, with the confusion in current approaches, it seems only to exacerbate them as they rely on the very mechanisms that are problematic in order to solve them. In the USA, where the pro-market system has failed the public's health so catastrophically, the American

CONSULTATION VERSION

government previously sought solutions from providers in order to create solutions that are against these providers' vested interests. The same problems are seen in the British government's initiatives and its reliance on NHS clinicians and administrators to solve the problems they have created; regulators everywhere are very slow to recognise the extent to which service-providers are unable to regulate themselves. Worse, the application of market-based self-regulation to pro-social services is inadequate to prevent malfeasance and protect the public's interests because the public's needs rather than wishes fail to be heard. Such conflicts of interest can result in catastrophes, whatever the field, be they the behaviours of the General Medical Council in Britain (Davies, 2007), the collapse of Enron, or the predatory lending by banks and the global financial collapse of 2009. The unedifying spectacle of marketeers' efforts to undermine medical reform in 2010 by the Obama administration in the USA is an exemplary warning of the unlimited nature of providers' self-interest. The foxes are, indeed, unable to guard the hen-house and a toothier protection of public interest against providers' self-interest is required.

A key problem has been in developing measures of performance and of the health-effectiveness of medical outcomes by which to determine whether providers are, in fact, providing adequate services in the public's interest. A narrowness of perspective and a lack of relevant expertise has underlain this; historically, outcomes were measured from a physician-centred viewpoint that was often narcissistic and irrelevant to the patient's needs—as in “the surgery was successful, but the patient died”. Currently, measurement of outcomes is from an administrator's viewpoint but suffers the same irrelevance to health-effectiveness: “we have stayed within our budget and provided treatment to the numbers required”. The undue deaths at Stafford Hospital were because of administrators meeting budgetary targets but ignoring patients' needs. Neither the physician-centred or the administrator-centred approach measures health-effectiveness, as in “it helped me, the patient, to get well and stay well”; consequently, neither approach can demonstrate whether the services are fit-for-purpose and their methods fail—singly and jointly—to produce health-effective medical governance and to prevent malpractice.

Patient-satisfaction is probably the measure of the quality of medical services that is most used internationally and it is a particularly egregious example of importing business-solutions that are irrelevant to medicine. One example should suffice: many of the patients of the physician Harold Shipman wrote in to express their satisfaction with, and their support for, his medical services during a trial that led eventually to his conviction for the murders of over 200 of his patients (Smith, 2002-5). This shows clearly that patient-satisfaction is not a valid indicator of health-effectiveness or public benefit—not least because of the problems of sampling-bias. In the measurement of patient-satisfaction, opinions are also often constrained to match the existing perspective of the people seeking the opinions, rather than being ways of getting fresh information, and so they serve only to consolidate the problems of the existing framework⁶. Patient-satisfaction is a conceptual and methodological mire and there is evidence that it is inadequate to deliver health-effective

⁶ This is also seen in psychological research on clinical interviewing by physicians where the actual nature of the patient's experience of illness is reduced through the physician's mindset to the 'correct' answers within a diagnostic algorithm, whether or not that relates to resolving the sickness for the patient.

CONSULTATION VERSION

medical services. Administrators have made a similar consumerist emphasis on issues such as 'patient-choice'. While this can result in a convenient and satisfying service, it is equally ineffective medically. If a medical service leaves a patient feeling 'satisfied' but fails to correct objective problems and to leave the patient experiencing health (including being at a reduced risk of future illness), then that service is not health-effective.

A market-solution is also not financially sustainable because it fails to address the fundamental difference between pro-market and pro-social services: the market is predicated upon consumerism, which seeks to expand demand (and thus expenditure) whereas pro-social services seek to shrink demand (and thus expenditure) by successfully meeting that demand and minimising what drives it. Consumerism is no substitute for health-effective medicine, even in an era where market-solutions are considered to be the only recourse for failures in the provision of pro-social public services (cf. Pollock, 2004) and altruism in medicine is anathema to the primacy of market-ideology. There is also a very real risk in consumerist solutions where economic competition and market-share are presumed to translate into service-excellence and this, by implication, into protecting patients' interests. Not least of the problems lies in the consequence where the public abdicates responsibility for getting and staying well, replacing that responsibility with a demand for their 'rights' to an increasing range of (expensive) medical technologies and products needed to compensate for a failure to regulate their own health-behaviours and self-care. As stated in the Bristol Inquiry Final Report (Kennedy, 2001 p. 411), a patient-centred service does not mean a patient-dominated service, with its attendant risks of escalating costs and malpractice-litigation. That this occurs is clear from American evidence. It is equally clear that it is financially and medically ineffective.

Consumerist medical services are also subject to greater political leverage from community-lobbyists: then, like shifting seats on the Titanic, the locus of power moves from clinicians to administrators to the public, but the ship is still going down. Once such a move towards market-solutions (euphemised as 'patient-choice') has been completed, returning it from a pro-market to a pro-social system will be virtually impossible (regardless of the social consequences), due to providers' self-interest (see above); the experience in the USA shows very clearly that if you trade on sickness as a commodity, you make society sick.

In Britain, the public owns the NHS; this contrasts strongly with privatised medicine where, even though it is the insureds' premiums that fund the service, its basis is a financial, not a social, contract. There is a fallacy in the assumption that the democratisation of medical governance through public participation will necessarily result in more health-effective medical services; just as with clinicians or administrators, patients do not know what is going to be health-effective for themselves or for others simply through being 'the public'. The failure of both the pro-market and the pro-democracy solutions suggests a need for a more sophisticated analysis.

A further conceptual mistake is to confuse participative medical governance with patient-centred medicine (or, better, 'public-centred medicine' for the public needs medicine but is not always in the role of the patient). Patient-centredness is not enough to ensure health-effectiveness, as is shown on p.40 ff below. Patient-centredness is not simple

CONSULTATION VERSION

to define but it can be disambiguated from what it is not: medical practice can not be patient-centred if it is not health-effective. To be health-effective, medical practice needs to address the needs of the whole patient, to include the patient as an active agent in the recovery from illness, and to use the skills of the most appropriately trained clinicians to provide the treatments most appropriate to the patient in the most professional manner. According to the scientific evidence, this much is not moot. However, it is important to note that there can be patient-centred practice without participative medical governance and, equally, participative medical governance without patient-centred practice, but neither is able to be health-effective without the other. For instance, there can a superficial form of patient-centred practice, as where a physician focuses on communication skills to elicit information from the patient, but the quality of this information is limited to the particular professional bias of the physician (i.e., diagnostic biology) and his limited competence in other domains of medicine (e.g., detection of mental dysfunction), so any referrals will be of limited accuracy; the patient's needs will be neither competently assessed nor provided for; the resultant data on medical outcomes will be of limited value; and, as a consequence, the governance of medical practice-standards will be limited in its health-effectiveness no matter how thoroughly it is organised and how participative it is. This is the problem seen in the current, physician-centred form of medical practice and in the physician-centred alternatives proposed (Bodenheimer et al., 2002a, 2002b; Wagner et al., 2001); they suffer from a physician-centric solipsism as to what defines a successful outcome, therefore what patients need, and therefore what medicine is and, thus, are not patient-centred, despite what their proponents claim.

The Bristol Inquiry's Final Report states "For a healthcare service to be truly patient-centred it must be infused with the views and values of the public (as patients, past, present or future)" (Kennedy, 2001; Ch. 28, p. 400); although it is true that the public's views are necessary to patient-centred service, they are not sufficient to deliver patient-centred medical practice and patient-centred medicine is confused with participative medical governance. For instance, 'patient-empowerment' through participative governance is confused with treatment modalities in behavioural medicine such as skilled self-management of chronic illness (Coulter and Ellins, 2006), as well as with some secondary preventive and rehabilitative treatment modalities. This is shown most clearly in both the British political-administrative initiative called the "Expert Patients Programme" (CMO, 2007) and the Scottish national policy document "Better Health, Better Care: Action Plan" (Scottish Government, 2007), both of which emerged as a result of the Bristol Inquiry. Such confusion occurs most often among administrators who have no clinical experience, who fail to understand the diversity of treatment modalities within medicine, and who consequently promote administrative/political solutions to problems by mislabeling such modalities and porting over pro-market solutions.

Another reason for the confusion between patient-centred medicine and participative medical governance lies with clinicians who only have experience in one area of medicine (e.g., biomedicine) and do not know of, or care to know of, other modalities within medicine, which they regard as 'ancillary'—i.e., the maidservants—to 'proper medicine'⁷.

⁷ a term used in EH Wagner's model of chronic-illness treatment; it is worth noting that the root of the word ancillary is the Latin word for 'handmaid': thus, 'ancillary' providers, such as nurses, psychologists, and medical social workers, are literally handmaids to the physician (Wagner et al, 2001).

CONSULTATION VERSION

While this narcissistic attitude is evident in all medical professions—physician, nurse, clinical psychologist, physiotherapist, etc.—it is most obvious in the physician-profession, where it is unacceptably prevalent and is a prime obstacle in creating patient-centred services. In physician-centred medicine, patients are more-or-less-passive objects to which pharmacotherapeutic agents or surgical interventions are administered. Patient-centred medicine, on the other hand, requires the active mental and physical participation of the patient in treatment; consequently, with narcissistic physicians, active patients are considered the subject of ‘allied healthcare’ rather than ‘proper medicine’, indicating the linguistic and actual balkanisation of medicine into silos to meet clinicians’ needs for distinct professional identities while acting against the patients’ needs to be treated comprehensively as a whole person (cf. Whitaker, 2010a). The theoretical and practical problems of the physician-centred model of medicine are pervasive and not only cause confusion between patient-centred medicine and participative medical governance but create a system of medicine that is health-ineffective and financially inefficient.

There are other obstacles too. In 2007, the Picker Institute Europe published a report of a survey that identified several factors that prevented effective public participation in medicine, notably antipathy and apathy in clinicians, administrators, and the public towards the process on top of a failure to understand how to achieve the goals specified (Chisholm et al., 2007)⁸. Related obstacles have been identified previously (Kennedy, 2001; p. 402), including: a negative culture towards empowering the public that pervades the NHS; a lack of awareness of the benefits of an empowered public; a lack of clarity about how to get appropriate public participation; the difficulties in reaching a cross-section of the public; a perception among the public that public participation is just an exercise in public relations and that there is a lack of real commitment to act; practical difficulties such as lack of time, skills, confidence, and knowledge; and a sense among the public participants of being a lone voice amongst professionals. Once again, these obstacles reflect a resistance to losing power by clinicians and administrators. Among administrators specifically, they are due primarily to a lack of medically specific competence and a struggle with clinicians for power, while, among the public, the problems are largely due to a loss of trust. The Bristol Inquiry’s Final Report (Kennedy, 2001; p.401) recognised that existent and long-standing efforts to include the public have resulted in little in terms of value due to tokenism, which is ascribed to the imbalance of professionals and public on a board, indicating that having board-based governance alone is inadequate; such tokenism has damaged public trust further and promotes apathy, disengagement, and cynicism; preserved professionals’ status; and maintained the same substandard performance as before.

It should be clear that in order for a nationalised medical service-system to be both health-effective and financially efficient, it needs both patient-centred medicine and participative medical governance. But as with any closed system left to correct itself, there is a failure to look for solutions outside the existing conceptual framework of pro-market biomedicine. The NHS is a well-established, self-maintaining system that expresses chaotic bureaucracy against a very stable

⁸ This survey was of public involvement in service-commissioning (not medical governance per se) but the issue of public involvement is identical

background resistant to fundamental change; any efforts to create real change—such as participative medical governance—are resisted by interpreting initiatives within existing frameworks, through which the initiatives are neutralised and the administrator, rather than being a facilitator, becomes an inhibitor of progress. This is the nature of a stable system and has caused great ferment with little result other than to consolidate the system and its products—with escalating expenditure, diminishing health-effectiveness, and public distrust being chief among those products. The Titanic of pro-social medicine is foundering; while the locus of power may shift among clinicians, administrators, and the public as between deck-chairs, without plotting a new course for medical practice and its governance, the Titanic will go down.

Health-effective PMG

Finding a solution: Overview, principles, and standards

The sole goal of PMG (participative medical governance) should be to ensure health-effective medicine delivered in the public's interest; if it also promotes the values of democracy and social justice, then that is a welcome—though unnecessary—bonus. For medicine to be health-effective, it must address the long-term resolution of illness, disease, and/or sickness⁹ and if patients are not 'treated well'—in all senses of the phrase—services will not be maximally health-effective. To achieve this, one must measure both the subjective—the individual patient's idiographic, experiential framework of illness—as well as the objective—the disease, the clinicians' knowledge of both disease and illness, and the behaviour of patients, clinicians, and administrators.

An implicit principle of this model is that any system that is not also health-effective for the providers can not be health-effective for the patients; a positive, equitable work-environment based on a service-culture that is collaborative and supportive of providers' performance is an important step towards this. This comprehensive, contextual approach demonstrates the application of behavioural medicine not only to patients but also to the providers of medical services. Each type of variable used in the assessment of providers' service-behaviours has parallels in the types of behavioural assessment of patients where, for example, patients are assessed for their ability to engage effectively with medical treatment and to maintain health-effective medical behaviours (e.g., adherence, minimising risky behaviours). The specification of such variables in the assessment of clinicians comes from a realisation that the best medical outcomes emerge

⁹ these three terms are distinguished in the following ways: a person may have a disease—i.e., a disorder of structure or function affecting the body and/or mind—but this does not mean that that person necessarily experiences 'illness', as is seen in asymptomatic HIV infection or cancer. Furthermore, that person may not be 'sick', a word used in common parlance interchangeably with 'ill' but in the scientific literature is used to refer primarily to the ability of the social group within which a person lives to perceive that person as 'ill'. In this paper, the word 'illness' is used primarily, except when indicating an objectively measurable disorder of structure and/or function affecting the body and/or mind.

CONSULTATION VERSION

from mutual co-operation and respect. Most research to date has focused on the effects of patients' baseline-illness, limited patient-behaviours (such as medication-adherence), and treatment-outcomes measured by objective but often ecologically invalid variables, while other research has focused on practice-variation in delivery and its effects on outcomes. However, the mediating variables of clinician- and administrator-behaviours must also be included to achieve information of good quality for governance.

The primary challenge lies, firstly, in how services can be designed to be optimally health-effective and, next, how the delivery of such medical services is to be governed so that they continue to be health-effective. An example problem is in the treatment of long-term HIV-infection (Whitaker et al., 2006): given that the purpose of treating a person with HIV is so that he or she can live a healthy life, if that person's biological issues are treated (e.g., viral and T cell-levels) but not his mental or social issues (e.g., depression, social deprivation), then this will lead to behaviours that promote further illness (e.g., sexually transmitted infections, drug-misuse, occupational failure, welfare-dependence) and that will increase the burden of illness on the patient as well as on the medical system and society. This has become unavoidably obvious in the problem of persistently increasing HIV infection-rates, multiple chronic infections, and HIV's global prevalence. It is a prime example of why physician-centred medicine and its one-pill-fits-all approach fails to be health-effective or cost-effective.

Health-effective medicine can not be based solely on administrators' policies or clinicians' perceptions of what patients need, as we have seen, so a form of public participation in both medical treatment and its governance is required that is based equally in patients' knowledge and experience as in clinicians' and administrators' knowledge and experience. In this model, the public participates in treatment and governance in one or more of the following ways:

1. providing data on their illness-status at baseline, during treatment, and after treatment (i.e., their treatment-outcomes) in order to bench-mark and measure ecologically valid and individualised outcomes for each individual. This is a core feature of patient-centred medical practice.
2. providing (pseudonymously) review-data on the performance of clinicians and administrators with whom each patient interacts in the treatment-process and providing such data on named providers to governance groups.
3. participating in governance groups at various gradations away from the patient's own treatment, starting from a person's own clinic and moving outwards, to meta-clinics such as hospital departments, entire hospitals, hospital networks, to regional and national PMG committees. The most critical aspect of the framework presented here is that the model has the patient at the centre, not a clinician or an administrator, and it moves outwards from there.

All three of these forms of participation are necessary for the valid governance of health-effective medical services. While each of these elements is discussed in more detail below, it is important to emphasise that the ability of participative medical governance to ensure health-effective medical services depends on the quality of the data collected

CONSULTATION VERSION

with each individual patient. Without excellent evidence of the health-effectiveness of providers' performance based in the outcomes of individually identifiable patients, governance may be highly participatory but it will be unable to ensure health-effective services and is therefore invalid.

Measuring health-effectiveness allows the definition of service-standards, which has been a long-standing challenge both medically and medicolegally. In the medicolegal field, a court has to determine whether treatment was to standard or not but, so far, such standards have been set by the very clinicians whose colleagues are charged, which is absurdly influenced by providers' self-interest. The model here proposes a more practical method of defining such standards medically by measuring whether the treatment used actually achieve the outcomes required for each individual and how they do; medicolegally, these outcomes can then be compared to the health-effectiveness of such practice across individuals, as would be done in any case in practice-audit for the purpose of medical governance. If treatment fails to be health-effective for a given individual, this is due to a small number of possibilities: inadequate identification of the illness; inadequate treatment; or the illness is untreatable by any modality singly or in combination. If the treatment is inadequate, it may be that adequate treatment is available elsewhere or it is unavailable for financial reasons (a reason often claimed but rarely true and more often used to conceal the fact that it is available elsewhere). If the provider knows or should know that adequate treatment is available elsewhere, then that provider has a professional and social duty to ensure that the necessary treatment is received, otherwise he commits malpractice. If adequate treatment is claimed to be unavailable for financial reasons, the adequacy of these reasons needs to be explored to rule out provider-malpractice.

The relevance of administrative behaviours to health-effectiveness is highly important but of limited scope. Administration is carried out by all providers and it may include everything from commissioning new hospitals to ensuring adequate paper-clips. Non-clinical administrators have traditionally stayed in the background, away from the clinical interface, but this has encouraged in them such solipsisms as discussions of cost-effectiveness without reference to health-effectiveness, with the gravest results: I fail to see any ethical difference in unresearched and ethically-unapproved experimentation that leads to unnecessary death, be it administrative (cf. Stafford Hospital) or surgical (cf. Bristol Royal Infirmary) experimentation. Such solipsisms reflect the fact that medical administrators (even former physicians) often have little understanding of the means through which medicine is health-effective, which is a complex scientific issue beyond physicians' or administrators' trainings.

This utilitarian definition of health-effectiveness means that a given provider's competence needs to be defined more specifically in terms of the ability to achieve health-effective medical outcomes. If the required and actual outcomes are not both known, then performance can not be measured and the duty of governance can not be fulfilled. If performance is not measured in a way directly relevant to individual outcomes, then *how* medical outcomes are achieved and *why* they vary can not be known, and the duty of governance can not be fulfilled.

Defining and gathering information useful to medical governance

Since medical governance relies on the quality of information on health-effectiveness, defining and gathering relevant data must be the first and most important challenge to meet. Health-effectiveness has at least five determinants:

1. the patient's illness-status at the start, during, and at the conclusion of any one episode of treatment
2. individual clinician-behaviours during medical service
3. individual administrator-behaviours during treatment-delivery: including behaviours in relation to individual clinicians, other administrators, and patients as well as technical behaviours in making available medical service-materiel within secondary administrative constraints such as financing¹⁰
4. patient-behaviours during treatment-delivery: including individual behaviours in relation to clinicians and administrators, in self-treatment such as 'self-management' skills, and in a wider, illness-related social context
5. health-effectiveness of treatment, by medical modality: this influence on medical outcomes can be separated statistically in order to disambiguate the effects of personnel vs. materiel vs. methods.

Each of these elements will be discussed in the relevant subsection below but it is worth noting that they form a system; each element is necessary and, synergistically, they create a system of information that is more useful than the sum utility of the elements. During medical audit, such a system allows the partialling-out of causes in individual- and group-outcomes, which is necessary for adequacy in medical governance.

The system of information-gathering starts with the patient's interface with the medical service-system, described below. To determine health-effectiveness it is necessary to measure both objective and subjective variables during a comprehensive medical assessment; this both provides a baseline as well as benchmarks the intended short-term and long-term medical outcomes, allowing one to measure health-effectiveness. The purpose of comprehensive, patient-centred assessment is not simply to understand the patient's perspective—a laudable if incompletely practicable goal—but it is to measure the health-effectiveness of the service. Using only subjective assessment is inadequate as disease that is outside a patient's awareness (such as the presence of an occult infection) will not be considered. Using only objective variables (such as levels of glycosylated haemoglobin, free testosterone, or CD4 T cells) is also inadequate in that they do not necessarily relate directly to illness; the criteria of success may be irrelevant from a patient's point-of-view and would allow one to conclude that treatment was successful even if the patient died. Similarly, people can be ill while their objective markers are within the range of normality; this is almost always because the marker is inadequately sensitive, inappropriately applied, or, more usually, it is the wrong marker of a disorder. Some diseases do not have adequate biomark-

¹⁰ Administrators might equally have a version of the surgeon's motto: "the service was delivered within budget but the patient died". Such putative cost-efficiency can hardly be called health-effective. Stafford Hospital is a tragic case in point.

ers currently (e.g., motor neuron disease) but the use of the wrong marker is more often due to the lack of a comprehensive assessment of the patient where mental or social variables are reduced to physical ones and, consequently, inappropriate tests are used and conclusions reached.

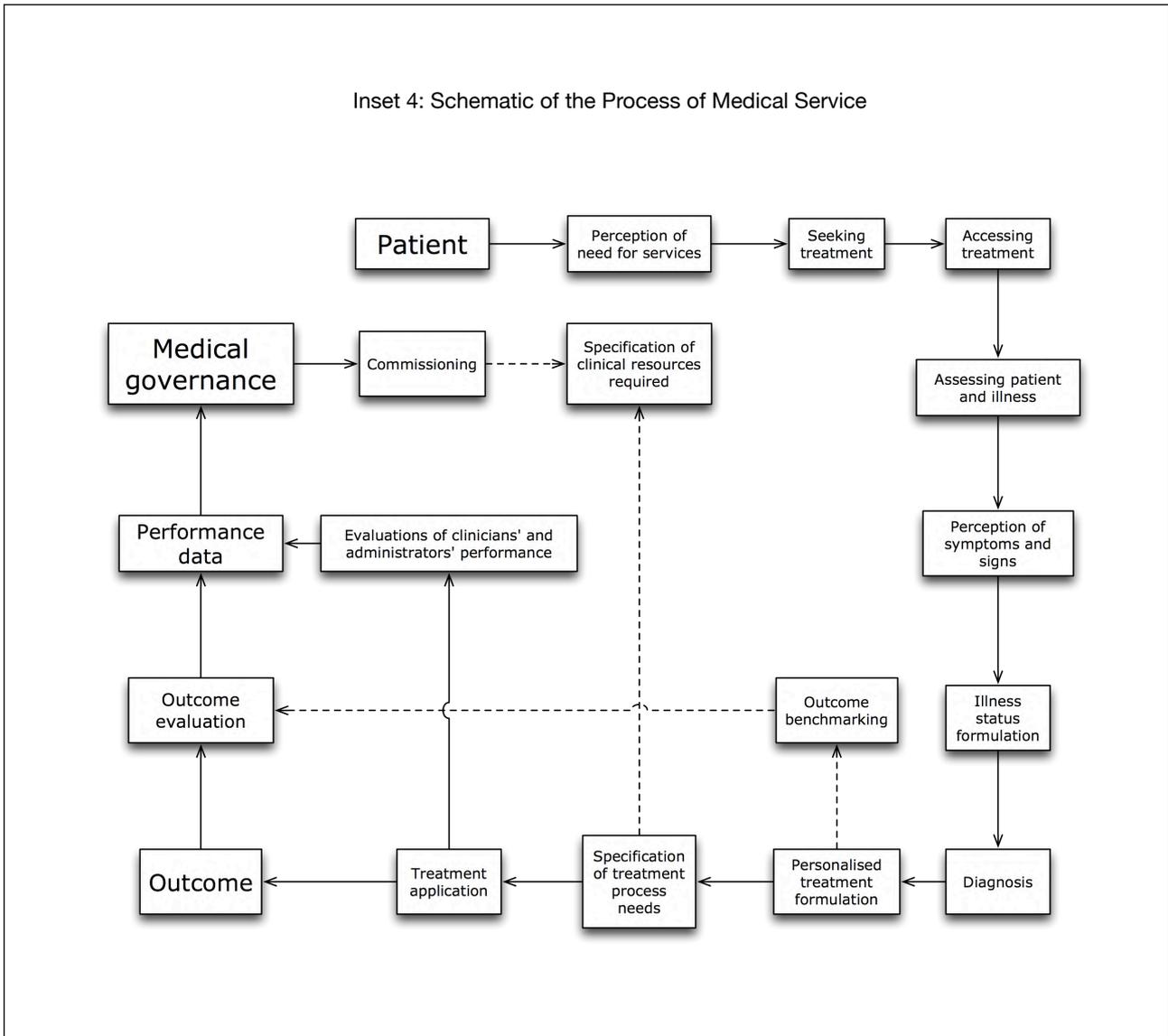
Given that health-effective medicine needs to address the person rather than just the disease, the most obviously appropriate professional with whom the patient should have the primary, long-term medical relationship is the nurse. Person-centred variables are biopsychosocial not just biological, so they require a broader competence in their assessment than that provided by any physician's or psychologist's training. The nurse's professional orientation is the one best qualified to achieve a comprehensive, biopsychosocial assessment of the patient in order to create the benchmark for individual health-effectiveness. Nursing is also the profession best able to understand the nature of necessary referrals for biopsychosocial illness (with expert opinion from the specialists in physical, mental, and social medicine); the profession best-suited to integrating treatment-plans and ensuring treatment-continuity in a way that is most meaningful and relevant to the patient; and the profession best able to provide the relational continuity within this context and its benefits of motivation, secondary prevention, and consistency. The reason for this is that nurse-training, as in the experience of illness in the patient, is not limited to one aspect of medicine (biological, psychological, or social) and it includes a balanced respect for the subjective and objective.

The system of information-collection

We look now at the process of medical services and identify some points at which measures of medical outcomes can be used to inform the governance of medical services to ensure health-effectiveness. A rough characterisation of the process of treatment can be seen in Inset 4: firstly, a person perceives a need for medical treatment either directly through symptoms or because of information received from his social context, mediated by his mental function. These services may then be sought and a method of access determined by the patient-to-be. Once in the clinic, the lead-clinician (a nurse) completes the initial assessment of signs and symptoms and how they are affecting the patient's life; based on this information and the personal knowledge that the nurse has of the patient, the patient is referred to any one or more of the other primary medical specialists (physician, medical psychologist, medical social worker) who do more comprehensive assessments based on the primary assessment and feed their conclusions back to the lead-clinician with suggested treatment-plans. Such treatment-plans include the services of all therapists with skills appropriate to the illness in question, perhaps including a psychotherapist, physiotherapist, surgeon, etc. The nurse then integrates these recommendations, updates the baseline assessment and the consequent outcome-benchmarks, formulates the treatment-plan, sets it in process and manages its delivery. The comprehensive assessment occurs at baseline, is updated following subsequent specialist assessments, during treatment-progress, and at the end of each treatment-episode. As with all medical practice, there is a degree of concurrency as well as recursiveness between assessment and treatment and as new information is

CONSULTATION VERSION

uncovered, the treatment-plan and the outcome-goals are updated in conjunction with the patient's input and such updated goals are specified for future auditing-purposes. The comprehensive assessment provides most of the content of the outcome-benchmark for that individual patient.



Each required treatment is applied, which may be clinic- or community-based, and the effects are measured against the benchmarked outcome-goals; at the same time, the patient, each clinician, and each administrator involved in the process does 360-review of each treatment process as the information they need is delivered to them, leading to evaluation of each providers' performance as well as the patient's relevant medical behaviours (such as treatment-adherence, safer sexual practices, etc). Outcomes-assessment is progressive, especially with chronic conditions, and a concurrent analysis of contributors to treatment-effectiveness is required. If, at the end of a treatment episode, the outcome is measured against the outcome-benchmark and seen to be inadequate in terms of resolving illness or in the perceived durability of the outcome, then further assessment and/or treatment are required. The lead-clinician can identify common fail-

ures that have impeded the delivery of health-effective services, such as lack of materiel (e.g., missing files, lack of access to a specific medical product or type of clinician), and/or inadequate performance by one or more clinicians; each of these failures can be remedied and, if not, the problem is flagged and sent to the appropriate PMG-group to sort it out: this enters the black-box of “Medical governance”, discussed in greater detail below and, via this audit of outcomes related directly to specific performance, it leads either to remediation or to progression to the next stage of PMG. The likelihood of escalation is reduced due to transparency and the resultant accountability that the quality of the data engenders in individual providers: if a provider’s performance is inadequate and the public have ready access to this information, it is most likely that the provider will do his or her best to remedy inadequate performance spontaneously.

It is possible to have good outcomes with sub-standard performance by clinicians as a skilled and motivated patient can be effective in counteracting the deleterious effects of poor provider-performance. However, there is a limit to what even the most competent, experienced, and motivated patient can do to compensate for the incompetent delivery of treatment by clinicians and administrators—no matter how effective that treatment may be independently. Objectively-effective treatments can be rendered ineffective by the way in which they are delivered, the most obvious example being because a patient rejects the treatment as a rejection of the clinician’s behaviour; if objectively-effective treatments fail in the end, it is almost always related to poor or inappropriate delivery.

Similarly, provider-performance can be good and outcomes poor; this can be due to the nature of the condition or the behaviour of the patient (which may amount to the same in certain instances) and the limited ability of high-quality services to treat these patient-based problems due to the state of current medical knowledge or the lack of availability of the required treatment for financial reasons. So, no matter the outcome, provider-performance needs to be assessed in both a discrete and a continuous manner. If it can be shown that the services are of high quality, that the providers performed well, that the patient contributed fully, that the treatment was the best available anywhere for that illness, and that the outcomes were poor despite this, this treatment-failure could be ascribed to the inadequacy of medical technologies (both treatment-methods and -products), which scientific progress would ideally reduce over time. However, it is reasonable to assert that such a reason would account for few of the treatment-failures experienced today.

Assessment of the patient’s illness-related status

Inset 5 outlines the variable-domains in the assessment of patient’s illness-status as well as the flow from primary assessment to outcome-benchmarking and the initiation of treatment. Four domains have been specified (physical, mental, behavioural, and social) to cover comprehensively the nature and causation of illness.

A comprehensive assessment of illness-status takes into account such variables as how sick, how objectively and subjectively ‘serious’ the disease is to the patient’s current and future functionality and in itself, how motivated the patient is, how skilled in self-treatment, how experienced with illness and with interacting with medical services, mental

Inset 5: Variable-domains in the Assessment of a Patient's Illness-Status and the Flow from Primary Assessment to Outcome-Benchmarking

1. Symptoms:
 - a. physical
 - b. mental
 - c. behavioural
 - d. social
2. Signs (i.e., problems measured in an objective context):
 - a. physical
 - b. mental
 - c. behavioural
 - d. social
3. Initial case-formulation
4. Diagnostic causation-assessment by specialists:
 - a. Systemic element:
 - i. physical (e.g., head-injury)
 - ii. mental (e.g., developmental lack)
 - iii. behavioural (e.g., lack of specific skill)
 - iv. social (e.g., lack of specific resource)
 - b. Systemic dysfunction
 - i. physical (e.g., epilepsy)
 - ii. mental (e.g., depression)
 - iii. behavioural (e.g., unskilled self-treatment)
 - iv. social (e.g., family violence)
5. Case-reformulation
6. Treatment-formulation (integrated by lead-nurse with input from patient and specialists)
 - a. benchmarking of personalised outcomes
7. Treatment-initiation

and behavioural predispositions in relation to illness, and so forth. While a comprehensive form of personalised assessment has yet to be developed, the Tuke Institute and others—e.g., the Osher Center for Integrative Medicine in San Francisco, California—are exploring this. A variety of generalist and specialist assessment-methods are available already (Frank-Stromborg and Olson, 2004; Bowling, 2001; McDowell and Newell, 1996) in addition to a variety of diagnostic procedures and criteria, the best known of which is the International Statistical Classification of Diseases and Health-Related Problems (ICD-10; WHO, 2009) and the International Classification of Functioning, Disability and Health (ICF;

WHO, 2001)¹¹. These need, firstly, to be synthesised into a scientifically standardised assessment tool that can be used in general practice, on which, secondly, to base more focused specialist assessments. ‘Standardisation’ is not to be misinterpreted to mean using solely population-based/nomothetic and objective variables, but a scientifically validated approach that includes person-based/idiographic and subjective variables that are proven to relate to health-effectiveness of medical services within individuals as well as across individuals, groups, and populations.

In order for treatment to qualify as medicine rather than pseudo-science, the comprehensive assessment of illness-status must be relevant to the individual patient's health-related goals: for instance, two people with identical HIV disease-status will have very different needs in order to get and stay well and these needs will vary on physical, mental, behavioural, and social levels, all of which need to be assessed and treated. The patient is also included actively in the assessment because, not only must the clinician be able to grasp the patient's ways of looking at things, the patient's illness-status and outcome-goals must be framed explicitly and in a way that is meaningful to the patient and in a process of mutual and motivating collaboration in reference to the way the patient behaves and responds to illness or disease; this also helps clinical medicine connect with aspects of social medicine such as planning for life-care, which is what the patient does (or receives, if severely disabled) in the course of daily life outside the clinic. This is basic good medical practice.

Assessment of clinician-performance

The second element of the information required is the assessment of clinician-behaviours that reflect the delivery of treatment. While there are plenty of methods and tools to assess the performance of individuals at work, medical services struggle with the complexity of the challenge of measuring clinician's performance, largely due to a failure to understand what causes good medical outcomes. This results in the implementation of crude and Byzantine administrative methods (cf. Kovner and Knickman, 2008), such as “pay-for-performance”; as experienced patients attest the measurement of performance in these initiatives has vanishingly little to do with the health-effectiveness. In order to develop an ecologically valid assessment of clinician-performance, there needs to be research into what variables determine health-effectiveness: this includes those variables that are consistent across all clinical encounters (i.e., primarily interpersonal and organisational behaviours in relation to the patient and to colleagues in a medical team) as well as those that are specific to a given disease or illness (e.g., therapies used in stroke are different from those used in HIV), or technical skills specific to a medical profession—e.g., the technical skills of a surgeon will be different from those of a behavioural therapist, although both may treat the same person and the same illness. The choice of technical variables to assess should be best informed by adequate and comprehensive best-practice guidelines for given disorders but—despite the work of

¹¹ These classification-systems might include in the future a classification of clinician-behaviours that are therapeutic.

CONSULTATION VERSION

institutions like the UK's National Institute for Health and Clinical Excellence—I am unaware of any practice-guidelines that may be used to frame performance-assessment. This is a significant and telling problem.

Nevertheless, there is good reason to believe that variables may be identified that can be assessed validly in order to determine the contribution of a given clinician's performance to a given patient's medical outcomes. Such a measure needs to be predictive of health-effectiveness but sufficiently practicable and integrated with service-delivery to facilitate, rather than impede, it. Example variables are given in Inset 6, which have been gathered from existing research into clinicians' performance and are most likely to have determinative effects on long- and short-term medical outcomes. Which—and to what degree—such example variables predict medical outcomes through clinicians' behaviours remains to be studied scientifically, but the literature is replete with evidence that indicates each of these variables and their groupings and have been used to construct different but related measures (e.g., Chisholm and Askham, 2006).

Assessment requires the development of a scientifically standardised and ecologically valid tool that addresses both the subjective and objective aspects of effective clinician-performance, just as with patients' illness-assessment. As clinicians almost always work in a team of some sort, there is a need to be able to assess the quality of the interaction between clinicians and how these interactions mediate the health-effectiveness of their medical services. In comprehensive assessment of these variables, "360-degree" data are best currently, which include the patient's perceptions. As part of the delivery of services, the clinician's performance-assessment is completed by the patient, the clinician (as part of reflexive practice), and every other member of the medical team in reference to the delivery of treatment for a given patient. Each clinician evaluates the performance of their colleagues confidentially in the delivery of treatments; small-team practices present an additional challenge to this principle.

This is also likely to reduce significantly both the number of complaints about clinicians as well as malpractice claims. A significant proportion of medical malpractice claims hinge, at the beginning, on the perception of trustworthiness of the clinician in question. A direct consequence of such an assessment is the ability to identify problematic *teams* (and why), even when individual members of the team are not dysfunctional, allowing for prompt remediation and prevention of deleterious consequences. The use of such a method is a sure and valid way to restore confidence and trust in the services of individual clinicians and practices which has been undermined by narcissistic and negligent behaviour by clinicians for years.

Inset 6: Example Variables in the Assessment of Clinician-Performance

1. behaviours, attitude, and mood, showing the clinician to be:
 - a. focused above all on patient's needs
 - b. caring
 - c. respectful
 - d. collaborative with patient and colleagues
 - e. constructive
 - f. flexible
 - g. encouraging
 - h. realistic
 - i. considerate
 - j. trustworthy
2. interpersonal communication, showing
 - a. deep listening
 - b. sensitivity
 - c. ability to take more than one perspective
 - d. empathy
 - e. responsiveness
 - f. clarity
3. technical performance, demonstrating
 - a. adequacy of patient-assessment within field of competence
 - b. diagnostic process and relevance to the patient's experience of illness
 - c. thoroughness
 - d. treatment-formulation
 - e. treatment-implementation
 - f. mental and behavioural hygiene
 - g. co-operativeness with colleagues
 - h. avoidance of areas outside competence
 - i. competence in making health-effective referrals
4. administrative performance
 - a. integration of treatment-plans with other clinicians' plans
 - b. organisation of treatment-delivery
 - c. quality of referral-requests and -provision
 - d. problem-solving

Assessment of the administrator's performance

Administration as a word has a Latin root that means 'to give service to'. In this instance, medical administrators' primary responsibility is to give service to the patient's needs, as opposed to, say, the institution's needs. Administrator-behaviours result in the materiel and personnel without which medical services can not be delivered. Variables associated with administrators' actions are constant sources of contention in initiatives to deliver services, whether it is the availability of appointments with a clinician, the availability of a therapy, the response to complaints when services go wrong, etc.. Administrators rarely have direct contact with patients until something goes wrong and the competent and respectful management of complaints at this point is the most important opportunity for maintaining standards, improving performance, improving health-effectiveness of services, and preventing escalation to litigation. The behaviour of administrators in the health-effective delivery of medical services—including public trust and goodwill towards those services—is paramount.

Example variables that might be included in such an assessment are given in Inset 7. With participative medical governance, administrators would have greater contact with the public than currently and be more directly informed of the realities required in getting and staying well. Patients may review administrators performance insofar as they have interaction with administrators (e.g., with clinicians who have administrative duties in the delivery of a given patient's care, such as the lead-nurse); this would most often be in the resolution and secondary prevention of problems, as in complaints. Other aspects of administrative performance such as budgeting, recruiting, and planning would not be relevant to individual patients' outcomes and so would only be included at a gradation of participative medical governance—e.g., where an administrator is reviewed by clinicians as failing to provide materiel or by patients in failing to provide competent clinicians—and a pattern is discerned in the data which needs to be addressed in a participative medical governance group. This is feasible with the proposed assessment-set and requires a consolidation of data across patients but within each specific provider, which would be done at the relevant level of the participative medical governance-group.

Inset 7: Example Variables in the Assessment of Administrator-Performance

1. behaviours, attitude, and mood, showing the administrator to be:
 - a. focused above all on the patients' needs
 - b. caring
 - c. respectful
 - d. collaborative with patient and colleagues
 - e. positive
 - f. constructive
 - g. flexible
 - h. encouraging
 - i. realistic
 - j. considerate
 - k. trustworthy
2. interpersonal communication, showing:
 - a. deep listening
 - b. sensitivity
 - c. ability to take more than one perspective
 - d. empathy
 - e. responsiveness (speed and quality)
 - f. clarity
 - g. leadership
3. administrative performance, showing:
 - a. constructive decision-making
 - b. pro-activeness and planning
 - c. provision of staff
 - d. provision of materiel
 - e. management of staff
 - f. management of materiel availability
 - g. resolution of problems, including conflicts
 - h. facilitation of health-effectiveness
 - i. facilitation of financial-efficiency

Translating good data into good governance

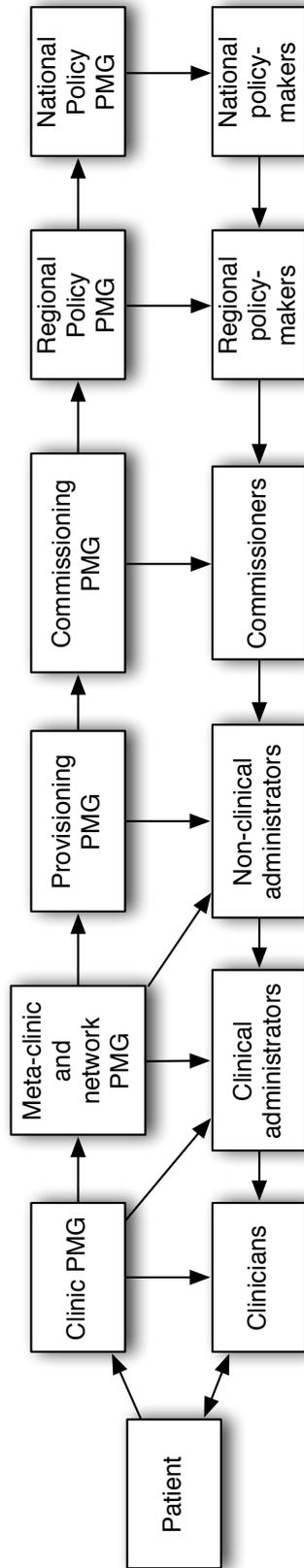
Based on a patient-centred model and analytic techniques of forensic and organisational behavioural medicine (cf. Whitaker, 2009b), Inset 8 shows the various gradations of a system of participative medical governance that moves from the patient outwards all the way to national policy-setting. The figure is a 2-dimensional, linear schematic of what is, in reality, a multi-dimensional network that makes the system as a whole non-linear; it also makes knowledge-transfer more efficient in both directions and reduces the system's vulnerability to reliance on a single mechanism. The directions of the arrows indicate the directions of influence and, implicitly, the sphere of control that the related functionaries have. All clinicians and administrators should be able to understand these simple charts and their implications.

Structure

The effective use of information on clinician- and administrator-performance requires a structure that can translate it from the patient, via medical governance, back to the patient. If the patient is at the centre of medical practice, it is possible to build a model representing various gradations of governance outwards from the patient, to the clinic (e.g., HIV, diabetes), to the multi-clinic/department (e.g., infectious diseases, endocrinology), to the meta-clinic (e.g., hospital), to administration involving more complex issues in personnel and materiel-buying and -commissioning, risk-management, local and increasingly non-local policy, and so on.

This model is qualitatively different from the model currently in use in that it is: horizontal rather than obviously hierarchical; it is rigorously developed from practice-principles; it gives primacy to the individual patient's medical outcomes; and it bases all decisions at subsequent gradations on considerations of health-effectiveness. There is a PMG-group at each gradation away from the centre (the patient), there is a PMG group, the tasks of which vary from ensuring that the needs of individual patients are met through governance of direct medical service, to ensuring health-effectiveness of clinics and meta-clinics, to decreasingly clinical and increasingly administrative and public health concerns such as buying and commissioning, to practice-variation between clinicians and within clinics, to practice-variation between clinics and within local meta-clinics, to practice-variation within aggregated meta-clinics and between non-aggregated meta-clinics, to local health-policy, and to national health-policy. By 'clinic' one may infer a primary clinic or a secondary clinic, either of which may be part of a larger clinic or a delivery-network—that is, either linked clinics with the same focus or linked clinics with different foci. Examples with specialist clinics might be an HIV clinic, a sexual infections clinic, an infectious disease clinic—in patient-centred practice all are at the same gradation from the patient-centre and can be seen as different aspects of a meta-clinic; a meta-clinic is along the lines of a multi-clinical department or a local network of clinics. This is slightly but significantly different from the standard administrative organisation of hierarchies, as it is not hierarchical (being concerned with status and authority over the lower levels) but centripetal (being

Inset 8: The Parallel of PMG to Service-Provision



concerned with service and responsibility to the centre: the patient). All are rooted in the evidence of medical outcomes for individuals, the data for which are aggregated and used at various gradations in this organisational model.

There is a need for a strong, parallel, integrated, but independent system of participative medical governance because of the various pressures that clinicians and administrators experience from a variety of single-interest groups, be they labour-unions, trade-lobbyists (e.g., British Medical Association), merchants' lobbies (e.g., pharmaceutical companies), community-groups, or more senior public servants. Each of these influences can be negative by wresting the goal away from meeting individuals' and society's medical needs and towards addressing political interests. An example problem might be in trying to hire personnel for nurse-led practices, where the British Medical Association may seek to require a certain physician-to-nurse ratio regardless of health-effectiveness, with the result that the administrators cannot afford to hire one or more nurses with expertise more appropriate than a physician's to be in charge of a clinic. Workers' unions and professionals' organisations may lobby against administrators' abilities to discipline or dismiss providers, despite clear evidence of inadequate performance, even though this pressure is against the medical interests of the public. Further, governmental administrators and community-lobbies may demand the primacy of certain political values over health-effectiveness, as the American government and Christian groups have done repeatedly by making the funding of medical services conditional upon the removal of abortion-services. Only equally powerful, national, participative medical governance rooted in evidence of health-effectiveness is able to constrain the damage from such self-interest.

Process

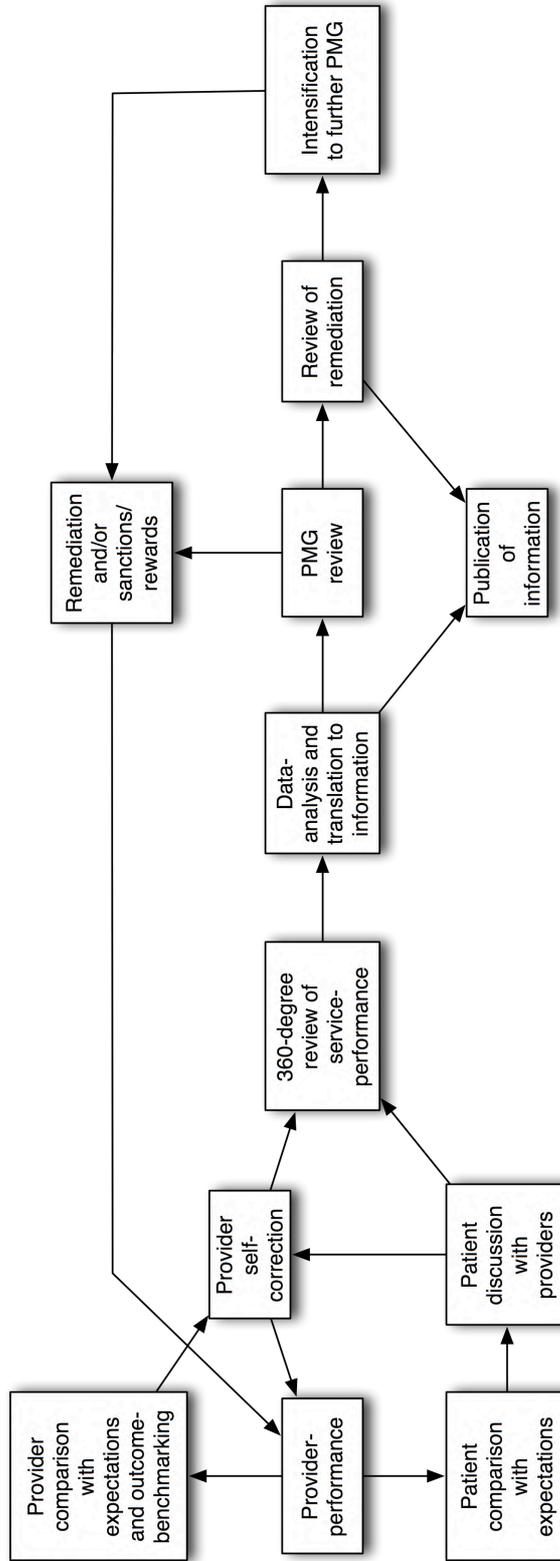
Inset 9 is a schematic of the process of governing provider-performance. Simple in principle, it requires a more detailed analysis of what it represents and how the various elements interact with one another:

1. In tandem with the purely clinical interactions with medical professionals who assess a given patient's illness-related variables (as outlined above), a given patient interacts with administrators in various ways:
 - a. the patient interacts with an administrative clinician (the nurse-lead in the primary clinic) during the integration of treatment-plans from specialist clinicians in primary and post-primary practice, in terms of the delivery and experience of the quality of referrals and the referring clinicians' performance. A poor referral¹² to or poor practice¹³ by a secondary clinician would need to be corrected by the lead-clinician in the primary practice.
 - b. the patient interacts next with administration if he lodges a complaint with a non-clinical administrator; this complaint is then addressed by the non-clinical administrator and medical governors at the gradation of PMG closest to the patient; the medical governors review the nature of the complaint as well as the thoroughness and efficiency with which the administrator resolves the problem in a way that is health-effective (and

¹² e.g., a physician making a referral a patient for 'tremulousness' with a three-week delay when in fact the patient is acutely psychotic and at severe risk of self-harm due to a medication's toxicity; cf. case-report on Tuke Institute website, which occurred at the Chelsea and Westminster Hospital, London.

¹³ e.g., the psychotic patient is not assessed and receives counselling rather than having the toxic medication changed

Inset 9: Process of data collection and use in PMG



CONSULTATION VERSION

therefore meaningful) to the patient¹⁴. The clinic-gradation of medical governors consists of patients and administrators who review the quality of the services provided and have readily available advice from a reference group of scientists and clinicians expert in the relevant areas. Most importantly, scientifically valid data are available that are directly relevant to the problem in question and can answer the most common questions in malpractice: what, who, when, where, why, why not prevented, and why not resolved?

c. a failure to resolve a problem means that this is recorded in the clinic's PMG-review of both the administrator's performance and, as appropriate, the performance of one or more specified clinicians; the call to resolve the problem is then intensified by passing the issue to the PMG-group at the next (second) gradation away from the patient, to which the first PMG-group reports. Intensification involves increasing pressure to resolve the problem, including sanctions.

d. further failures would be recorded publicly, with the named identification of providers who have tried and/or failed to resolve the issue and required a referral to more distal gradations of PMG.

2. Patients also interact with administrators if they are part of a participative medical governance group. As noted above, there are several gradations of these groups:

a. the primary clinic-gradation: this is the clinical base of the patient, where patients get their comprehensive assessments, treatment-plans, and most treatment. Referrals to post-primary clinics mean that part of the patient's treatment is carried out in one or more specialist clinics, but all the clinics are kept on the same 'page' by reference to the common treatment-plan, which is also the basis for the assessment of all clinicians' performances. Failures at the gradation of the primary clinic are dealt with in the manner described above. It is important to note a hybrid that is developing in practice, that of the primary-secondary or generalist-specialist clinic, where a patient with HIV, for example, has a primary practice as her clinical base that lies within a specialist HIV clinic; this is more than co-localisation of practices and makes for more health-effective treatment in chronic illnesses requiring specialist treatment regularly.

b. the secondary clinic-gradation: e.g., a specialist clinic for treating neural illnesses. Here, the data on individual patients' treatment are reviewed (pseudonymously for the patient, publicly for the service-providers); the effectiveness of treatment relating to the comprehensive treatment-plan for the patient that is created and maintained by the primary clinic's nurse-lead and amended with input from the primary and secondary specialist clinicians. Failures at the secondary clinic are assessed by the PMG within the secondary clinic in reference to the treatment-plan that is maintained by the primary clinic¹⁵.

¹⁴ there is a separation of service-delivery from service-regulation insofar as no clinician or administrator regulates his or her own practice.

¹⁵ How this is corrected via flows of information and actions in governance is a complex problem; it does not alter the basic premisses here of the nature of practice and of the information on performance that are required in order to have health-effective medical governance. The topic of data-handling in governance-networks, the specification of its complex statistical methods, in tandem with the mathematical aspects of the localised-distributed nature of the structure of participative medical governance, is intended for a future methodological report. It would allow a more critical refinement of the system through modelling but is not necessary for the proposition and implementation of the system.

CONSULTATION VERSION

The meaning of this schema is that the primary clinics' PMG-groups focus on meeting the patient's needs; the secondary clinics' PMG-groups focus primarily on the quality of service-provision (which is more complex in specialist treatment) since meeting the patient's needs are being assessed and advocated for primarily by the primary clinics' PMG-groups. Both issues of meeting patients' needs and quality of service-provision are integrally linked and synergistic but reflect different foci to achieve a common goal. Currently, most governance efforts focus nominally on the latter—the quality of services—without concerning themselves about meeting the patients' needs through, for example, monitoring health-effectiveness; this is clearly inadequate and is the core problem with current medical administration.

A further consequence of the system described here is that the causes of treatment-failures and malpractice are more readily apparent in the information provided from the scientifically validated methods specified above, thus reducing the knowledge and skills that members of the public need to have in order to participate in PMG-groups. The skills they need are then more personal and interpersonal and can be taught in programmes to train patients in communication and advocacy skills. More focus can then be put on ensuring that administrators and clinicians perform their contracted jobs in order to meet the public's needs.

There are further loci where the public and providers connect in the context of PMG, not just in the clinic and meta-clinics. Each clinic has its PMG-group and there is a PMG-group that governs the conjoint work of specialist clinics. Just as providers often practise in more than one clinic, so do patients access services in more than one clinic: for example, an African sex-worker suffering from HIV and domestic violence, who has trouble feeding his children, one of whom has malaria, will have highly complex medical needs within both primary and secondary clinics. The proposed system can handle this and still maintain continuity in the governance of the health-effectiveness of services to individual patients as well as maintaining the continuity of governance of individual providers' performances. PMG also provides the evidence and methods for integrating services most health-effectively within individual clinics.

Information-delivery

Now that we have both the methods for gaining data of good quality within the very act of service-delivery and a coherent system in terms of structural elements and the process-relationships of those elements, how do the data move from the patient through the system and back to the patient in such a way that the data become—and are used as—meaningful information?

Firstly, the data need to be handled properly. They are collated pseudonymously within the delivery of service to a given patient (to assess the health-effectiveness of the treatment of a given patient) but also across patients and within individual clinicians and administrators to measure the performance of individual providers' practices and their team-based function and co-operation. The sources and subject of the information should be confidential (be they from the patient or clinicians) but the object of the information (i.e., the performance of a specific clinician or administrator) can

CONSULTATION VERSION

not be confidential. Standard data-analytic techniques and statistics should be used to perceive performance in a given instance and over time, much like the performance of a monetary instrument over hours, days and years, or the real-time assessment of performance of a nuclear reactor. During the process of treatment, performance-data are delivered continuously to the PMG-group to identify patterns and events that signal ineffective or impaired performance in clinicians and administrators and, above all, to ensure that no single patient receives substandard treatment. This information reflects a richer aggregation of data, which can be used to identify patterns that the less-complex data available to the nurse would not be able to identify; it allows local resolution of many more problems than currently possible. Given that the data are so complex and 'rich', they need to be handled and their meaning extracted automatically and pseudonymously by clinician-scientists who are qualified to understand the nature of the data, the process of data-collection, the statistical analyses, the valid ways in which the data can be used, their limits, and how they are best translated into meaningful information. The specification of such a job and its tasks remains to be made, but it is likely that organisational health psychologists would be among the most appropriate for this sort of task.

Once transformed from data into information, it is then used by the PMG-group in the primary clinic to define changes required in the performance of individual clinicians, of individual administrators, and of teams, and in the health-effectiveness of treatment to individual, pseudonymised patients (in terms of medical outcomes and the need for future treatment) provided at the specific clinic. The experience of the patient-members in the work of the medical governance group is also assessed but pseudonymously¹⁶; if the administrators who are part of that team fail to facilitate needed changes, then this is identified at that point and that report is passed onto the PMG-group at the next governance gradation at which it is possible to modify that administrator's performance (e.g., by cutting pay).

The information on higher-level aspects of performance, generally and specifically, is passed to the PMG-group and to subsequent gradations of PMG-groups within meta-clinics; it is used to resolve issues at a more distal gradation from the patient—such as issues of systemic under-performance or malpractice—with the purpose of managing risks to patients as a group, firstly, and to the organisation, secondly. Information on how this has been handled is then passed on to PMG-groups for commissioning and the regulation of medical professions (including medical administrators), to ensure that meaningful measures are taken to protect the public's health; this information is also then passed onto the more distal PMG-gradations remitted with the task of policy-making, which can now base its policy on evidence relevant to the lives of patients and the requirements of health-effective medical services. This ensures the health-effectiveness of services and that decisions are made on good, local evidence that can also be directly traced to its source—the service-provider. It provides unparalleled leverage to all parties to ensure that the medical services provided are health-effective, that the services are of consistently good quality, and that they are responsive to changes needed.

¹⁶ the need for this should be obvious where patients have a stigmatised condition

CONSULTATION VERSION

It is worth noting specifically that having meaningful information on performance at a given instance is important to allow administrators to respond promptly to potential malpractice. On the other hand, performance over time is necessary to provide a context to specific events and to help determine the best way to ameliorate problems. The importance of event relative to their context in terms of the acceptability of performance of a given clinician is a question for further analysis (so that the consistency and validity of such decisions between clinicians, over time, and between PMG-groups can be measured and optimised). Given data on performance being available publicly at any given instance and over time for a specific provider, in tandem with data on the decisions made by a given PMG-group, the implicit standards by which PMGs operate will become explicit. The effectiveness of PMG-groups in protecting patients' medical interests through the implementation of such standards will also be visible and will provide the means by which the performance of PMG-groups may be bettered. This is the nature of a true system¹⁷, where each element is designed to synergise in the maintenance of the system's function.

The value of this system can be indicated by two examples. In physician-centred practice, the system of integrated assessment would flag up quickly the problem, in that physician-centred goals would not match patient-centred outcomes (e.g., treatment of a patient's levels of glycosylated haemoglobin would not translate necessarily into resolving fatigue and ensuring that the patient can pick her grandchildren up after school). Furthermore, it has often been the case in my professional and personal experience that when a physician has treated the objective disorder and it has not resulted in the outcome he expects, the patient is blamed: the physician assumes that there is poor adherence, the patient is irresponsible, a hypochondriac, or simply 'difficult'. Such narcissistic problems of scapegoating patients for clinicians' failures would be identified easily in patient-centred performance data and actions could be taken to ensure the clinician takes responsibility for the adequacy of his service-delivery. Likewise, if an administrator is constantly making decisions based on cost rather than health-effectiveness, this would be easily identified and the administrator would be helped to adjust her behaviour; it would not have to wait until the number of deaths reaches a high enough level for administrators to be forced to recognise the problem by the media. If the problems are with clinicians' or administrators' job-performance, then these can be flagged dynamically and early interventions become possible, based on data of good quality. Clinician-supervision can be informed by such performance-data—and is, in itself, an important local regulatory sub-system; it is a standard practice among psychotherapists in maintaining license to practice, but not among physicians or even psychologists. It should become a standard method of maintaining service-performance in all clinicians.

What are the options in remedying problems? If the problems are due to personnel shortages (e.g., the lack of behavioural medicine services in an HIV clinic), then the data are available to assess the effects of such shortages, the cost in terms of health-effectiveness, the likely consequences of altering priorities in personnel hiring, and the organisational

¹⁷ Systems theory and analysis provide increasingly important scientific tools for examining the nature and behaviour of systems, including complex ones such as the British NHS. A good introduction may be found in Coyle (1996) and a more mathematical approach to complex systems in general is found in Bar-Yam (1997).

needs for administration; the clinic can be compared with other such clinics quite readily. If the problems are due to materiel shortages, then these can be identified and the appropriate decisions taken at the gradation of buying. If there are problems with materiel and decisions have to be made about the appropriate allocation of funds, the data are there for these ethical decisions to be considered—and the data on those decisions are handed on to the next gradation of PMG, which has a slightly broader perspective. For instance, with a limited budget, does one buy an expensive treatment for one person or provide less-expensive treatment for ten people? These ethical decisions will be local and culturally relevant and will be charted against long-term health-effectiveness of medical services, leading to a change in the values in due course on the basis of evidence. This system does not predispose a specific value-system: one locality may believe that it is better to provide the funds for assisted reproduction-services over those for abortion-services; another locality may not. But both will have the same, comparable and publicly available data on which to base—and defend—their decisions publicly.

The act of governance

The teeth of governance lie in a number of synergistic mechanisms: transparency and accountability based on effective measures of performance and health-effectiveness, which promotes responsibility in the service-provider to monitor his or her own behaviour and remedy problems independently before anyone else has to intervene; the motivation to ask for help, knowing that this will be in their favour, rather than let things get worse; clinical supervision, where problems can be addressed; the availability of audit-data on performance and governance-decisions at all gradations; evidence with which to rationalise the modification of provider-performance and shape it into health-effective service-provision to the public, through rewards, sanctions, continuing medical training, etc.

There are two sets of standards by which poor performance must be judged; firstly, poor performance is established by inadequate medical outcomes, which answer negatively the question: “are these services health-effective?”. When they are not adequate, then the causes lie in two general domains: personnel and materiel. Under personnel comes the service-performance of individual clinicians and administrators—and the latter’s performance includes the adequate commissioning and filling of clinical positions through hiring. The skills and behaviours of personnel are the primary cause of health-effectiveness in the adequate performance of medical services: with all possible technical products and funding available, unskilled performance of medical practice will not translate into health-effectiveness; furthermore, variations in practice that relate to health-effectiveness are not dependent solely (or even primarily) on technical products and materiel available.

This insight has a number of consequences. Firstly, data on the performance of individual clinicians and administrators must be made public; medicine is a socially essential service to the public, paid for by the public. Public service and its governance can not be seen to be done in a trustworthy fashion without transparency and accountability. Public ac-

countability is not possible with anonymised performance-data and a consensus on the importance of publicly available information on the performance of providers of public services is increasing (Clarke and Oakley, 2007), which reflects international discontent with the current governmental regulation of a number of public services, including banking, public transport, and medicine. Failures in providers' performance have specific consequences: as information on the performance of job-related responsibilities is made public, the public within PMG-groups and external to them has the evidence with which to demand appropriate changes, and the clinician or administrator in question has motivation to monitor his or her own performance and to seek solutions sooner in terms of further training, supervision, or treatment for personal problems. There are also the consequences of reduced pay, career-stasis, negative letters of referral, and evidentiary grounds for dismissal. In this way, problems like those seen in the Bristol, Alder Hey, and Kerr/Haslam Inquiries are less able to escalate to such an extent that governmental Inquiries are necessary, with the extreme social, personal, and financial costs that result from such failures. A corollary of this system is that responsibility and its placement are clearly located—and so a failure to provide the means by which to fulfill those duties is clearly located in the appropriate provider further out, not on the hapless provider who is required, metaphorically speaking, to provide bread to 5,000 people with only half a loaf.

Critical analysis of the model

The model proposed here provides a thoroughly rationalised solution to the problems of providing health-effective medical services to the public. In the process of its development, it has relied on analysing the particular failures of British and American service-forms, with an emphasis on the former as the latter suffers from a basic and cardinal flaw: as the evidence shows, it can not protect the public's health through market-driven services (cf., Heirich, 1998). However, both systems have provided evidence for and against proposed solutions and have been useful in developing the current model in that they show what a model must be able to prevent in order to be robust. Having proposed and reasoned the model, let me try to break it now in the interests of scientific rigour.

Testing the model against the findings of the Bristol Inquiry

To assess whether this model addresses the problems of current medical practice, the problems identified in the Bristol Inquiry report are explored in turn.

1. Patient-centredness

The model addresses this issue well. The solutions specified in the Bristol Inquiry included: the public being at the centre of services; specific patient-centred medical standards; performance data gathered as the by-product of clinical service; and a clear, single locus where patients can complain about service quality. In this model, the public is at the very centre of medical services, which are designed and implemented according to evidence gathered not as a by-product of clinical service but, better, as an integral part of clinical service, using a unitary method that is consistent from the individual patient outward to the most distal gradations of PMG, which are responsible for the specification, commissioning, design, and implementation of services. One method addresses all these requirements and, when they don't work properly, there is one clear, single locus where patients can complain about service-quality: the PMG-group at the level closest to the patient.

The model of participative medical governance presented here is built on top of a related model of deeply patient-centred medicine (PCM) that is distinguished clearly from participative medical governance (p14.ff); the PCM model is necessary in that it is the only one able to provide information of the quality needed to govern the performance of individuals, groups, and systems and ensure that they provide health-effective medicine. Without information of such quality, medical governance of any form can not be health-effective. Participative medical governance relies on the comprehensive measurement, firstly, of patient-centred illness-related variables and, subsequently, of patient-specific medical outcomes over time; on the basis of this information, the health-effectiveness of performance can be audited and governed from the gradation of the individual provider out to the policy for the whole service.

But patient-centred medicine is not enough to ensure health-effectiveness. There can be a deep form of patient-centred practice where quality of information is high but it is not health-effective over time; let us also pose that, at first, this high-quality information is passed along in a system as thorough and robust as the one proposed here but one which lacks public participation in medical governance. The problem arises first in what is done with the data. Given the historical weaknesses of a system such as the British NHS, one particular issue will interfere with governance: the fight for control between the various clinical professions and between clinicians and administrators. In a dynamic system, the result will be that each will seek to try and impose changes on the nature of the data collected, the manner in which it is collected, and the manner in which it is used, such that, for example, physicians will re-assert the primacy of diagnostic biology and protect the profession's social status while administrators will emphasise short-term costs over health-effectiveness. The result is that patients' and the public's needs in other areas of medicine and for health-effective services will become lost again, as they are now and as was seen in the Bristol Inquiry, and the system will return to its original and current dysfunction, which is closed and entropic. Mathematically, this can be likened to an immensely strong attractor and any system that seeks to avoid this particular black hole needs to have a number of mechanisms that act synergistically to prevent the system's performance being sucked back into it. Thus, it is not sufficient to have only

patient-centred practice or only participative medical governance; both are necessary. That participative medical governance relies on this deep form of patient-centred practice entails a degree of complexity but it also provides an efficient backbone of consistent and excellent information throughout the system as a whole, with counteractive and synergistic mechanisms to prevent its misuse.

This model shows how it is possible to maximise health-effectiveness through personalised medical outcomes without promoting a consumerist, 'patient-led' model, which only serves to exacerbate the problem; as long as patient-centred outcomes are maximised (i.e., service is health-effective) then the system of integrated delivery and governance is working well. The information on progress towards these outcomes is available at all stages of service-delivery and governance; it is the single compass point by which all providers navigate and all governors measure providers' success, regardless of the type of treatment or their degree or distance from the centre, the patient. At each gradation away from the patient there is a local self-regulatory loop that achieves two things in each stream of service: for clinical and administrative services, it is: (1) the delivery of medical services local to that gradation, and (2) the continuity of services between the inner and outer gradations of service (e.g., between the patient and the specialist service); for governance, it is: (1) the delivery of local governance, and (2) continuity of governance with the inner and outer gradations of governance (e.g., between a clinic-specific PMG-group and a meta-clinic PMG-group). Importantly, as medical practice moves from generalist to specialist treatment, it maintains a consistent focus on the individual patient at all times; as governance moves outward from the patient, it moves from the highly individual to the collective, while maintaining a focus on the determinative relation between the two, which is in the best tradition of science and evidence-based policy.

2. Integration of services

This model addresses this issue well and it is, in fact, one of its three strengths. Again, the Bristol Inquiry outlined solutions to the problems it encountered, noting a requirement for team-based services that are integrated across professions and disciplines, as well as across primary, acute, community, and specialist services with links to external systems. The current model addresses these issues specifically in that it requires a cross-disciplinary team of providers that is integrated by the nurse; all are on the same treatment-plan, the formulation of which is led by the patient and the nurse jointly; treatment-delivery is integrated and monitored through the nurse; failure to provide it in a competent, integrated way is measured concurrently and monitored continuously by the PMG-group—the example seen in the Bristol Inquiry of inadequate services in psychological medicine to the index-patient's family caregivers would not be feasible in the system proposed here without inducing prompt corrective action by the PMG-group to amend the issue and address the broken link in the chain of service-delivery. This trans-professional team-work is based within the clinic and it is integrated with external providers via the lead-clinician, the nurse, in association with the specialists. For instance, social treatment can be integrated with judicial or governmental agencies via the medical social therapist.

CONSULTATION VERSION

The Bristol Inquiry also identified a need for funding of community-based organisations for the work they provide to the NHS in reducing its load. Funding the work of community-based organisations can be rationalised on the basis of the evidence of their contribution to health-effectiveness that they can provide using the same method of assessment specified here. However, out-sourcing is not supported by this model; in fact, it begs the question of why a statutory service would not provide the service itself. Out-sourcing is a business-solution to a failure in pro-social services and, in a pro-market system, it becomes a question of negotiating financial interests between multiple agencies where the patients' interests of health-effectiveness become very much secondary. Out-sourcing can not be maximally health-effective due to discontinuity in treatment and, even more importantly, in participative medical governance.

In terms of integration of services, a potential weakness of this model is that it relies on the competence of the nurse to assess and integrate services in a comprehensively patient-centred manner, much as current practice relies on the competence of the physician. With the physician, there is an inherent perceptual bias towards biological medicine, which is absent in the more broadly trained nurse. There are a number of mechanisms that function to compensate for and cross-brace against this weakness (again, which the physician-profession has historically resisted), including: an encouraged *increase* in patient expectations as to the adequacy of case-formulation and treatment-formulation as part of treatment (physician-literature is constantly pathologising patients' expectations and failing to understand how to use them therapeutically); 360-degree review of the lead-clinician by the patient and the clinician's colleagues; continuous monitoring of the health-effectiveness of treatment; and clinician-supervision. Given the historically greater openness of the nurses' profession to such mechanisms, these mechanisms are likely to work, although it will require a change in the way lead-nurses are trained. More analysis needs to be undertaken to explore this crucial point in order to make the model even more robust. Nevertheless, it is safe to say that no system will work if it uses clinicians who are not equally competent in all the domains necessary.

Another crucial link in the system is the competence of the nurse-lead in the integrated-practice model on which the model of participative medical governance relies. This is particularly so in relation to communication-skills, which are a necessary part of the assessment of illness-status, of providers' performance, and of participative medical governance. Sub-standard communication with patients and their proxies, unresponsiveness to complaints, and imprudence about patient-safety were all raised as distinct problems in the Bristol Inquiry. Communication-skills are required by all parties (clinician, patient, administrator) and should be enhanced as a necessary part of treatment by the nurse and psychologist: patient-centred, biopsychosocial practice includes increasing communication-skills and communication-expectations in patients, which are then used in the measurement of these variables. It is a crucial link that needs to be addressed, most probably in the specification for training standards in nurses who assume this advanced medical role.

The Bristol Inquiry identified some solutions to the problems of unintegrated and disorganised services, which included an amount of joint training for all medical professionals, including administrators that would ensure that certain knowledge and skills (e.g., in medical communication) are common to all providers. This theme is also explored else-

where (Whitaker, 2010a). Joint training would increase providers' understanding as to what other professions can competently provide, promoting mutual respect and a greater ability to work in an integrated environment. For administrators, it would also mean trained competence in the specialty of medicine which, as noted above, requires different skills than those in the administration of public swimming-pools. The Bristol Inquiry also proposed a requirement for continuing training in order to be allowed to continue to provide services as well as participative approaches to specifying the criteria for entrance to medical training, qualification, and hiring. It is a short step from here to the integrated, governmental regulation of both clinicians and administrators, overseen by PMG-groups at the appropriate gradation of governance. This model provides a framework for the common aspects of training, of competence-assessment, and of participative medical governance. Combining the solutions from the Bristol Inquiry and this model, these solutions are even more effective, whereas the solutions proposed in the Bristol Inquiry would not be adequate in themselves.

3. Creating useful information of high quality for governance

The model addresses this issue very well. High-quality information is gained on provider-performance and medical outcomes using a unitary approach to data-collection, while health-effective performance is assured through participative medical audit. The data collected are ultimately useful in that they measure health-effectiveness of provider-performance. These data are transformed into information that is valuable both in terms of health-effectiveness in real-time and in that it is collected and used in real-time also. This system provides more valuable information than signal events alone can provide. The signal-event approach is susceptible to a number of measurement-related, conceptual, and perceptual errors, most obvious in the problem of the signal-to-noise ratio and the indeterminate relationship to health-effectiveness. In the metaphor of an iceberg, the tip of the iceberg may be likened to a signal event, in that it is salient; however, it is more often not the tip of the iceberg that is dangerous to shipping but what lies out of sight beneath the waves. This model measures both what is beneath the waves and the general environment in order to predict what may lead to a hazardous circumstance before one is able to recognise a signal event.

The Bristol Inquiry also cited a need for effective methods of feedback. This it is one of this model's strengths. The system here has multiple, efficient, and highly functional feedback-mechanisms, including: the assessment of health-effectiveness of service-delivery in real-time; 360-degree assessment of performance in real-time with continuous review by PMG; the facilitation of complaints directly to the PMG or via the nurse-lead; and the integration of the gradations of PMG through the common framework of personalised indices of health-effectiveness. The generation of high-quality information integrated with the feedback mechanisms grounded in patient-centred assessment is the second principal strength of the proposed model.

4. Transparency and clear lines of accountability

This model addresses this issue extremely well: it is the third of the principal strengths of the model, where the method of medical audit is based on good information on clinical and administrative service-performance. Further, the science behind the development of the methods of measurement is transparent, its collection is transparent, and its public reporting of information about named providers and the nature of their responsibilities is transparent. This delivers accountability that is supported greatly by the quality of the evidence, which PMG-groups and the public in general can use to rationalise and implement change.

5. Insight and honesty, with an ability to learn from errors

This model does address the ability of organisations to learn from errors but it is moot that it addresses adequately the inability or, more often, unwillingness of individuals to learn from errors, let alone maintain or develop insight and honesty. One can not ensure that individuals will change their beliefs, personality, or behaviours, but one can ensure that the organisation that hires them and the public that pays for their service is able to discipline poor performance and disperse with those service when the individual is acting against the interests of the patient and the public. This is the crux of the model: it provides the means by which to gather evidence of the highest quality on which to govern the behaviour of service-providers and to discipline them when they fall below an acceptable standard, including the recourse of evidence-based dismissal and the risks of career-termination. This is a preferable route to the excessively costly and inadequate mechanisms available today of complaint to the providers and the organisations, which often protect them (cf., Dr. John Roylance at the Bristol Royal Infirmary), or of litigation for malpractice, the definition for which is determined largely by clinicians, with the sole outcome of financial compensation—at the taxpayers' expense—without requiring the providers to change anything they do in the future.

The quality of the information provided by this model, in tandem with the model's systemic nature, means that an *inability* to learn from errors will be identified in the assessment of the performance of clinical and administrative behaviours. If ignorance is the cause of an inability to learn from errors, the quality of the information and the nature of the informational system measures this, prevents it through team-based practice and remediates it more quickly and effectively than in other models. If a clinician is unable to learn from errors due to an inadequacy of cognitive or social intelligence, as happens in learning-disorders, then this will cause a necessary re-evaluation of the providers chosen career and indicate alternative career-choices: for instance, a neurological physician might be better off re-training as a forensic pathologist if it evident that his clinical behaviours are causing his patients to stay ill.

However, this model addresses only partly the issue of *unwillingness* to learn from errors. An *inability* to learn from errors due to lack of knowledge or the identification of learning disorders is distinct from an *unwillingness* to do so due to personality dysfunction; the distinction between the two requires again a psychologically informed method of behav-

CONSULTATION VERSION

journal measurement of performance. For an important minority, the model's methods of transparency and accountability supported by the system of measurement and clinical supervision will not be enough of a preventative, as in those whose behaviour indicates one of a cluster of psychopathologies reflecting dysfunctional behavioural styles and/or moral-developmental problems, which have been linked to medical malpractice (Banja, 2005). Such pathologies focus on narcissistic and antisocial disorders indicated by low empathy, perspectival inflexibility, entitlement, a sense of specialness, and poor insight. These reflect pervasive problems in the medical professions, most obviously in the situations surrounding the paediatric physicians Professor Sir Roy Meadow and Professor David Southall, the surgical physician Dr. Rodney Ledward, and the physician-administrator Dr. John Roylance. These problems are exacerbated by professional privilege, an inadequate service-culture in medical professions, as well as by problems from pro-market solutions in medicine where, for instance, insurance companies intrude upon a clinician's professional responsibility by preventing her from acknowledging fault because of the insurance company's selfish fears of exposure to litigation-related costs.

Apart from the obvious need to exclude pro-market solutions from the delivery of pro-social services, methods in this model that offer solutions to these problems include:

1. comprehensive performance-assessment that assesses variables that relate to insight, honesty, and an ability to learn from errors
2. mechanisms enabling transparent, public accountability that addresses these areas specifically and increase motivation for self-initiated remediation
3. participative medical governance that is confident in the sensitive and specific identification of these variables in service-providers and which is equally confident in the use of effective sanctions
4. the provision of psychologically skilled supervision of all clinicians, the results of which are integrated into the 360-review of providers' performance
5. ensuring that the screening of candidates for, and the training of, all the medical professions has, as a required element in competence, high interpersonal skills, empathy, and insight, and that these are primary requirements, not secondary to more technical skills
6. the use of the above assessment-methods in clinicians' and administrators' training which may be used to identify problems early, not just during their post-qualification practice
7. the inclusion of these areas in regulatory requirements for initial and post-qualification training

For methods to be effective in ensuring good insight, honesty, and an ability to learn from errors, they must be quick, efficient, and robust, which includes their not being easily disabled or circumvented. As individual, unintegrated solutions, they are ineffective and easily perverted: the movement towards clinical supervision, for example, has been fiercely resisted by the physician-profession in Britain, which sought instead to have 'mentoring'; this, then, came to fo-

CONSULTATION VERSION

cus solely on career-development, undermining its original purpose. Additionally, the promotion of 'reflexive practice' is supposed to help promote insight, but relies on an understanding of what the standards are and the behaviours that support or hinder them; without such an understanding, reflexive practice focuses on technical competence of non-interpersonal and -intrapersonal skills. Consequently, the solution lies in integrating the methods systemically and this PMG model is the best way to achieve this within service-delivery.

Furthermore, while the methods above can remediate to some degree the effects of poor insight, dishonesty, and an inability to learn from errors (a type of secondary prevention among providers), they can not prevent these problems from occurring in the first place (i.e., primary prevention). The solution of participative medical governance would be enhanced by extending its techniques to the medical training of clinicians and administrators—including the specification of such training's contents, rather than leaving it to the professions, which evidently does not work. It can be extended additionally to the setting of provider-recruitment. Effective prevention of the problems of poor insight, dishonesty, and an inability to learn from errors would include the prevention of clinical or administrative students with signs of the existence of, or susceptibility to, these problems from entering fields entailing any contact with or responsibility to living patients or their families. Part of the reporting of individual providers' performance might even include the institution where they were trained and the name of their primary supervisor in their specialty field; schools and supervisors with low scrutiny of these issues would be identified over time and motivated to increase their level of scrutiny or develop a reputation for qualifying students who are less able to find jobs or further their careers for these specific reasons. Prevention would be enhanced by a culture that promotes honesty and insight framed by a stated value of duty and service to the public. As with all cultures, this would develop over time and be promoted by low tolerance in practice, with significant sanctions against those lacking them. Toothy implementation of participative medical governance would mean that these values are made a high priority and the identification of their inadequacy must be sensitive and specific in order for the sanctions to be just.

However, the success of this model relies finally on whether or not a PMG-group is willing to implement sanctions. Learning from errors requires a willingness to implement changes that include sanctions on those personnel that do not act in the public's best interests and remediation depends on toothy mechanisms of behavioural change. If a PMG-group is unwilling to act on the evidence—even when that the group's unwillingness or ineffectiveness itself is made publicly evident—and this continues out along the chain of participative medical governance, then there is nothing to be done unless external agents can prompt a re-appraisal of the need for action. This eventuality is also accounted for in the fact that the information on providers' and their governors' performance is publicly available and community-interest groups can use it to advocate for health-effective change, firstly in the PMG groups responsible. This is the strength of pro-social medical services within a framework of what has been called 'monitory democracy' (Keane, 2009) and points up another weakness of pro-market medical services: the market does not do democracy, especially monitory democracy, but it is essential to health-effective medicine. This mechanism of external input into PMG forms part of the self-

correcting nature of a system that is able to learn. Only open systems can learn and this system is designed fundamentally to be open and adaptive (i.e., able to self-correct on the basis of what it has learned). The model proposes a system where learning from errors is as easy as possible; an unwillingness to change problematic behaviours requires that that unwillingness must pervade the whole chain of provision and governance in order for it to be a successful obstacle and the likelihood of this is reduced greatly due to the equally pervasive, transparent and, above all, participative nature of governance.

This model does not specify the nature of the sanctions required to correct the behaviour of providers in delivering health-effective services. Suggestions are made, such as reduced pay, career-stasis, negative letters of referral, and the increase in availability of evidentiary grounds for dismissal. The nature and efficacy of such sanctions in professional behaviour-change should be identified in future scientific research.

6. A culture of public service and collaboration

The model addresses this issue quite well: it counteracts effectively all the behaviours that underlie the current 'club-culture' of narcissistic self-service in providers and promotes factors that engender a culture of public service and collaboration. The problem of club-culture was identified in the Bristol Inquiry as a primary determinant of the systemic dysfunction leading to almost all the subsequent problems (Dyer, 2001). As culture is an emergent function of a system, it is difficult to demonstrate its causation reductively, but we will explore it in some detail for the sake of thoroughness. Some primary causative factors have been discussed above in relation to an *unwillingness* to learn from errors. However, others exist.

Currently, medical administrators often lack adequate—or any—training in medical administration and have little sense of common identity with clinical providers, let alone patients, resulting in factionalism and ideological conflicts; much administrative energy is spent trying to herd cats. In tandem with a lack of common agreement on the definition and specification of goals, it means that stated goals relate to outcomes that are unreliably measured, have little value to the clinicians or patients, and have little relevance to the health-effectiveness of services. Without common goals, common standards, and common methods, perceptions of inadequate performance are viewed as unreasonable and any sanctions are experienced as unjust, causing low morale, exacerbating factionalism, and resulting in an unwillingness to do anything but the minimum. This causes a passive bystander-effect where, in the presence of obvious malfeasance, no one is willing to take the responsibility even to blow the whistle and, in such an environment, a culture of public service is not feasible. Nevertheless, most people prefer to get along with those they have to work alongside and, as with any group with internal trouble, a cohering effect occurs in response to criticism from outside the group, resulting in the closing of ranks and the strengthening of a club-culture (or tribalism).

CONSULTATION VERSION

A club-culture has a number of functions that include the maintenance of group-security, including markers of relative security such as group-privilege; where a 'club' is a group composed of sub-groups, efforts are focused on the protection and privilege of the most powerful sub-group (which in medicine has traditionally been the physicians') even by those subordinate to it (Nadler, 2010; van Leeuwen and Täuber, 2010). While it is valid to note physician-privilege as a particular problem, it is important to recognise that such privilege is not unique to the physician-profession; other medical professions have benefited from this same sort of privilege either directly, through similar professional protectionism, or indirectly, through the vicarious benefit derived from the protection of physicians' privilege. This latter was evident in the Bristol Inquiry in the behaviour towards the parents of sick children by those most closely allied with physicians, such as nurses and administrators.

The club-culture in modern medicine stems from two proximal roots. The first root is the lack of accountability of service-providers in a socialised service, largely due to aggressive professional protectionism from physicians' lobbies; as medicine has moved towards 'managed' services it has meant that administrators have gained some of the privilege previously unique to physicians, most noticeably a lack of accountability. Administrators are more adept at avoiding accountability by using organisational obfuscations such as the 'many-hands' problem (Thompson, 2005; p.11 ff.). The second root lies in the social privilege afforded to physicians historically, which has impeded much progress in medicine (Whitaker, 2010a). This privilege has been bolstered by the fact that, while group socio-medical (e.g., public health) initiatives have been far more effective in minimising acute illness's depredations than biomedical treatment has ever been (Porter, 1997), we are less able to perceive (and, thus, value) the effects of the prevention of illness than of the quasi-heroism of preserving life in serious, acute illness. It is the biomedical treatment of serious, acute illness that physicians are identified with and which underlies the profession's kudos. However, acute illness has been displaced nowadays by chronic illness as the greatest burden to society in developed nations, and the value of physicians' contribution to the resolution of these illnesses is, at best, only on a par with those of the other medical professions of nursing, psychological, behavioural, and social medicine. Quasi-heroic acts are not visible in chronic illness until it becomes life threatening, by which time it is safe to say that treatment has failed already. As research has also shown, the use of purely biomedical treatment is ineffective in terms of both health-costs and financial costs in chronic illnesses (Cummings, 1997, 2001; Strohsahl and Sobel, 1996) and physician-privilege becomes increasingly untenable.

In a better-educated and -informed age that values equality and social justice, it is appropriate that such unmerited privilege should be removed, especially where it is socially deleterious. Such privileges are already being eroded by scientific evidence of the relative value of each profession's contribution to health-effectiveness, by the scientific evidence as to the safety and efficacy of formerly exclusive treatment modalities in the hands of those other than physicians—e.g., pharmaceutical prescribing by non-physicians such as nurses and psychologists or surgery by non-physician podiatrists—and by the increasing evidence-base for the health-effectiveness of medical therapies that are not purely under physician-control, such as phytotherapeutic, nutritional, rehabilitative, and behavioural medicine. Other privileges af-

CONSULTATION VERSION

forded by hospitals and insurance companies (such as admission-privileges and higher consultancy fees) will be eroded in due course, as they have already been in the medicolegal field, by the same sort of scientific evidence. But a discussion of provider-privilege necessarily raises its parallel—patient-privilege—which is a particular risk in promoting ‘patient-led’ services and medical consumerism and is equally detrimental to the delivery of health-effective medical services. While a culture of public service means that meeting the public’s needs must come first—which means that pro-market and provider-centred medical services must be excluded—such an orientation must not be at the cost of health-effective medicine. Having avoided Scylla one must be careful not to be pulled under by Charybdis.

Any model that seeks to address the problem of club-culture must address the issue of privilege generally, not just that exemplified in a given sub-group of professionals in a given era. The model of participative medical governance described here does exactly that. Problems associated with a club-culture by privileged groups are impeded by the three principal factors of the model: i) a service-framework defined by health-effectiveness; ii) publicly available information on the health-effective performance of named service-providers, which provides an evidentiary basis for governance; and (iii), above all, the fact that governance is participative and empowered through the use of this evidence on health-effectiveness. Additionally, physician-privilege is solved in this model through a nurse-led, team-based practice that reflects the biopsychosocial nature of illness and medicine; it relies equally on clinicians in each of the domains of medicine allowing each to practise in their particular area equally; it is guided by accurate and patient-centred data on health-effectiveness of medical practice; and it is audited by individually identifiable data on contributions to health-effectiveness that may be partialled out by profession as well as by individual; and its governance is supported by the transparency and accountability afforded by these data and the systemic nature of the public’s participation. The according of privilege to any of the medical professions over the patient—or vice versa—is prevented by these same mechanisms.

These methods also facilitate the assignment of job-positions on the basis of evidential competence rather than professional status. A culture of public service also permits leadership¹⁸ to emerge in those who have the trained competence to implement and maintain these methods. The work-environment can then focus on excellence rather than avoidance of negative consequences and the common narcissistic complaint of a ‘blame-culture’. Terms of employment can be informed by the health-effectiveness of practice, which may be analysed by profession and field, and would allow clinicians of different professions to be employed and remunerated on the basis of that health-effectiveness; this means that it is quite reasonable to expect a nurse to be remunerated at a higher level than a physician if the performance assessment shows that, across the group of patients, his practice is more highly predictive of health-effectiveness than that of the physician in question. Each provider is enabled to do what she does best within a particular field, increasing morale, while an individual provider’s contribution to individual and group outcomes can be identified and excellence is re-

¹⁸ Leadership may be defined roughly as the ability to influence others socially to achieve a goal; it is distinct from manipulation in that the goal is commonly acknowledged.

warded just as easily as underperformance is penalised. The quality of the information derived for the purposes of participative medical governance also means that interference by professional lobbying bodies will be severely constrained by the evidence of health-effectiveness, meaning that providers can be dealt with as proper employees carrying out a job that is specified in terms of performing a health-effective medical service to the public—with the sanctions consequent to underperformance.

Finally, any system that intends to foster a culture of public service and collaboration must be experienced as just. Each of the factors cited also promotes a sense of justice in both the public and the providers. The methods in patient-centred medicine and participative medical governance entail mechanisms that facilitate each of the three identifiable forms of justice (Vardi and Weitz, 2004):

1. distributive (relating to the perception of equity in the reward system of an organisation)
2. procedural (relating to the perceived equitability of organisational policies)
3. interactional (relating to the quality of interpersonal treatment by individuals with authority).

With common goals and methods applied equally, it is possible to create a coherence in service, a sense of integration, of equity and justice, and, consequently, a culture of public service where everyone is either pulling in the same direction of health-effectiveness or it is publicly evident that they are not, with its just consequences. From this, where providers can *show meaningful evidence* that they are trustworthy (rather than just claiming it through expenditure on public relations), a less naïve and more empowered form of public trust in medical services can grow.

General Analysis

The value of any model lies not in how well it functions under good conditions but in what happens when something goes wrong—and that is most often due to human factors. This focus on robustness to human factors is one of the strengths of the model. Although it requires a significant re-organisation of the elements of services as well as the relations between the professions, given that it is evidentially in the public's best interests, it would be difficult for any profession to object to this without its members being shown to be self-serving. With the the system implemented, there are also inherent mechanisms to identify passive-aggressive forms of malfeasance, such as sabotage, whether it is individually or as a team: indeed, the model is designed specifically to be resilient to weaknesses in the human character such as narcissism and to minimise the effects of such.

A weakness in almost all proposed solutions to systemic problems is that they are simple answers to a complex problem: the solutions tend to address only isolated elements of a system and the solutions proposed are rarely if ever crash-tested against human factors. When the implementation of those simple solutions encounters further problems in

CONSULTATION VERSION

the system and there is no ability to stand back and analyse the problem as a complex whole, it leads to increasingly frantic efforts that end up doing little but destabilising the system by 'boiling' it and exacerbating its dysfunction while leaving core-problems untouched. This has been seen for over a quarter-century in the British NHS, where government and more proximal administrators have introduced changes that are ill-conceived, poorly thought-through, and which are replaced by yet other changes before there has been a chance to assess the first changes properly. This has served only to aggravate professional balkanisation and the struggles for dominance between professions, goals, and methods. The only effective solution is to analyse the system as a whole, to re-engineer it from the centre out—holding nothing but health-effectiveness sacred—and to develop adaptive sub-systems to cross-brace any weaknesses discovered during robustness-testing if those weaknesses can not be eliminated altogether¹⁹. This is how this model of participative medical governance came about.

There is no evidence for the model proposed here as a whole, since the model—as a whole—has not been put into effect. Another way of looking at this is that the model has more evidence of health-effectiveness than the current model of physician-centred practice, which has none, as there have been no randomised, controlled trials (RCTs) of physician-centred vs. other forms of practice, and there is no evidence against the new model, unlike the ample evidence for the *ineffectiveness* of physician-centred practice (as in chronic illness treatment). However, it is not reasonable to say that just because A has no RCT-evidence, therefore B (which also has no RCT-evidence) will be equally or more effective, and to say that B is the lesser of two evils is hardly an adequate recommendation.

Therefore, the above statements should be clarified: while there is no evidence for the proposed model *as a whole*, there is ample evidence for identified elements of the model achieving its stated purpose; for example, both integrative practice-models and rationalised provider-roles (such as nurse-led practice) are in line with extensive evidence with many millions of patients (cf. Cummings 1997). Furthermore, the model's elements have been predicated on scientific evidence of health-effectiveness and patient-centredness, then individually and jointly rationalised, and then integrated to form a system—i.e., a coherent whole, the sum of which is greater than its parts, which is adaptive and self-correcting with multiple forms of feedback and layers of cross-control, all of which rely on a consistent, common foundation: a horizontal, team-based, biopsychosocial practice-model using a comprehensive assessment of illness-status, by which health-effectiveness, treatment-delivery, and provider-performance are evaluated in a scientifically valid manner to produce information of high quality for participative medical governance that is robust to human factors. The Bristol Inquiry explicitly validated such a systemic method but it did not actually use it; the model proposed here does. It can be tested through the analysis of each of its components in reference to the local outcomes expected from each sub-region of the model (e.g., administrative competence), as well as in reference to the outcomes expected of the model system as a

¹⁹ A preferred analytic technique for analysing the behaviour of complex systems such as medical services is Systems Dynamics Analysis (Coyle, 1996); software that can be recommended in particular includes STELLA and iThink (www.iseesystems.com), which can be used for both qualitative and quantitative analyses within a logical-analytic framework and requires little specialist training.

CONSULTATION VERSION

whole (i.e., individualised health-effectiveness). Still, while cogent reasoning underlies this model of participative medical governance and the failure of alternative models is clearly evident, scientific research is needed on the implementation and tuning of the model as it is not a simple, reductive framework.

An anticipated criticism is that this system might cause excessive administrative burden. Firstly, this concern reflects an assumption that the currently-used processes are efficient in some way, which they are clearly not, so a perception of burden is certainly biased due to a lack of valid comparators by which to judge it—and one always prefers the devil one knows, but especially so if one doesn't know quite how much of a devil it is. It would seem obvious that, if the system here were superimposed on the current system, it would be enormously burdensome, but much of the current system's administrative burden can be dispensed with. In current approaches, medical governance is not embedded in the very process that it is supposed to protect—the patient's treatment—and the currently-used methods are highly dependent on providers' goodwill; it is a task given over to administrators who have little idea of what medicine is, what public participation can achieve, how health-effective services are best delivered and best measured, it relies on separate sources of funding, and it relies on participative medical governance to be created through purely administrative means, which have so far neutralised it by, for example, delegating it to unskilled and powerless junior staff. In contrast, this model of participative medical governance focuses on exclusively medical, not political or administrative, processes. By integrating participative medical governance this way, it means also that it can not be shunted aside by political or financial issues in the future, because it is part of medical practice. Therefore, this would not mean an increase in administrative burden but feasibly may mean a substantial reduction in it: both the administrative and financial burdens can be significantly reduced as efficiency through health-effectiveness increases.

An example of the implicit efficiency of the system is in the front-loading of the system by the patient-centred assessment; such patient-centred, biopsychosocial models as the one presented here require patients to take part actively in their treatment and recovery; this involvement is supported scientifically in terms of health-effectiveness and it is a necessary part of case- and treatment-formulation. Exclusion of patients from choices about their treatment is prevented by the method of collaborative case-assessment and formulation prior to diagnostic work-ups. This means, among other things, that participative governance does not have to suffer from the burden of democratic representativeness of frangible social groups, avoiding the allegorical problem of the partially-sighted heterosexual man with a stroke-related neuromuscular disorder and HIV who demands separate representation from the partially-sighted lesbian with a stroke-related neuromuscular disorder and HIV, all in the name of representative democracy. If a clinic is providing services to 60 sociomedical sub-groups and the data on medical outcomes show that the services are not health-effective in one group, then, regardless of which group that may be, this needs to be addressed but it does not require 60 representatives to sit on a participative medical governance-group. It is, indeed, necessary to have everyone's views represented in terms of determining the health-effectiveness of medical outcomes and the views of each patient from every possible group are already included in their personalised, participative treatment-plan and outcome-benchmarking. As long as there is ade-

CONSULTATION VERSION

quately participative medical governance where the evidence on performance is used to protect others' medical interests, then that is enough. A further example is that there is no need to gather the perceptions of children in their treatment other than in how it is health-effective. If the colour of a ward's walls means that their medical outcomes are better, then that is about health-effectiveness, not political ideologies of a child-led NHS. No medical system can afford to meet consumers' wishes over patients' medical needs.

Another criticism may be that the proposed model seems rather mechanical and objective, not actually reflecting the personal needs of patients. The reality is to the contrary: person-centred medical outcomes require the good treatment of the person as well as their illness and health-effective practice means practice that helps patients feel motivated, engaged, trusting, and skilled. This means that treatment and its outcomes must be meaningful and motivating to the individual patient, otherwise one falls into the logical fallacy exemplified by "the surgery was successful but the patient died" as well as problems with irrelevance, non-adherence, late presentation of illness, and patient-irresponsibility. It also dispenses with methodologically problematic and scientifically questionable measures such as 'patient-satisfaction' that are, at best, useful for public relations. Nevertheless, the model here does not prescribe the finer details of the model of person-centred medical practice; it leaves these details to another paper and for further scientific development, while also preventing rigidity in future medical practice. However, the adequacy of the model relies on the quality of the performance-assessment methods, which is a concern as the methods used to assess quality of provider-performance, particularly 'technical skills', are notably difficult to assess in real-time. This is a crucial link in the system and points out the importance of scientifically-developed, valid methods of patient- and provider-assessment if this model is to succeed.

It is also unlikely that this model might increase litigation, even though it creates excellent and publicly available evidence about the performance of named individuals and their responsibilities. Inadequate prudence about patient-safety is identifiable in specific clinical and administrative behaviours and is detected in performance-audit, analyses secondary to specific concerns raised (pseudonymously) by patients or by colleagues as part of 360-degree assessment, and by the analysis of data for the purposes of patient-centred risk-management. Consequently, sub-standard performance is identified early, it is remediable early, the necessary actions to remediate it are clear, and most of the motivations towards litigation are addressed early through liaison with the PMG-groups. Litigation is mostly about revenge, creating change, or getting compensation for increased hardships that can be expensive to the patient. In the instance that there is no actual case to answer for—as where a patient is psychotically unhappy and attributes this to his service-providers—the evidence as to the specific efforts in the case of the individual and the results for other people in the same situation should identify where treatment can be more health-effective, which is different from substandard. On the other hand, if, in fact, there has been a criminal event due to incompetence or discrimination²⁰, then this is clearly identi-

²⁰ an example is where gay men are uniquely barred from reproductive services due to a "need for child-protection" but told to go to buy the services privately in Spain "where they don't ask so many questions"; this example of illegal discrimination occurred at the Chelsea and Westminster Hospital, London.

fied and the clinician is motivated to remediate and settle early, reducing administrative waste through bodies such as the NHS Litigation Authority. However, the incidence of such events will be lower (through performance-assurance by participative medical governance and consequent shifts in culture) and there will be more money available because it is not being wasted through health-ineffective and cost-ineffective service.

Consequences of this model of Participative Medical Governance

This model of participative medical governance provides a robust, systemic solution to the problems identified in the Bristol Inquiry and elsewhere. However, it requires the following 10 obstacles to be surmounted before it can be implemented nationally:

1. The development of methods of a comprehensive, patient-centred assessment of illness-status, by which also to measure the health-effectiveness of services
2. The development of methods to assess the performance of clinical and/or administrative providers during treatment, in order to measure the health-effectiveness of service and to identify providers' relative contribution to medical outcomes
3. The training of nurses to understand and deliver comprehensive assessment for the purpose of case-formulation and -management and to implement patient-centred practice within this framework
4. The specification of the types of data-analyses that need to be done in order to deliver information useful to medical governance
5. The development of standardised and automated methods to analyse and translate data into meaningful evidence of the quality of medical practice
6. The development of efficient data-management methods
7. The implementation and analysis of fully patient-centred, biopsychosocial medical services
8. The implementation of participative medical governance to apply this data in daily governance
9. An analysis of how participative medical governance-groups use this information, so as to ensure that it is used as health-effectively as possible
10. A comparison of this form of service with the current, physician-centred model in terms of health-effectiveness and cost-effectiveness, as with a randomised, controlled trial

CONSULTATION VERSION

Most of these elements have already been developed to some degree or have well-established precedents: some are developed but insufficiently, some need to be ported over to the context in question (e.g., data-analysis), some simply need to be deployed. Additional elements that would consolidate the gains in this model include:

1. commissioning of medical training that includes all clinicians and medical administrators, with the development of common areas of basic training
2. the application of participative medical governance to the admission-process for clinicians and administrators to medical school, to curricula for initial and continuing education, and to translational research systems
3. a national expansion of this model on the basis of its proof of effectiveness
4. funding for an independent body for the representation of the public's medical interests to oversee the functioning and integration of this system of participative medical governance nationally and to create links throughout all gradations of the governance-network

The principles of this model are applicable to more than clinical services alone; as noted, they are equally and directly applicable to 'social care' and other community-based medical services. This model has also been used already as the basis for the framework of public participation in scientific research and its governance that the author designed in 2009-10 for the national research-capability programme on translational medical science for the British National Institute of Health Research (Whitaker and von Hildebrand, 2009). It is a flexible and highly adaptive model that should be applicable to a broad range of public services that require accountability and effective delivery in the public's interest.

Acknowledgements

In writing this paper, the author gratefully acknowledges significant benefit from discussions with the following: Professor Max Heirich (University of Michigan, USA), Dr. Martin Green (English Community Care Association, UK), Dr. Ford Hickson (Sigma Research, UK), Professor Jim Wiley (San Francisco State University, USA), Professor Jacqueline Gahagan (University of Dalhousie, Canada), Professor Claus Vögele (Roehampton University, UK), the late Professor Janet Askham (Picker Institute), and Ms. Maria von Hildebrand (formerly Shortis; Dept Health UK).

References

- Banja J (2005): *Medical errors and medical narcissism*. Jones and Bartlett.
- Bar-Yam Y (1997): *Dynamics of complex systems*. Westview Press.
- BBC (2009): Calls for death hospital inquiry. Available 09.04.09 at: news.bbc.co.uk/1/hi/england/staffordshire/7958202.stm
- Bodenheimer T, Wagner FH, Grumbach K (2002a): Improving primary care for patients with chronic illness. *JAMA*, 288, 1775-9
- Bodenheimer T, Wagner FH, Grumbach K (2002b): Improving primary care for patients with chronic illness: The chronic care model, Part 2. *JAMA*, 288, 1909-14.
- Bowling A (2001): *Measuring Disease*. 2nd edition. Open University Press.
- Chisholm A, Askham J (2006): What do you think of your doctor? A review of questionnaires for gathering patients' feedback on their doctor. Picker Institute Europe. Available at: www.pickereurope.org/reports
- Chisholm A, Redding D, Cross P, Coulter A (2007): Patient and public involvement in PCT commissioning: A survey of primary care trusts. Picker Institute Europe. Available at: www.pickereurope.org/reports
- Clarke S, Oakley J (2007): *Informed consent and clinician accountability: The ethics of report cards on surgeon performance*. Cambridge University Press.
- CMO (2007): The Expert Patients Programme. Department of Health, UK. Available 09.04.09 at www.dh.gov.uk/en/Aboutus/MinistersandDepartmentLeaders/ChiefMedicalOfficer/ProgressOnPolicy/ProgressBrowsableDocument/DH_4102757
- Coulter A, Ellins J (2006): Patient-focused interventions: A review of the evidence. Picker Institute Europe. Available at: www.pickereurope.org/reports
- Coyle RG (1996) *System dynamics modelling: A practical approach*. Chapman and Hall/CRC.
- Cummings NA (1997): Behavioral health in primary care: Dollars and sense. In Cummings NA, Cummings JL, Johnson JN (eds) *Behavioral health in primary care: A guide for clinical integration*. Psychosocial Press.
- Cummings NA (2001): The history of behavioral healthcare: A perspective from a lifetime of involvement. In Cummings NA, O'Donohue W, Hayes SC, Follette (eds), *Integrated behavioral healthcare*. Academic Press.
- Davies M (2007): *Medical self-regulation: Crisis and change*. Ashgate Publishing.
- DoH (1998): *A First Class Service: Quality in the new NHS*. British Department of Health publication available at www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4006902
- DoH (2003): *Strengthening Accountability*. Gateway Ref. 938. British Department of Health publication available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/publicationspolicyandguidance/DH_4008005
- Dyer C (2001): Bristol Inquiry condemns hospital's "club culture". *British Medical Journal*, 323, 181. 28th July 2001.
- Erdmann MD, Lundmann RJ (eds; 2002a): *Corporate and governmental deviance: Problems of organizational behavior in contemporary society*. 6th edition. Oxford University Press.
- Erdmann MD, Lundmann RJ (2002b): Corporate and governmental deviance: Origins, patterns, and reactions. In Erdmann MD, Lundmann RJ (eds; 2002): *Corporate and governmental deviance: Problems of organizational behavior in contemporary society*. 6th edition. Oxford University Press.
- Frank-Stromborg M, Olson S (eds; 2004): *Instrument for Clinical Health-Care Research*. 3rd Edition. Jones and Bartlett Publishers.
- Heirich M (1998): *Rethinking health care: Innovation and change in America*. Westview Press.
- Hogg C (2007): Patient and public involvement: What next for the NHS? *Health Expectations*, 10, 129-138.
- Keane J (2009): *The life and death of democracy*. Simon and Schuster.

- Kennedy I (2001): Learning from Bristol: the report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984 -1995. Department of Health. Command Paper: CM 5207 Published by the Bristol Royal Infirmary Inquiry, July 2001. Available at www.bristol-inquiry.org.uk and at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005620
- Kovner AR, Knickman JR (2008): Jonas and Kovner's Health care delivery in the United States. 9th edition. Springer Publishing Company.
- McDowell I, Newell C (1996): Measuring health. 2nd edition. Oxford University Press.
- Minkler M, Wallerstein N (2008): Introduction to CBPR: New issue and emphases. In Minkler M and Wallerstein N (eds; 2008): Community-based participatory research for health: From process to outcomes. 2nd edition. Jossey-Bass.
- Nadler A (2010): Interpersonal and intergroup helping relations as power relations: Implications for real-world helping. In Stürmer S, Snyder M (eds; 2010): The psychology of pro-social behaviour. Wiley-Blackwell.
- Pleming N (2005): Kerr/Haslam Inquiry Report. Department of Health. Command Paper: CM 6640. Available at www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4115349
- Pollock A (2004): NHS plc: The privatisation of our health care. Verso Books.
- Porter R (1999): The greatest benefit to mankind: A medical history of humanity from antiquity to the present. Fontana Press.
- Redfern M, Keeling JW, Powell E (2001): Royal Liverpool Children's Inquiry Final Report. Available at www.rlcinquiry.org.uk/download/index.htm
- Scottish Government (2007): Better health, better care: Action plan. Available at www.scotland.gov.uk/Publications/2007/12/11103453/9
- Strosahl K, Sobel D (1006): Behavioral health and the medical cost offset effect: Current status, key concepts and future applications. HMO Practice, 10, 150-55.
- Thompson DF (2005): Restoring Responsibility: Ethics in Government, Business, and Healthcare. Cambridge University Press.
- van Leeuwen E, Täuber S: (2010): The strategic side of out-group helping. In Stürmer S, Snyder M (eds; 2010): The psychology of pro-social behaviour. Wiley-Blackwell.
- Vardi Y, Weitz E (2004): Misbehavior in organizations: Theory, research, and management. Lawrence Erlbaum Associates.
- Wagner EH, Austin BT, Davis, C, Hindmarsh M, Schaefer J, Bonomi A (2001): Improving chronic illness care: Translating evidence into action. Health Affairs, 20 (6), 64-78.
- Whitaker R (2009a): The Tuke Institute's framework for participative medical science and policy. Tuke Institute Briefing Edition 0907-BR1.1. Available at www.tukeinstitute.org
- Whitaker R (2009b): Difficult doctors, sick doctors: Behavioural forensics in clinician misconduct and malpractice. Your Witness, March 2009, pp. 40-41
- Whitaker R (2010a): 'Medicine', 'healthcare', and 'doctors': Mislabelling and medical progress. Tuke Institute Briefing Edition 1004-BR1.1. Available at: www.tukeinstitute.org
- Whitaker R, Vögele C, McSherry K, Goldstein E (2006): The experience of long-term diagnosis with human immunodeficiency virus: A stimulus to clinical eupraxia and person-centred medicine. Chronic Illness, 2, 311-20.
- Whitaker R, von Hildebrand M (2009): Use of patient date: Exploring Public Participation in Research. Invited presentation, Patient Partner North-Western European Regional Workshop, London. 12th October, 2009.
- WHO (1946): Preamble to the Constitution of the World Health Organization as adopted by the International Health Conference, New York, 19-22 June, 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
- WHO (2001): International Classification of Functioning, Disability and Health: ICF. World Health Organization.
- WHO (2009): The International Statistical Classification of Diseases and Health Related Problems: ICD-10. 2008 edition, 10th revision, volumes 1-3. World Health Organization.