The University of Hull

Critical systems thinking, dialogue and quality management in the National Health Service

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by

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Summary

Critical systems thinking, dialogue and quality management

in the National Health Service

by Michael P. Walsh

This thesis considers quality in the National Health Service (NHS), the theories of dialogue, critical systems thinking, and quality - and how these domains can be related together to produce a new concept of quality called critical quality.

A quality gap is identified between what the NHS produces and what the public requires of it. It is argued that this gap is unfair because of the generally unequal access of stakeholders to decisions about quality in the NHS. It is suggested that only through dialogue can the gap be reduced in size in a non-oppressive way.

Principles of dialogue are derived from Habermas's (1991a,b) theory of communicative action and applied to interest group relationships using Grant's (1989) insider/outsider model. It is argued that critical systems thinking can be enhanced by embedding interventions within processes of dialogue, and that the analysis of insider/outsider relationships in situations can guide the use of critical systems thinking in creating dialogues.

Three modes of quality management are identified (strategic, normative and critical). It is argued that the requirements and needs of the public cannot be met by an NHS that is dominated by strategic and normative quality. Instead critical quality, defined as the specification of services by mediation through dialogue between stakeholders, is advocated as a fairer mode of quality management for the NHS.

An NHS quality dialogue (the Trent Quality Initiative) is evaluated. Dialogue is found to have occurred both within and between meetings. Two modes of peer group participation are identified (main dialogue vs meta-dialogue) and two general approaches to the implementation of critical quality in the NHS (incremental vs radical). Finally critical quality in public welfare services is discussed and a research agenda outlined for dialogue, quality and critical systems thinking.
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The truth is often sluiced by farce
Dr Madsen Pirie (1988), spell checked typo, seems better than the original.
Chapter 1

The aims and structure of the thesis

In this thesis I address the problem that there is a gap between the quality of what the National Health Service (NHS) provides and what individuals and collective members of the public want from it. My main aim is to provide guidelines for the creation and conduct of dialogue on quality issues in the NHS, between it’s users, purchasers and providers, and show how this may reduce the quality gap systemically, systematically and above all fairly. These guidelines are based on developments in critical systems thinking and are intended to create the conditions for the achievement of what I shall term critical quality. To do this I will derive the principles of dialogue from Habermas's (1991a, 1991b) theory of communication action, analyse the potentials for dialogue between individuals and collective actors in a variety of situations, discuss how the communicative element of critical systems thinking may be enhanced, analyse various modes of quality management, and finally evaluate a practical research project on quality dialogue in the National Health Service (Gregory, Romm and Walsh, 1994). Consequently the thesis widens the scope for the practical application of critical systems thinking to issues in the public and private sectors of health and social care. In the following sections I will describe the aims and content of the succeeding chapters but first I will give an overview of methodological aspects of the thesis.

Throughout the thesis, so that the main argument remains as direct as possible, strands of complimentary discussion are explained in notes and appendices. All
quotes include the original emphasis unless otherwise stated. Because the works of Jurgan Habermas are often published in English years after they were first published in German I have included in appendix ‘A’ a chronology of all his texts cited in the thesis. In this way I hope to avoid confusing readers when I cite references with conflicting dates.

1.1 The aims and content of chapter 2
My aim in chapter 2 is to identify the gap in quality between public requirements and National Health Service (NHS) provision, explain it in terms of social, political and cultural diversity, and explain why this gap is unfair. I will suggest that the NHS should be managed in a way that will tend to reduce the size of this gap in a fair way.

I will define the concept of a ‘quality gap’ in terms of a hypothetical map, on which can be drawn boundaries around the ‘requirements’ that the NHS might be called upon to fulfil, and the requirements that the NHS arguably attempts to fulfil. By requirements I mean all the possible types and specifications of service that the NHS might be conceivably called upon to provide by members of the public, experts, academics, politicians and so on.

I will support the notion of a quality gap by showing that there are many alternative socially, politically and culturally influenced views about the nature and means of delivery of NHS services. Fundamental political differences are briefly touched upon which have massively influenced the structures and function of the NHS. I will argue that changes to the NHS in the 1980s have not led to full commercial privatisation, despite the Conservative Government’s
commitment to markets and executive autonomy, because of the influence of powerful public norms that impose limits upon the way the NHS can be managed. I will also argue that there are many kinds of health care services, practitioners and practices within and outside the NHS. I aim to show briefly that this political and cultural diversity often reflects fundamentally differing theories about the nature of health, illness, healing and medicine, and of practices based on these theories. I will argue that sometimes these differences emerge as inconsistencies of provision and practice of care in the NHS. However I will also argue that the NHS quality gap is not characterised merely by differences arising out of diversity and inconsistency but by fundamental inequalities which I define as unfair differences. I will argue that the NHS quality gap is partly constituted by certain unfair differences resulting from undemocratic management processes. I will propose that more equally accessible (or egalitarian) processes of management are required to reduce the size of the NHS quality gap in a non-oppressive way and that the exemplary process for this is dialogue between NHS users, purchasers and providers. The rest of the thesis develops the the theoretical and practical basis of dialogue and relates it to critical systems thinking, the management of quality and the pursuit of critical quality. In chapter 3 therefore I develop the theoretical ground of dialogue.

1.2 The aims and content of chapter 3
My task in chapter 3 is to set out why and how dialogue can underpin an egalitarian mode of NHS management which will tend to reduce the size of the NHS quality gap. To do this I will define dialogue as a special conditional process and identify the conditions for it to take place and the nature of the principles for action that these imply.
I will develop the theoretical ground of dialogue initially by explaining how Habermas's theory of communicative action (Habermas, 1991a, 1991b) developed from his earlier work on knowledge and human interests (Habermas, 1972). The theory of communicative action supersedes his earlier work by focusing on the critique of social action rather than the critique of knowledge. Habermas identifies five kinds of social action of which the fifth kind he terms communicative action. He argues that communicative action uniquely offers validity claims through all other forms of social action may be evaluated through debate. I will argue that this form of critique is inherently more accessible to the public. In particular I will identify what I view as the most practical, challenging and potentially useful elements of his theory - two fundamental conditions that can permit a minimally competent individual to engage in dialogue with other individuals and groups, and coordinate their actions on the basis of understandings. These are the ability to deny the validity claims made by another individual or group during acts of communication, and the commitment to respond to such challenges by redeeming any claims made. I will argue that these two conditions imply principles for the design and conduct of dialogue processes that can be expressed in terms of who may participate in a dialogue and how they may participate. Habermas's elucidation of the kinds of validity claims made during acts of communication forms a crucial step in defining how individuals may participate in dialogue and therefore I will discuss them in detail.

One of the most important concepts in the theory of communicative action is that of understanding. This concept has been subject to much criticism and debate and I therefore attempt to clarify a practical meaning for the nature of
understanding. I will argue that the only *necessary* understanding for participants to achieve in a process of dialogue, in order that participants may coordinate their actions in a mutually non-oppressive manner, is *agreement* over the *status* of the validity claims being made during the course of dialogue. i.e. over what claims have been made, challenged, successfully redeemed, and failed. I reject the notion that any further consensus (for example over 'truth') *necessarily* will emerge from dialogue but I accept that there is a possibility of consensus on other matters.

I will also argue that dialogue can work only with special arrangements because there is a constant threat to dialogue from strategically acting individuals or groups which I will illustrate by comparing *rational choice* and communicative action in terms of the *prisoner's dilemma*. I will also assess the postmodern viewpoint of dialogue typified by Baumann (1992). Nevertheless I will argue that the repudiation of *social engineering* by postmodernists is, *in practice*, tantamount to rejecting dialogue itself as a form of social organisation and will frustrate the (ironically universal) goal of postmodernists, like Baumann, which is to spread *moral subjectivity*. I conclude therefore that postmodernists must also consider how to make special arrangements for dialogue to occur between themselves and others who have different viewpoints - such as myself.

Finally I will suggest that the NHS quality gap is, as it stands, irremediably unfair unless special arrangements are made for widespread dialogues on the quality of NHS services. Therefore the conditions and principles of dialogue need to be developed further and operationalised in a practical way. The next chapter contributes to this operationalisation by explaining how the social action
potentials of groups and individuals may be analysed structurally with a view to making strategic preparations for dialogues.

1.3 The aims and content of chapter 4

The operationalisation of dialogue demands some consideration of the situations that individuals and groups find themselves in. So in chapter 4 I will show how a model of interest group relationships proposed by Grant (1978, 1989) can be modified in order that social action potentials and obstacles to dialogue between groups can be analysed.

Grant's model was limited to the analysis of forms of strategic action expressed in terms of insider and outsider relations with central Government. I will broaden Grant's model so that relations between any group may be analysed in terms of all kinds of social action. This requires that many of Grant's assumptions are carefully revised, in particular, the assertion that equitable access to the political decision making process would lead to inefficiency and political paralysis. In contrast I will argue that unequal access to decision making mechanisms is a principle cause of the unfairness of the NHS quality gap with the waste of resources such an unfair gap implies. Instead I will argue that public access to decision making through dialogue processes is a technical problem to which practical solutions can be found. Moreover I will argue that research into this problem is essential if creativity, diversity and opportunity are to be preserved and enhanced in the management of the NHS rather than diminished. Finally in this chapter I will carry out a brief insider / outsider analysis of the NHS both to illustrate the use of the enriched model and to gain some insights into the difficulties that need to be addressed if dialogues are to be created in the NHS.
The identification of conditions and principles for dialogue, and the analysis of social action potentials between groups, are not in themselves sufficient to bring about an NHS quality dialogue, nor equips participants in such a dialogue with the agenda, knowledge and tools to begin one. In the next chapter I will consider how critical systems thinking may contribute to filling this deficit by providing a critical methodological framework for systemic interventions aimed at creating dialogue.

1.4 The aims and content of chapter 5

In this chapter I intend to show how critical systems thinking (CST) can provide a rigorous framework for participants in an NHS quality dialogue to undertake creative thinking, choose from diverse options for coordinated social action, and manage the implementation of these options. I will do this in two ways. Firstly by discussing how critical systems thinking may harness diversity in the management and systems sciences, and secondly by assessing the communicative status of critical systems thinking.

Critical systems thinking remains a relatively new attempt to make critical and theoretically consistent use, in systemic interventions, of the abundant diversity of organisational perspectives. So I will begin chapter 5 by contrasting and comparing various theories of diversity of organisational perspectives that have impinged on critical systems thinking. In brief I review the paradigm theory of Burrell and Morgan (1979), Reed’s (1985) pluralistic theory, Gregory’s (1992) discordant pluralism (which comes from within the CST movement) and critical systems thinking’s main pluralistic theory which is termed complementarism. There are now two variants of the latter, one that I term Flood’s and Jackson’s
(1991) complementarism (based mainly on Habermasian theory) and Flood's and Romm's (1995) post-critical complementarism (which introduces aspects of postmodernism). I will review each of these theories in terms of their implications for the process of dialogue and choice of action.

The discipline of CST has always been committed more or less explicitly to conditions of ideal speech and communicative competence as part and parcel of its status as the application of critical social theory to problem solving. Indeed in this thesis I am attempting to enhance the communicative aspect of CST and bring the discipline more fully into what Habermas terms the communicative paradigm. However a recent development in CST, the oblique use of methods (Flood, 1995), has implications for dialogue that I will assess. Finally therefore I will discuss the relation between CST and dialogue and outline the elements of a dialogue framework for interventions drawing on the insider/outsider model developed in chapter 4.

1.5 The aims and content of chapter 6
My aim in chapter 6 is to show how limited and constraining are the existing notions of quality in manufacturing and service industries, and how the theory of dialogue can be used to criticise constructively the management of quality. I will do this by examining mainstream quality management approaches including the so-called 'Guru' methods, Total Quality Management and quality methods in the NHS. Three hidden meanings of quality are identified - strategic, normative and critical - and the implications and variations of these are explored. Their impact on the NHS quality gap is assessed.
1.6 The aims and content of chapter 7

In the seventh chapter I intend to show how dialogue processes can be operationalised and evaluated. Therefore I will begin by discussing the practical design and application of guidelines in a pilot study of dialogue on quality in the NHS in Sheffield (the 'Trent Quality Initiative' - Gregory, Romm and Walsh, 1994). I will evaluate the practical project in terms of the social action framework developed in chapter 3:

- Aspects of strategic success or failure of the dialogue: were the preconditions for dialogue satisfied? Chiefly: did dialogue occur during the Trent Quality Initiative?
- Issues of acceptability: to what extent were issues of acceptability raised in the dialogue and how were they dealt with?
- Issues of sincerity and genuineness: in what ways was sincerity challenged or claimed?
- Extent of communicatively coordinated actions: were any actions coordinated through dialogue?

I will use the framework to show how a meta-dialogue can be identified that participants were not generally aware of. I will argue that providing feedback about meta-dialogue will improve the efficiency of dialogue processes. I will also argue that meta-dialogue might also form an alternative mode of participation in dialogue. I will then assess two approaches to the implementation of critical quality that I term incremental and radical.

Finally in chapter 8 I will assess to what extent the original objectivers of research have been met, what contributions to knowledge have been made, and what
further research is suggested by the thesis on the development of critical quality in public services, the relationship between quality and risk, and the future development and application of critical systems thinking.

Now I have outlined the structure of the thesis I will clarify some of the methodological issues underlying it.

1.7 Methodological aspects of the thesis
A large proportion of the thesis is given over to discussing the question about how a fair hearing can be given to alternative public viewpoints given the potentially adverse influence of social and political conditions. My answer is to propose the process of dialogue. In making this proposal I have had to give thought to the method of analysis that I have employed at various stages of the research on which my thesis is based. Fortunately the analyses of Flood and Gregory (1989) and Flood (1990) provide a basic framework which has been used by Jackson (1991a) and Gregory (1992) with which to assess the methodological hinterland to this thesis as I will now explain.

The key difficulty faced by a researcher in giving an account of how an issue or idea came into being is summed up by Dr Madsen Pirie (1988, p3): 'The most difficult explanations to find are the ones no one is looking for' or, in other words, how do you know the explanation you have found is the right one and not some other explanation which you have no knowledge of yet? Flood and Gregory (1989) and Flood (1990), referring to systems science provide four answers to this. They argue that there are four approaches to explaining the emergence of a theory or method. The first approach is to describe and explain the development of the theory, or even more broadly an idea or situation, as a linear
chronological pathway. Logic is seen as sequential and therefore systematic inquiry leads like natural science, with the occasional serendipitous hop, to the accumulation of knowledge which grows ever more complete. This view is exemplified by Popper's (1979, ch.7) (biblical?) metaphor of a tree of knowledge that can both grow steadily and evolve Darwinistically. This kind of theory is implicit in the work of Jackson (1991a) and Reed (1992a) who both explain how theories and methods have evolved from the deficiencies of previous theory and methods.

Pirie qualifies this linear sequential view:

In our world truth is often silenced by force. Galileo is made to recant; heretical books are consigned to the flames, sometimes accompanied by their hapless authors. The more velvet-gloved force of modern times gives academic preference to those who toe the line, and denies it to others. Opinionated academics in positions of power advance supporters and sycophants and try to deny a hearing to those who would challenge the work on which a lifetime's career has been built.

Pirie (1988, p6).

At once Pirie (1988) has identified a key problem that some, perhaps all, ideas may be distorted by forces operating on them. This is a powerful theory that is discussed in chapter 3 drawing on the work of Habermas (1972, 1990, 1991a, 1991b). Nevertheless some ideas, true of false, 'win through' if the linear sequential approach is to be believed. Surely, it might be argued in a parody of Darwinistic natural selection, truthful ideas survive and false ones disappear?

Pirie (1988, p6) casts doubt:

It is true that some ideas did win through: these are the ones we know about. It is quite possible that other, true ideas did not: these are the ones we do not know about. We cannot say how many scholars failed to gain the position needed to develop and advance their ideas, or how many discontinued promising lines of research in order to be eligible for some temporal rewards.
We do know of some ruined by poverty or driven to suicide. We know of many cases in which powerful men were able to swing influence behind inferior ideas by successfully squeezing out better ones. The argument that the truth wins through eventually corrupts the Whig fallacy of history by assuming that the function of the past was to lead up to the present.

Pirie (1988, p6).

Truth is therefore not the inherent quality that an idea, theory, situation or event needs in order to survive, reproduce and prosper. An account of the emergence of the National Health Service (NHS), Habermasian theory, or critical systems thinking for that matter, then, cannot simply be a chronological table of events, inventions and innovations for that may overlook significant aspects of development. Therefore I will not give a simple history of the NHS. Instead I will suggest that the NHS can be seen as a rational political achievement and also the view that it is a product of social upheaval. I will do this to show that the current situation of the NHS may exist for reasons other than those commonly given.

Flood and Gregory (1989) review a second theory: structuralism. This theory states that there is some structural logic operating beneath the surface appearance (Flood, 1990, Jackson, 1991, Giddens, 1993) that may explain why some ideas succeed and others do not even come into being. Flood and Gregory (1989, p58) only identify two structural analyses of the 'systems paradigm': Cornock (1978) and Van Gich and Stolliday (1980). In the field of organisation studies Reed (1985, 1992a, 1992b) utilises Giddens (1984) structuration theory, which explains structures as the reflexive creations of the actions they produce, to explain organisations as central elements of modernisation but not to explain the emergence of management and systems sciences. The notion can be developed by considering the relations between individuals and groups in social action.
terms. This I will do in chapter 4 by modifying Grant’s (1989) insider / outsider model. Insider / outsider groups can be seen as structural sources of social actions, with potentials to act in particular ways with respect to other groups. This can lead to the domination of theory and practice in academic communities (Walsh and Gregory, 1994). There are other explanations to consider and one of these proposed by Flood and Gregory and deriving from Kuhn (1970) is that of 'world viewism'.

A 'world view' is characterised, as Pirie (1988, p7) puts it, by a 'community of interest' that forms and supports an idea perhaps under hostile conditions. They constitute a kind of intellectual pressure group and struggle over the years until the inconsistencies and inadequacies of the old paradigm become too great a burden. Then Kuhn (1970) argues that extraordinary science or, for Pirie (1988, p8), 'trail-blazing' politics, for a short time dominate until the new revolutionary paradigm is in place having sucked all that was worthwhile out of the old (Flood, 1990). Yet Pirie (1988) observes that Kuhn's model deals with the people who have the ideas and not the ideas themselves. The scientific revolution is in people's heads and therefore for Popper (1979) Kuhn's theory is inadequate as an explanation of the progression of scientific knowledge. As Flood puts it, world viewism is an interpretivistic theory of the 'progress' of positivistic knowledge (1990, P115). Pirie (1988, p9) argues that world viewism is an adequate theory of fashionable science, and of fashionable politics, but it does not explain how scientific theories become popularly acceptable or in other words how the new paradigm wins the grand 'battle for ideas' (Pirie 1988, p13). Moreover she disputes the presupposition inherent in world viewism that 'events will follow in the wake' of the 'victory' of ideas' (1988, p17), a notion she feels is exemplified
by Keynes famous remark that: '(m)admen in authority, who hear voices in the
air, are distilling their frenzy from some academic scribbler of a few years back'
(Pirie, 1988, p18). Pirie argues against this. In her opinion it is 'by no means
necessarily so that people in authority are the unwitting puppets of former
scribblers' and that it is the weakest assumption to suppose a link between 'the
intellectual victories and the practical ones' (Pirie 1988, p18).

Pirie does not entirely accept either the linear-sequential or world view theories
of emergence and therefore she proposes a 'public choice theory' of a 'political
market' to explain the predominance of ideas. Pirie's (1988, p71) approach (which
is in the tradition of Adam Smith (1910) requires an analysis of 'public choices' -
strategic, selfish, utility maximising action - at various moments of history. Her
public choice theory is explicitly based on the principle from economics that
'people act to maximise their advantage' (Pirie, 1988, p71). In Dunleavy's (1991)
terms it is a political economy approach. Although Pirie is concerned with local
or government policy her proposal has wider currency: a Pirian 'political market'
analysis of the emergence of an idea would focus on acts of selfishness amongst
the powerful. This would explain the dominance of some ideas rather than
others because of political market forces in which truthfulness offers no special
advantage.

However, the Habermasian theory I will develop in chapter 3 and 4 shows that
strategic action is just one of several kinds of social action. Where in Pirie's
analysis one only looks for micropolitical processes of selfishness, there are
certain other forms of action (normative, dramaturgical, communicative) and
structured circumstances (insider/outsider groups) that have also to be accounted
Pirie (1988, p129) acknowledges certain factors like those of 'tradition' and 'entrenched interest groups', which hint at an awareness of the potential for normatively regulated action, but she chooses to focus solely and simplistically upon strategic action and the selfish 'market of politics'. Consequently the Pirie model can only explain one aspect of the emergence of ideas. In contrast, the enriched insider/outsider model offers more detail of political structures and forms of action that can enhance or supplant linear-sequential and world view explanations. However there is one other approach to the emergence of theories, ideas and situations that Flood and Gregory (1989) and Flood (1990) refer to: Foucauldian genealogy.

Genealogy is an approach that effectively treats all ideas, issues, and situations as stories. Consequently knowledge of an event, a situation, an issue, or an idea is carried by language in a 'discursive formation' (Flood, 1990, p115). The domination and ascendancy of any particular idea is therefore due to the supreme inner micro-power of a discursive formation exerted over the inferior power of lesser formations. Knowledge and power are inextricably linked and so a dominating knowledge is congruent with dominating power. Discursive formations crisscross in 'living' networks of domination and subjugation. Truth is no longer an external virtue by which an idea can be judged but is simply a label given to some discursive formations. This label is 'not a timeless and essential secret, but the secret that they have no essence' (Foucault, 1984, p78) because that which is called 'true' dominates by exerting superior power rather than by superior reason. It is possible though to go back and 'read' discursive formations, especially but not solely in documents, and to see the points at which they begin to dominate or were subjugated, and to see the evidence of correcting
and rewriting as formations succumbed or triumphed (Foucault 1971 pp 145-172). Through this a genealogical tree can be written that charts the flux and wane of discourses in generating what is in being today. If this approach had been adopted this thesis would look quite different. Interestingly it remains unapplied to the domain of systems science. As Flood and Gregory (1989), Flood (1990), Jackson (1991) and (Gregory, 1992) each point out at a different chronological point, no one has yet attempted the massive task of exploring all the writings that branch backwards from the moment of ascendancy enjoyed by critical systems thinking. Flood (1990) attempts a systematic integration of Foucauldian and Habermasian methodology to produce a new meta-paradigmatic perspective that he calls 'liberating systems theory' which is a development of the critical systems thinking paradigm. As such Flood attempts to explain the emergence of systems thinking by drawing upon the four approaches to emergence as theoretical elements of a meta-approach legitimated by his complementarist perspective in which he seeks to liberate and critique knowledges. For example, Flood (1990, p120-130) undertakes an ideological liberating discourse of resistance to the subjugation of General Systems Theory but not, despite his overall Foucauldian theme, a genealogy of critical systems thinking.

However, as Gregory (1992) points out, it is not clear that this approach offers a better account than any of other three. Rather it would offer a different explanation of the emergence of theory and practice. Moreover the poststructural / postmodern theory that has grown rapidly in recent years threatens to privilege language over other important elements of social life as Hughes (1992) points out.
Each of these approaches can offer only a partial approach to the discussion of ideas. I will be using the insider / outsider model (developed in chapter 4) at various moments in chapters 5, 6 and 7 to give accounts that apply elements of linear-sequentialism in the description of evolving situations, structuralism in the description of the pattern and regularity of relations between and within insider / outsider groups and world viewism as one or other group is seen to dominate.

Another methodological aspect of the thesis is that it is inevitably heavily influenced by the work of Jurgan Habermas. His theory follows what Popper (1979) terms the 'traditional western' philosophical split between mind and body. Arising out of this dualism is the phenomenology in which the human ability to act (centred in the ego) is separated from the physical apparatus with which actions are carried out - the body. This is problematical and has led to all manner of debates such as that between 'foundationalist' (belief in universal truths) / anti-foundationalist (nothing is universal) schools of philosophy reviewed by Flood (1990). In chapter 3 I discuss Habermas's theory in some depth but I am not attempting a comprehensive philosophical critique of Habermas or his critics - those are listed in the references!

The thesis to some extent tests Habermas's theory of communicative action (1991a, 1991b) heuristically and empirically which are processes he regards as characteristic of what he terms 'reconstructive science' (White, 1988, p130). This has been challenged as not being science at all (Alford, 1985) which is a fair comment if the term science is reserved for the belief that through 'scientific method' (such as that evinced by Popper) truth accumulates in hops, skips and
jumps either through a growing tree of knowledge (Popper, 1979, pp 256-285) or through 'scientific revolutions' (Kuhn, 1970). The key to Habermasian theory is what he terms the lifeworld. The lifeworld is a sociocultural 'cognitive reference system' (1991b, p136) which consists of symbolic structures 'reproduced by way of the continuation of valid knowledge' - a taken-for-granted background to everyday life which is continually revised and refreshed during social interaction. Central to this process of cultural reproduction is 'communicative action which serves to transmit and renew cultural knowledge' (Habermas, 1991b, p137). Given this view, theory and observation can never be value neutral, and objectivity is intersubjective. In other words a key assumption of this thesis is that all theory has been constructed from a background full of social influence and interaction that also influences observation - such a view is increasingly common in organisational sociology / behaviour (e.g. Reed and Hughes, 1992; Tsoukas, 1994) and in debates about important social variables such as quality (Flood, 1993) and risk (Pidgeon, Hood, Jones, Turner and Gibson, 1992). Therefore no inquiry can ever be regarded as anything other than a partial view and all conclusions are tentative or contestable not simply as to whether the 'experiment' has been conducted appropriately, but also as to whether the concepts represent something other than what is given.

While this means Popper's tree is somewhat wilted, and Kuhnian revolutions are not they appear to be (see chapter 5), there is still a task of logical discussion and empirical observation to be undertaken. Accordingly the heuristic test of the theory of communicative action is in the degree of coherence and logical applicability of Habermas's theory when, following critical discussion and suitable qualification, it is used to illuminate other fields of inquiry. In this thesis
this is done by discussing the background to, and development of the theory of communicative action in chapter 3. Then in chapter 4 I apply the theory of communicative action to enrich Grant's (1989) model of pressure group relationships. The enriched model has been applied elsewhere to model a variety of human situations including that of terrorism in Northern Ireland and the problem of paradigm incommensurability in the systems sciences (Walsh and Gregory, 1994). Habermas's theory is also applied to the analysis of the communicative status of critical systems thinking (chapter 5) and it used later to differentiate various modes of quality management (chapter 6). Secondly Habermas's theory has been empirically tested to some extent during the Trent Quality Initiative (Gregory, Romm and Walsh, 1994). I review this practical project in chapter 7. The empirical categories are derived from the theory of communicative action and are outlined in chapter 7 (paragraph 7.1).

Finally the practical project discussed in chapter 7 employed the premises of action research (Gill, 1975; Jackson, 1991), by involving researchers and participants in a learning exercise, in which the participants were making decisions about the agendas of subsequent research meetings. The goal of the project was to create a dialogue between NHS users, purchasers and providers in which the participants would be able to 'generate increased understanding as well as enriched conceptions of possibilities for action' (Gregory, Romm and Walsh, 1994, p14). I will be enlarging upon the role of dialogue in the project and of the project findings for the process of dialogue in chapter 7. The thesis opens then in chapter 2, with a discussion about the NHS quality gap.
Chapter 2

Diversity, inequality and the National Health Service

The following policy question is central to this thesis: how should the National Health Service (NHS) be managed? In this chapter I will argue that there is often an unfair gap in quality between what the National Health Service (NHS) provides and what is often required by the British public both individually and collectively. I will further argue that the NHS should be managed in a way that will close the quality gap systematically and systemically. This, I will suggest, cannot be achieved fairly in a narrow, expert, monological way but only through a widespread series of public dialogues.

I will approach this task by highlighting the diversity of the politics of the NHS, of beliefs about the nature of health, illness, disease and healing and some of the inconsistencies of professional practice in the NHS. The implications of such diversity and inconsistency of health care in the United Kingdom can begin to be revealed by an hypothetical mapping of perceived requirements and identifying ethical and technical boundaries in service provision. The difference between what is provided and what is required I will term the NHS quality gap. I will argue that this throws into relief aspects of inequality that need to be addressed in NHS quality management if there is to be a fair provision of services to the public.

I will begin however with an appreciation of some of the background and vital statistics of the NHS as it currently stands.
2.1 The National Health Service in the 1990s

The NHS is not an easily described institution. Simply in terms of size it is unique: it has been called the largest European employer since the disbandment of the Warsaw Pact (Ellis and Whittington, 1994). In one form or another it pervades virtually every part of the United Kingdom providing all residents, visitors and travellers with access at least to emergency medical care through accident and emergency departments. General Practitioners (GPs) offer primary care services to registered patients, (and visitors who register as temporary patients), and there are few communities that do not have a GP surgery located within a few miles. The NHS provides hospital and community health care although local social services now have the main responsibility for providing continuing care in the community for those individuals with permanent disabilities and infirmities.

Although NHS users have always borne some of the costs of using services (for example patients are not compensated by the NHS for lost work or leisure time) the NHS remains largely free at the point of delivery. The most common charge (which is by no means insignificant) is for prescribed medicine obtained from pharmacies. The NHS is the second largest public expense after Defence spending with a budget of some £32 billion per annum (Robertson, 1994, para 20/2) of which more than half goes on salaries for its more than 800,000 employees (Department of Health, 1992d, and see Robertson, 1994, para 19/6). NHS hospitals, clinics and surgeries offer and create local employment. Consequently the NHS not only redistributes wealth from richer people to poorer people by making services accessible at lower costs it also a major redistributor of wealth around British communities.
The structure of the NHS has altered several times since it was formed in 1948. The current structure is given in Figure 1. From 1989 the NHS has been increasingly based upon the separation of purchasers, providers and users of NHS services (Department of Health, 1989b) and this change is now virtually complete. The NHS reforms were intended to create an *internal market* for health services. In this market NHS *purchasers* (the Health Authorities and ‘fund holding’ GPs), NHS *providers* (meaning NHS Trust hospitals, community, ambulance and other NHS trusts and non-NHS providers) and NHS *users* (or ‘patients’) act *strategically* with respect to one another.

Figure 1: The structure of the National Health Service from April 1995, based on The Health Services Year Book, 1994, p.xii

The meaning of *strategic action* I will explore in great detail in chapter 3 but in practice it means that NHS purchasers are supposed to buy comprehensive
health services for their local communities and individual patients and to do this they must ‘shop around’ to find the best ‘deals’ from health service providers (whether NHS Trusts or private sector providers). Providers are supposed to compete with each other for purchaser revenue by offering better or cheaper or innovatory health services. NHS users are supposed to be able to choose between treatment options purchased on their behalf by their GPs. Providers can ‘win’ revenue or ‘lose’ revenue to competitors. Although NHS Trusts are not permitted to make profits or losses they can invest surplus revenues in developing services and improve pay and conditions. If they lose revenues they may conceivably cease to exist although emergency management to prevent this is likely to be installed by the Department of Health. No NHS Trust has yet ceased ‘trading’ although some, like the Bradford Royal Hospitals Trust do seem to have been in difficulties (Harvey-Jones, 1992).

There are signs of changes to the original market structure envisaged in 1989 which enabled NHS purchasing authorities to buy services from any source. These include the emergence of purchaser conglomerates comprising numbers of GP fundholders and Health Authorities that have made agreements to coordinate their spending (Harrison, 1994; Robertson, 1994). Further changes are forecast in the distribution and activity of NHS units since they can now operate with greater autonomy.

Now that a flavour of the NHS in terms of its gross structure, size and disposition has been given I shall discuss an aspect of diversity that is implicated in the creation of the NHS and in it's potential demise - the diversity of political views about the NHS.
2.2 The diverse politics of the NHS

The history of the NHS is marked by fluctuating political tensions that are still present and influencing the corporate whole of the NHS. In order to try and reveal some of these tensions I will discuss the political background to the creation and continuation of the NHS. However it is necessary to provide two cautions. Firstly I am using the term politics in this context to refer to fundamental decisions about the NHS that are sometimes termed macro-political. These are usually regarded as national in scale (in that they directly affect people within specific parts of the United Kingdom), and dominate the policy analysis literature (for example see Stacy, 1991; Hill, 1991). Policy analysis is a contentious area because there is no consensus explanation as to how policy is made, implemented or evaluated (for many debates see Hill, 1991). I do not intend to undertake a policy analysis. Instead I will concentrate on illustrating the diversity of political viewpoints and how political decision making may be constrained by subtle but powerful public expectations (or norms). I will argue that these influences need to be recognised and accounted for in any programme of NHS quality management. Secondly in contrast to the macro level policy decisions, myriad local micro-political decisions are made by individuals but are often assumed to be summative, with macro-political outcomes - this is a typical assumption in economics. I will deal with micro-politics mainly in chapter 3 in the more specific and more powerful social action terms of Habermasian sociology. However I will discuss some of the influences on local individual decisions in section 2.3 under the diversity of health-illness and healing beliefs.

Political views about the NHS vary from consensus about its general role as a provider of social welfare to political extremes of the 'new right' and the Democratic Left: the NHS is accused by the new right of being a potentially infinite drain on resources requiring immediate reform - a 'monopolistic
monster' as Marsland and Segalman (1989) put it. Or it is seen as a marvellous example of socialism redistributing the national wealth, 'from those according to means, to those according to needs' as the Democratic Left would express it. Or again the NHS is seen by the World Health Organisation (WHO) as a vital health and welfare support system satisfying fundamental human rights. The intensity of such views and the tensions they produce are discernible in the debate over what has been termed the welfare state as I will now explain.

2.2.1 The NHS and the postwar welfare consensus

The NHS is inseparably linked with the welfare state. Johnson (1987, chapter 1) defines the 'welfare state' as a post war shorthand for economic and social policy changes that were supposed to 'transform British society'. These politically socialist changes were concerned with expanding social services, maintaining full employment and nationalising industry. Each change required the state to intervene and plan for the nation as a whole. The NHS may be regarded as both an expanded social service and as a nationalised industry.

According to Johnson (1987) this kind of change has been an international phenomenon with all democratic-capitalist economies developing social programmes to a greater or lesser extent since the late 19th century. Whilst it does not explain the development of the post war welfare state, arguably one of it's fundamental characteristics (in Britain and abroad), is the broad political consensus of support for welfare amongst both Governments and oppositions. Johnson remarks that 'the growth of state intervention [...] occurred which ever party was in power; parties of the centre, right and left seemed to be in agreement' (1987, p155). In the United Kingdom the NHS remains a startling
sign that there has been a British political consensus on welfare. A consensus what is more about the NHS in particular that has seemingly remained intact in the face of ever increasing political conflict since the 1970s - something Klein has called a 'paradox' (Klein, 1989, p203). He argues that although the NHS 'has become more politically controversial than ever before' nevertheless 'all parties (have) embraced the NHS' (1989, p203). However he adds that this continuing consensus remains 'more apparent than real since it contains disagreement about what the 'principles' of the NHS actually entail' (1989, p203). In other words the diversity of political viewpoints in Great Britain remained even though there seemed to be a consensus over health care. He argues that consensus was possibly more related to the intolerance of 'muddle, inefficiency and incompetence' than to social injustice and that it concerned a common policy end but not the means (1989, p7).

Nevertheless the longevity of the NHS health care consensus has been sustained against an international climate of political fragmentation and increasing dissensus. Mishra (1990) argues that the consensus over welfare in general all over the western world has declined as material conditions became more difficult especially from the late 1970s onwards. Therefore he entitles chapter 1 'the end of post-war consensus around the mixed economy and the welfare state'. According to Mishra 'welfare-capitalism' in the West was riven with difficulties during the 1970s not least amongst which was 'stagflation' (Mishra, 1990, p12) which means the condition of rising deficit between Government spending and income, rising unemployment, increasing inflation and economic stagnation. Western economies were perceived by some to be out of control and in crisis. This led to dissatisfaction and misery in workplaces and in communities, and to the
radicalism of the new right in advocating 'purer' capitalism, while the left had no electorally viable radical ways to go (Mishra, 1990, p14; Glennerster and Midley, 1991, p22).

Mishra argues that in the West generally no new economic and social political 'orthodoxy' has yet emerged in place of the declining consensus. In Great Britain in 1979 Margaret Thatcher came to power after the 'winter of discontent' at the height of disillusionment with the old political settlements but not at the head of a new radical and complete consensus. Less than half of the electorate at any General Election from 1979 onwards have ever voted for the Conservative party and its radical anti-corporatist policies. Therefore Conservative political dominance since 1979 may be defined partly as a consequence of dissent in the opposing ranks and the mathematical trick of the British first-past-the-post electoral process. So it is safe to say that whereas there had been a welfare consensus there was and there remains a diversity of macro-political views about the future of welfare and of the NHS.

Johnson (1987, p30), referring to Britain, is anyway less certain about the role of 'consensus' arguing that there have always been 'criticisms in plenty from all quarters' about the welfare state and (literally) puts a question mark against the notion of the 'end' of consensus. Yet she too detects that 'a change in emphasis has undoubtably occurred' (1987, p54) from what used to be a welfare state to welfare pluralism in which there is ambivalence toward the continuation of state provision of any kind, and a greater reliance on individual resources, and self-help.
In order to illustrate some of the tensions of the politics of the NHS, and of the complexity of policy analysis, I now want to briefly review two explanations as to how the NHS came into being. The first is the traditional view that the NHS came into being as a rationally forged consensus of political action. The other view is that the NHS exists not because of rational planning but because of the effects of powerful nation-girdling norms crystallised through war effort in the 20th century.

2.2.2 The NHS: consensus forged

The National Health Service came into being through the National Health Service Act (1946) of the post-war landslide Labour Government and began working in 1948. The key functional commitment of the NHS, spelled out during the war, was that

(t)he availability of necessary medical services shall not depend on whether people can afford to pay for them, or any other factor irrelevant to real need [...] money should not be allowed to stand in the way of providing advice, early diagnosis and speedy treatment.

Command 6502 (1944).

Allsop (1984, p11) calls the Act 'a major political achievement' for Aneurin Bevan. If Churchill was the political dynamo for the war effort then Bevan was the political dynamo for what might be termed the 'health effort'. In the way that Churchill's role was to oppose 'Nazism and it's odious apparatus' (Churchill, 1940) Bevan's role was to oppose the 'Giant of Sickness' that he identified in the famous 'Beveridge Report' on social insurance (Command 6404) in 1942 (Allsop, 1984, p11).
Bevan was a contemporary of Beveridge who, with the economist Keynes, leant what Johnson (1987, p3) calls 'intellectual credibility' to the welfare state. However

Even more significant, perhaps, was that neither Keynes nor Beveridge saw increased state intervention as being inimical to capitalism and the market economy. Indeed, they would be more efficient


So here is an indication of the argument that had been won, on which the future development of welfarism and the NHS would depend, for even conservatives expressed their 'reluctant acceptance' of the welfare state and a National Health Service (Johnson, 1987, p155):

We accept the principle, and we accept the consequences that flow from it. We understand, for example, that once we are committed, to the principle of a 100 per cent service, we require an enormous expansion and development in the health services as a whole.

Mr Richard Law (conservative), debate with Mr Bevan on the NHS, Hansard, 30th April 1946 (Bevan, 1946).

However, there was hostility amongst many politicians and doctors toward the perceived interference of the state in the 'sacred' domain of medicine, because it seemed 'reminiscent of state fascism' of the kind recently subjugated during the war (Allsop, 1984, p12). Nevertheless there was widespread acceptance of the collectivist principle: 'The Second World War had changed the whole mood of influential sections of the population to state intervention' (Allsop, 1984, p13).

This mood change eventually led to Bevan's political victory in obtaining, as
Allsop notes, the 'eventual agreement of the majority of doctors to join the service' (1984, p11). The post-war welfare consensus may therefore be regarded as a politically skilful achievement of tact and intellect. However seeing the inception of the NHS as an achievement of socialist politics, although the argument in Command 6502 is clear, may risk overlooking the role of the war in forging another kind of political consensus - a norm based unity.

2.2.3 NHS welfare, social upheaval and war

It would be very hard not to see the enactment of the socialist principle of the NHS - collective responsibility for comprehensive, equally accessible, health services for all - as not unrelated to the great national war effort based on strategically and nationally planned rationing (of work, goods, services, dangers etc). War has often spurred concern for the citizens health:

In the Manchester district 11,000 men offered themselves for war service between the outbreak of hostilities in October 1899 and July 1900. Of this number 8000 were found to be physically unfit to carry a rifle and stand the fatigues of discipline. Of the 3000 who were accepted only 1200 attained the moderate standard of muscular power and chest measurement required by the military authorities. In other words, two out of every three men willing to bear arms in the Manchester district are virtual invalids.

White (1901), p100-103

The Boer War, the Great War and the Second World War are each seen by Allsop to have some part in leading to the establishment of the NHS. However it may be that the creation of the NHS has nothing to do with wartime strategy (for obtaining fit soldiers) or high socialist principles but everything to do with the public experience of war and social upheaval: World War Two mobilised British
people in new ways and to new extremes creating public entitlements to collective striving for a common goal - to defeat the unambiguously identified enemies: Germany, Japan and sickness. The NHS is therefore possibly part of the war debt of the nation to the vast majority of its people who, united through war effort rather than socialistic ideals, feel individually entitled to a guarantee of social security of which the NHS is part.

How can this nation-girdling norm be shown to exist? There are no absolute proofs but there are right wing factions who advocate the abolition of the NHS and yet despite the unprecedented term of Conservative government somehow cannot achieve it. This is expressed very clearly by Marsland and Segalman (1989) who argue that the NHS should be abolished. In its place they advocate a Swiss style private health care system with a 'safety net' incorporating strict forms of economic and social rehabilitation for those whose circumstances merit it. In their view the NHS is simply another enormous example of the kind of free welfare that creates the problems it is intended to solve. According to them the NHS creates social dependency and it is economically crippling for both subscriber and dependent. There is no ambiguity about their attitude to the NHS! What is more the whole thrust of the Conservative government under Thatcher and Major generally is that socialism is finished (Hunt, 1994), the 'nanny' state is dead (Clarke, 1994), and consequently privatisation, claimed John Redwood in 1988 (who was the only Prime-ministerial candidate other than John Major in 1995) is the solution to the problems of the NHS (Redwood, 1988; Letwin and Redwood, 1988).

If the NHS were to be privatised it would reduce the public tax burden by a potentially substantial proportion of £31bn, allowing a reduction of income tax by
several percent; it would pull in billions in share capital into NHS trusts - perhaps far more than for any other privatisation undertaken by the government; it would solve the perennial problem of deciding which hospitals to keep open in places like London (where several world famous centres of excellence are threatened with closure because of over supply, (Kings Fund, 1992)) because the market would decide. Moreover the Conservative Bow Group (1983) of MPs deplored the Thatcher pledge on the NHS ('safe in our hands') and were simply being consistent with new right ideals in the 1980s. Most recently the former Chief Executive of the NHS, Duncan Nicholl (a Thatcherite who implemented the 1989 reforms of the NHS and is now chair of BUPA a private health insurance company), stated that the NHS should begin to sell its services privately and rejects the premise that it can continue to provide services out of general taxation. He argued that the NHS cannot provide all the services demanded of it - there is a gap between demand and the supply of resources that can only be made up through some patients paying fees (BBC, Breakfast News, 19th September, 1995). So it can be seen that the NHS should be a prime target for privatisation under the current Conservative government. Consequently it appears strange, given the right wing rhetoric of the 1980s and the resource panics of the 90's, that the NHS has not been privatised even though it has been reformed to the stage that it could be done - the NHS now comprises quasi-autonomous units that could become fully independent corporations. Yet Stephen Dorrell, the Secretary of State for Health, was put in the position throughout the day on the 19th September 1995 of restating the long term commitment of the government to the NHS as a service financed out of general taxation. This is surely not because the government have lost faith in capitalism! Rather, it may be that no government can privatise the NHS because it is protected by a widespread view, a feeling of entitlement, that it should not be
privatised. The government *dare not waver* for a moment on it's commitment to the NHS. If this is so then it is *not surprising* that the NHS remains in public ownership. What other explanation can account for the stupendous revenues probably foregone by the Government?

I will not speculate further about why and how the NHS continues to exist even as it is, although there are other possibilities I could explore, political-economic arguments for example. Rather I simply wish to show that whenever supposedly rational plans are made for the NHS, they must take into account that implementation may be profoundly affected by extra-rational considerations. I will enlarge upon this in chapter 3. However I now want to turn to another aspect of diversity that influences the management of the NHS - the cultural variation in health-illness beliefs.

2.3 The diverse meanings of health, illness, disease and healing

It may seem obvious but neither the communities served by the NHS, nor the professions and professionals of the NHS, nor its organisational units, nor the international environment of health care, are culturally and socially homogeneous. Indeed it is widely acknowledged that there are enormous variations in any variable you care to define between geographical and social situations of the NHS whether it is community health indicators by social class (Department of Health and Social Security, 1980), GP referral rates (Department of Health, 1989b), anomalies of medical practice (Peckham, 1995), or health-illness beliefs and practices (Helman, 1990).

Given that such variation exists it may appear bizarre to deal with issues like
quality as if the population were, or more provocatively should be, homogeneous. Yet to an extent this attitude may be no better exemplified than in the forthcoming research and development conference organised by the NHS management on the scientific basis of health services (Department of Health, 1995). To see why this is an inadequate basis for the management of the NHS it is necessary to examine the diversity of views about the nature of health, illness and healing.

To begin with despite being called the National Health Service, the meaning of health is rarely mentioned in any NHS policy discussion except as a passing and inadequate definition (Seedhouse, 1986). This seeming neglect of the meaning of health in local and national NHS policy making is at odds with the diversity of health-illness belief and practices that are observable amongst its employees and users. Indeed Helman (1990) observes that variations of perception of the meanings of health, illness, disease and healing occurs across and within all communities of the UK, including the NHS professions.

The providers of health care in the United Kingdom can be divided into formal and informal, charitable, commercial and public sectors including the NHS. These sectors offer a wide variety of what Helman (1990) calls 'therapeutic options'. He lists more than sixty kinds of 'healer' that a British citizen might consult some of whom are available 'on' the NHS. The most common form of medicine offered by the NHS is given a variety of names. Leslie (1976) refers to it as 'western' or 'cosmopolitan' medicine. More familiarly Helman (1990) calls it 'scientific' or 'orthodox' medicine. This is the usual form of medicine 'produced' by the NHS.
However the NHS also officially offers *homeopathy* which originated in Europe and is also a professionalised form of medicine. Although it is practised by 'scientific' doctors in the NHS, and there are NHS hospitals that specialise in homeopathy, it is based on principles that are clearly antithetical to scientific medicine (Gregory and Walsh, 1993). So while the NHS is an orthodox source of medicine sometimes it is scientific medicine and at other times not. The provision of unorthodox alternative or complementary medicine through the NHS is growing although this is often provided less formally (Helman, 1990; Gregory and Walsh, 1993).

A major source of professionalised alternative medicine is the variety of ethnic groups in Britain that preserve and transfer beliefs and practices that originate in other parts of the world. The most prevalent and well known examples are the Asian professionalised 'medical systems' as Leslie (1976) calls them. These include Hindu vaids, Muslim fakims, acupuncturists, chiropractors, Chinese herbalists and so on.

Another source of diversity of health-illness beliefs and practices are the varieties of what Helman (1990) calls 'folk medicine'. These are not professionalised 'medical systems' in Leslie's sense although terms can become confusing since Fitzpatrick (1986) also refers to *Ayurvedic medicine*, which is highly professionalised, as a 'folk' system. Folk medicine may still be the preserve of special practitioners who are called upon for assistance, such as faith healers or local herbalists, but this category also includes family remedies for illnesses and they correspond more to a notion of 'lay' belief when they are compared with
The diversity of lay perceptions of health, illness, disease and healing have been well documented. For example Helman (1986) gives British examples of lay models of colds and fever that feature their own detailed notions of cause and appropriate treatment and later (1990) gives an international anthropological summary. Sometimes lay anatomical beliefs involve metaphors. Helman (1990) gives an example of beliefs in which the internal body is likened to domestic plumbing. Other powerful metaphors feature strongly in lay 'representation' of disease as Fox (1993, p3) observes like those identifying cancer as 'the enemy' and AIDS as a 'plague'. Kleinman (1988) discusses how illness can be seen as a process involving myth-making rather than as a phenomena to be objectively scrutinised in the manner of scientific medicine.

In contrast to lay perceptions, professional scientific concepts of disease make far stricter claims to represent an underlying reality than simple metaphors (Fox, 1993). Very often however this takes the form of simple description made mysterious by the use of special language. For instance hepatitis simply translates from Latin as 'inflamed liver' and, similarly, polymorphic dermatitis means 'skin rash with irregularly shaped lumps'. In other words the diagnostic terms simply describe objects of concern at a relatively superficial level and do not necessarily imply a specific cause although this might not be obvious to a patient. The special knowledge claimed by scientific doctors emphasises objectivism in diagnosis through the anatomically and physiologically based medical model (Fox, 1993) although this begins to break down as the diagnosis moves from 'cold dissected' physiology to that of psychological and social pathology.
Kleinman remarks that 'healing is an embarrassing word' to scientific medicine because it exposes 'how little we really know about the most central function of clinical care' (1980, p312). He was perhaps criticising the narrow cure orientation of scientific medicine. Perhaps it is the difficulties in achieving a consistent scientific medical objectivity of the psychological and social that underlie his comments. Moreover his remark about 'how little we really know' makes it clear that he takes a scientific medical perspective without committing himself to a judgment about the genuineness of 'healing' in other medical systems.

Perhaps it is not surprising then that lay representations and professional representations of illness, disease, health and healing do not tally. One of the quantified signs of this, as Fox (1993, p3) points out, is the famous research by Hannay (1980) in which he identifies a 'clinical iceberg' of unreported and untreated medical problems in the community while a mass of 'trivial' problems are reported to GPs.

Cultural variation might provide one explanation as to why there is a diversity of medical systems in the UK. Culturally speaking the perceived efficaciousness of medicine is not dependent upon uniform scientific evaluation but upon the satisfaction of cultural criteria determined by such elements of social life as norms, values, myths and rituals. Arguably this may help explain some of the variations in scientific medicine and the burgeoning of alternative medicine in the NHS as NHS professionals respond to a public with diverse demands (Helman, 1990).

On the other hand Fitzpatrick (1986) argues that the 'traditional health care
systems', in contrast to scientific medicine, frequently deal more with the healing of distress and anxiety of the patient and family than with curing the disease' (p 12). The diversity of therapeutic options in the UK, and even in the NHS, is therefore perhaps due not only to the presence of local sub-cultures but also to the satisfaction of more widespread public requirements that scientific medicine does not and perhaps cannot address. The simple diversity of health-illness perceptions, beliefs and practice is one source of complexity for NHS decision makers. Another is the inconsistency of these perceptions, beliefs and practices even amongst those who make special claims to rigour - scientific doctors.

2.4 The inconsistency of NHS health care

According to Leslie (1976) one of the characteristics of medicine in Asia is the eclectic nature of practice. Folk, professional and scientific medicine may be practised together. However this has also always been a feature of the NHS in which scientific doctors offer homeopathy and an increasing number of so-called alternative and complementary therapies (Helman, 1990).

Acupuncture, osteopathy and chiropractor are not uncommon - and increasingly popular - sidelines amongst GPs. However this seems to raise the possibility of theoretical and practical inconsistency. In the first place the knowledge differences between medical systems like those of scientific medicine, acupuncture, Chinese herbalism and homeopathy prevent a meaningful conceptualisation of one in terms of the other. For instance the power of an homeopathic medicine increases with dilution while a scientific medicine increases in power if it is increasingly concentrated. The logic of homeopathy is contradicted by science and vice versa.
From the scientific medical perspective doctors may seek scientific justifications for the use, or perceived consequences of the use, of alternative medicines. So naturally the therapeutic processes and benefits of acupuncture has been conceptualised in terms of endorphins and has been tried recently in the control of acute diseases like AIDS (Fogg, 1994). Chinese herbal remedies are being investigated to discover the therapeutic component that is efficacious against dermatitis (Stuttaford, 1990), and the placebo effect is a well known phenomenon that might be a last refuge for theoretical consistency in homeopathic practice (Gregory and Walsh, 1993).

It seems that a degree of eclecticism in the NHS may be made acceptable to the scientific medical establishment by this 'scientizing' of alternative therapies. However while it may seem to be 'unscientific', and legally and professionally hazardous, for NHS doctors to practice a form of medicine without scientific evaluation the practice of scientific medicine is itself inconsistent both nationally and internationally. So called 'anomalies' of scientific medical practice are a target for elimination by an NHS research and development strategy (Peckham, 1995).

There is broad acknowledgement of the international inconsistency and diversity within the practice of scientific medicine. Helman (1990) points out that 'crise de foia' in France, 'Krisekollaps' in Germany and 'chilblains' in Britain are each accepted scientific diagnoses - but only in the host country. In other countries as diagnostic concepts they do not exist: the language of scientific medicine is not wholly international.
More often the scientific diagnosis is similar but the treatment differs. Maynard (1992) criticises unnecessary operations in the NHS and cites the case of 'glue ear', a childhood ear condition, which when diagnosed is frequently operated on in the UK but hardly ever in North America. So what might explain this? Is it that the diagnosis in the UK and in North America uses the same terms but the whole concept of the course of the disease, the right treatment and the prognosis is different? Or is it that the 'culture clubs' of British and American medicine have differing valuations of the weight of scientific evidence? Or is it that the patients differ, or the competence of the surgical teams differ, so that it is genuinely better not to have grommets inserted in 'glue' ears in the US?

International inconsistencies in scientific medicine are more than matched by national inconsistencies in the UK. The 1989 NHS reforms were partly predicated on the elimination of inconsistency in practice that resulted in 'wide variations' in drug prescribing by GPs and 'twentyfold' variations in referrals to hospital across the UK (Department of Health, 1989b). The Government clearly implies that these inconsistencies are illegitimate. 'Correctable anomalies' are a target for elimination by the NHS (Peckham, 1995). Surgical practice in the NHS is also known to vary and it is not clear if this is due to 'welcome diversity or disturbing differences' (Jennet, 1988). The variation in medical and surgical practice is arguably one of the driving forces behind the non-statutory development of medical audit in the UK over the last twenty years since the reflection it stimulates is supposed to bring quality improvements (Shaw, 1986).

Part of this voluntary tradition of review, reflection and audit led to the NCEPOD series of reports which focus on peri-operative mortality and are the most comprehensive analysis of outcomes of scientific medicine in the UK (Campling,
Devlin, Hoile and Lunn 1993). The whole point about the data is that it reflects variations in practice and therefore systematic investigation is supposed to provide insight into ideal practices. NCEPOD is one of the only examples of a large scale systematic attempt to measure treatment outcomes of scientific medicine in the UK and make inferences about the preceding surgical care. What the report does not do is inquire into subcultural factors that may have influenced the treatment. In other words it is assumed, with the considerable authority of all the concerned Royal Colleges, that the problem of variable outcome for matched surgical cases is simply due to technical variations and variations in surgical competence.

While these may be crucial there may be other underlying differences of appreciation of a situation that may broadly be construed as cultural. It might be possible to reveal these to some extent by challenging the normative content of surgical decisions for example by asking surgeons to specify why an outcome was acceptable or unacceptable. This either has not occurred to the concerned Royal Colleges and other participants in NCEPOD or cultural variation is regarded as unimportant or an illegitimate source of variation in surgical practice.

Sometimes inconsistency in medical practice can lead to hidden conflicts. Walsh (1991) observes that the use of eusol as a wound dressing is scientifically contentious. Some doctors will not prescribe it yet it is prescribed by some dermatologists, surgeons and consultants in Sheffield hospitals. Again perhaps this is a dispute over the 'weight' of evidence and therefore the lay person must be guided by the expert. However the prescribed use of eusol in Sheffield is, in at least some cases, quietly sabotaged by nurses who have the responsibility for
implementing the prescribed care but instead use other substances. The use of eusol is based on the expert judgment of experienced dermatologists and surgeons that it is efficacious rather than upon scientifically controlled trials. Trials in rabbits ears wound models (Leaper, 1986) find against the efficaciousness of eusol. Nurses who use scientifically 'proven' alternatives such hydrocolloidal or enzymal dressings instead of eusol are therefore at least as well grounded, if not more so, than the doctors whose prescribed care is sabotaged. If an hypothetical patient had the option how can a choice be made between experts whose views are inconsistent with each other but who both make claims to scientifically grounded practice (and knowledge that the lay person does not have)? Or between experts from differing medical systems? Logically, choice between expert views requires that these views need to be tested or otherwise the 'expertise' is irrelevant to the choice. Yet how can lay people do this without becoming as 'expert' as the experts? Of course one possible resolution to the eusol and like issues in the NHS could be achieved through a determination about whose view is legitimate rather than rational. Arguably this occurred when Wessex Region circulated a letter around the NHS in 1989 with the legal advice that nurses may not have a professional right to withhold prescribed treatment. This letter specifically concerned the use of eusol (Wessex, 1991). Another possibility is raised by Giddens (1991) who suggests that it is possible for lay people to regain some of the knowledge that has been monopolised by experts, yet this is hardly feasible for all occasions that an expert is required. Another possibility is developed in the course of this thesis: dialogue can provide the conditions for the assessment of competing expert claims, even to the minimally competent, at least to some extent. I will begin a discussion about that possibility in chapter 3 but for now I want to consider yet another source of diversity and inconsistency in the NHS - professional subcultures and professional rivalry.
2.4.1 Professional diversity in the NHS

In the last example it became clear that doctors are only one subset of all the clinical professions within the NHS which may have the greatest variety of professionals in any single organisation in Europe or even on earth. Helman (1990) observes that these diverse professions have their own jargon, notions of health, disease, course of illness and healing. He therefore provides a convenient explanation for variations and inconsistencies in the medicine of the NHS: they are due to cultural differences of knowledge and perception transmitted through professional and occupational subcultures.

Nevertheless all these professions are nevertheless closely linked with that of scientific medicine given the dominance of the medics in the NHS establishment. However professional diversity creates new twists of complexity for NHS management by forming loci for battles for supremacy (or at least superiority) between professional groupings whose perceptions of good care differ.

So while inconsistency of 'scientific' treatments might stem from differences of 'scientific' perception it may also be due to the dominance of professional strategy. This has traditionally been a theme in the modernist 'doctor bashing' sociology of health and healing (as Fox, 1993, p70 puts it) where the medical establishment is seen to be acting in an oppressive and self-interested way. Professional tensions can be seen in Professor Mitchell's attack on the nursing process (introduced in 1984 as a systematic approach to nursing care) because he saw this to be in 'time and manner calculated to offend my profession' (Mitchell,
Yet the nursing process was also seen to be a path toward more rational nursing practice and away from the use of myth and fable (Rowden, 1984).

Inconsistency of practices is also influenced by the law and this is revealed in management policy. The problem that excellent care is *often* constrained by legal imperatives may be widespread but is often only noticeable in more contentious areas of health and social care. Professionals may deny choice to their patients where this conflicts with issues of professional perception of safety or professional liability. There is undoubtably a hazard for the clinician that they may be retrospectively blamed for some disaster unless they have demonstrated reasonable insight into the consequences of a some aspect of care (Alaszewski, 1994).

This is especially so in obstetrics where home confinements, birthing pools and delivery positions are all matters of conflict particularly in terms of safety. The midwife who responded to a survey in Trent Region by stating that the most important issue in the NHS was 'to give the patient as much choice as is safe' (Gregory, Romm and Walsh, 1994) was merely stating the condition for the rendering of care with minimised professional liability. The acceptability of any risks for patients in this view is not an issue.

Similarly Walsh (1991) found that the likelihood of an older patient having cot sides on their bed depends upon which hospital unit they are in rather than upon the outcome of a clinical assessment. Consequently the same person transferred from one Sheffield hospital to another might find cot sides applied in one place but not in another with no choice in the matter for legal reasons.
In contrast to the mere denial of choice, legal imperatives may constrain genuinely excellent care which is aimed at enabling individuals to choose, who may seem unable to make preferences known. Shelton (1992) made extraordinary arrangements to facilitate the sex education of an adult with learning difficulties, (including being observed every sixty seconds by a colleague) in order to minimise the risks of prosecution for assault or sexual abuse. The legal risks to the professionals in situations like this are such that excellent care like Shelton’s may be exceptional - but no-one really knows because there has not been any large scale widely generalisable inquiry into this.

2.4.2 Social inequality

Inequality is not the same as diversity. There may be diverse incomes in a town for example, meaning simply that some individuals earn more and others less. However inequality of income means that some people earn more than others for the same work and conditions. This is not merely a difference of income but an unfair difference of income. Chadwick (1842) in his famous report documented social inequality from London to Glasgow. For example in London (Bethnal Green) he observed that professional life expectancy was 45 years while servants was 16 years. Clearly this fact was related to social conditions - but so what? The issue of course was that the social difference was not harmless. It was perceived that poor life styles harmed health. Moreover, this was perceived to be unfair. This was not diversity - it was inequality. Inequalities like this continue to exist, even if the scale has lessened. The Department of Health (1980) reported inequalities in health (the ‘Black Report’) claiming that social differences often also represented health differences. Blane (1986) examines British inequalities of wealth, income, living conditions and working conditions and links these with
rates of death and disease by social class, the broad finding being that in general, unskilled workers are less likely to live as long, and as healthily, as professional workers.

However it is the perception that this is unfair that makes such observations contentious because unfairness suggests that some correction is needed. Action is required to overcome inequalities - this was the conclusion of the Black report (Department of Health, 1980) which recommended various moves to eliminate class inequality including increased spending on housing and the abolition of child poverty. So it can be seen that the perception of unfairness implies a perceived need to allocate resources in alternative ways, something which the NHS is already involved in.

It should be clear by now that the production of NHS services is dominated by political and cultural diversity. Sometimes services are inconsistent between professionals, hospitals and areas of the country. These variations may be ascribed to a variety of influences including technical constraints, professional competence, cultural differences in perception and beliefs, professional competitiveness, legal imperatives and varying client demands. I now want to bring out some of the implications of diversity and inconsistency in the NHS and to do this I will introduce the notion of quality and the idea of an NHS quality gap.

2.5 The nature of the NHS quality gap

To begin to understand the implications of diversity and inconsistency in the NHS it is helpful to introduce an elementary if uncritical definition of quality
which is that quality means simply meeting the customer’s requirements (Oakland, 1989).

Figure 2: The NHS ‘quality gap”. Key: A - Unknown, unserviced, requirements. B - Requirements recognised as legitimate but unserviced. C - Requirements not recognised as legitimate and unserviced. D - Serviced requirements. E - Unrequired services

Within this can be sketched an inner boundary around requirements that are serviced by the NHS (area D). Between the two lie ‘unserviced’ requirements which can be termed a quality gap in NHS provision. If the NHS could satisfy all these requirements without contradiction or dispute then the NHS would be providing perfect quality and there would be no gap between the inner and outer boundaries. While this has to be seen as a gross simplification of the meaning of quality the map can illustrate important areas of dispute about quality in the NHS. For example the map notionally represents an NHS planner’s viewpoint in which the area (A) represents unknown, unserviced requirements. Yet this
boundary is constantly shifting and opens up all manner of hitherto fantastic requirements. Heart transplants are regularly undertaken in provincial British cities, such as Sheffield. Aldous Huxley's *Brave New World* illustrates how a 1950s fantasy has now come 'true'. Humans can be conceived and grow outside of the womb, twins can be born years apart, human clones can be produced. Robert White has, since 1963, been able to remove monkey and dog brains from their bodies and keep them alive for a few days sometimes by transplanting them into other bodies (Lausch, 1975)8.

Which of these new technologies will become public requirements of the NHS in the future? (B) represents requirements known to NHS management but that are unserviced perhaps because they are lower priority or unserviceable within the bounds of current technology. For an example of the latter drug companies are striving to find new medicines to cure hitherto intractable diseases, e.g. AIDS; Area (C) represents 'requirements' that are postulated or claimed as legitimate by some members of the public but are not accepted as legitimate by NHS planners - euthanasia is a good example, general cosmetic surgery, or many kinds of 'alternative' medicine are others. (D) comprises all those requirements currently satisfied by the NHS. Of course this area could be broken down a number of ways, such as into formal services and informally provided NHS services. For example colleagues of mine would often do favours for patients because my hospital simply did not seem able to meet expressed requirements which are often taken for granted elsewhere, like getting newspapers or arranging shopping expeditions after work hours or trips to the pub. Another notional boundary could be added to the map around requirements that are serviced *uncontentiously*. i.e. with the complete agreement of everybody. (However, how would any such boundary be identified?) Finally, intuitively speaking, there

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are those services provided that continue to be provided despite their obsolescence or uselessness (E). The grommets example mentioned earlier might fit into this category.

What it is important to realise is that all of these boundaries can be, and are, disputed. Indeed as anyone who writes about the NHS will realise there are continuing acrimonious adversarial debates about how and what services the NHS should provide. Yet it is not always clear that the frequent adverse publicity about the NHS is to do with 'quality' at all. This stems from the lack of agreement between commentators as to what quality in the NHS actually is, or is not, and therefore debate is wildly unconstrained and anecdotal. Turrill (1987) exemplifies the 'bad' experience stories about the NHS with a serious personal account about waiting for treatment. Sir John Harvey Jones visit to the Bradford Hospitals NHS Trust on behalf of the BBC series 'Troubleshooter 2' to 'troubleshoot' an entire hospital is an anecdote about problems at the opposite end of the organisational scale (Harvey-Jones, 1992). O'Brien (1987) blames communication failures for complaints and sees quality assurance as a 'response' to this problem. Even the government joins in the polemical rubbing of NHS quality by referring to 'twenty-fold variations' in GP referral rates, without actually saying what the particular 'problem' with this is, but implying it would be solved by the NHS reforms (Department of Health, 1989b). Waiting lists have been a focus of attention because they are perceived to be related to 'performance'. The Government even 'ring-fenced' a special budget from 1989 to reduce them which, as Holloway (1990) observes, was seen by some commentators to reward poor performance. Probably the most emotive NHS quality 'problems' are those concerning children such as the frequent claims about the lack of special baby care cots and staff that have made peak hour news
following criticisms by specialists (Bennett, 1993; Hunt, 1993; Hall, 1991; Sherman, 1991).

In this contentious and adversarial atmosphere how can quality in the NHS be managed fairly? How can any criteria or specification for any service boundary like those in figure 2 be determined and justified? The current approaches to defining the boundaries of quality in the NHS tend to reflect the professional and autonomous executive characteristics of the reformed NHS. Increasing executive autonomy has been a feature of the 1989 NHS reforms. All NHS providers have chief executives who have a responsibility to compete with other providers, and to be individually responsible for what occurs in the trust. Marketing techniques have been recommended by the Department of Health (Department of Health, 1992b; Department of Health, 1992a) to identify priority services and previously unrecognised requirements. These techniques include quantitative surveys, and qualitative interviews. Another way that requirements are defined and achieved is through the use of standard setting formulae (e.g. Maxwell, 1984) and a variety of audit techniques, including large hospital wide surveys (e.g. Health Policy Advisory Service surveys*), within existing NHS services.

All these techniques provide operational data and strategic intelligence. However the evaluation and exploitation of this information is very much the preserve of narrow groups of professionals within the executive management of NHS units. The use of marketing techniques (and for that matter public inquiries into NHS service failures), can also be seen as ways of preserving the strategic superiority of NHS management. By commissioning these kinds of 'research' (e.g. the Cleveland inquiry 1988) NHS executives do not merely 'find out' useful information but may also influence and control the public by
controlling the quality agenda. Under the current managerial arrangements of the NHS any process of consultation in the NHS is likely to take place through 'ritualised' channels adapted to executive requirements (e.g. marketing, 'patient representatives', health education). Furthermore inquiries may deflect the actions of individuals and groups of the public who must decide whether to continue campaigning if it appears that their issue of concern is being dealt with.

This channelling might help to protect the autonomy of NHS executives but it also means NHS users and NHS management cannot give a full account of their views to each other about quality boundaries. Consequently no matter how increasingly effective and efficient the NHS may appear to be to it's management, the Government, or even to parts of the general public, to those whose views are never heard the NHS will still appear ineffective, uncaring and low quality. Even those NHS users whose views are selectively listened to by management may still not be satisfied with the way their views are accounted for. What is needed is some way of broadening participation in decisions about the boundaries of NHS quality, so that NHS users have equal access to mechanisms for making their viewpoints known, with the confidence that their views will be given the weight and merit they deserve. I contend that this can only occur within a dialogue. I will argue over the next few chapters that dialogue can underpin a mode of quality management that is more fair than that currently dominating the NHS. So what is dialogue? and what are these modes of quality management? To begin to answer these questions I need to discuss the meaning and nature of social action. This I will do in the next chapter.
Although gross expenditure is in fact much higher, around £40bn. This is set against what are termed 'appropriations' including charges for prescriptions, the private use of NHS services, land sales, interest charges and so worth around £8bn.

Just how much is debatable but the figures for English health authorities expenditure for the year ended 31st March 1991 were total revenue expended £15bn of which £11bn comprised salaries and wages (Robertson, 1994, para 20/10).

This is whole time equivalents for England only up to April 1991.

The policy literature has abounded with micro-politics ever since Downs (1957) proposed that voters are utility-maximisers and political parties are vote-maximisers - characteristics referred to in economic literature as rational. For examples of discussions of political-economic explanations of policy based on rational choice see in addition to Downs, Hartley (1977), Pirie (1988) and Dunleavy (1991). I contend that Downs assumptions are flawed - in chapter 3 I discuss five kinds of social action of which rational choice is only one variety.

For more examples of accounts about lay perceptions and beliefs refer to Currer and Stacy (1986) edited volume, Calnan (1987), and Fox (1993).

This uncertainty about the genuineness of the healing offered by scientific and 'alternative' medicines illustrates the relative weakness of lay people when confronted with so-called choices by those with presumed expertise. How can a lay person choose between experts? My answer to this is summarised in chapters 3 and 7 - through dialogue.

I undertake a detailed critical discussion of the meaning of quality in chapter 6. However for the purposes of chapter 2 a simple, uncritical definition is adequate.

The fantastic should not be taken with a pinch of salt. Is Jurassic Park so fanciful?

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Chapter 3

Dialogue and the theory of communicative action

In this chapter I will set out the reasons why dialogue is a more fair basis for the management of quality in the NHS. The meaning of dialogue is central to this thesis, and the main plank in the theory of dialogue is Jurgan Habermas's massive *theory of communicative action*, from which this chapter takes its title. It is spelled out in two volumes in a total of around 1000 pages (Habermas 1991a, 1991b). It provides the basis for the discussion of the communicative element of critical systems thinking in chapter 5 and of quality management in chapter 6. In chapter 7 it is invoked to evaluate the Trent Quality Initiative which implemented many of the principles of dialogue in 1994 (Gregory, Romm and Walsh, 1994). In this chapter it also forms a sociological framework for a theory of dialogue between individuals and groups of actors.

The theory of communicative action only has meaning within a particular context - that of *modernity* - and it is in this context that the theory has its roots. So I shall begin by discussing the nature of modernity and explain how the theory of communicative action came about as a deliberate modern project of social critique by Jurgan Habermas. Following this I shall discuss some of the important theoretical elements of Habermas's theory of communicative action. These are the presumed nature of the *actor* in the theory, the qualified use of Popper's differentiation between objective, social and subjective 'worlds' and the meaning and nature of *social action*, the *lifeworld*, and *situations*. I will compare and contrast competition (based on so called 'rational choice') with collaboration

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(based on communicative action) as a basis for individual, institutional and governmental decision making. The *prisoner's dilemma* provides a useful insight into the difference between these modes of management. Finally I will suggest that it is only through dialogue that the inequalities of the NHS quality gap can begin to be resolved. Firstly then I shall discuss the theoretical roots of dialogue - *modernity*.

The theory of modernity is a major battleground for contemporary sociology and anthropology. It is variously regarded as 'high' (Giddens, 1991), 'late' Beck (1992), and 'post' Baumann (1992). It is also contrasted with 'pre' and 'post' modernity. Clearly pre-modernity is retrospectively defined as 'what used to be' (or in modernistic opinion even still exists in 'primitive' parts of the world) and is situated by reference to 'modernity'. Similarly theories of post-modernity situate modernity in the past (or the oppressed present). Best and Kellner (1991) identify Marx and Weber's modernity as an 'historical periodizing term which refers to the epoch that follows the “middle ages” or feudalism' (p2). This is affirmed and qualified by Giddens who argues that the term refers 'to the institutions and modes of behaviour established first of all in post-feudal Europe, but which in the twentieth century increasingly have become world-historical in their impact' (Giddens, 1991, p15). Modernity (or 'modern' life) in Giddens' view therefore only came into being after the industrial revolution but is not regarded generally as the product or sole-progenitor of the industrial revolution. Giddens regards industrialism as 'one institutional axis' of modernity; others he identifies as capitalism, surveillance, 'industrialised' violence, the nation-state and organisation (Giddens, 1991, pp15-16).
Theories of modernity can all be characterised by a qualified and 'enlightened' belief in 'reason as the source of progress in knowledge and society, as well as the privileged locus of truth and the foundation of systematic knowledge' (Best and Kellner, 1991, p2). Ultimately there is the firm belief that it is possible to discern what is rational and irrational about a human situation and to act accordingly.

Yet sometimes criticisms of modernity can be very pessimistic like those of Weber (1930) on the 'iron cage' of bureaucracy or of Horkheimer and Adorno (1972) in the so-called Frankfurt School of sociology. In these versions of the theory the structures and processes of modern life are seen as enshrining and debilitating - akin to saying that no plan can overcome the unfairness of the NHS quality gap. There is even an argument that Adorno 'anticipated certain trends of postmodern theory' (Best and Kellner, 1991, p32). However even 'pessimistic' modernity implies that there is another substantively better endpoint or fulfilment of the lives of individuals and of society - it is simply unattainable for reasons of structure or power. Optimistic modernity, on the other hand, as represented by Habermas, Giddens and Beck in contrast rejects the certainty of ensnarement into substandard living and is explicitly about seeking ways of critique and emancipation from constraints.

Thus the argument about the nature of modern life is not an esoteric or trivial question (like which end of an egg should be opened). Instead theories of modernity are views about the structures and processes of life, what gives rise to them, and what can be done about them - if anything. In the optimistic view a 'way through' the complexity of modern life (and of difficulties like the NHS quality 'problem') can be found by reasoning. If there are problems in life it is
because there has been inadequate reasoning and not necessarily that the requisite degree of rationality is impossible to attain.

Not all modern theorists are necessarily equally concerned with what to do about the conditions of life (or social critique). For example Giddens (1993) argues that sociology deals with the analysis and explanation of intended and unintended consequences of human action. These are pivotal to social critique but Giddens does not make a 'crusade' out of them. Indeed Bryant and Jary (1989) observe that Giddens considers sociology to be inherently critical, and therefore he does not bother with developing a critical sociology like that of Bauman or Habermas; on the other hand Bernstein (1989) finds Giddens 'vague' on the nature of critique and considers that Habermas, in contrast, directly confronts the problem of how normative judgments may be justified. Habermas surely can be regarded as crusading no more clearly than in his confrontation of apologists for Nazism (Holub, 1991). Perhaps it is this explicitly purposeful characteristic of Habermas work that makes his theories more amenable to intervention in the world through, for example, critical systems thinking. So how has Habermas arrived at the theory of communicative action as an approach to social critique? What happened to his previous theories? Did they fail or not work? Answering these questions coincidentally justifies the theory of communicative action as the lynch-pin of dialogue and all that follows in this thesis.

3.1 Habermas's critical theory

Early in his career, during the early 1960s, Habermas set out the heart of his modernistic thinking with concern for the 'liberal and democratic public sphere in which individuals critically discussed their common interests and public
concerns' (Best and Kellner, 1991, p235). In Habermas's (1991) view the public sphere declined as a forum for enlightened debate under the pressures of unreflective instrumentalism. In the 1960s he explored the relationship between knowledge and human interest (Habermas, 1970; Habermas, 1972). In the late 70s and early 80s this led to the 'linguistic turn' in Habermas's work as many commentators have observed e.g. (McCarthy, 1978; White, 1988; Holub, 1991; Best and Kellner, 1991).

Habermas's linguistic turn took him to the theory of communicative action. He produced this through the massive task of logical reconstruction and integration of sociological theories by Durkheim, Weber, Mead and Parsons. The 'glue' between the theories is the idea of communicative rationality and out of it emerges critical theories about society and processes of rationalisation involving the displacement of what might be termed 'means-end mindedness': the modern strategic instrumentality characteristic of modern capitalistic society.

In order to help understand why Habermas believes that communicative rationality is the key to 'finishing' the project of modernity (Holub, 1991) I shall discuss how the theory of communicative action developed from his earlier work on knowledge and human interest.

3.2 The move from 'knowledge and human interests' to 'communicative action.'

In the theory of 'knowledge and human interests' Habermas (1972) deals with the weaknesses of traditional 'instrumental' methods of human inquiry. The pith of the theory is in the critique of the hidden underlying purposes in the way knowledge is gained and used. It is especially focussed on positivism which
Habermas defines broadly as the gaining and use of knowledge without 'reflection' (Habermas 1972, vii and see pp4-5). Put in simpler terms positivism is like an arrogant scientist who believes that she or he is producing the only valid knowledge and about which the only questions are technical ones of refinement. This lack of reflection leaves other questions (which have no 'scientific' meaning) to the realm of philosophy (or in Popper's (1979) view psychology) which had split away from science (Habermas, 1972, p4).

Habermas argues that modern science 'regressed behind the level of reflection once attained by Kant' (Habermas, 1972, p63) because the illusory objectivism of science represses other kinds of knowledge (Habermas, 1972, p88). To Habermas modern science has tended only to support techniques enabling people to control their environment instrumentally with ever more sophisticated tools. However he argues that this technical interest is, on it's own, insufficient as a rationale for contemporary human life. So he postulated that the technical interest, which is expressed through the use of instrumental reason, is and should be, complemented by a practical interest in making social arrangements to expedite technical success and an emancipatory interest in achieving freedom from domination produced by the pursuit of technical and practical interests.

By positing practical and emancipatory interests Habermas was producing a model for the critique of knowledge that would lead, ultimately, to the emancipation of people from conditions of repressed knowledge and repressing instrumental reason. This does not in Habermas's view invalidate the technical knowledge gained per se but simply overvalues and distorts one kind of knowledge at the expense of another.
Turning to Freud and psychoanalysis Habermas likened the repression of knowledges to the neurotic states of people whose distorted self-perception could be released by psychotherapeutic 'critical reflection'. So likewise reflection on knowledge, and the repressive interest dominating it, could lead to the emancipation of people from local social or societal repression. This work has formed the cornerstone of critical systems thinking hitherto (Jackson, 1991) and has led to reflective organisational thinking like 'Total Systems Intervention' (TSI) (Flood and Jackson, 1991) and Gregory's (1992) 'New Constellation' in which technical, practical and emancipatory interests are methodologically balanced.

There is a problem in this because Habermas abandoned this approach in favour of critique based on language. Perhaps the most important practical reason for this was because the theory of knowledge and human interest does not itself suggest the conditions for universal access to the therapeutic emancipative process. Yet the theory of knowledge constitutive interests is founded upon the need for people to arrive 'at mutual understanding' (Habermas 1972, p196) and this is at least one of the rays in the 'sunbeam shining on communicative action in Habermas's later theory' (Holub, 1991, p8).

The theory of communicative action was conceived by Habermas during the late 1960s and early 1970s, as a 'language-theoretic foundation of the social sciences', and was 'the beginning of a social theory concerned to validate it's critical standards' (Habermas, 1991, pxlii). Habermas wanted to produce a theory of 'communicative rationality' that was 'resistant to cognitive-instrumental abridgements of reason' (Habermas, 1991, pxlii). In other words to be robustly
critical.

According to White (1988), Habermas's theory of communicative action is based on a theory of communicative competence and ideal speech (which Habermas had been elucidating during the 1970s, for example see Habermas, 1970, 1973). A communicatively competent speaker has 'mastery of the rules' for 'raising and redeeming' speech act validity claims and an ideal speech situation is one in which competent speakers and listeners put aside all motives other than that of reaching consensus (Habermas, 1973). However Habermas uses neither the term communicative competence nor ideal speech as such in his theory of communicative action (Habermas, 1991a; Habermas, 1991b). Instead Habermas identifies fundamental conditions that potentially allow anyone who engages in speech to enter into social critique, if only at the most basic level by competently rejecting the validity claimed by someone else for their proposition.

Even the name of the theory suggests a quite different approach to that of knowledge and human interests: while action may follow from reflection upon knowledge constitutive interests, and mutual understanding be achieved in due course, action is not the focus of the 1972 theory. In contrast among several categories of social action one particular kind is clearly the focus in the later theory: communicative action.

Both of Habermas's theories outlined in this section identify the possibility of emancipation but in knowledge and human interests it is achieved through psychoanalysis (or it's social analogue). In the theory of communicative action emancipation begins at a more fundamental level: that of communication
between people. Unless the conditions for communication are satisfactory any ‘therapy’ will be either less effective or completely ineffective. Considering communication reveals a different set of conditions for emancipation. For example reflecting upon who can or should communicate partly precedes and partly constitutes reflection upon whose interest is being satisfied. This does not dismiss the earlier (1972) work but rather reveals a constraint upon it's usefulness.

Now that the transition from knowledge and human interests to communicative action has been outlined I shall explain the role of the actor about whom Habermas makes fundamental assumptions. He developed these notions in the era of knowledge and human interests but they also underpin the theory of communicative action.

In all his theories Habermas generally views individuals as entities living biologically in one context but egoistically in another. The relation between an ego and it’s context is interpreted and has a meaning that is validated intersubjectively. This is Habermas’s analytical rather than normative or ethical proposition. He is positing the idea that the unique identity of an individual is reflexively maintained through lots of interactions with others. It is this ‘reflexive life experience [...] which brings about the continuity of life history through cumulative understanding of oneself as a stack of autobiographical interpretations’ (Habermas 1972, p156).

Interaction and understanding are crucial in both Habermas’s early and later work. Interaction and understanding are intersubjective, that is between egos,
and this requires some form of mediation by definition:

(E)very form of interaction and mutual understanding between individuals is mediated by an intersubjectively valid employment of symbols that refer in the last instance to ordinary language. Language is the ground of intersubjectivity, and every person must already have set foot on it before he can objectivate himself in his first expression of life, whether in words, attitudes or actions [...] Language is the medium in which meanings are shared, not only in the cognitive sense but in the comprehensive sense of significance that encompasses affective and normative modes.

Habermas (1972, p157).

Here we have another sign as to Habermas’s later linguistic direction, guided by a view of the nature of the human life-world, as ego and as thing in reflexive communicative interaction. Without dialogue between people, in the sense of interpreted reflexive interactions, there can be no ego identity. Individuality therefore depends upon interaction.

Now that Habermas’s earlier thoughts on individual egos and their relation to each other have been reviewed it is possible to turn to his development of them in the theory of communicative action (Habermas 1991a, 1991b).

3.3 The social action context: the three worlds model

In his later work Habermas examines the presuppositions of social action in terms of 'the relations between actor and world' (Habermas, 1991, p76). This required the further development of the idea of a life-relation from a primarily cognitive relation, symbolically or linguistically mediated, into an action relation. This again is one of the key differences between knowledge and human interests and the theory of communicative action. The latter directly concerns actor-world relations while the former only really considers the ego and relations with an
unspecified world governed by cognitive interests. However in the theory of communicative action Habermas explicitly addresses the nature of the 'world' with which an ego (in his older terminology) can have a life relation in the form of five kinds of social action. To do this Habermas had to consider the nature of the context of the things and egos perceived at the 'other' end of the relationship - the theory of communicative action could not be developed without a model or theory of the 'world' in which action takes place. So I will now consider the nature of the world in which, according to Habermas, egos and things exist.

Habermas (1991a) follows Jarvie (1972) in adapting Popper's (1979) 'three-world' theory to explicate the context in which social action may occur. Habermas makes it clear that his use of the term 'world' refers to a perceived world which is an interpreted aspect of reality that therefore may not be perceived in the same way by another actor. He also makes it clear that this perceived world is not the same entity as the 'lifeworld' which I will return to shortly.

In Habermas's adaptation of Popper's theory an 'actor' (ego, subject, individual person or other simile) can have three 'actor-world relations'. These are life-relations to an objective world (of propositional truths), to a social world (shared by all members of a 'collective') and to the actor's own subjective world (Habermas, 1991a, p120).

Popper (1979) envisaged the three worlds as each containing real objects, though he argued that only the physical world contains physical things, the other two worlds contain 'virtual' objects about which objective knowledge could be produced. Habermas however rejects this version of the three world theory. Instead he maintains that the three worlds are distinct entities of which 'only
one, namely the objective world, can be understood objectively as the correlate of the totality of true propositions' and furthermore the special character of the three worlds is such that

taken together the worlds form a reference system that is mutually presupposed in communication processes. With this reference system participants lay down what there can possibly be understanding about at all.


In this can be seen the necessity of a model of the context of communicative action. Through this model Habermas can contextualise his previous (1972) criticisms about instrumentality, scientism and empiricism because:

Participants in communication who are seeking to come to an understanding with one another do not take up a relation only to the one objective world, as is suggested by the precommunicative model suggested by empiricism. They by no means refer only to things that happen or could be made to happen in the objective world, but to things in the social and subjective worlds as well. Speakers and hearers operate with a system of several equally primordial worlds.


Habermas's main purpose in utilising a three-worlds theory is to analyse the presuppositions of several kinds of social action of which one is communicative action. The distinctions between these forms of action will be discussed next.

3.4 Five kinds of social action

Habermas defines action as the process of ‘mastering situations’ (Habermas, 1990, p134) and distinguishes five types of social action: teleological, strategic, normatively regulated, dramaturgical and communicative action. Each form of social action is clearly distinguishable from the next by relating it to one of the primordial worlds mentioned previously and as shall become clear they can be
linked together through communication.

3.4.1 Teleological action

Habermas defines this as the action taken when an actor has decided it is the best way of realising a desired aim or outcome. It is the epitome of instrumental means-end mindedness but Habermas differentiates it from:

3.4.2 Strategic action

Habermas argues that strategic action can be regarded as a special case of teleological action when the actor can anticipate or guess the decisions of at least one other actor. The distinction is not necessarily clear since few social actions can be implemented regardless of other actor's decision making. Habermas argues that strategic action is often regarded as a utilitarian form of action: the actor acts strategically in order to maximise her/his utility. He regards this then as the form of action underpinning decision/game models in economics, sociology and social psychology.

Teleological and strategic action both assume that the actor is able to perceive an objective world. On the strength of this perception it is assumed that the actor is able independently and voluntarily to form beliefs and make decisions about what action to take.

The analytical quality of this form of action is that the actor concerned can make beliefs and intentions known as propositions about the objective world - i.e. claims to truth - that can be evaluated by others as true or false. Furthermore the
actor can carry out the intended action and others may judge whether or not it has succeeded or failed. This is a little more complicated in strategic action where the 'others' may be the objects strategically targeted by an actor feigning success or failure to gain an ultimate advantage.

3.4.3 **Normatively regulated action**

Actors who are members of a social group are, to an extent, identifiable as members of that group because they behave in particular ways characteristic of the group - in other words they conform to norms.

If a norm has relevance in a particular situation then some actions are preferred while others are barred because members of the group are 'entitled to expect a certain behaviour' (Habermas, 1991a, p85). That is the action may be judged to be right or wrong. Habermas identifies this form of action as the basis of role theory in sociology.

Judgments about normatively regulated action require a perception not only of the objective world but also of the social world. The social world delimits possible actions that might otherwise be wholly teleological in character. Habermas argues that as meaning in the objective world can be clarified by reference to the existence of 'objective' realities then, analogously, meaning in the social world is clarified with reference to the existence of norms.

This means that while truth and efficacy can be judged by others in relation to the objective world the rightness (or wrongness) of a normatively regulated action is
judged by others in relation to their general normative expectations (or 'norms') about what can, must or should be done.

According to Habermas the virtue of a norm is found in the assent that a valid action commands because the action will have been regulated in the social group's common interest. Habermas does not pursue how this common interest may have come about but it implies a process of environmental selection. For example first cousins do not marry because of the health consequences of inbreeding. In Darwinistic (or Dawkins, 1989) terms norms survive if they have survival value for a group that share in it.

Habermas (1991a) distinguishes between a social norm and a cultural value. The latter is an attitude but not an entitlement to certain actions taken by by others. It is less specific, more general, and potentially more variable. It does not in itself directly pose evaluative criteria and therefore cannot regulate action. A value may become a norm but if it does it will have acquired a specific nature that values do not have.

### 3.4.4 Dramaturgical action

When an actor 'presents' her/himself to an audience the

actor evokes in his public a certain image, an impression of himself, by more or less disclosing his own subjectivity. Each agent can monitor public access to the systems of his own intentions, thoughts, attitudes, desires, feelings, and the like, to which only he has privileged access. In Dramaturgical action participants make use of this and steer their interactions through regulating mutual access to their own subjectivities.

Habermas (1991a, p86)
If there were such a thing as a 'pure situation' then the actor is 'playing to an audience' and purely conveying her/his own interpretation of the drama. The actor is not acting strategically by trying to influence others by making up an interpretation. Nor is the actor acting as a normatively regulated member of a social group. To some extent this form of action can appear like a strategic goal-directed action because the actor reveals something of her/his subjective world in being 'seen by his public in a particular way' (Habermas, 1991, p90) and may do this with some goal in mind. Habermas argues that to be theoretically rigorous the notion of the subjective world must also have elements analogous to 'propositions' and 'norms' that can be contested by others. Therefore he posits 'sincerity' as the analytical quality of the subjective world. The public are then put in the position of making judgments, objectified as propositions, about the sincerity of the expression of an actors views, desires and feelings.

3.4.5 Communicative action

The final kind of action is the focus of Habermas's theory. Communicative action occurs when two or more actors

establish interpersonal relations (whether by verbal or extra-verbal means). The actors seek to reach an understanding about the action situation and their plans of action in order to coordinate their actions by way of agreement.

Habermas (1991a, p86.)

There are several points arising from this. Firstly Habermas emphasises that communicative action is not the same as acts of communication. The latter, speech for example, are simply physical acts in the objective world. Although an 'act of communication' is a very broad heading for a variety of symbolically mediated interactions (including body language for example), communicative action is dependent upon interpretation by actors who must negotiate a
definition of a situation with other actors. This means that language necessarily has a 'prominent place' (Habermas, 1991a, p86) in communicative action since it is the media by which understandings are achieved. Each of the other three forms of action have criteria that potentially enable someone else to make a judgment. Teleological and strategic actions have truth and efficacy criteria, normatively regulated actions have rightness criteria, dramaturgical actions have sincerity criteria. These criteria inevitably necessitate some form of language of expression or else they could not be appraised. However Habermas argues that only communicative action utilises a linguistic medium to allow speakers and hearers to refer simultaneously to all three worlds 'in order to negotiate common definitions of the situation' (Habermas, 1991, p95). It is this linguistic basis of these other forms of action that opens them up to argument and the coordination of action in general between actors.

Communicative action presumes that an individual is genuinely trying to reach an understanding with others, rather than being strategically manipulative or normatively regulated, and to that extent it is clearly teleological (Habermas, 1991a). This has led to the criticism from Dallmayr that Habermas's theory is individualistic and that it turns language into an instrumental tool, while overlooking more passive non-instrumental use of language (Dallmayr, 1984). However White (1988) counter-argues that Dallmayr fails to recognise both the practical and everyday teleological aspect of communication and its role as a context in Habermas's theory. However it is helpful to clarify what Habermas means when using the concept of 'understanding' as the telos of communicative action.
According to Habermas it is through acts of communication, in which understandings between people are reached, that all other forms of action can be coordinated. In fact for Habermas reaching understandings is the whole point of communication and this forms an anthropological imperative. He quotes Kanngiesser’s argument that ‘(t)he necessity for coordinated action generates in society a certain need for communication which must be met if it is to be possible to coordinate actions effectively for the purpose of satisfying needs’ (Kanngiesser, 1976, p278).

Habermas defines basic understanding as the knowledge of what makes a particular speech act acceptable. This means the listener must know what action the speech act refers to and what claims are inherent in it that would require agreement were it to be a basis for the coordination of actions between individuals. White (1988) does point out that Habermas also uses the phrase ‘reach an understanding’ to mean, in addition to the listener’s knowledge of the actions and claims being made by a speaker, that both listener and speaker do eventually actually agree with each other.

White cautions that these two meanings of understanding are often muddled by readers, so it is worth restating them in a slightly different way: to understand a speech act individuals must know what actions are being referred to, and what claims are inherent in it. There are then at least three possible degrees of agreement. Either (A) both speaker and listener heartily and completely agree in toto (in Habermas’s terms they have reached a full understanding); Or (B), the listener, though well aware of the claims being made (i.e. understands the speech act), does not agree with them, but both speaker and listener know and agree this
(a partial understanding). Or (C), finally, while the listener understands the speech act, she/he does not agree with the speaker but, furthermore, either one or both individuals are not aware of this (a fragmentary understanding).

Each of these possibilities represent degrees of understanding varying from very clear to very tenuous and they presume that in addition to the speech act claims being made clear that agreement or otherwise is signalled from one individual to another, for instance through another speech act. This has given rise to some controversy because Habermas argues that in order for listeners to fully understand a speaker they must necessarily be able to put themselves in the ‘shoes’ (as it were) of the speaker; that is, correct interpretation requires that a ‘performative attitude’ is adopted and that a ‘position’ is taken (Habermas, 1991a). This means that listeners are not neutral and could, if desired, signal their personal agreement or otherwise with the claims being made. If they are not in a ‘position’ to do this then, in Habermas’s view, they have not understood the speech act.

This seems very clear but both White (1988) and McCarthy (1984) disagree with this element of Habermas’s theory. The question is, does the listener’s knowledge of the claims being made necessarily entail agreement or disagreement? In both White’s and Thompson’s view, full understanding does not require a listener (who may be a third party interpreter) to ‘take a position’ as to the acceptability of any claims being made. They argue that judgment can be suspended while claims are nevertheless unerringly represented although McCarthy carefully explains that this does not mean adopting a value neutral or objective position. However this point seems less clear than Habermas’s and it is
resolvable in a practical way: action cannot be coordinated between individuals without judgments being made - there must be at least a partial understanding (point B above) between individuals (who beg to differ) and actions coordinated in respect of this. Moreover interpreters can be questioned as to their understanding of a speech act and if they cannot ‘take a position’ doubt may be cast on their grasp of the situation.

There is another corollary of the above which is that it is not necessary for individuals to have total agreement in order to coordinate their actions. Indeed, if understandings are created out of non-understanding, then there will always be matters not yet discussed, or understandings not fully achieved. That is action is probably nearly always coordinated through partial understandings. Yet the debate about ‘reaching an understanding’ has a static ‘once and for all’ feel which risks severely abridging the dynamism inherent in social relations. There will always be the need to establish and reestablish understandings in changing circumstances and this may mean that full understandings are always temporary and possibly quite rare. What would damage the ability to coordinate action is the failure to agree about differences - this would be a serious lack of understanding. A degree of understanding is necessary if action is to be coordinated socially.

Participants can reach an understanding but, given that claims can be disputed, what characteristic of an argument gives it ‘force’, thereby making it a basis for reaching agreement and coordinating social action, if strategic and normative ‘forces’ between actors have been somehow ‘neutralised’? Habermas’s answer is that rational arguments possess binding force deriving from the warranty offered
by a speaker (Habermas, 1991a). White explains the meaning of this as the 'underlying, mutual expectation between actors that they can, if challenged, defend the specific claims they raise, which in turn creates the 'binding force' for the coordination of action' (White, 1988, p35). What is perhaps underemphasised by Habermas (and White) is the expectation that the actor defending a claim will defend it to the challenger whoever that may be (for instance whether a lawyer or a learning disabled NHS user). While, as Habermas believes, there may be a universal anthropological imperative for understandings to reached, this will be constrained by strategic and normatively regulated action unless individuals are reliably committed to the institutionalisation of communicative action - in other words some process of dialogue. This commitment has previously been claimed to be related in some way to ideology (Gregory and Walsh, 1993, p177) - the communicative ideology of democratic debate in the public sphere.

The five kinds of action that have been reviewed are analysed by Habermas in terms of actor-world relations but he also considers the relation between social action and physical events such as the bodily movements involved in speaking. The relation between physical human acts and communicative action affects to what extent empirical observation can assist in reaching understandings so I will now explore this relationship.

3.5 Social action and physical events
Habermas argues that bodily movements are not actions in themselves but are merely operations through which social actions are mediated. In his theory of communicative action the most that can be said about a physical act, such as the uttering of a word or the making of a gesture, is whether or not it is 'well-
formed' (Habermas, 1991, p98) or in other words intelligible or coded correctly.

This situation arises because of the dualistic nature of an actor (as ego-thing) and the purely referential nature of an actors perceived three worlds. These 'worlds' are however only a linguistically based reference frame relating to the form and use of knowledge about social action.

Physical acts therefore are not represented by the three-world model except as linguistic statements. That is physical acts must be interpreted into linguistic statements in order for them to be analysed. Consequently actors may draw upon knowledge of physical acts for evidence in making judgments about action but judgment ultimately depends upon there being a way of showing that the use of a linguistic statement is based on a valid interpretation of the situation.

Although movement and physical change are signs of action, and are sometimes defined as 'basic actions' (Danto, 1965), Habermas chooses not to define them in this way. Instead Habermas regards them as operations that occur in the process of an action: 'A bodily movement is an element of an action but not an action' (Habermas, 1991a). This means also that although a physical event must take place in order to mediate the action (for instance in forming an utterance by saying a word), the judgment made by others about the efficacy, rightness and sincerity of the action cannot be dependent upon an empirical analysis of the movement. Furthermore Habermas (1991a) argues that the language of empirical observation is not 'basic'. To carry out a 'lie-test' for example by attaching sensors to a person's skin, requires observations that are also linguistic propositions about what has been observed. So propositions must be made about propositions *ad infinitum*, and all of which may be disputed: the familiar vicious
circle of empirical-analytical science.

Habermas argues that communicative action is not concerned with grammatical analysis, except in so far as an act of speech or writing is intelligible (which is a basic requirement), or any other form of linguistic analysis such as semantics, phonetics and other empirical/structural or scientific modes of linguistic investigation. Instead communicative action is concerned with the pragmatic use of language between speakers and listeners when they are unreservedly coordinating their individual actions on the basis of 'communicatively achieved agreement' (Habermas, 1991a, p305).

Now that the relation between physical events and social action has been explored and found to be limited in Habermas's view to a simple operational function of well-formedness it is possible to concentrate upon the non-physical aspects of communicative action. The next section is a discussion of speech acts and the validity claims associated with them. This will lead to the rigorous definition of a meaning of dialogue that then forms the basis for the rest of the thesis.

3.6 Communicative action and validity claims

Habermas argues that the first four forms of action may be judged according to particular criteria that are presupposed by the three worlds of actor-perception - objective, social and subjective. However, by what criteria can the judgment of one actor, expressed in the course of communicative action, be evaluated by another?
This is calling for a new set of criteria that are related to those by which the other forms of social actions are judged but, because of the intuitive background nature of the logic involved (Habermas, 1982), which gives communicative action its universalistic property. These criteria are validity claims made by speakers during acts of communication. Habermas identifies within an utterance (referred to linguistically as 'locution') two elements: propositional content and constative content (a form of 'illocution' or utterance with a specific intent such as a command). He also identifies three ways in which language is used: Speech acts in which propositions are made make cognitive use of language. Interactive use of language (of the constative speech component made up of commands, promises etc) establishes a relationship between people in conversation. Lastly expressive use of language states the intention of the speaker (Habermas, 1991a, pp286-305).

Now Habermas (1990, 1991a) also argues that any utterance relates to at least one of the three worlds - the referential frame of social actions - and in so doing make validity claims that exactly correspond to the use being made of the speech act. In the first place the simple act of speaking is a claim that what is being said is intelligible or 'well-formed' as Habermas puts it (Habermas, 1991a, p98). This is a precondition for any attempt to reach an understanding. The other speech act validity claims assume intelligibility as a given.

The other claims - truth, rightness and sincerity - are each related to one of the three worlds: cognitive use claims truth of proposition (for example by reference to objective facts). Interactive use claims rightness of interpersonal relations according to norms (for example by reference to what is socially 'acceptable') and
expressive use claims sincerity of the speakers intention.

Furthermore, Habermas argues that any particular speech act can make all three validity claims simultaneously: A speaker may claim to be stating something true about the objective world and normatively right about the social world. Finally the speaker is claiming to be sincerely stating their subjective world belief in the truth and rightness of their speech act (Habermas, 1991a, p278).

Actors that are listening can accept or deny, in a simple yes/no fashion, the truth, rightness or sincerity of another actor's utterance:

In rejecting a speech act as (normatively) wrong or untrue or insincere, he is expressing with his 'no' the fact that the utterance has not fulfilled it's function of securing an interpersonal relationship, or representing states of affairs, or of manifesting experiences. It is not in agreement with our world of legitimately ordered interpersonal relations, or with the world of existing states of affairs, or with the speakers own world of subjective experiences'.

Habermas, (1991a, p308.)

Speech acts and validity claims which form the mechanism of individual communicative actions are only part of the theory which concerns how situations are mastered. The three world theory is a tool used by Habermas to analyse the details of social action but it seems to fragment and reduces social action to do this. Yet social action inevitably involves a context into which it is integrated because it never comes 'out of the blue'. Habermas refers to this context as the lifeworld.
3.7 Lifeworld

Habermas (1991a, 1991b) has a specific vision of the lifeworld that he links to action, the concept of society and to the processes of rationalisation that he believes occur in modern society. He describes the lifeworld as a cognitive structure of 'taken for granted' and 'unproblematic' background knowledge (1991a, p335 and 1991b, chapter VI). Without this 'unproblematic' knowledge action would become impossible since action depends upon existing pre-reflective assumptions and 'naively mastered skills' (1991a, p335). It is this intuitive background that gives actors an 'everyday certainty' (Habermas, 1982, p234) about the status of validity claims.

Habermas also links the lifeworld, the necessary a-priori knowledge for the occurrence of any action, with concepts of society:

The concept of society has to be linked to a concept of the lifeworld that is complementary to the concept of communicative action. Communicative action provides the medium for the reproduction of the lifeworlds.

Habermas (1991a, p33)

'Society' is identified as a structural component of the lifeworld, along with 'Culture' and 'Person' (Habermas, 1991b, p142). The lifeworld is reproduced through processes that are linked to these structural elements - culturally reproductive, socially integrative and socialising - and mediated through communicative action. In particular the 'coordination of actions via intersubjectively recognised validity claims', a socially integrative process of which dialogue as defined previously is an example, reproduces the society element of the lifeworld (Habermas, 1991b, p144).
There is an ambiguity here in Habermas’s concept of the lifeworld that is worth clarifying. It is that while the lifeworld is described initially as simply (or merely) a cognitive structure of 'background knowledge', implying a local egocentric structure, Habermas eventually enriches the lifeworld into an highly differentiated and independent entity: a 'transcendental site' (Habermas, 1991b, p126) with all encompassing structural components from persons to whole societies. This goes beyond the narrow implications of local egocentrism. Indeed Habermas situates the processes of rationalisation of society 'more in implicitly known structures of the lifeworld' (Habermas, 1991a, p336) and therefore the lifeworld is not merely 'background knowledge' in individual minds but a locus for the action of reaching mutual understanding. In a way the lifeworld assumes a 'virtual reality' not unlike Popper's (1979) 'World 3'.

3.7.1 Actor-world relations, lifeworld segments and situations

The focus of the lifeworld is the 'actor' with the three 'actor-world relations' discussed previously. Communicative relations, the linguistic media of interaction between people, are 'embedded' in these three worlds simultaneously. Previously the three formal world-concept was used to analyse social action. Now the three worlds are being used to denote the reference system, the 'interpretive framework', within which actors who are talking to one another 'work out their common situation definitions' (Habermas, 1991a, p120).

Here Habermas has drawn implicitly upon his earlier work about the ego's life relation which 'firmly establishes' the significance of other things and egos (Habermas, 1972, p151). Only now Habermas clearly defines a 'situation' about which actors try to reach understandings that was left implicit in his earlier (1972) work. According to Habermas a situation is a shared context in which actions
may be defined and take place. It has spatial, temporal and normative dimensions. The normative dimension is a collective's shared and tacitly accepted framework of norms (Habermas, 1991b).

Situations are continually redefined by their actors as they 'negotiate' new or affirm old understandings with actors. The constant flux of definition and redefinition relies upon assumptions of 'commonality' between actors as to the content of their three worlds. Nor can these situations be sharply defined: they are a perceptual horizon moving with each change of theme - limited 'segments', of the portions of the lifeworld relevant to the situation (Habermas, 1991b, p122). Put another way the three dimensions of a situation are not absolute. They alter every time there is a new agreement, or disagreement, between the group of actors.

The greater the 'distance' along each dimension of the situation, the wider a situation is defined, the more uncertainty there is about the relevance, or the quality, of the background information called upon. So Habermas regards the immediate situation in which we are placed as a world 'that is within my actual reach' (Habermas, 1991b, p123). Raising our gaze more toward the horizon calls for a wider redefinition of our situation and reveals 'a world within my potential reach' (Habermas, 1991b, p123). Habermas has openly used Husserl's 'image of the horizon that shifts according to one's position and that can expand and shrink as one moves through the rough countryside' (Habermas, 1991b, p123 and Kuhn, 1940, p106). In this way situations are defined in the 'eye of the beholder', are never static, and they can be purposefully redefined by 'stepping over the boundary'.

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A simple example of a situation will help to clarify its meaning: some neighbours on an housing estate have a common perception about how far it is to the shops - a shared viewpoint about the spatial dimension of their situation. This common definition could alter simply if some physically fitter people move into the neighbourhood. There may be a redefinition resulting in a common perception of a single new situation: everyone agrees it is now a walk instead of a bus-ride, or there may be a conflict between actors who perceive two situations with slightly differing dimensions.

In each case, the appropriate background knowledge is enclosed within an horizon of relevance to the situation and includes perceptions common to each actor such as subjective estimations of distance, objective information - the number of the bus service - and norms about an acceptable distance to walk.

The horizon of relevance may be altered abruptly, and deliberately, if a new closer shopping development is proposed and then contested on planning grounds. Suddenly local people may have to accommodate vague or unfamiliar new relevancies within the old situation such as the council's planning department and local political parties. The world within potential reach acquires new significance.

3.7.2 Situations and action
In the above example the immediate situation, a lifeworld segment of local significance, had always been a focus for some action, such as getting a bus or
taking a walk, or talking to someone. Some actions have been a part of the redefinition of the situation which will itself lead actors to take some new forms of action. From this it can be seen that a situation is a locus both in defining and being reflexively defined by action (a very similar notion to Giddens' (1984) theory of structuration.

To an actor this locus is the 'centre of their lifeworld' as Habermas (1991b, p126) puts it. But as soon as a redefinition takes place, and new relevancies of taken-for-granted possibly unconscious knowledge are called upon, this newly relevant knowledge becomes contestable. Habermas finds that this analysis, based on action oriented to reaching understandings and on strategic action, is inadequate however because societies are also reproduced and integrated by other mechanisms that are not reliant upon social action. In this way Habermas introduces the notion of system into his theory.

3.7.3 System and lifeworld

Habermas defines situations (or 'lifeworld segments') in terms of three dimensions - spatial, temporal and normative. In this context actions have spatial, temporal and normative consequences, but often these are the coordinated but nevertheless unintended outcomes of individual and collective actions. Habermas argues that

goal-directed actions are coordinated not only through processes of reaching understanding, but also through functional interconnections that are not intended by them and are usually not even perceived within the horizon of everyday practice. In capitalist societies the market is the most important example of a norm-free regulation of cooperative contexts. The market is one of those systemic mechanisms that stabilise non-intended interconnections of action by way of fundamentally intermeshing action consequences, whereas the mechanism of mutual understanding harmonises the action orientations of participants.
Habermas (1991b, p150)

It is this 'functional interconnection', a mechanism for involvement and influence mediated through countless transactions (whether of market or some other kind) that leads Habermas to propose a system element to the theory of communicative action and a systemic definition of society: 'societies are systemically stabilised complexes of action of socially integrated groups' (1991b, p152). This definition is explicitly developed from Parson's systems theory of society which is based upon structural differentiation and functional integration.

According to Habermas the relationship between social action and society is systemic and steered by 'blind' mechanisms of which markets are the chief example. The very blindness of these mechanisms and the unreflective nature of instrumental thinking limit and constrain the rationalisation of society to which the only response is a public renaissance of communicative action. In its own small way this thesis attempts to contribute to that renaissance. However in order to illustrate and bring out some of the implications of the theory I will now contrast rational choice (a synonym for the strategic action that central to the economic theory of markets) with communicative action and the respective broad modes of management they support - competition versus collaboration.

3.8 Rational choice

The view that people are wholly selfish individuals who will always do that which they believe to be in their own best interests, in other words maximise utility, is a standard assumption made by economists. It is usually called 'rational choice' (White, 1988) and this view has been severely criticised because of the number of assumptions necessary to make economic theories empirically
verifiable. These assumptions are often disguised as *ceteris paribus* ('other things being equal') clauses (Rosenberg, 1988).

For instance if offered a choice between half a biscuit and whole biscuit most people would, other things being equal, choose the whole biscuit. That would be a rational choice. It would be irrational to choose the half biscuit unless other things were not equal such as the recipes of the biscuits, or the health of the subjects chosen for the experiment. Similarly other experimental situations can be contrived in which the rational choice appears intuitively obvious. It is on the basis of induction from this simple situation that economic theory arrives at rational choice which Habermas (1991a) identifies as a form of strategic social action - only one of five kinds of social action.

Yet the theory of rational choice breaks down immediately at *ceteris paribus*. In day to day life very few things can be demonstrably equal. Only under the strictest laboratory control can a majority of variables be accounted for and individuals do not usually live in laboratories.

Very often deep seated problems in the theory of rational choices result in anomalies like the *caring externality* (Mooney, 1993) which means that individuals seem to obtain utility out of providing care for nothing. Indeed the way Mooney uses the term seems to imply that care is something given without payment. Such anomalies are serious because they are are regarded as one of the reasons health care markets are, in Mooney's economic terms, *inefficient*. 
The problem of individuals providing price-free services is just one reason why it is not surprising to discover internationally that all health care markets are peculiar under whatever political system. Other reasons are the dominance of experts as gatekeepers for public access to services, the reliance on insurance to finance health care, the lack of information and so on (Mooney, 1993). Moreover rational choice is not considered politically reliable as a basis for the market allocation of health services. As it was shown in chapter 2 the NHS has survived the era of privatisation (more or less) intact when capitalist logic would suggest that it be sold off, and given over to blind steering mechanisms, with an immense short term tax payoff.

According to economists rational choice should lead to bargaining over price, quality and delivery of goods and services. It is this theory that underpins the NHS reforms of 1989 in which the so called ‘internal market’ was created (Department of Health, 1989a). Yet rational bargains can only be struck if there is adequate information. If information is less than perfect then inefficiencies will appear. Since bargains require the least concessions for the greatest gains, in other words maximum profit, this will involve concealing information about strengths and weaknesses and making maximum use of certainty and uncertainty to weaken the resolve of the other party. Put simply economic truth is the first casualty of economic war which is central to economic ‘competition red in tooth and claw’ (Maynard, 1992).

Selfish bargaining means that concern for others may be seen to be a weakness to be exploited in pursuit of maximum gains. The concealment of information and promotion of uncertainty further limits the information available about

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alternative actions. These are constraints that necessarily offer fewer potential resolutions to a situation than rational argumentation through which all forms of social action may be coordinated and to which I now turn.

It is possible to conceive of a quantitative difference between rational choice and communicative action in the number of options for individual action that are available to those involved. This can be explored through the famous prisoner’s dilemma.

3.9 The prisoners dilemma
The original model concerned two prisoners who are accused of committing a joint crime (Rosenberg, 1988). They are isolated from one another but independently offered enormous incentives by the gaoler to ‘sell out’ their crony - or be sold out. If the prisoners cooperate with each other by refusing to blame the other then they know they will soon be released to benefit equally from their crime - a moderate reward. If the prisoners both defect and lay the blame on the other then they will each receive short jail sentences and must wait longer to benefit - a moderate penalty. If however one defects while the other cooperates the latter will be fully blamed and be given a life sentence - a massive penalty - while the former will go free to enjoy all the ill-gotten gains - a massive reward.

In Habermasian terms the prisoners are faced with deciding a course of teleological action by guessing what the other prisoner is going to do. Analytically the teleological action involves two elements: deciding which teleological goal the other prisoner will pursue knowing he is faced with the same situation and payoffs. Then deciding what action to take - cooperate or
It is usually assumed that individuals are risk averse (Wharton, 1992) meaning in economic terms that they strive to maximise their expected utility while avoiding losses. Or, to put it another way, it is 'bottom line' preference to live with a small loss and the possibility of a big gain than with a small gain and the possibility of losing everything.

Most observers would probably agree in the light of this that the individual rational choice in the dilemma is to defect since this automatically avoids a massive penalty and offers either an individually moderate penalty or a potentially massive reward. Cooperation yields either a moderate reward or the loss of everything. Consequently it is assumed that both prisoners will inevitably defect and the payoff will be a moderate penalty to each. It is also assumed that this is what the gaoler wants.

The notion of the prisoners dilemma as a one off once and for all situation is used to explore the theory of rational choice. However it is recognised that this is only one version of the dilemma. An alternative is the prisoners dilemma in a repeated situation (Rosenberg, 1988). The payoffs differ slightly - it takes repetitions to build up the rewards and the penalties. The prisoners are told what action the other took and they can change their action from occasion to occasion. Thus they can act strategically rather than merely teleologically.

In this situation the prisoners have the option of cooperating without incurring
massive short term penalties. Cooperation is a viable 'something for nothing' short term strategy. If one prisoner cooperates and the other responds by similarly cooperating then they can achieve a cooperate-cooperate outcome with a moderate reward rather than the alternative inevitable moderate penalty. It would be considered pathological if one prisoner continued to cooperate while the other defected because this would build up a massive penalty.

This notion of repeated prisoners dilemmas has been explored extensively in the management literature particularly in the field of games theory (e.g. see Ward, 1989). In these discussions the rewards and penalties are no longer usually allocated by a sole human authority. More often the method of payoff is implicit in the discussion and it is often down to an economic 'invisible hand' type mechanism. This replacement of a discrete and manipulative human authority with a natural mechanism has been used by Dawkins (1989) to model cooperation between species in the natural world. However Dawkins is able to remove all human cognition from his model: he models cooperation and competition amongst birds and crocodiles (amongst other organisms) - some of the least 'intelligent' and most 'instinctive' forms of life known.

Dawkins argues that randomly arising instances of cooperation between individuals of differing species that might otherwise eat or avoid each other, coincidently increases their individual prospects for survival and the transmission of cooperative genes. Therefore certain species of birds can be seen earning a living by cleaning crocodiles teeth. Both crocodiles and the birds cooperate. Crocodiles get improved dental protection, which is crucial to their lifestyle while the birds get a free lunch without any fear of predation from other animals. At any time a croc can defect and eat the bird - but the crocodiles that do
this will on the whole not prosper in great numbers - they will fail to pass on their less collaborative and more competitive genes. Similarly birds may not clean crocodile teeth but they too will tend not to prosper because they miss the free safe food supply. Repeated cooperation between individuals of species when established in this situation produces a longer term social payoff, through a 'blind' natural world steering mechanism, because the partner's overall competitiveness is enhanced. Cooperate-cooperate is a better long term social strategy than defect-defect. Cooperate-defect is inherently unstable. If all birds were eaten by crocodiles there would be no birds left to pass on 'suicide' genes.

This natural world analogy is extended by Dawkins back into the social world on the issue of the North Sea fishing and competitive fish markets. Since fish stocks have become depleted fishing has become regulated. If all fishermen cooperate and continually land small quotas there will continue to be fish available for the foreseeable future providing a modest long term reward for fishing. If some fishermen defect and land large catches then they can make a large amount of money - those who do not break their quotas are losing big potential rewards and may be regarded as less viable long term businesses. Yet if all fishermen did this very soon there would be no fish at all. The long term reward for repeated defect-defect is the end of the fishing industry yet this is the only viable resolution of the dilemma, unless there is some totally reliable means of social regulation - in other words policing of the cooperate-cooperate strategy.

Similar situations can be constructed out of more common experiences - any situation in fact where there are identifiable alternatives of competition or cooperation with the familiar pattern of payoffs.
So in Habermasian terms what is the characteristic in a prisoners’ dilemma that enables a cooperate-cooperate social strategy to succeed? It is the sincerity of the claim made by another individual or group that is the crucial factor in deciding whether or not one could cooperate. If sincerity in other parties cannot be established then the prisoners’ dilemma leads inevitably to the short term rational choice of defect. This becomes a double defect in fact - the least desirable collective solution to a social problem.

3.10 Competition versus cooperation

If communicative action can be established between stakeholders in a prisoners dilemma then sincerity can be checked and options for cooperative action will become available that are otherwise not viable. On the one hand because without evidence of sincerity there are risks and uncertainties in cooperation and, on the other hand, because some options will simply remain unexplored or even unknowable because of the way information is strategically exploited. Collaboration, in repeated prisoners dilemmas, is the key to longer term stability and prosperity, although this does not mean that stakeholders will choose to cooperate because a big payoff for defect will always threaten cooperation.

The prisoners’ dilemma is only one way of exploring rational choice and only one scenario although it is an important model. The model is nevertheless very narrow. It is not the general case of human choices but a special case in which defect at low risk for an extra special reward is possible at any time. Very often in social situations the payoffs are not nearly so clear cut and the repetition of a situation is cognitively dependent rather than reproductively dependent as in
Dawkins natural world examples. Instead of the 'blind watchmaker' (Dawkins 1989) acting over aeons in the natural world there is the social world analogue of Adam Smith's 'invisible hand' (Smith 1910) or Habermas's steering mechanism acting over hours, days, months and years. The model has served to show however that economic and political competition may lead to undesirable social outcomes.

A key assumption of the prisoners dilemma though is the mutual exclusivity of competition and cooperation - but even competitive social, economic and political markets require a degree of collaboration. Midgley (1992) comments that his ideal of collaboration in research and change might seem at odds with the antagonistic, even competitive, necessity of independent viewpoint formulation. This is resolved in Midgely's model by the presence of a common forum in which an understanding may be achieved between otherwise potentially anarchically competitive viewpoints. In other words there are presumed commitments to communicative action and a forum for it to occur.

This simply emphasises that competition and collaboration are not at opposite ends of a continuum as may be supposed. The logical opposite of collaboration is anarchy which as Flood (1993) observes is what all the actors in a situation are trying to avoid. Competition is a special case of collaboration. Therefore competition is regulated in economic markets (see Maynard's (1992) comments on competition). Indeed there is such a thing as unfair competition and exploitation recognised in law in the Western world. Black markets are abhorred by socialists and capitalists alike - drug pushers for example operate in a black market.
3.11 The conditions for dialogue

Although Habermas argues for communicative action, as a critical basis for coordinating action, he does not clearly state the arrangements that would have to be made to operationalise his theory. Any such methodological steps are implied within the body of his theory. One way of beginning to understand the practical implications of the theory of communicative action is to consider it within a special process of dialogue. This term is frequently used to indicate that two or more actors are communicating with each other with the serious intention of increasing mutual understanding.

According to the Oxford English Dictionary (Sykes, 1976) the term can simply refer to a conversation between people, or to a piece of written or dramatic work in the form of conversation, or to an exchange of proposals between parties. However the term is used in many more walks of life and this is reflected in the general literature. For instance, it is used to refer to an educational approach to children with learning difficulties (Englert, Tarrant, Mariage, Oxer 1994). Jackson (1991a) uses the term in a loose ill-defined sense when referring to the need for communication between advocates of differing positions in systems science. So does Reed (1992a) on the sociology of organisations. Other authors use the term in a more purely sociological context: Bubner (1982) uses the term in his critique of Habermas while Baumann (1992) develops a postmodern meaning for the term. The term dialogue generally implies notions of a presumed diversity of viewpoints, an ethical attitude that dialogue is right and necessary, and that there are suitable structures and processes for social action to occur in the light of dialogue. My concern is with certain normative and structural conditions of the process which determine when, how and between whom communicative action

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should occur. I shall bring out aspects of these conditions of Habermas’s theory by contrasting Bauman’s postmodern view of dialogue with Habermas’s views but I do not intend to launch into a large scale modern-postmodern debate. Rather I simply wish to show that for dialogue to have a role in society in general suitable arrangements have to be made to expedite it and that this can be accessibly understood as a democratic and egalitarian process aimed at defining and pursuing fair goals. I shall begin with the postmodern view of dialogue represented by Bauman.

Baumann (1992) argues that dialogue is the special conditional process of communication between individuals when those with differing viewpoints are not merely tolerated by others out of ‘generosity’ but are accepted and respected for their differing viewpoints which are deemed to be equally relevant and valid (ppxxi-xxii). This means that there is no claimable universally appropriate viewpoint - this is one of the defining features of Bauman’s postmodern perspective. He would argue that there is no way of evaluating social action in the way proposed by Habermas which suggests that there is an ultimate and universally agreeable ethic for action (Habermas 1991b). Bauman rejects this presumed ultimate objectivity.

This sounds like an invitation into ethical relativism - all views are equally valid and good for the believer to act on - but Bauman carefully qualifies this in what seems to be a typically negative postmodern way: if all actions are pronounced equally valid (no matter how barbaric) then this simply reasserts selfish, individual ‘superiority’ by permitting immoral things to happen (pxxiii). Instead Bauman advocates individual responsibility for moral choice but without the
prop of some universal guidance however this is supposed to be obtained. Bauman’s viewpoint therefore effectively seems to rule out a Habermasian form of communicative action as an element of a dialogue process.

Indeed Bauman rejects the idea that sociology can define the conditions for a dialogue process. He follows Bakhtin (1986) in claiming that modern sociology (like that of Habermas) is monological: By this he means that it treats its subjects as objects, not as conscious partners in dialogue (Baumann 1992, p78). Moreover it is un-democratic, meaning that it supports the ‘accomplishments of the powers that be’ as ‘objectively given and non-negotiable ‘facts of reality’’ (Baumann 1992, p78). Modern sociology, Bauman argues, accepts ‘without questioning the right of the managers of social processes to determine the distinction between proper and improper’ (Baumann 1992, p78). Instead Bauman argues that dialogue is the way in which subjective authority can be produced:

Purposes can no longer be substantiated monologically; having become perforce subjects of dialogue, they must now refer to principles wide enough to command authority of the sort that belongs solely to ethical values.

Baumann (1992, p202)

However Bauman’s views on modern sociology seem to be both too pessimistic and too sweeping. Habermas would completely reject the idea that modern sociology always unquestioningly supports arrogant objectivity in managing social processes. Habermas pursues quite the opposite path to that criticised by Bauman. He opposes the instrumentalism that is implicit in monologic - as I have discussed earlier. He produced the theory of communicative action in opposition to such instrumentality. Habermas rejects the strategy of monologic and advocates a dialogic involving actors in reaching understandings where they have some confidence as to what is agreed and disagreed upon and what is
So while Habermas's theory of communicative action is built on a notion of universal ethics this is achieved through debate between subjects in the public sphere. Such debate is conducted because there is a diversity of viewpoints with no a-priori knowledge of which is 'the' best. Moreover conclusions are always tentative. In practical terms perhaps the most fundamental aspect of the theory of communicative action is the option of an individual to say 'no' (or 'not yes') to a validity claim: - I do not understand your words, or I do not think you are being sincere, or I do not think that your view is moral or finally I do not believe that the 'facts' you have provided support your point of view. This is in the expectation that there will be a genuine attempt to respond.

The universal 'rational' society is not homogeneous or homogenised by some arrogant powerful authority or code as is implied and decried by Bauman. That is the antithesis of what Habermas would agree is a rational society in which individuals must be able to challenge and receive answer on any such proposed code at any time. In the theory of communicative action Habermas does not specify a universal moral code or formula by which to make judgments about what is proper. What he does do is argue that social action is decided very often without communicative action between those whom it involves and that this fact should be changed. In other words there should not be a universal code but an accessible process in which moral argumentation can occur. McCarthy puts it this way:

The aim of the latter is to reconstruct the moral point of view as the perspective from which competing claims can be fairly and impartially adjudicated. Like Kant, Habermas understands this sort of practical reasoning as universal in import: it is geared to
what everyone could radically will to be a norm binding on everyone alike. His 'discourse ethics', however, replaces Kant's categorical imperatives with a procedure of moral argumentation: normative justification is tied to reasoned agreement among those subject to the norm in question.

Thomas McCarthy (1990, p.viii)

In general then the absence of challenges to validity claims or responses to them are potential distortions not only of argument but also of justice. If an actor does not have the option to say 'no' to a validity claim then they cannot coordinate their actions with others on the basis of genuine understanding. With unequal access to the forum at best they are faced with making solo decisions to act, in spite or ignorance of what other people think, either as selfish or unwilling competitors - a recipe for loneliness. Or they can conform mindlessly or unwillingly to dominant norms or they can be driven by other people's strategies and be forced into a corner. None of these options will tend to eliminate unfairness in the NHS quality gap. Habermas (1991b) identifies such communicative failure as a 'pathology' of society.

However Habermas argues that individuals do attempt to reach genuine understandings with others. Indeed life cannot be lived without communicative action and in the absence of understandings - Habermas argues that it is the way that the lifeworld and society are reproduced. It is simply that it does not always occur when and in the way it should because of distorting factors and it is veiled by complex human society.

Perhaps the most important methodological principle of the theory of communicative action is the option to say 'no' to some claim to validity being
made. It is this option that defines the democratic conditions for dialogue. To argue against the idea that everyone is entitled to exercise the option means arguing for the undemocratic and inegalitarian monologic deprecated by Bauman, or for ethical relativism. Habermas at least provides an indication of the mechanism to satisfy Bauman's postmodern call for the 'authority' of ethical propositions to be tested: it is through the democratic responsibility of someone making a proposition to redeem the validity claims inherent in it when challenged. In other words can you substantiate your view if someone says 'no' to the claims you are making? Of course the problems are who genuinely has this democratic option? How can it be operationalised? Would anyone bother responding?

The optimistic answer to the latter question, based on the view that individuals instinctively need to coordinate actions, is yes but without special arrangements most people may never have the opportunity to exercise the option to say 'no' because of the general emphasis on strategic action. This is the democratic hot potato which Bauman avoids by rather sweepingly condemning 'social engineering' (1992, pxxiv) in favour of a new class of 'moral subjects':

All in all, in the postmodern context agents are constantly faced with moral issues and obliged to choose between equally well founded (or equally unfounded) ethical precepts. The choice always means the assumption of responsibility, and for this reason bears the character of a moral act. Under the postmodern condition the actor is perforce not just an actor and decision-maker, but a moral subject. The performance of life functions demands also that the agent be a morally competent subject.

Baumann (1992, p203)

But unless there is a collective democratic solution to the problem of inequalities how can individuals learn to be morally competent? How can they learn to live
out their moral subjectivity? How do they get the life-chance? Or is postmodern ethics always to be lived out by the privileged few in the interstices of whatever political system is thrown up by society? If so then the majority of people who will ever live risk becoming powerless victims, bereft of the means of critique, rather than empowered moral subjects. Bauman cannot avoid making some collective arrangements for dialogue or else he simply favours some strong and fortunate people (who may have had access to his book).

Therefore it is a mistake automatically to regard the institution of dialogue as simply more social engineering because *structure counts* a premise that is missing it seems from postmodern critiques such as that offered by Taket and White (1994). The theory of communicative action does suggest that a suitable democratic arrangement can be conceived of in which individuals may equably exercise their option to challenge the claims being made by others. Habermas implies that a democratic structure is a prerequisite for justice to be done because it is necessary to establish, in his words, ‘a *procedure* based on presuppositions and designed to guarantee the impartiality of judging’ (Habermas 1990, p122).

To make such a procedure work ideally requires that there be equal access to the process for all citizens. A good enough process is one in which equality of access is striven for as a basic commitment of participation. The commitment to equality of access is the acid test of dialogue and without it there remain only markets or norms or moral subjectivity as modes of management. As I have attempted to argue in this chapter none of these are likely to reduce the unfairness inherent in the quality gap of the NHS because they do not address fundamental social inequalities. Perhaps a better way of explaining the *acrimony*
over the NHS quality gap is because there is a lack of dialogue. Without dialogue there can be no overall just resolution to quality matters. On the other hand if dialogue were to occur between NHS users, purchasers and providers issues of inequality and inconsistency could be resolved in ways that are not amenable to the blind or part-regulated steering of market forces. What is needed then are some arrangements to be made for dialogue on quality between NHS purchasers, providers and users. Through this the concept of quality can be made intelligible, goals can be ratified as right and genuine by the public, and understandings can be reached about the situation in common.

Although the theory of communicative action points the way toward a continuing dialogical process of resolution of the NHS quality gap how this can be pragmatised is yet to be dealt with. To assist in this task the Habermasian definition of a situation can be taken further by considering and characterising the circumstances in which individual and group actors (or ‘stakeholders’) employ the various categories of social action. In the next chapter therefore I will suggest how social action relationships between identified stakeholders can be modelled.
White (1988) explains that Habermas's *knowledge and human interest* has attracted much criticism, especially the accusation that his theory is philosophically *foundationalist*, meaning that it claims a universal basis for morality or knowledge. This includes the notion, for example, that all morally *just* acts 'partake of a common nature, which will be found in whatever is just and in nothing else' (Russell, 1912). White argues that Habermas has dealt with these criticisms by undertaking his linguistic turn. Instead of identifying full blown Kantian universal conditions for all possible knowledge, Habermas *hypothesises* that conditions of validity of expression can be identified through the reconstruction of what is intuitively in-built into speech. As well as being a logical task in which contradictions can be screened out it is also an empirical task (Habermas, 1991). Habermas rejects the idea that formulating hypothetical universals for empirical testing is the same as *being* foundationalist (Habermas, 1990, ch.1). Instead philosophy can merely 'stand-in' and be 'interpreter' for a while, whilst hypothetical reconstructions are tested out in empirical research projects. Philosophy did not produce science and technology, law and morality and aesthetics. These came into being 'without the aid of philosophy' (Habermas, 1990, ch.1, and see; Habermas, 1991). Of course this has led to accusations that there is no difference between Habermasian 'reconstructive science' hypotheses and those of the positivistic science he criticises (for example see Alford (1985). It seems to me that one of the key characteristics of positivistic science is the lack of reflection on the grounds for verification or falsification of theory. Strangely enough Habermas's theory of communicative action addresses the conditions under which such grounds can be challenged. To that extent there is clear water between the hypotheses contained within the theory of communicative action and those of positivistic science. In the second volume of the theory of communicative action Habermas (1991) enlarges on the reconstructive sciences to which the interested reader can refer.
Virtual objects in Popper’s three worlds theory are not physical but nevertheless exist independently of individual egos. Mind / body duality, which Popper argues has dominated Western philosophy, exemplifies two worlds. The body personifies the real physical world. The mind is a world of ‘mental states’ and contains ‘subjective or personal experiences’ (Popper, 1979, p155). However Popper argues that a third world can be discerned - a world of ‘ideas in the objective sense’ which contains theories, their logical relations, arguments and problem situations, (p154) Together these form a theory which ‘transcends the dualistic schema’ (Popper, 1979, p154). Responding to criticisms Popper dropped the terms first, second and third world replacing them with world 1, world 2 and world 3.

It is ironic that Habermas who opposes scientism is sucked into implying a process of ‘natural selection’ of norms because this idea is very similar to the ‘meme’ posited by Dawkins (1989). Dawkins is an archetypical scientist who argues that ideas reproduce in a way contingent upon their environment. He suggests that God is one such idea propagated by the human fear of eternal hellfire and damnation.

Rational choice has a big and influential lobby. Classical works include Downs (1957) and Olsen (1971). Pirie (1988) and Dunleavy (1991) are more contemporary examples of the rational choice view. Mooney (1993) could not have written his book without making rational choice assumptions. None of these authors deal adequately with non-strategic forms of social action.

Let me be personal for a moment - I worry about my children: I want them to have the option to say ‘no’ to some outrageous policy made by a third party (like sending my daughter to a special school), and crucially, to be entitled to the justification (which currently they are not). Of course if no-one else shares this democratic viewpoint then there is nothing that can be done other than to resist and struggle for a brief lifetime. However I do not know that this is the case. So I shall argue for dialogue as a mode of local, national and international management. Enough people call for dialogue - so why not be optimistic?
Chapter 4

Pressure group politics

In the previous chapter it was argued that social action occurs in a context defined as a situation - a segment of the lifeworld - and that there is a constant flux of definition and redefinition of the situation as participants negotiate a common understanding of it. What has not been described yet is how the theory of communicative action can be applied in a constructive way to 'real' situations and so the task in this chapter is show how situations can be analysed in terms of social action.

The political theory of interest groups provides a useful starting point for this discussion. In particular Grant (1989) provides a ready made model of interest group relationships with the British government that can be modified and enriched. In fact Grant's model can be developed to assist in understanding political relations in a variety of situations involving groups of people in a way that is far more generalised than his original proposal with the help of the theoretical discussion of social action undertaken in chapter four. This chapter outlines Grant's original version of his interest group model taking in the theoretical issues as he presents them. The model is then enriched and applied to three scenarios both to explain them but reciprocally to illuminate the model.

4.1 Insiders and outsiders

Grant's (1989) insider/outsider classification of interest group strategies is a
simple but flexible model of the relationships that may exist between pressure
groups and Government. He focusses on Government-pressure group relations
because he regarded this as the general case of political processes in any
democratic society. Grant distinguishes this from other situations where a
specific organisation is being challenged by an 'internal' pressure group as, for
example, occurred in the Anglican Church over many years on the issue of the
ordination of women.

The first point to note is that in Grant's model there must be an authority (the
Government) capable of making important decisions that can be influenced by
'pressure'. Grant does not clearly say what the 'pressure' is but leaves this to be
implied by the tactics employed. For example, Grant mentions acts of violence,
the entertainment of members of Parliament, letter writing, personal persuasion
and use of the media as ways of exerting pressure on the Government. He also
argues that pressure is at least one part of a bargaining process (Grant, 1989 p18).

Grant argues that pressure groups are defined by the existence of a clear cut
membership and group objectives and often their employment of paid staff. He
differentiates organised pressure groups from unorganised 'interests' by arguing
that pressure groups may promote 'amorphous' interests which are often
economically or socially defined (e.g.: Sheffield Pensioners Action Group or
'SPAG' ostensibly represents working class retired people in Sheffield). Grant
typifies groups whose main objective is to apply pressure as 'primary' groups.
However exerting political pressure may be secondary objective since many
'secondary' groups exist mainly to supply a service to their members as in the
Royal Automobile Club. 'Sectional' groups represent a sector of the community
(e.g.: SPAG or Age Concern) while 'cause' groups represent a particular ideal or
principle (e.g.: Friends of the Earth).

However, the most useful and important element of Grant's model for the theory and practice of dialogue is that of pressure group strategy. Pressure groups can be regarded as 'insiders' or 'outsiders' with respect to the Government. In fact Grant identifies a whole range of inside or outside strategies: Insider, thresher, outsider and these are subdivided: prisoner, potential insider, low profile insider, high profile insider, outsider by necessity and ideological outsiders.

Grant defines prisoner insider groups as those that are virtual extensions of government departments in helping to form and implement Government policy as at times, arguably, has the Confederation of British Industry (CBI). The other insider groups may adopt very public (high profile) or hidden (low profile) roles in helping to formulate and implement Government policy. Thresholder groups were identified by May and Nugent (1987) as groups that might at times be insider or outsider. Potential insider groups seek closer relationships with Government. Outsider groups by necessity are simply less politically able than potential insider groups. At the other extreme to prisoner insider groups are ideological outsider pressure groups whose members see no lawful means of achieving their goals and act accordingly - paramilitary terrorist groups, among others, fall into this category. Between these extremes of Grant's classification are degrees of insider/outsider strategy.

Group strategies might alter over time moving them closer to or further away from the Government. It is possible that some pressure groups might have
'insider' and 'outsider' factions. Government too might alter its position with respect to the interest groups - especially if there is a change of government.

4.2 The pressure group context - political pluralism, democracy and efficiency

Pressure group activity does not occur in a vacuum. Grant defines a context in which pressure groups operate their strategies with respect to government. This context Grant defines as one of political pluralism\(^2\) which he contrasts with that of political corporatism.\(^3\) What Grant does not discuss is how pressure groups relate to each other, something I redress later in this chapter.

According to Grant pluralism is, broadly speaking, a context where there are many pressure groups with competing interests in a 'balanced' situation, of distinct 'issue areas', where 'power in society is fragmented and dispersed' (Grant, 1989, p25). The pressure groups are themselves distinct and diverse with differing styles, tactics and strategies.

Grant also argues that in theory pluralism should mean that pressure groups can easily form and disappear although he admits that this does not occur in practice. For one thing some pressure groups acquire assets that enable them to continue in the long term while other potential groups are too poor to come into being. What Grant argues is a balanced situation can also be construed as an unfair and illegitimate situation. However while Grant agrees that there is a potential distortion of democracy by the reinforcing of the political status quo by pressure groups - particularly business interests - he emphasises that pluralism does not mean that there is equality of access to, or influence over, the political process.
He argues without giving precise reasons that if this occurred it would 'paralyse' the political system. Perhaps Grant believes that for everyone to have access to the political process would 'tie it up' with an endless trivial agenda.

So what is it in Grant’s view that makes the competitive dominance of some pressure groups under political pluralism both legitimate and rational? On the one hand Grant takes refuge in the power of democracy explaining away the special position of business as ‘a value choice of society, expressed through the outcome of elections, in favour of a capitalist, free enterprise society’ (Grant, 1989, p22). On the other hand Grant argues that Governments need the advice, support and cooperation of interest groups (among them businesses) in forming and implementing policy. Groups therefore tend to dominate if they have something especially valuable to contribute in the national interest and they improve democracy by ‘contributing to the quality of the decision making process. Those that have axes to grind may something to say that is relevant to the issue under consideration’ (Grant, 1989, p21). Consequently pressure groups allow democracy to register the intensity of opinion and the quality of argument rather than simply the number of votes cast.

These views certainly need some qualifying. It is not clear for example that the pluralistic conditions of balance described by Grant actually do or could exist although he advocates them. Furthermore the characterisation of society as an entity capable of making ‘value choices’ demands clarification. In what way has ‘society’ (reified by Grant) made an ethical choice on behalf of its members that they should accept? Grant seems to be trying to legitimate what a substantial number of individuals find unacceptable - the inequalities in society and a lack of
dialogue. Yet if dialogue is lacking then there is no way those who do not like the status quo ‘value-choice’ to register their disapproval - the messages will be garbled and distorted. Only those with sufficient power can ‘break through’. Society cannot make a democratic ‘value choice’ in the fashion presumed by Grant unless he defines democracy as a ‘pecking order’ dominated by strategic and normatively regulated action. Nevertheless Grant makes what at first seems to be a good point: equal access would lead to political paralysis. Surely there would be no point in desiring equitable access to a process that ceased to exist because of decisiveness or sheer complexity?

However Grant does not substantiate this problem. He does not demonstrate that equity necessarily equals paralysis. It would be more productive to ask how can a political process be arranged that is demonstrably efficient and equitable? Indeed this thesis is based upon the premise that it is vital for the welfare of all members of society to produce equitable democratic decision making, without political paralysis, by design - a practical dialogue. The management of quality in the NHS is, in that regard, simply an exemplar and calls upon critical systems thinking in chapter 5 and the theory of quality in chapter 6 to support this.

Grant neither supports his ‘political paralysis’ claim nor does he spell out what he means by ‘intensity of opinion’. Possibly he means that if a pressure group comes into being its members must be prepared to make substantial sacrifices to get their views across. Those with existing resources and opportunities have a massive advantage but in Habermasian terms does this make their view more intelligible? or acceptable? or sincere? or supportable with other information or experience? All the more reason in fact for there to be an equitable process of
critique so that the excessive zeal, resources and opportunities of a minority do not prevail simply because of that excess.

Grant acknowledges this. Intensity of viewpoint, however it is registered, is in itself an inadequate legitimator of a viewpoint. Arguments must also be of high quality. Yet if there is one thing to distort and reduce the quality of argument according to the Habermasian validity claims discussed previously it is inequity of access to the political process - arguments cannot be weighed if they are not heard. Madsen Pirie (1988) of the 'right wing' Adam Smith Institute similarly observes that it is not quality arguments that prevail under conditions of political inequity. In general, she argues, it is the most powerful socioeconomic interest expressed through a sociopolitical market - what Dunleavy (1991) calls a 'political economy' - dominated by selfishness. Unfortunately Dunleavy, Pirie and the rest of the school of 'public choice theory' deal only with strategic social action. They do not consider the role of other forms of social action especially communicative action in influencing decision making.

It is now necessary to go back over the insider-outsider model to enrich it from the perspective of the paradigm of communicative action thereby overcoming its shortcomings and produce a tool for the analysis of political scenarios.

4.3 Enriching Grant's insider - outsider model

Grant's model was intended to portray strategies between government and pressure groups. The key explicit assumptions in the original model are those of 'balance' in the political context that is nevertheless dominated by the
government, diversity of political groupings, a democratic freedom. 
association, freedom for groups to come into being or disappear voluntarily and 
of a rationalising and legitimising societal value choice that some powerful 
minorities (especially business) should dominate public policy. There are also 
some important implicit assumptions that actors are selfish utility maximisers 
and that the dominant form of social action in a democracy is (and should be) 
strategic. It is also assumed that actors can only take on positions of 
insider/outsider with respect to government and not with each other.

These assumptions will now be reexamined and it will be argued that they are 
inadequate even in terms of the original purpose of Grant’s model.

4.4 Actors

Although he excludes inter-organisational relationships from his model Grant 
argues that he is attempting to model the democratic process generally. It is 
therefore in keeping with his intention to widen the locus of concern of the 
model from government and pressure groups to any set of actors (or groups of 
actors) even if this is within a particular organisation.

4.5 Situations

The change in the identity of those whom the model is concerned with makes it 
more complex not least in terms of the situations being modelled. Grant did not 
clearly define a political situation but rather implied two boundaries. One 
boundary is that of pluralistic democracy (in Great Britain) while the other is that 
of an ideological socio-legal boundary. A pressure group that lies beyond this
boundary (for example the IRA) either in beliefs or actions is beyond what is normatively acceptable.

These boundary definitions can be enriched by defining the political situation of diverse actors as a Habermasian lifeworld segment. When this is done the ideological socio-legal boundary simply becomes a fault line, perhaps one of many normative discontinuities, between areas of normatively regulated action. Likewise the pluralistic democracy boundary also becomes a discontinuity between areas of normatively regulated action.

4.6 Social action

At no point in the model did Grant go on to clarify the nature of the relations between pressure groups and government. Rather the model vaguely portrays what Grant calls 'strategies'. The list of tactics that are employed by pressure groups in practice do largely imply relations of strategic action between pressure groups and government although it is possible to see that dining with a minister, for example, is also a forum in which the other forms of Habermasian social action can occur.

While Grant's model did not extend to a discussion of the other forms of social action nor did Habermas's theory extend to a pragmatic attempt to illustrate the types of possible relations between actors. Clearly Grant's model can be enriched by defining the several forms of action involved in a political relation while his terminology can help to operationalise Habermas's social action concepts.
Grant's insider - outsider strategies can be seen as potentials for social action of particular kinds between actors. These potential differences for social action are summarised in table 1, for two actors A and B, where A is regarded as an insider or outsider with respect to B. The discussion following elaborates on the summary.

<table>
<thead>
<tr>
<th>B's relation to A</th>
<th>Insider High/Low Profile</th>
<th>Outsider By necessity Ideological</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic</td>
<td>Low</td>
<td>High</td>
</tr>
<tr>
<td>Normative</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Dramaturgical</td>
<td>Present</td>
<td>Present</td>
</tr>
<tr>
<td>Communicative</td>
<td>High</td>
<td>Low</td>
</tr>
</tbody>
</table>

Table 1: potentials for social action between actor A and actor B

4.7 High/low profile insider

Where individual or group actors are low or high profile insiders with respect to another actor then strategic action is limited to a decision as to whether to continue with the relationship or not. This is important because the purposeful creation of dialogues between diverse actors requires, initially, a strategic commitment. Sometimes this might be a covert relationship or it could be an highly public relationship.

When dialogue is established in some forum thus cementing the insider
relationship then communicative action will begin to dominate. Subsequently other forms of social action will become much less significant in mastering the situation.

If dialogue is not established properly then the relationship will be fragile. Commitments will be difficult to test, sincerity may be doubted, and norms may not be challenged.

4.8 Prisoner insider

This is a special case of insider relation where one actor is a 'prisoner' of the other. Normatively regulated action dominates the relationship and the dominant norms are those of the imprisoning actor.

Strategic action between the actors is limited to the creation of the special conditions of complete compliance and may consist of extreme rewards or punishments offered or threatened by the imprisoning actor. Communicative action is very restricted - there is no basis for a prisoner to challenge what the powerful imprisoner has to say. Dramaturgical action is limited to expressions of compliance and acceptance. Expressions of rebelliousness would meet with increased strategic activity leading to a guarded sincerity.

4.9 Outsider by necessity

Where an actor is an outsider by necessity with respect to another dominant actor then diverse strategic actions become significant in political relations. Communicative action is limited to reaching understandings as to whether it is
strategically useful to enter into a mutual insider relationship. Normatively regulated and dramaturgical action may also occur and the former may still predominate in the guise, for example at a societal level, of civil law or human rights conventions. Dramaturgical action may also become significant as actors attempt to impress and convince one another with the importance of their strategic positions but of course sincerity may be doubted.  

4.10 Ideological outsider

The main difference between this and the previous relationship is that there is a diminished level of normatively regulated action between the actors. Even so it is not a total absence of normatively regulated action since the actors may share norms that are unassociated with their political positions.

Nevertheless in some key way there will be a normative discontinuity that may be perceived by insiders, and outsiders, as an ideological boundary. In health services for example it was traditionally expected that health service staff would not go on strike in industrial disputes because of the risk and discomfort to patients. This norm has been embodied in some professional codes like that of the Royal College of Nursing which until mid 1995 forbade members from taking strike action. Remarkably this norm has been overturned to some extent during 1995 as the Royal nursing and midwifery colleges have become disenchanted with the way the NHS is being managed. However the expectation of the public and the government may remain intact. There may still be an ideological boundary.
In general clinical professionals are exempt from the obligation of strike action when called for by their unions. However there have been several occasions now when health service staff have gone on strike in contravention of the appropriate norms. One of the most famous of these was the strike called at Normansfield Hospital (1976) when nurses took strategic action in protest over the actions of the main consultant. The nurses moved into a new domain of normatively regulated action not shared with the other actors in the situation. This is reflected in the report which condemned the strike even though it rightly brought to an end a scandalous regime. The inquiry found that various groups of employees had stopped talking to and cooperating with one another hence communicative action was grossly limited.

4.11 Insider - thresholder

The potential difference between two actors in this case is variable perhaps because of a wavering commitment to an insider relationship on the part of one of the actors or it may be a strategy.

4.12 Modifying Grant's assumptions

Grant's model has been modified in three broad ways: firstly the focus has been widened from pressure group relations with government to political relations between actors generally. Secondly the political context has been clarified as a situation defined as a segment of the lifeworld relevant to the situation. Thirdly the relations between actors have been widened from mainly strategic forms of social action to include dramaturgical, normatively regulated and communicative forms of social action.
These three modifications introduce new assumptions from the theory of communicative action into Grant's model and call for a clarification of the existing ones.

### 4.13 The meaning of 'balance' in the political context

Grant (1989) argues that pressure groups in Great Britain exist in a 'balanced' pluralistic situation that avoids a paralysing equality of access to Government. Those with 'axes to grind' can take strategic action. The implicit assumption is that the more important the issue the more likely are pressure groups to form and strive for a resolution of the matter. These assumptions are weak as I have explained above. There are barriers to the formation of some groups while others have resource and organisational advantages that mean any 'balance' unfairly favour powerful interests. I argued that this is a question of design so that there is equality of access to the political process. Therefore facilitating dialogue processes will allow situations to be mastered by balancing all Habermasian forms of social action and not just the strategic. It should be noted that it is possible to see an imbalance in actor situations from the Habermasian perspective even where there is a strategic balance produced through blind steering for example. These imbalances may manifest themselves as pathological conditions of society and are discussed at length by Habermas (1991b).

### 4.14 The diversity of political groupings

Grant's model is analytically concerned with political diversity as is the enriched model. Diversity is regarded by Grant as beneficial to the 'pluralistic balance' of
the nation's democracy as it reflects the aspirations and unique needs and wants of the many groups in society. Political diversity in the enriched model is regarded as a reflection of the naturally occurring situations of actors who necessarily differ in their temporal, spatial and normative dimensions of their lifeworlds. Without these differences there would be no basis for distinguishing one actor from the next. The diversity of unique actor perspectives is resolved, in particular situations, through communicative action and steering mechanisms.

4.15 Democratic freedom of association and freedom for groups to appear or disappear

A pluralistic balance cannot be maintained, argues Grant, without freedom of association as a fundamental democratic principle. If this principle is violated then pressure groups could not form and democracy would wane. Hence Grant explicitly links the quality of democracy with strategic action but overlooks communicative action.

In contrast the enriched model assumes that communicative action is the only inherently democratic form of action. So the democratic status of Grant's pluralistic balance is dependent upon the degree to which actions can be coordinated through processes of dialogue rather than the ability of some groups to come into existence for strategic purposes. The freedom of association is therefore important in facilitating communicative action as well as strategic action.
4.16 Pluralistic balance: society’s value choice

This assumption about the democratic legitimation of the role of powerful minorities in the British policy process is perhaps Grant’s least realistic (or the most optimistic). It is that society has rationally chosen the way things are and that this is acceptable to all. However to impute that society has ‘made’ any rational choice only has meaning if the choice is manifested in the form of competently networked understandings between all actors about how their actions should be coordinated. Yet in chapter 2 and chapter 4 I have argued that there is a general lack of the dialogue processes required to achieve this. Consequently there has been a failure of rationalisation in society so it seems absurd to argue that ‘society’ has ‘made’ a value choice.

It would be more accurate to say that the pluralistic balance and minority domination of public policy is more due to steering mechanisms and strategic actions of a powerful few with the means rather than a nation wide understanding systemically manifested as society’s value choice. This also underlies the unequal access to decision making which, in the case of the NHS, leads to the unfairness of the quality gap.

4.17 Political relations between actors

Grant does not model the relationships between interest groups. This limitation is necessarily dropped in the course of widening the locus of concern to actors in political situations generally. The key assumption of the enriched model now is that it is possible to identify which actors have which social action potentials in each situation. It is important to remember that the insider/outsider positions are not fixed values but differences from which arise the potential for social
actions. This leads to several possibilities that require careful description.

4.18 An insider community

In figure 3 actors A, B, and C have been labelled an 'insider community'. From the labels it is possible to determine what varieties of social action may be expected to occur betw

Figure 3: Insider actors A, B, C, Outsider actor D

In figure 3 actor D is identified as an outsider with respect to the insider community. Now if D strikes up a low profile insider relation with one of the actors in the insider community, for example with A (figure 4), then the situation has subtly
Firstly D is no longer a complete outsider. D has perhaps become a 'low profile thresholder' with respect to the community. Secondly this may or may not be a stable relationship since there may be a need for strategic actions within the insider community to obscure the existence of the relation.

Indeed the understandings that are reached with D will have some impact within the community. It may be that D is admitted to the community or alternatively that D comes in while B goes out. Or again strategic action by B and D may lead to them forming their own insider community from which A and C are excluded. At each stage where strategic actions in the insider community are concealed through systematic distortion of communications there is some likelihood of detection. This would lead immediately to a reduction in the level of trust between the actors who would be more likely to challenge the sincerity of statements and actions. If D is an ideological outsider with respect to the community then the above scenario could lead to more extreme strategic actions.

4.19 Defining the insiders and outsiders

In the above situation A, B and C were identified as an insider community and the designation of D as an outsider represented no difficulty. However what happens when the situation is not as intuitively clear? For example in figure 5 there is a political situation that has been labelled 'X' and in this particular situation A and B can be labelled as outsiders with respect to one another. In figure 5 another actor C has been introduced who is an insider with respect to B. A and C are related through the mediation of B but what is their potential difference? In the absence of some mechanism for reaching understandings there
is little option but to regard A and C as mutual outsiders. Any relation between them is likely to be tenuous unless one or the other begins some strategic actions to create a more direct relation. However the A-C outsider potential difference will be influenced by any norms they share.

Several questions arise from the above: Can the actors be said to be in the same situation? In one sense the answer is 'yes' because the potential differences between the actors actually help to define the situation which is constituted from relevant elements of the lifeworld (as explained in chapter 4). Does this mean then that A, B and C are all concerned with the same issue? Not necessarily. There is no reason to suppose that all the social actions between the three actors will be related to issues in common. In fact the political situation may arise as actors come together to try and find out what they have got in common and perhaps to negotiate a common situation. Is it possible then that actors can simultaneously have one social action potential on one issue and another possibly contradictory social action potential on another? This possibility cannot be excluded so long as the issues in question remain separated in the minds of

Figure 5: Insider actors B, C, Outsiders A, B & C

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each of the actors.

In certain circumstances it may be possible to separate out more than one situation involving the same group of actors in differing sets of social action potentials (figure 6). However, the maintenance of the potential differences may result in conflicts. These could be logical contradictions at a personal level (in an ego's subjective world) arising from understandings reached with other members of a group (in an ego's social world). Or again they could be normative contradictions within a group that create seemingly social perverse action potentials between individuals according to the temporarily dominant issue of concern. Such contradictions in situations may create social instability which might lead to the increased use of strategic action. Dialogue is called for in this circumstance.

Figure 6 Situation X, Insiders, A, B, C; Outsider, D
Situation Y, Insiders, B, C, D; Outsider, A
Now that a basic pattern of potential differences in political situations has been mapped out it is useful to go on to consider the NHS quality gap. For this exercise I will draw on research carried out in Sheffield in 1993/94.

4.20 Insiders and outsiders in the NHS

From figure 1 it is possible to identify a community of well networked insiders in the NHS, that comprises most of the NHS executive and advisory agencies, around the Department of Health (figure 7). Other insider communities exist around NHS Trusts. However these communities are not thoroughly integrated. In figure 7 for instance the RCN is shown as a thresholder. There is a socio-legal boundary of legitimacy and it is conceivable that some professional factions might cross it and, in ethical terms, become ideological outsiders. This has occurred previously with strikes by nursing staff at a time when strike action is not usually considered acceptable (e.g. Normansfield Hospital, 1976). GP fund-

![Diagram of Insiders and outsiders in the NHS]

Figure 7 Insiders and outsiders in the NHS

Key: DOH: Department of Health
NHSME: National Health Service Management Executive
BMA: British Medical Association
RCN: Royal College of Nursing
CHC: Community Health Council
holders and health authorities have been forming purchaser conglomerates (Robertson, 1994) and these therefore clearly have degrees of insider status with each other which is shown as overlapping areas in figure 7.

There are a large number of other groups that lie outside of NHS policy communities. Some ideological outsiders are well known cause groups lobbying for particular rights such as the voluntary euthanasia society (EXIT). However it is worth noting that groups like EXIT often do not operate as ideological outsiders even if some members break the law. In contrast to this the IRA is a clear ideological outsider - it is a criminal offence simply to be a member.

![Diagram](image)

**Figure 8** A view of insiders and outsiders of the NHS in Sheffield

Key: CSHUT: Central Sheffield University Hospitals Trust
NGH: Northern General Hospitals Trust
CHC: Community Health Council
SHA: Sheffield Health Authority
F&CS: Family and Community Services
RSIB: Royal Sheffield Institution for Blind people
VIPs: Visually Impaired People’s Group

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In figure 8 a simple schema of elements of the NHS in Sheffield is shown based on my discussions with a large number of individuals during the Trent Quality Initiative (Gregory, Romm and Walsh, 1994). In the figure the two ‘provider’ NHS trusts are shown as outsiders by necessity with respect to one another (they do not overlap or touch at any point in the figure), reflecting their competitive status in the reformed NHS. The Community Health Council (CHC) is acting as a thresholder with respect to both trusts and offers some linkage between them.

Similarly the ‘purchasers’, Sheffield Health Authority (SHA) and Family and Community Services (F&CS), are outsiders by necessity. There is a joint planning committee which is attended by executives from both F&CS and SHA which therefore offers a thresholding relation between the two purchasers. Two NHS user groups are also shown in figure 8: the Royal Sheffield Institution for Blind people (RSIB) and the Visually Impaired People’s Group (or VIP’s as they call themselves). These are outsiders by necessity in terms of NHS decision making. However the RSIB does have long standing excellent relations with the ophthalmic services within the adjacent NHS trust. The RSIB are also contacted by F&CS whenever they register a new client with visual impairment. In contrast the VIPs like to remain as outsiders. To some extent the members that I have spoken with regard themselves as ideologically distinct from the RSIB membership. The thresholding link between the VIPs and the RSIB that I have depicted in the figure is very tenuous indeed but I have indicated it on the strength that the VIPs hold a meeting every month on RSIB premises. This indicates some link though precisely what is unclear. In the current situation insider status is associated with increased strategic power yet even the NHS user groups mentioned, though superficially seeming to have a lot in common
because of their visual impairment are not regarded as the same by their members. To create a new forum in which quality can be discussed equably is no easy undertaking. It would require finding some point of strategic interest to create what is likely to be a thresholder group from the various stakeholders.

This analysis of the NHS in Sheffield is clearly embryonic however it does focus attention on the issue that in order to begin a dialogue between NHS purchasers, providers and users that there is a need to create an insider forum from representatives drawn from all the groups mentioned. Those who are making commitments to dialogue will be able to act as low profile insiders with respect to other stakeholders. The insider forum can then begin to consider how to facilitate the process of dialogue by reflecting on the specific actions arising from the potentials of the situation.

In this chapter I have argued that relationships between groups and individuals can be modelled in terms of Habermasian social action through a modification of Grant’s (1989) insider-outsider model. With this model I have provided a view of the social action potentials of some NHS user, purchaser and provider groups in Sheffield. I will be returning to this scenario in chapter 7 when evaluating the Trent Quality Initiative. However the creation of an insider forum needs more than the principles of dialogue in order to get started. In the next chapter I will discuss a methodological framework that can provide the tools for the job - critical systems thinking.
Whitely and Winyard (1987) developed a multi-dimensional approach to the political theory of interest groups but Grant's (1989) insider/outsider classification of interest group strategies is simpler and more clearly indicative of the potentials for social action that may exist between groups, Government, and public services.

Grant acknowledges that pluralism is an 'elastic' term but that it has a particular place in the political theory of pressure groups. He particularly distinguishes analytical usages of the term pluralism (e.g.: how does it exist?) and normative usages (e.g.: should it exist?) arguing that this distinction is often obscured in political literature (1989, p24). However there are a multitude of other usages of the term. The macro-political use of the term is commonly indicative of an alternative national political system. It is also used to indicate multiple 'lifestyle choices' (Giddens, 1991, p83). Pluralism is used to refer to the variety of health-illness beliefs of the British public (Gregory and Walsh, 1993, p173). Morgan (1986) refers to political pluralism as one possible analytical 'image of organisation'. Gregory (1992) discusses issues of pluralism in the social and management sciences in great detail and, like Grant in political theory, finds that the term has great elasticity with theoretically, methodologically and politically defined pluralisms within just one strand of management science. Pluralism in management and systems science is returned to in chapter 6.
The special form of insider group relationship called corporatism has been a particular concern of the Conservative Government. A corporatist agreement between Government and a pressure group obliges mutual cooperation. Grant (1989) cannot find an overall consensus as to what corporatism actually is but he observes that it is ideologically cemented by a belief in 'social partnership'.

The most important aspect of corporatism for our purposes is that the Thatcher Government blamed corporatism by name for British economic ills. Grant (1989) argues that this was a 'surprise' to analysts because attempts to create corporatism had failed. Probably the last attempt at corporatism in UK politics was the 1974 to 1979 Labour Government’s social contract between Government and unions that ended in the so-called 'winter of discontent' where dissensus prevailed over corporatist consensus.

It is even possible that if the corporate partners had found a way of handling dissensus that the Labour Party in 1979 would have remained in Government. It is perhaps the way disagreements are handled that enables corporatist relations, like marriages, to survive. This also sets a condition for a successful dialogue: dialogue must hold dissensus to be as important as consensus. otherwise simplistic utilitarian bargaining would take over. Arguably this occurred during the Winter of Discontent of 1979 and continued afterwards as a policy with the Thatcher Government which confronted and coerced the Trades Unions.

Grant (1989) leaves no doubt that the Conservative Party have rejected any form of corporatism or corporatist like management. Recent evidence of this can be seen in the reforms of the National Health Service (Department of Health 1989a) where elected council representatives have been removed from Health Authority boards.

The significance of this rejection is in its potentially negative influence on any form of quality dialogue in the NHS as will be outlined later.
British Rail stations always announce train delays with an apology: 'we are sorry for any inconvenience this may have caused'. Is this apology a sincere statement? Is it a dramaturgically truthful action? For who, in fact, is the actor claiming to be sorry?

The apology is more understandable as a strategic action, initiated by management, that (it is hoped) will be interpreted as a truthful dramaturgical action by those people waiting for trains (and not just those whose trains are late).

In this situation the passenger is subject to strategic actions that clearly places her/him in an outsider position with respect to British Rail. If the validity claim to sincerity of the apology had to redeemed it would require some statement of support by a BR employee, often an executive. The strategic purpose of the action is to help retain the custom of passengers in the longer term who might other wise favour alternative travel arrangements. The difficulty in this action is that although it is immediately effective, everyone can hear it, the redemption of the validity claim is not immediate nor is the identity of the actor clear. The value of the action is therefore much reduced. A competitor that is able to redeem the validity claims of dramaturgical action immediately and with clarity as to who is apologising would be offering a more personal service of much greater value. In this latter case strategic action will have been subordinated to dramaturgical action that is unquestionably of great importance. Any hint of strategic content immediately brings into question the sincerity of the speaker and the sincerity of dramaturgical action.

The thesis is focussed on the management of quality in the NHS through dialogue which is concerned with the healthy reproduction of society and should be seen in that context but society per se is tangential to the thesis.
Chapter 5

Critical systems thinking

In the last two chapters I have begun to develop an approach to the analysis of situations, focussing on the social action potentials of individuals and groups. The analysis of the NHS in Sheffield provides one view as to the social action potentials of the groups that between them will define the local boundaries of quality. In this chapter I will discuss critical systems thinking (CST) and how this framework can contribute to the fair renegotiation of the boundaries of quality in the NHS. Justifying the appropriateness of CST as a framework for the management of quality in the NHS, rather than the many other often apparently conflicting alternative theories and methods in the organisational literature, is a another theme of this chapter. This theme and that of CST itself is explored in two ways. On the one hand theories about the nature of the diversity in management and systems sciences (often referred to as pluralism) are discussed. This is done by comparing and contrasting the pluralism which is central to critical systems thinking with other examples of pluralistic frameworks. Through this an appreciation is gained of the theoretical basis of critical systems thinking.

Another significant conclusion is that CST can increase its emancipative potential, and may be undertaken in more widely varied situations, by the analysis of the social action potentials of those situations with a view to starting dialogues. However other recent developments in CST, particularly the oblique use of systems methods proposed by Flood and Romm (1995b), have implications for dialogue which I will explore.

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Finally the development of dialogue theory in chapter 3 is formalised as a set of guidelines for the dialogue element of critical systems thinking. Consequently the scope and potential for critical systems thinking in situational analysis and intervention is increased. I will begin the exploration of CST therefore by comparing theories about the nature of the theoretical and practical diversity of the management and systems sciences.

5.1 Theories of diversity in systems and management sciences

It is generally acknowledged that the social sciences, including what Jackson (1991) calls management and systems science, are characterised by a diversity of viewpoints (for example see Burrell and Morgan, 1979; Morgan, 1986; Jackson, 1987; Flood, 1989; Midgley, 1989; Jackson, 1991; Reed, 1992; Willmott, 1993). This diversity is expressed in the form of differences of philosophy, principles and methods of research into, and the management of, organisations. For example Reed (1992) lists five different frameworks for sociological inquiry into organisations. Flood and Jackson (1991a) discuss a variety of systems methodologies. Morgan (1986) provides an overview of theoretical and practical diversity in management and systems sciences through several 'metaphors' of organisation.

What is not agreed upon between advocates of different positions is the meaning of this diversity. For example, there are those who suggest that social scientific diversity represents fundamentally differing kinds of knowledge, and notions of social goal, being utilised within disciplines (e.g. Burrell and Morgan, 1979), with more than one 'orthodoxy'. Others argue that differences in the social sciences
are being overplayed perhaps mischievously (Reed, 1992) and claim that while there are many perspectives they may be explicity related. While others like Flood and Jackson (1991a) argue that the diversity is an expression of a fundamental unity on another level.

Very often in the social sciences the term pluralism is used to signify a theory of diversity (with analytical and descriptive implications) unlike the purely descriptive terms 'diversity' or 'multiplicity' (as Aldrich 1992, p37 uses). For example Midgley (1989) defines one view of pluralism as the theory that 'paradigms might be commensurate on a theoretical level, while the methodologies associated with these remain incommensurate when applied in practice' (p220). Another view like that of Reed (1985) is that there is more than one 'orthodoxy' and a dominance of many rather than one social scientific paradigm but that these are nevertheless explicity related.

In general theories of diversity can be differentiated in terms of their assumptions about the notions of paradigms and paradigm incommensurability. So, firstly, what is meant by the terms paradigms and paradigm incommensurability?

The original concept of scientific progress and 'paradigm incommensurability' was proposed by Kuhn (1970) who referred almost entirely to natural science. This term has been broadened by, amongst others, Burrell and Morgan (1979), Pirie (1988) and (Gregory 1992) to include the so-called social sciences although this is one of the only things in common between any of these authors. The most important Kuhnian premise is that theories win by revolution as the old
paradigm of knowledge fails under a burden of inconsistencies that a replacement paradigm addresses (Kuhn 1970).

Crucially the paradigms differ to the extent that they are 'incommensurable' without any possibility of communication of theory between them. This issue of incompatibility (as Bernstein (1983) refers to it) means on the face of it that no inductive or deductive logical operation can ever lead from one paradigm to another, for even if the scientists involved are using the same vocabulary, they perceive a different situation (Kuhn 1970, p200). However Kuhn also argues that this incompatibility does not stop the scientists involved from talking to one another. Put another way how else would scientists realise that they differ if their personal interrelations are dominated by strategic and normatively regulated action?

There are a number of implications in Kuhn's reasoning. He cannot avoid assuming that there is a universal criterion operating against which the success or effectiveness and coherence of the revolutionary paradigm is measured or, in Popper's (1979) and Pirie's (1988) words, which make it 'fashionable'. Neither can Kuhn avoid a political situation in the choices confronting actors who must speculate as to which paradigm to support and develop. Kuhn (1970) addresses this to some extent because he denies the existence of a single valid view of data or of value-neutrality in the production of theory and even admits that some alternative viewpoints, though seen retrospectively to be valuable, are sometimes ignored because they do not find the right audience (Kuhn 1970, p76). Nor is it universally accepted that Kuhn's definition of an 'incommensurable paradigm' (1970, p200) necessarily indicates genuine incompatibility. Indeed
Gregory (1992) argues that Kuhn's scientific revolutions are intra-paradigmatic. On the other hand, Kuhn does argue that 'superior' theory survives in the academic jungle - a view contradicted by both Popper (1979), who calls for resistance to 'fashion' in the natural sciences, and Pirie (1988) in the social sciences, who argues that 'truth is often silenced by force' (p6).

Kuhn's concern with the natural sciences did not lead him to address the difficulty recognised by many writers in the social sciences that there is a 'pluralistic' situation (Bernstein 1991, p338; Reed 1992, p1) or a 'plethora of approaches' (Jackson 1987, p134) or a 'proliferation of frameworks' (Hughes 1992, p296). Like the social, cultural and political diversity of perspectives in the NHS (discussed in chapter 2) the social sciences in general are dominated by a diversity of viewpoints.

CST has produced several original responses to the diversity in systems sciences, but firstly I will deal briefly with other theories about diversity in the organisational social sciences beginning with Burrell and Morgan's famous contribution.

5.1.2 The strongly incommensurable divergent paradigms thesis

Burrell and Morgan's (1979) framework of four incommensurable macro-paradigms into which they subsume all the fragments of social science perspectives (figure 9), is taken by Reed (1985, 1992a) and Hughes (1992) (who uses the term 'antipluralism') as the antithesis of the pluralistic unity of science, and
Burrell and Morgan propose four paradigms that they claim express wholly incompatible logics - similar in a way to the relationship between homeopathy and scientific medicine discussed in chapter 2. Within these macro-paradigms the diversity or patterns of paradigmatic viewpoints may be typified. Nevertheless the macro-paradigms are mutually exclusive with, in Burrell’s and Morgan’s view, no grounds for communication in a common theory-language between them.

![Figure 9: Burrell’s and Morgan’s (1979) sociological framework](image)

Jackson and Carter (1991) argue that Burrell’s and Morgan’s (1979) theory has been misunderstood and misrepresented with a consequent failure to grasp its significance. In the first place they deny that Burrell and Morgan’s (1979) definition of paradigm is the same as Kuhn’s (1970). The only element they share according to Jackson and Carter is the theoretical position that 'what is incommensurable are the languages used by each paradigm'. Although the 'signifiers' may be the same, Jackson and Carter explain, the 'signifieds' are

The signifier-language issue is perhaps clarified by the example of the conflict implied by scientific doctors of the NHS who practise homeopathy (see chapter 2) who must reconcile mutually exclusive logics in order to practice. Similarly coming to an understanding of the functionalist social sciences and the interpretive social sciences necessitates the conflict, in Burrell and Morgan's (1979) scheme, of internally reconciling seemingly mutually exclusive philosophical and social theory assumptions. If Burrell and Morgan are correct, theoretically this is impossible, and therefore an irrational state sustained by some political distortion may be the consequence.

This leaves lay people with the problem, identified by Gregory and Walsh (1993), of choosing between experts advocating differing paradigms - for example how can a choice be made between scientific and alternative medicine? More broadly Giddens (1991) argues that everyone, for much of their day to day life, is a lay-person dependent on experts for decisions at 'fateful-moments'. Although deciding-between-experts was not the concern of Burrell and Morgan their advocacy of paradigm incommensurability has a related corollary as clarified by Jackson and Carter:

> distinct paradigms should encourage debate and should that debate bring about résolution of differences so much the better, provided such resolution is not achieved through the exercise of power.


Yet while Jackson and Carter argue that debate is necessary they do not consider how such a debate should be organised nor how lay people can engage
competently in debate with so-called experts. In chapter 3 I argued that the basic condition for dialogue is the mutual respect for the denial of a validity claim. Otherwise strategic and normatively regulated action may dominate - the very thing opposed by both Burrell and Morgan and Jackson and Carter.

In health care this might be seen in the dominance of scientific medicine over the paradigmatically different fields of alternative and complementary medicines (e.g. through control of resources). This is highly visible in the NHS Research and Development Directorate's call for papers for a special conference on the 'Scientific Basis of Health Services' in 1995 (Department of Health 1995). It is highly unlikely that alternative medicine will be represented at the conference in its own terms.

Jackson and Carter (1991, p122) observe that the call for dialogue is contrary to the contention of Reed (1985) that Burrell and Morgan's strong paradigm incommensurability thesis necessarily puts an end to the point or prospect of any dispute and debate between positions. Indeed the accounts of Reed (1992) and Reed and Hughes (1992) appear to indicate a high degree of antagonism toward the issue of paradigm incommensurability particularly emanating from what might be termed the 'organisational analysis community' at Lancaster Management School of which Reed is a part. Given this, any polemical attempts to discredit Burrell and Morgan's (1979) framework without logical refutation of the incommensurability thesis must be politically suspect. For instance, Ackroyd (1992, p112) (also a member of the Lancaster Management School) argues that the 'uncompromising' position of Burrell and Morgan was soon 'broken down' with a renewed emphasis on the desirability of 'dialogue between different positions'.
From this it is clear that Ackroyd believes (like Reed) that paradigm incommensurability terminates the possibility of, or need for, dialogue.

Moreover Ackroyd dismisses the seriousness of paradigmatic theory:

The paradigm idea, despite some lingering support for it [...] has been lost. Instead there is a partial reinstatement of serialism in the presentation of the history of the field. It cannot be emphasised too strongly, however, that several features of the paradigmatic approach, including much of its sterile academism, remain.

Ackroyd (1992, p112).

It is difficult to tease out what Ackroyd means by this: on the one hand he argues that paradigm theory has gone (but where to?) while on the other he suggests it is still here poisoning the atmosphere. He repudiates paradigmatic theory, anti-pluralism, pluralism and 'paradigm mentality' in favour of a more 'routine' ordering of 'diversity' because

what is indefensible about these approaches to organisation studies is that they can make no contribution to knowledge in the field; they merely record what is already there.

Ackroyd (1992, p112)

Put another way, Ackroyd is saying that theories of pluralism or anti-pluralism simply describe the field of knowledge with no more consequence, and perhaps a lot less utility, than a library catalogue. Yet he has not rebutted the logic of paradigm incommensurability, preferring to deal with it instead in a polemical and political way. Ackroyd gives his own political explanation of the diversity of paradigms:

it is implausible to think of these disagreements in terms of conservatism versus radicalism as is sometimes implied. On the basis of the analysis of audiences, the radicalism of some organisational writers can be understood as an attempt to retain a particular (undergraduate student or academic) audience for the subject in the face of competition from those with other (graduate student or business) audiences in mind. The best that can be said is that the 'radicals' did not yield to rising pressures

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on academics to achieve more practical relevance in their work. In these circumstances however, radicalism largely amounts to a desire to preserve a place for dissenting voices, and, through that, to maintain a secure attachment to traditional institutions. Ackroyd (1992, p113).

So Ackroyd believes that the support for positions like that of Burrell and Morgan, is due to normatively regulated action, arising out of the norms of tradition, and strategic action aimed at survival. What he denies or perhaps overlooks is the seriousness of the underlying issue which affects the meaningfulness of choice and social action. Is soft systems methodology reconcilable with organisational cybernetics, one as a subset of the other? Are they both equally suitable means for managing quality in the NHS? How can a choice be made between them? Similarly is the practice of homeopathy reconcilable with chiropractor and 'scientific' medicine? Should they both be available in the NHS? In the face of these conflicts can Ackroyd be really confident that there is really no longer any urgency or crisis over the tensions and divisions within the social sciences? Academics on organisation like to claim relevance for their discipline to social life: that is their raison d'etre. Surely the theory of paradigms is an important issue for all those communities who face the consequences of theoretically or 'pragmatically' informed decision making?

If paradigm theories are logically supportable then they should not be down-played or ignored. Potentially they offer analytical and normative properties without which diversity itself cannot be managed except possibly in a blind pragmatic selfish way dictated by anything but undistorted understandings. It is this premise that underlies the efforts of Jackson (1987, 1991) and Flood (1990) among others to produce an enlightened systems science.
Another Lancaster Management School critic of the strong paradigm incommensurability thesis is Reed (1985, 1992a, 1992b) whose work has already been referred to several times. Since 1985 Reed (1992) has only slightly shifted his position, aware of Jackson and Carter's (1991) defence of Burrell and Morgan, in claiming that the strong paradigm incommensurability thesis clearly 'advocate(s) separate intellectual development within each paradigm' (Reed 1992, p261). What Reed is saying is that Burrell and Morgan define their theory as normatively opposed to dialogue between advocates of paradigms. Referring to Goia and Pitres (1990) argument, Reed also claims that Jackson and Carter have underestimated the 'permeability' of paradigm boundaries:

paradigmatic boundaries are much more permeable than Jackson and Carter and Burrell and Morgan allow in that they are most appropriately conceived as 'transition zones' rather than as hard and fast domains [...] a pluralistic, multiple-perspective view can be developed by building conceptual bridges across transition zones in such a way that complementary interpretations of organisational reality are made available.

Reed (1992, p262).

He calls therefore

for a more sensible balance between diversity and complementarity or accommodation than that made possible by a commitment to fundamentalist concepts of incommensurability and closure. Diversity, plurality and conflict are recognised as facts of intellectual life, but they are not regarded in such a way that epistemological incommensurability and strict closure become the only basis on which long term intellectual development can be realised.

Reed (1992, p262-3).

Reed abstractly supports this position on the one hand by adopting a position critical of power based orthodoxy and on the other by repudiating a Foucauldian argument.
To begin with he ties the strong thesis to pragmatism because the ‘separate development recipe’ proposed by Burrell and Morgan ‘shades’, he maintains, into the ‘anything goes’ option (Reed, 1992, p263). Reed then focuses on pragmatism which is now the proxy for the real target of the strong thesis.

Pragmatism proposes that these activities can only be meaningfully pursued on the basis of what ‘works’, pragmatically, within a particular problem domain or area of an analysis.

Reed (1992, p263).

Because what ‘works’ is determined by who is powerful, pragmatism ‘legitimates a focus on power relationships’ that determine what is regarded is knowledge, and how it is produced even at the micro level of ‘epistemological/methodological procedures’ (1992a, p263). It is at this point for Reed that the strong paradigm incommensurability thesis slides down the slippery slope of pragmatism:

A rather idealistic and pristine belief in the distinctiveness of, if not separation between, intellectual discourse and political practice is superseded by a viewpoint that tends to collapse the former into the latter. The organisational needs of identifiable power groups within society now becomes the ineluctable driving force behind intellectual development and change.

Reed (1992, p263-4).

What Reed has done is politically clever. He is really making a political argument against the strong paradigm incommensurability thesis. He is saying that the thesis is unsustainable in practice and melts away into the strategic and normatively regulated action of certain powerful and dominating academic/social insider communities:

Those organisation theories which will survive and prosper are those which will be most closely and effectively aligned to the interests and needs of powerful groups within the wider society. Thus, organisational knowledge becomes a vital ingredient
amongst a number of socio-technical resources that power groups mobilize to construct and maintain viable coalitions or 'actor networks'.

Reed (1992, p264).

So Reed in a neat double-shuffle explicitly argues that his own position 'resonates' with a radical critique, of the interests and ideologies underlying orthodoxy, and roundly condemns the strong paradigm incommensurability thesis on the grounds that it serves narrow powerful interests. A bizarre transpositioning, if sustained, of the very motive Burrell and Morgan and Jackson and Carter have for advocating the strong thesis as a way of resisting domination by functionalist orthodoxy in the first place.

Reed goes further however, boxing clever, by introducing a Foucauldian notion of the 'interpretation of knowledge growth and development within organisational analysis' (1992a, p264). This view, he argues, has overtaken the 'moralising' and 'universalising' critiques of Marxism with the sociopolitical critique of power-knowledge. However in a piece de resistance he rejects the Foucauldian arguments of Burrell (1988) that organisations are dominated by practice rather than theory, that organisations are consequently episodic and unpredictable, and that the very discussion of organisation reproduces the disciplinary society. Intellectual growth and development, Reed argues, is not simply the by-product of service to political and administrative interests because this view

grossly overstates the internal coherence of these practices and networks which generate knowledge claims. It also overestimates the 'totalizing' achievements of specific disciplinary regimes or technologies.

Reed (1992a, p265).

On historical and empirical evidence, which is not elucidated, he questions the coherence presumed by the disciplinary regimes of Foucauldian theories and he
rejects the 'seamlessness' (or continuity) of power-knowledge domination. In so doing, and some distance away from the original difficulty he was dealing with, Reed rejects the seamlessness presumed by the incommensurable power-knowledge discursive formations that constitute Burrell and Morgan's paradigms. Whilst, for example, interpretive and functionalist discursive formations may exist, seemingly incommensurable, according to Reed they are flawed and not coherent. Micro-politically they are not complete and, therefore, should not be dealt with separately. Instead, Reed endorses Goia and Pitres (1990, p599) argument that

limited reconciliation is possible within organisational analysis by juxtaposing or meshing alternative theoretical perspectives into multi-faceted theoretical views of organisation phenomena.

Reed (1992, p266).

Moreover it is nothing more than 'an assumption'

that advocates of competing perspectives or paradigms are entirely the prisoners of their preferred frameworks and the cognitive categories which these legitimate.

Reed (1992, p266).

This is now full circle in Reed's argument: (1) Strong paradigm incommensurability is politically unsustainable because it slips into power dominated pragmatism, satisfying limited interests and ideologies; (2) the strong paradigm incommensurability thesis is theoretically unsustainable because it assumes an empirically unsupportable coherence and seamlessness of discursive formation and of disciplinary practices in organisation; (3) therefore no political or theoretical ground exists for separate intellectual development (which defines an absence of dialogue); (4) hence Reed calls for dialogue.

Reed's argument is tortuous. His political argument against the strong thesis may be seen as a validity challenge in two ways to the efficacy, and in one way to
the normative acceptability, of Burrell and Morgan's strategy which was to resist the political hegemony of orthodoxy (Willmott, 1993). Firstly, the strategic success of their argument in resisting political domination is explicitly challenged by Reed on the grounds that their theory succumbs to pragmatism. However it is difficult to see how orthodoxy can be challenged without challenging it! - even if this unintentionally promotes pragmatism. Jackson and Carter (1991, 1994) continue to support the strong thesis and although it may have led, in Reed's view, to some new pragmatic modes of domination, it remains supportive of distinctiveness in diversity, that may allow less constrained development in new fields as yet unreported. If the theory were abolished and struck out of the record it might demolish novel research (as yet unreported) but it would not remove the orthodoxy.

However, the second challenge to the efficacy of the strong thesis in resisting domination is embodied by Reed's argument - he explicitly attempts to reassert orthodoxy as defined by the academic community of which he is a part. Like a 'red rag' the strong thesis sets up a target for counter-resistance by academics like Reed. Nevertheless, Burrell and Morgan's (1979) theory has contributed for more than a decade to resistance to domination by powerful orthodoxies embodied by academic communities - like that of the organisational analysts. It is at least a minority resistance surfacing occasionally in the journals (for example Jackson and Carter, 1991; Willmott, 1993). On the other hand it is a significant resistance or else it would not get the attention it receives from Reed (1985; 1992; 1992), Hughes (1992), Ackroyd (1992), Jackson (1987; 1991) and others. So the first two validity challenges to the efficacy of the strong thesis are rejected - to an extent. Burrell and Morgan's (1979) strategy is, at least to a degree, strategically efficacious.
despite hints of pragmatism and counter-resistance. More evidence is called for from Reed to substantiate his truth claim that the strong thesis does indeed lead to pragmatism.

It is more difficult to redeem the claim that the strong thesis is normatively acceptable in the light of Reed's mainly polemical accusation that it may serve pragmatism. Jackson (1991) applies Burrell and Morgan's framework in a heavily qualified way, as one clearly partial element of methodological analysis, in which he is at pains to repudiate pragmatism. What is more, any theory may be (mis)used in a pragmatic way by someone who identifies the opportunity, and therefore Reed's accusation against Burrell and Morgan's thesis could be turned against his own version of pluralism. To what extent, it may be asked, is Reed's theory of pluralism (discussed in the following section) a bridge to unacceptable pragmatism? It might also be asked in what way can a theory be insulated against pragmatism?

The theory of dialogue suggests that only dialogue offers the conditions for the long run legitimation of social action, including the pragmatic use of a social scientific theory. Given that Burrell and Morgan, Reed, Jackson and this thesis all call for dialogue, the normative acceptability issue should be resolvable. If it is not resolvable then the process of dialogue should also reveal the distorting factors involved. Finally, Reed's criticism of the postmodern basis of Burrell's and Morgan's theory is weakened by a failure to directly cite the evidence. Goia and Pitre's argument does not help to resolve the issue. Reed's rejection of the postmodernism in the strong thesis needs more support if it is to be sustained. If his argument is sustainable it is probably the only genuinely theoretical
argument that Burrell and Morgan have to contend with since virtually all other argument attacking their theory is polemical. Reed's political challenges to the strong thesis do not wholly hit the mark and need further substantiation.

In this section the anti-pluralism of Burrell and Morgan (1979) was reviewed with a series of political and theoretical objections to it. The following sections deal with theories of pluralism. The first of these is Reed's (1985) alternative 'weak' paradigm incommensurability thesis which stems largely from his criticisms of Burrell and Morgan's anti-pluralism theory that have just been discussed.

5.1.3 The weakly incommensurable parallel paradigms thesis - pluralism according to Reed

Reed (1985) proposes a theory of diversity in which, as Jackson and Carter (1991, p119) put it, he seeks to 'dissolve the need for paradigm boundaries'. He argues that the strong paradigm incommensurability thesis is a gross overstatement of incompatibility between paradigms that leads to the circumscribed 'potential for creative theoretical development' (Reed, 1985, p205) and maintains that it is possible to carry out 'rational comparison and assessment across paradigm boundaries'.

Although Reed has not spelled out the fine detail of his pluralistic argument it assumes, in Bernstein's (1983) terminology, that paradigms are comparable in a language that enables the logic of them to be stated and that all logics are to some extent also compatible. In other words, the same signifiers may to an extent
indicate different signifieds but eventually, through dialogue, their differences can be overcome. Reed argues for a ‘middle course’ pluralism rejecting the (structurally determined Burrell and Morgan type) irreconcilability of logics but, similarly, avoiding cognitive relativisation (like that eventually seen according to Reed and Hughes (1992) in Morgan, 1986).

Unfortunately as Jackson and Carter (1991, p120) observe it is at this point that Reed’s (1985) theory becomes inexplicit. He has not explained the theoretical ground for the middle course mediation that he is calling for. How does the process of mediation work? In Jackson and Carter’s view it is through political processes based on power that do not address the theoretical issue as to why one paradigm may be regarded as containing more ‘truth’ than another. On what grounds can a paradigm legitimately dominate? Jackson and Carter (1991, p121) argue that Reed’s theory is based on excluding extremists, without logical justification, and therefore is an exercise of power that ‘underlines the potential for a return to conditions of domination’. Jackson and Carter (1991) maintain that Reed’s pluralism will inevitably lead to the incorporation of one logic as a subset of the other or its dismissal entirely (in a Kuhnian sense), in neither case on grounds of logic (which is impossible in the Burrell and Morgan view) but through the distorting influences of the strategic and normatively regulated actions of insider communities.

In contrast, and central to Reed’s position he argues the reverse claiming that the Burrell and Morgan view leads to ‘production and evaluation’ being subordinated to ‘ideologically mediated interests’ (1985, p205). Furthermore he argues that the unacceptable alternatives to a weakly incommensurable
pluralistic framework are the now well known strategies of future development (adapted later by Jackson 1987, 1991; and Flood, 1990): 'integrationism', 'imperialism' and 'isolationism' (Reed, 1985, pp174-209)

The final twist (but not the last laugh surely) is that Reed's (1985,1992a) pluralistic view is, arguably, entirely politically pragmatic: it does indeed moderate along the middle ground rejecting extremes and therefore actually fulfils Jackson and Carter's (1991) prediction of the reassertion of the powerful orthodoxy at a political and not a theoretical level. To that extent the Burrell and Morgan strong thesis has (in Foucauldian terms) perhaps failed to resist the 'inscriptive forces of orthodoxy'. However, Reed has not shown that strong paradigm incommensurability means that communicative action is impossible. On the contrary, like the antithetical medical systems discussed in chapter 2, dialogue is essential if only to continually verify that old theoretical positions remain incommensurable because of the lack of a-priori certainty about future developments in theory and practice.

In this section Reed's pluralistic theory was held to be seriously under detailed and based on a false premise that dialogue is impossible or unnecessary under the conditions identified by Burrell and Morgan. Another much more detailed and highly pragmatic theory of pluralism is proposed by Flood (1990) and Jackson (1991) as a theoretically robust response to diversity in systems science and to the strong paradigm incommensurability thesis. This is the theory of 'complementarism' which is now examined.
5.1.4 Complementarism

Complementarism is one of the fundamental tenets of critical systems thinking. It is claimed to be so by Jackson (1987, 1991), Flood (1990) and Flood and Jackson (1991a) and Flood and Romm (1995a). In the following section I shall consider the theory of complementarism as it has stood until recently. However in response to criticisms complementarism has been ‘brushed-up’ (Flood and Romm 1995a) and has developed in a new direction which seems to claim new ground between the modern and the postmodern. So when I have dealt with Flood and Jackson’s version of complementarism I shall consider Flood and Romm’s post-critical complementarism.

5.1.4.1 The weak-strong paradigm incommensurability theme - Flood and Jackson's complementarism

Floods' and Jackson's complementarism is another response to the diversity and conflict in management and systems sciences. It is another theory of pluralism but differs from Reed's (1985) whose perspective purports to be a sociological form of organisational analysis. It must be remembered that Reed is focussed on the role of organisation in producing modernity and that he regards systems thinking as a limited functionalist endeavour that produced no new insights after Talcott Parsons (1951). Jackson meantime is closely involved in systems methodology which is concerned with 'processes for gaining knowledge about systems and structured processes involved in intervening in and changing systems' (Jackson 1991, p134).

Jackson does claim a wider interest however. Although his writing is focused on systems of, in, or as, organisations, he is also concerned with 'procedures used by
a theorist in seeking to find out about social reality' (Jackson 1991, p3). Moreover

any principles of method for intervening in the real world must contain certain assumptions about how we can and should learn about reality and the nature of that reality. This is true whether these assumptions are stated explicitly or remain hidden. The designers of systems methodologies will have either consciously

or unconsciously incorporated into their methodologies assumptions about the nature of systems thinking and the nature of social systems. It would be insightful, and extremely illuminating, if we could find some means of unearthing the implied theoretical assumptions of different systems methodologies.


This is an alluring manifesto commitment. It makes it politically more difficult for other systems thinkers to practice in their fields of inquiry without accusations of blinkering if they ignore the 'unearthing of assumptions'. To argue against Jackson at this point would entail arguing that assumptions are generally not important which is untenable in most perspectives.

Jackson is interested both in the theory underlying and, perhaps even more so, the practice of systems thinking. His contribution to the development of complementarism begins with an initial hypothetical statement that problems have characteristics that differentiate them in unique ways to which special, unique, approaches must be taken. Therefore

Instead of seeing different 'directions' as competing for exactly the same area of concern [...] alternative approaches can be presented as being appropriate to the different types of situation in which management scientists are required to act. Each approach will be useful in certain defined areas and should only be used in the circumstances where it works best. The evaluation of each different approach should be confined to
assessment of its success in solving problems in such circumstances. If this perspective is adopted, then the diversity of approaches heralds not a crisis but increased competence and effectiveness in a variety of situations [...] classification must be produced which matches different approaches to different problem-situations.

Jackson (1987, p152).

Jackson's (1987) 'manifesto', which expresses a pragmatic concern to find the approach that 'works best' in the circumstance in which 'management scientists are required to act' (1987, p152), reads differently to that expressed in his later work (1991). They each emphasise one of Jackson's twin interests - to act effectively (1987, using what works best) and to act critically (1991, by 'unearthing' assumptions).

On the face of it, it would seem to be nonsensical to separate the two: to act effectively requires some way of discerning between options that are classifiable as more or less effective. This requires an understanding of the circumstances and the tools (and of the inevitable assumptions entering into the situation) but uncertainty and ignorance always precede certainty and knowledge and therefore actions can always be criticised - with hindsight new criteria will always makes all previous action appear obsolete.

Yet Jackson (1987, p152) in referring to the requirement 'to act' appears to have some intuitive presuppositions about these situations. What is it about a situation that 'requires' action? This becomes clearer a few years later when he argues that there is a 'unified management task' (1991, p265) which is a claim to some unity or meta-unity that even then he does not draw out with crystal clarity. It is left implicit in Jackson's (1991) work for the reader to determine what the unified task is. In Weber's (1930) terms Jackson's complementarism seems to
have emerged from eclectic practice as a vision of increasingly competent formal reason (in the guise of the plethora of systems approaches) and substantive reason (through the critical use of systems methods).

The link between these substantive and formal rationalities, between critical use and effective use, is Jackson and Keys (1984) system of systems methodologies as revised by Jackson (1987). Through this tool, from the fragmented plethora emerges an increasingly competent systems science, because it enables a diversity of systems methods to be applied critically to problem situations. So it is to a more detailed consideration of this that we now turn.

5.1.4.2 The system of systems methodologies

![Figure 10: Flood's and Jackson's (1991) System of Systems Methodologies](image)

Jackson and Keys (1984) proposed a four celled matrix of systems methods (later revised into a six cell matrix by Jackson (1987; 1991). The revised matrix 'unearths' assumptions about the external systemic and social conditions that
systems methods are logically designed to operate in (figure 10). This analysis is reminiscent of Burrell’s and Morgan’s (1979) framework (figure 9) that expresses social science paradigms that are purportedly based on irreconcilable social theory and philosophical differences. Yet the difference between the frameworks on the issue of incommensurability is marked: Burrell’s and Morgan’s framework resists the notion, at an abstract theoretical level, that methods can be fitted together for practical purposes. In contrast Jackson and Keys’ framework is constructed from empirically observed differences between systems methods, that are then abstractly organised according to the unifying principle of complementarism, something that has led to accusations of theoretical imperialism (Gregory, 1992). Hence the frameworks analyse different types of logical assumption and the full immediacy of logical connection between the two is not obvious. At first therefore the system of systems methodologies appears to have a much simpler, more pragmatic, basis than that of Burrell’s and Morgan’s (1979) framework.

Jackson and Keys do not deal with the dimensions as an empirical classification of problem-situations but as classifications of the assumptions about problem situations underpinning each systems method. This is a subtle but important difference that has led, Jackson, (Jackson 1990, Jackson 1991,) argues, to the confused and illegitimate use of the ‘framework’ as a ‘functionalist’ tool. He cites Banathy (1984; 1987; 1988) and Keys (1988) approaches as exemplars of the positivistic fallacy by their recommendations that the 'true' characteristics of problem-situations be identified thereby directly indicating what methods should be used - a functionalist correspondence. Jackson (1987, p15) is at pains to warn against the misinterpretation of 'ideal-type' problem contexts as 'unambiguous features' of the 'real world' and condemns such misinterpretations as 'a
completely indefensible form of positivism'. A positivistic lack of reflection in the use of the framework would limit an intervention to a simplistic formal rationality, rather than addressing the substantive end point of the intervention, to which the assumptions revealed in the system of systems methodologies are also vitally linked. This might lead to the pursuit of an apparently laudable goal, taking full advantage of the features of a particular systems method, and yet contradict or miss the crucial substantive end point because of the very same assumptions. This might produce what may seem to be counter-intuitive behaviour although propaganda may also be deliberately produced to disguise any unwelcome outcome.

In the NHS, for example, which was shown in chapter 2 to be a melting pot of political acrimony and sociocultural diversity, it is recognised by sections of management from the Department of Health down that executive management simply cannot address many important issues without consultation (Department of Health 1992b; 1992c), yet the emphasis on strategic action in the NHS may involve producing political 'smokescreens' that further distort the situation leading to the difficulty in deciding what actually has happened - a point observed by Maynard (1994).

Jackson (1987a, 1990, 1991, 1992) underlines his commitment to a reflective practice in which problem situations are not functionally related to the system of systems methodologies. Nevertheless, he does argue that problem situations are typifiable in terms of systemic complexity and political relations. The system of systems methodologies could not exist without the typification of problem contexts, which is an empirical process, nor the premise that methods are
limited, by their inherent assumptions to an appropriate domain of application—a view now challenged in post-critical complementarism (Flood and Romm 1995a).

At the time SOSM was devised no method was known to Jackson and Keys that assumed a prevailing coercive problem context so the eventual 'discovery' of Ulrich's (1983) critical heuristics of social planning (CSH) was, for Jackson, 'like finding an element predicted by the periodic table' (Jackson 1991, p199). Accordingly in 1987 Jackson explicitly extended the framework to include coercive contexts. Therefore the 'existence of these six problem contexts implies the need for six types of problem solving methodology' (Jackson 1987, p155). The event of the discovery of CSH is an indication of both the value and the theoretical fascination that the SOSM holds for Jackson.

At this stage, then, Jackson's framework served a pragmatic need for management scientists 'required to act' by facilitating an appropriate choice of system method in the light of reflection on the insights gained from SOSM. It is this latter implicit unity of purpose (‘to act’) that makes both complementarism and SOSM meaningful. Without this SOSM simply becomes a library classification system. The requirement to act is the principle that drives complementarism. This is as true for Flood and Romm (1995a) (who refer to the inevitability of choice) as for Jackson (1987) but in 1987 it was less theoretically secure. What was missing was the theoretical ground that would legitimate the use of a particular methodology. Jackson needed to justify his pragmatic methodological position and this he did by turning to the critical theory of Habermas with which he was already familiar (see Jackson, 1983, 1985).
Jackson (1990; 1991) claims support from Oliga (1988), for the keystone positioning of Habermas's (1972) knowledge constitutive interests as the theoretical grounding of complementarism, because they parallel Burrell and Morgan's (1979) framework, but 'reconcile' their erstwhile incommensurable paradigms as elements of universal human interests (Oliga, 1988, p93). It is because of this that Jackson (1991) drawing on Habermas (1970) argues it

is not necessary to accept the full implications of the doctrine of paradigm incommensurability. At the most fundamental level, all of the different strands of systems thinking are necessary as supports for the anthropologically based cognitive interests of the human species - the technical interest in predictive and central to the practical interest in mutual understanding, and the emancipating interest in removing constraints imposed by power relationships.

Jackson (1991, p263)

So the 'unified' management task (1991, p265) that requires management scientists to act is the three dimensional human interest identified by Habermas (discussed in chapter 3). In this statement Jackson justifies his pragmatic efforts to utilise a range of systems methods that he and Keys had empirically analysed (Jackson and Keys 1984). Not only was he relying on Habermas's theory to provide the rationalisation and legitimation for his pragmatic interests but he also claimed that there is a direct correspondence between the dimensions of the system of systems methodologies and knowledge constitutive interests: The participants dimension (unitary, pluralist, coercive) corresponds to the practical and emancipatory interests while the system dimension corresponds to the technical interest (Jackson, 1991, p30).

Even so Jackson (1991) was still not convinced that complementarism was adequately supported in theory although he seemed quite sure about how the
While it is not possible to quell all doubts at this time, it is clear enough in what direction critical systems thinking is looking for answers. The preferred vehicle to support critical system's thinking at the theoretical level (and, therefore, to give coherence to the systems of systems methodologies) is Habermas's theory of human interests.

Jackson (1991, p202)

Unlike Reed (1985, 1992) who is possibly 'fence-sitting', critical systems thinkers like Jackson are 'off' the fence but, it seems, similarly short of the justification they need for complete confidence in the 'fashion' of complementarism and this causes problems.

In chapter 3 I showed how Habermas had moved on from knowledge and human interest, preferring to ground critical theory in communicative action. Jackson's (1991) continuing adherence to knowledge and human interest therefore seems surprising. Furthermore neither problem-contexts as they have been expressed by Jackson and Keys (1984) onwards, nor the associated systems methods, are unequivocally predicted by the sociological theory called upon for support. Jackson's suggested connection between knowledge-constitutive interests and problem-contexts of the systems of systems methodologies has not been fully spelled out. Consequently the difficulties inherent in complementarism have led, to some extent, in Jackson's version of complementarism being developed in a new direction - or perhaps being replaced altogether in at least one community of critical systems thinkers. This development Flood and Romm (1995a) label post-critical complementarism and it is to this that I now turn.

5.1.4.3 Post-critical complementarism
On the face of it the definition of complementarism given by Flood and Romm appears wholly in keeping with Jackson’s view. It remains a commitment to ‘reveal and critique the theoretical (ontological and epistemological) and methodological bases of systems approaches, and to reflect upon the problem situations in which approaches can be properly employed and to critique their actual use’ (Flood and Romm 1995a). However they also believe that complementarism is ‘a little dusty’ and needs to be ‘brushed-up’. Clearly critical use and effective use of diverse systems methods appear to remain on the agenda but there are some major differences between Flood’s and Jackson’s, and Flood’s and Romm’s versions of complementarism.

Firstly SOSM is dropped as the lynch-pin of complementarism. It is not mentioned by Flood and Romm (1995a) and it has been expurgated from the latest published versions of Total Systems Intervention5 (TSI) (Flood, 1995). Whichever way you look at it this is such a major change that the old TSI and the old form of complementarism embedded in it (Flood and Jackson, 1991) is not instantly recognisable in its new guise.

Secondly Habermas’s knowledge constitutive interests are relegated from dominance as the theoretical ground of complementarism while elements of postmodernism are brought in. In old complementarism knowledge constitutive interests are regarded as the expression of a universal human interest which underlies even seemingly incommensurable paradigms. In new complementarism the theory of incommensurability (or commensurability) is the lynch-pin. However it is reconstructed and replaced with a new term that is written ‘(in)commensurability’ (Flood and Romm 1995a, p479). Plainly there is
something going on here which deserves a closer look.

Flood and Romm (1995a) begin with the problem, a version of which was expressed at the beginning of the thesis and this chapter, which is how can a choice be made between methods? They argue that the answer depends upon the meaning of commensurability (building on Flood (1990) who previously dealt with it, in his terms, theoretically and methodologically). They claim that this term has not been clearly defined in the systems literature but, following Gregory (1995), argue that to be commensurable theories must be 'measurable by a common standard' (Flood and Romm 1995a, p471). This means that theories can be reconciled and integrated. However integration, they argue, means that theories are 'denatured' because they are 'reduced in meaning to the fundamental tenets set by the measurement standard' (p471). In other words it is assumed that the integration (or unification?) of theories can mean no more than whatever principles and philosophy is contained within the measurement standard.

Flood and Romm argue that once the standard for measurement has been set, then, naturally in modernistic terms, measured action can be taken. This they argue is a recipe for what they also term isolationism (by which they mean that all action and intervention is measured by the one standard with no way of radically changing it) and which results in the inhibition of diversity and the loss to participants in a situation of possible solutions to their problems.

Flood and Romm set out the alternative to this, which is reminiscent of the position of Burrell and Morgan (1979). Incommensurability means (in theory) that no common measurement standards can be produced (so any frameworks
that purport to achieve this must be manifestations of power). These can be resisted and diversity can be maintained. However Flood and Romm argue that the corollary of this is that participants in a situation are confronted with choices that they can only make on arbitrary grounds. Put simply choice is unmeasured which means that there are no grounds for choice which seems to stifle all possibilities for action. Or they are choices made consistently on some arbitrary and relative criteria, ironically leading to the isolationism mentioned above.

Flood and Romm then turn to the postmodern perspective which they argue fares no better than the modern except that postmodernists do not want to 'resolve dilemmas' but instead wish to 'live by them'. However Flood and Romm reject 'naive postmodernism' on the grounds that by denying all possibility of measurement there is no way to choose between actions which are all perceived to be relative and contradictory. They argue that because there is no possibility of choice relativism is 'gloomy' and, ironically, may lead to the inherently conservative choice of inaction because there can be no measurably better alternative action to take. Crucially Flood and Romm regard action as unavoidable - even inaction is a choice. So how do they try and resolve this dilemma of the inevitability of choice without adequate criteria?

Firstly they believe that comparisons can be made between differing theories according to 'locally generated criteria' (p473). For example people can make comparisons between each other's perceptions of their own needs. Furthermore metaphors permit comparison between things that are unlike each other in a literal sense.
Secondly, Flood and Romm go further by reasserting Flood's (1990) view that knowledge can be liberated from repression and then critiqued. They imply in this that arguments against measurement and comparison of theories and practices (leading to relativism) can be as equally dominating and repressive as arguments for such measurement. In other words, the anti-comparison critique offered by postmodernity needs itself to be resisted tactically with such devices as the assertion of directly opposed argument (or 'oppositional thinking' (p474)). However, they also point out that postmodernists still face the problem of choice after knowledge has been liberated - there are more options to choose from but still no basis for choice. In the end, Flood and Romm argue that good argument is necessary in order to choose. Indeed, they argue that the tension between the need for good argument and liberation is a key feature of 'postcritical' theory (p474). They observe that there have been other attempts to preserve diversity of theory and practice by resisting domination whilst not sacrificing the possibility of good argument. One theoretical approach they suggest is the 'discordant pluralism' of Gregory (1992, 1995).

Gregory (1992) deals with the issue of pluralism as a problem of appreciation, beginning with a key observation that Burrell and Morgan (1979) presume to accurately represent the paradigms of social science without reflecting on their own position. This point is similarly observed by Willmott (1994) although the latter's viewpoint is rejected by Jackson and Carter (1994). While Gregory has criticised the unreflectiveness of Burrell and Morgan's theory, she does accept the pith of their argument that social science paradigms may express incompatible logics, something rejected by Reed (1985, 1992a, 1992b).
Gregory argues that a rigorous mode of appreciation must necessarily be reflexive and critical. Only through a reflexively acting combination of empirical-analytic, historical-hermeneutic, critical-self inquiry and ideology critique can the emancipative goal of Habermas (1972) be achieved. So far though critical systems thinking in the guise of Jackson (1991) has, Gregory argues, limited critical awareness to a methodological boundary which cannot fulfil Habermas's (1972) emancipative goals. Arguably, this constraint on the meaning of critical awareness arises out of the pragmatic need to act in the development of critical systems thinking discussed previously. Gregory's intention contrasts with this by raising the sights of critical systems thinking toward its theoretical ideals. Again in Weberian language a comprehensive approach to substantive reasoning should take precedence over formal rationality if critical systems thinking is to be performatively consistent. Gregory calls this mode of comprehensive reasoning 'critical appreciation' (1992).

Critical appreciation sets conditions under which the emancipative potential of critical modernism may be achieved. However, in order to begin critical appreciation political space is required in which to carry it out. This space is necessarily politically pluralistic because critical appreciation requires peaceful coexistence between potentially irreconcilable theories. Gregory illustrates this with the example of abortion which is both a theoretical (in religious and secular senses) and (micro/macro) political issue. Discordant pluralism is a condition where logical irreconcilability is not allowed to become the political criteria for the elimination of a contrary form of knowledge. It is grounded in the critical theory of Habermas which advocates, in Gregory's view, a critical appreciation that may emancipate both individuals and society through reflexive processes.
There is a key ethical implication of the logic of critical appreciation and discordant pluralism. Discordant pluralism necessarily entails the co-existence of antithetical viewpoints, like those of so called 'pro-life' / 'pro-abortion' factions, or political elements in Northern Ireland, where normally it would be expected that strategic action would lead to the (attempted) elimination of one or the other viewpoint. Moreover even if through a dialogue process all distortions are accounted for it does not necessarily follow that logical consensus, or political consensus, will result. However the possibility of reaching this stage of development necessarily requires a commitment to communicative action and a rejection of strategic action. Put another way, in the terms developed in chapter 4, strategic action is limited to the attempt to create insider communities without the strategically or normatively imprisoning or ideologically excluding tendencies that may ordinarily dominate social decision making. The Trent Quality Initiative was an exploration of this kind of political development and it is discussed in chapter 7.

Another approach Flood and Romm discuss is the 'ideology-critique' of Brown (1994) who argues that the destructive pessimism and relativism of postmodernism can be rejected, in favour of discussion between researchers, on the failure of knowledge to be explicit about it's construction. This critique seeks to establish how diversity and inventiveness can be preserved in knowledge creation. Turning to incommensurability Flood and Romm argue that this can be subjected to an ideology critique which thus juxtaposes the 'dark' (gloomy relativistic) side of postmodernism with it's 'positive' side represented by the view of Jackson and Carter (1991, discussed earlier in paragraph 5.1.2). This is
taken one step further by their reference to McKay's and Romm's (1992)
argument that the issue of domination is common to both Habermasian critical
modernism and (positive/dark) postmodernity and that therefore this can be a
focus for an 'encounter' between positions.

The heart of Flood and Romm's post-critical theory then is in the way that there
can be a juxtaposition of what might be termed Foucauldian (positive/dark)
postmodernity with Habermasian (good argument) critical modernism. What
they propose boils down to a call for dialogue between positions on local, not
universal, criteria (see paragraph 3.19) because 'alternative positions do not meet
outside of the process of people attempting to make sense of the variety' (p479).
Hence measurement is confined locally to evaluating the range of opportunities
for choice created for people in a situation. Argument is confined to local
discussion of these choices. Incommensurability is advocated until this stifles
diversity at which point it too is subjected to critique and resistance.

Moreover all knowledge is locally grounded in 'specific practical agendas for
action' (p479) rather than some universalist theory. It is this principle that
underlies the need to promote theoretical diversity since this also entails
promotion of diverse practical (and local) agendas for action - and possible
choices between them.

Flood and Romm cannot avoid making use of some universal 'truths': they do
claim that action is inevitable. People must act individually or collectively,
either by doing nothing or something (and even perhaps with systems
methods!). Diversity is better than dearth of theory and action. Some actions are
better than others (but specifically which is only locally decidable through argument). In other words the primacy of the local is universal.

Although Flood’s and Romm’s universals seem to contradict their premise of the non-universality of knowledge, ethics and action they explain this kind of problem away as a postmodern irony. By irony they appear to mean that in striving critically to get away from one difficulty sometimes such striving leads directly to another equally unpalatable difficulty. Inescapably one must simply choose and that is that. Flood and Romm make a choice about how to choose between methods: they propose choice according to critical principles that preserve and promote diversity in a local context with argument according to local criteria. Put another way Flood and Romm choose to make a justification breakoff (using Ulrich’s, 1983 terminology) with these particular universals. This boundary judgment (about which are the ‘best’ or only legitimate universals) can be disputed and this leads, in my view, to the need for special arrangements for dialogue as discussed in chapter 3.

They do not discuss whether or how local individuals may coordinate their actions collectively but leave this polemically circumscribed as ‘people attempting to make sense’ (p479) by using various tools and argument according to local criteria. In other words they do not specify the arrangements necessary in order that people can make sense of their local situation. Of course if they did it would be to appear to claim another universal generality - something forbidden by their theory. Yet omitting a discussion about how local people may engage in dialogue seems to presume that local critique is inherently proof against distortion or it does not matter that some (perhaps non-local) individuals can distort or
disregard the local agenda. This presumption flies in the face of the necessity for critique in the first place. If there is critique it is presumed that critique is necessary (an ironic postmodern universal). Flood and Romm's theory like that of Bauman's (reviewed in chapter 3) must consider how dialogue can be practised if their theory is to have any optimistic meaning. Habermas's theory of communicative action might be thought a possible framework for local dialogue but Flood and Romm appear to reject this because they argue that Habermasian theory invokes universal validity claims and universal consensus seeking. This needs some careful consideration.

The heart of the theory of communicative action is the ability to say 'no' to a validity claim. If this rejection is respected and responded to (with an attempt at redemption) then local participants in a situation can identify (or reach a consensus or mutual 'understanding') as to where they are in agreement and disagreement with each other and diversity is preserved. This process of identification is the only necessary consensus for dialogue to occur. It does not necessarily follow that any other kind of consensus will emerge even though Habermas (1990) seems to believe that this is a natural ethical outcome of dialogue.

However if the denial of a validity claim is not respected (which arguably is an origin of the necessity of critique) then critique must give way to the explicit exercise of power and/or the functioning of blind steering mechanisms such as the market. In this case as I argued in chapter 3 diversity is diminished. Without arrangements for the encounter differences between localities are likely to mediated by power rather than argument. Hence Flood and Romm's theory
needs the support of dialogue.

Another aspect of Flood's and Romm's theory that needs to be considered is the meaning of local. What is local? How local is local? Again Flood and Romm are vague and avoid a universal generality that would answer these questions. Yet without a criterion of locality there can be nothing other than what is local - no boundary between local and non-local. Local would then be a non-existing term since there could be no 'outside' to the locality. There would be no such thing as local decisions and no place for dialogue between positions.

However the term does exist and it is used by Flood and Romm. Local conceptually divides the world into two parts: the local and non-local. Such binary concepts are rejected by postmodernists as repressive (e.g. Fox, 1993) - a point noted by Flood and Romm yet the concept of local is a key element of their theory. If local is meaningful then it brings into focus the boundaries between localities and local and global issues. Flood and Romm argue that no other localities or global authorities are permitted to impose a non-local decision - that is to be resisted. A valid post-critical decision must be made locally. This creates the need for local people to make a boundary judgment as to whose opinion counts, and what wider considerations need to be represented and accounted for in their local argumentation, then they may choose.

This seems to overlook the problem that differing localities may compete in their judgments over their common boundaries and have differing effects upon their neighbours. For example is it any of our business what the Brazilians do with their rain forest? Or our business with what happens in Sellafield? Or with what
occurs in hospitals? Or with quality standards in the NHS? Ulrich (1983) implicitly offers one definition of local - all those involved in making a decision. He subjects this to critique arguing that the views of all those affected by but not involved in a decision should also be accounted for. This wider recognition of stakeholders in decision making is commonplace in NHS quality literature and in systems literature. This thesis is itself based on the premise of pushing out the boundary of involvement in NHS decision making.

All this implies that the term local is subject to inflation! However it is important to recognise that this is because the local and non-local interact. Unless the participation of the non-local is carefully organised it might overwhelm the local because it will often dispose of greater resources, diversity and potential - or a locality will concentrate such power as to resist or command and then dominate the non-local. Either way the outcome is unfair on those dominated. This is the 'mountain root' of inequality. The lack of an adequate process of mediation between the local and non-local will mean that a number of people (whether Asimov's Emperor's or Orwell's proles) will never have the option to deny validity claims raised by others or to choose an alternative way of life.

If locality is an issue there will always be processes of inclusion and exclusion from participation in decisions which will involve a whole variety of local/non-local claims - including universalistic ones! Under these circumstances dialogue is essential as a process of mediation between local and non-local influences. In the contemporary modern world local and global are bound together. As Giddens (1991) argues, it is the dynamic global nature of modern life that is one of
modernity's defining characteristics. The consequences of local decisions are
global in nature. Everyone alive now (or in centuries to come) is affected (if only
with doubt and uncertainty) by myriad individual choices systemically steered or
collectively managed. The only answer to this globalisation is to make
arrangements that can address both the local and the non-local on a 'level playing
field'. By definition this must be a suitable democratic process (as called for by
Giddens, 1994) but this implies certain conditions for the process - such as those
outlined in chapter 3. It is another universal that Flood and Romm (like
Bauman) cannot avoid: arrangements must be made to convene a suitable forum
so that boundary judgments can be disputed. Or else nothing can be decided, as
Flood and Romm note, except on purely relativistic or arbitrary terms. Reducing
the problem of choice to moral subjectivity in its entirety as advocated by
Bauman (1991), Fox (1993), Taket and White (1994) and other postmodernists,
does not avoid the need to make suitable arrangements for dialogue between
individuals so that individuals can learn how to make morally subjective
decisions from those who claim they know how.

It can be seen, that there are many theories of diversity and diverse practices to
match. I have argued that CST which currently espouses several theories of
pluralism must, almost inevitably, embrace the communicative paradigm in the
form of the process of dialogue more fully than hitherto. What I will discuss
now are the implications of dialogue for critical systems interventions, how the
communicative deficit in CST has been dealt with, and I will end the chapter by
defining the elements of a dialogue framework for CST.

5.5 Critical systems thinking and dialogue
If dialogue is the *only* process within which to embed critical systems interventions then surely this repudiates any form of intervention *not* based on dialogue and surely this appears to condemn all interventions that do not achieve it? This identifies dialogue with the 'ideal speech' situation and with 'communicative competence' (discussed in chapter 3). These concepts are used by Jackson (1991) in communicative critiques adjunctively to the critiques of human interests in his methodological study of systems thinking. In chapter 3 it was shown however that Habermas does not find it necessary to directly refer to these early concepts in his major work on communicative action (1991a; 1991b). Indeed the presence of perfectly competent speakers in an ideal speech situation *is not essential* to the pursuit of dialogue. Instead dialogue must be seen as an *ideal seeking* political process comprising participants who have a minimum communicative competence of the ability to deny the validity claims raised by others, and who are genuinely committed to the process. So the insidious argument against the consideration of communicative variables in systems thinking as 'hopeless idealism' is directed at the wrong target. Ideal speech may never exist - while dialogue can exist as I believe is demonstrated by the Trent Quality Initiative (Gregory, Romm and Walsh, 1994) which I review in chapter 7.

If communicative variables are disregarded it simply means that some unstated criteria are involved in discriminating for or against some participants in a situation. Yet clearly the participant selection criteria may be challenged, as 'unrepresentative' for example, but if so then communicative variables are being admitted to some extent. If communicative variables are being allowed into the intervention equation (to allow a challenge to the validity of participant selection) then, as Ulrich (1983) points out, a polemical alternative may always be
employed to challenge any existing boundary judgment. So far from being 'hopeless idealism' the consideration of communicative variables is methodologically inescapable and is inevitably dealt with implicitly or explicitly.

However at this stage the argument has become recursive because the question remains, polemically raised at each boundary judgment, how do you decide whose opinion counts? It is the failure to address this that Jackson (1991) finds communicatively deficient about Soft Systems Methodology. However similarly the same might also be levelled at Flood and Jackson's (1991) version of Total Systems Intervention as I shall now explain.

5.6 A communicative critique of Total Systems Intervention (TSI)

Nowhere do Flood and Jackson (1991a) describe guidelines that specify or prescribe under what conditions an 'undistorted' Total Systems Intervention may occur although there was recognition of the need for communicative competence and for the creation of ideal speech. There was also critical awareness of the communicative deficiency of the methods within the TSI framework (e.g. see Jackson, 1991). However there was no method to invoke communicative principles. To use a colleague's phrase there was no 'front end' on TSI. Yet the whole issue in contemporary Habermasian critical theory is that without systematic communicative action between participants in a situation, i.e. dialogue, there is a potentially pathological distortion of culture, society and individuality (Habermas, 1991b). In its 1991 published form TSI was (and is) dependent upon forms of participation that are necessarily sensitive to the effects and consequences of power. Yet previously published TSI research cannot now be qualified as to the degree of distortion of the substantive grounding of the
strategic goals of intervention because there is no evidence of the systematic validity challenges that characterise dialogue.

This has created suspicions, raised by Tsoukas (1993), that the substantive goals are narrowly defined by boards of directors although publications may not allow the space to explain the democratic processes involved in TSI. However the under development of communicative variables in the old TSI is equivalent to a failure to deal with the issue of power, a point also made by Tsoukas (1993). Conversely, where dialogue is achieved then power is being systemically and systematically dealt with, through the mobilisation of resources in new forms of coordinated action, in a way that may be evaluated through an examination of dialogue records¹¹.

If TSI as published in 1991 were proposed as a tool for any work in the NHS it would be confronted with the increasingly anti-corporatist atmosphere that is imposing more and more strategic responsibility on executives, and narrow performance indicators on management. This increasing emphasis on strategic action as a legitimate mode of management militates against the use of dialogue processes, which may be seen by managers to incur an undesirable loss of control. Without addressing the communicative variables of any particular intervention in the NHS it would be impossible to validate it except in narrow strategic terms already broadly given. Consequently the old TSI (Flood and Jackson, 1991) in the NHS might achieve little more than a limited reform similar, for example, to a soft systems study like that of Atkinson, Stanley and Bundred (1989).

5.6.1 The communicative development of TSI

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It might appear that there are only four possible responses to the apparent communicative under development of systems approaches including TSI. Firstly assuming the ideal speech situation is unattainable, then on the face of it there seems no way of making any arrangement for participation that does not lead to an arbitrary boundary judgment, by the dominant participant, as to who is permitted to participate in an intervention. If this is so then critical systems thinking, interpretivistic systems methods, and hard system methods, all ultimately depend upon the dominant participant. In this view it would simply have to be accepted that interventions are optimised within the bounds of what the dominant participant believes is right.

A second approach suggested by Ulrich (1983) rejects the above scenario and takes an heuristic route to systemically and systematically challenging the boundary judgments involved in instrumental social planning and intervention. He similarly rejects as an idealistic impossibility the Habermasian 'ideal speech' route. Nevertheless according to Jackson 'Ulrich is unable to reflect upon the conditions that would guarantee free and open debate and how these might be brought about' (1991, p209) in other words communicative variables are inadequately addressed although, contradicting himself somewhat, Jackson also argues that Ulrich's approach 'is highly original in the matters of promoting informed and challenging debate and safeguarding his methodology from the possibility of authoritarian usage' (1991, p211).

Yet if Ulrich's methodology does not adequately address communicative variables then it does not necessarily protect against autocratic interventions and authoritarian usage although it is more likely not to be used at all. Ulrich (1988)
appreciates this arguing that an expansion in the use of practical reason, e.g. via SSM, is sufficiently emancipatory without regard to the political complications of communicative variables. Nevertheless Ulrich’s method was used in the Trent Quality Initiative (see the next chapter).

The third route is to intervene obliquely in organisations as Flood and Romm (1995b) put it. This notion is tied to recent developments in TSI specifically but also in critical systems thinking in general. I shall discuss this briefly.

Flood and Romm (1995b) argue that methods for intervention in organisations are usually presumed to have a ‘given and immediate purpose’ (p378). For example hammers are used to hammer, nails are used to nail, and SSM is used to produce interpretivistic models of what is, and what should be the case, in complex situations. Flood and Romm argue that this given can be challenged: ‘for example, with astute and careful handling a cybernetic or soft systems method can be employed to tackle emancipatory issues in a way which undercuts and redirects its theoretical underpinning’ (p378). If this is true then it indicates another radical departure from the old TSI (Flood and Jackson, 1991a) in which methods had to used where they were most appropriate and in which the System of Systems Methodologies was a prime tool. Now it seems that methods previously regarded as making assumptions (revealed in SOSM) restricting their use to particular situations (as assessed by the practitioner) and often needing the support of other methods to deal with the full situational complexity, are more flexible than hitherto supposed. This ‘sophistication’ is necessary Flood and Romm argue because it provides a useful alternative when head-on employment of emancipatory methods in a problem solving context comes up
against barriers such as subversion of the intervention by people who feel threatened by it.

Flood and Romm (1995b, p378)

This interesting remark is full of implications. It says that emancipation requires a strategy in order to be achieved because of resistance coming from narrow, selfish, interests. It also says that emancipatory methods sometimes (or often?) only work in the absence of subversion (which may be overt or covert). It also begins to distinguish between 'head-on' and what is later termed oblique use of methods. What is meant by these things?

In the first place Flood and Romm observe that some stakeholders are 'disadvantaged' and situations may be socially asymmetric (p378). In other words there is a condition of inequality. This they link with the issue of coercion which they define as a dynamic variable which they imply causes these inequalities. (In their view) coercion causes inequality. They also reiterate the criticism of cybernetics and soft systems thinking (made, for example, in Jackson, 1991) that these methods still cannot address coercion despite their authors commitment to debate. They argue that this is because the 'immediate and given purpose' of these methods and the principles for action arising out their purpose 'are not immediately best suited to coercive contexts' (p378). Moreover the use of 'head on' (p387) emancipatory methods may lead to the entrenchment of situations and therefore may be unable to resolve the dilemma faced by practitioners who would like to intervene to help disadvantaged people but cannot without making the situation worse, or without result.

This appears implicitly to reject the idea that dialogue (and a communicative
framework) is a necessary or feasible part of intervention. After all dialogue is potentially the most threatening form of emancipative intervention of all - it specifies the conditions under which selfishness, insincerity, immorality and failure can be exposed and criticised. If 'head on' methods based on dialogue are always debarred by powerful individuals and interests then this seems to rule out the use of dialogue in any setting (for example the NHS) characterised by inequalities that have been generated by coercion. This seems a grave blow against dialogue but it is necessary to dig a little deeper before Flood and Romm's meaning becomes clearer and also to qualify the use of dialogue. So how do Flood and Romm envisage the operation of oblique use?

Flood and Romm argue that enhancing the process of choice (in TSI) can overcome the problem of coercion. They claim that this is because TSI allows the possibility of choosing to fulfil a purpose other than the immediate given one. Flood and Romm term this the oblique use of a method and they claim the same basis for this as Flood and Jackson who argued that tackling coercion is a 'matter of (both) strategy and conscience' (Flood and Jackson 1991b, p244).

The choice is made in TSI by 'aligning method(s) with their immediate and given purpose to the core issues in the circumstances (or, [...] by deciding to employ methods obliquely)' (p380). This latter extension of choice is placed in the context of post-critical complementarism (discussed earlier in paragraph 5.1.4.3) in which local argument and decision criteria are given primacy. Indeed Flood and Romm see TSI as the framework through which post-critical complementarism is operationalised. Therefore the strategy and conscience clause of the new TSI is also a post-critical clause. Strategy and conscience are subject to local argument
and choice. It is in these terms that oblique use of a method can be considered.

Flood and Romm (1995b) give a key theoretical justification for considering oblique use of methods. They argue that all methods express three purposes: they express how something ‘should’ be done (arising out of a technical need for prediction and control, p383), what should be done (arising out of a need for mutual understanding, p384) and why it should be done (arising out of a need for fairness, p384). These needs are reminiscent of Habermas's technical, practical and emancipatory interests (see chapter 3) although that particular source is not acknowledged. However the important link Flood and Romm make between emancipation and (otherwise non-emancipatory) methods is that each purpose can be expressed in terms of freedom (or emancipation in the older terminology of Habermas): (in answer to ‘how?’) freedom can be technically designed into efficient and effective organisations. They also claim that (in answer to ‘what?’) methods exist that encourage freedom through open debate and finally (in answer to ‘why?’) there are methods that encourage group freedom through debate.

Flood and Romm are little unclear in their narrative about what the difference is between the debating methods for the latter two purposes. However what they perhaps mean is that some methods facilitate the achievement of what Habermas terms the human practical interest (through for example soft systems methodology) while the final mode of debate facilitates the emancipatory interest (through for example critical heuristics of social planning). The notion of designing freedom comes from cybernetics (Beer 1981) and the idea that cybernetics could be used in an inherently (if obliquely) emancipative way is
another sign of how far TSI has moved from its state in 1991. So how is this obliqueness realised?

Oblique use means continuing to work in the situation, with clientele that includes all the stakeholders (including the powerful) and make best use of it - even if some of TSI’s principles (such as those which support emancipation) have to be temporarily sidelined.

Flood and Romm (1995b, p389)

In other words, in the terms developed in chapter 3, Flood and Romm argue for strategic action in coercive situations by using systems methods (within the TSI framework) to realise some benefit for disadvantaged participants. What they argue is that, for example, a technical method may be used according to the principles of an emancipatory method. There are two pivotal aspects to this:

Firstly Flood and Romm specifically exclude ‘duping any of the clients’ (p390). Indeed they argue that the purpose of oblique use of methods is to manage likely client resistance by formulating one’s mediating role as a practitioner in such a way as to begin to engage the various parties in acceptable terms - as a starting point for continued conversation.

Flood and Romm (1995, p391)

So Flood and Romm see oblique use as a strategic approach to facilitating a form of dialogue! What they do not do, paradoxically, is explain what this form of dialogue entails.

Secondly they argue that oblique use will be acceptable to the dominant powers in some organisations because, as Habermas (1982) argues, the failure to engage the support of employees and other stakeholders, is ultimately self-destructive.
Flood and Romm argue that self-preservation (if there is no hint of altruism in the management) puts emancipation on the agenda. Practitioners can help managers understand why emancipation of the workforce is 'good' for the business - but without advocating a (perceived) dangerous loss of managerial control or threat to their self-interest.

This is a remarkably ironic argument because it defines a universal rather than local principle for intervention ('selfishness is self-destructive') - and suggests that emancipative intervention (overcoming disadvantage) need be non-threatening (to the advantaged). Put crudely everyone can be 'levelled up' to a condition of fair diversity without sacrificing elite privileges, strategic advantages, and with the elite's support.

It is this latter point that is perhaps the weakest part of Flood and Romm's rather optimistic argument. Yet they are vague about how you do explain to (or 'persuade'?) a manager about the self-destructiveness of selfishness. In the end Flood and Romm do not supply the conversational details for oblique use of TSI. TSI is left as an ethical tool (mobilising moral subjectivity and argument) that may well be rejected by those with power because the basis of their self-interest is unchallengeable. Once more dialogue is indicated and not debarred but the strategic motivation for participation in dialogue needs to be strengthened...

I will argue in the next chapter that there are persuasive strategic reasons for engaging in dialogue: dialogue is necessary if quality is to be achieved and longer term organisational viability is to be assured. However I will also argue that 'short-termism' remains a serious threat to quality in industry generally
(including the NHS) and only nation-wide dialogues can achieve a fair result.

This leads me to the fourth route for overcoming the communicative inadequacy of TSI - it is that of implementing dialogue as a genuinely local political framework within which to work out the methods of intervention.

The implementation of dialogue means that, rather than beginning with an impossible ideal, a dynamic situation may be created in which situations may move toward an idealised state and in which imbalances of power may possibly be handled with increasing effectiveness. This sounds very similar to Flood's and Romm's conclusion to their argument. However it also flies in the face of the demand for strategic relations that the government has tried to propagate in, say, the NHS. Dialogue sounds expensive in terms of resources and inefficient as a mode of decision making as well as threatening the powerful. This is a fallacy though.

Giddens (1994), Beck (1992), Habermas (1991a; 1991b) and Ulrich (1983) each in their different ways reflect a belief that strategic action is only one facet of human nature. Habermas's theory of communicative action is specifically directed toward stating the democratic conditions under which the rationality of the force of the better argument can begin to operate in public life. Giddens (1994) advocates democratisation in new ways reaching from nations to individuals. As I argued in chapter 3 it is simply not supportable to state (like the public choice theorists) that only strategic actions count. The pathological social condition this represents (Habermas, 1991b) is highly destructive of individual life chances, of institutions, and of society. What is more this process of destruction should
already be visible were strategic action dominating to the extent claimed by public choice theorists, economists, the government and so on.

Yet there are signs of altruism in some social groups like health care workers in the NHS that contradict the wholly strategic Dawkins-eqsue view of social life. Furthermore dialogue processes can offer a society at least sufficient coordination and control of social action that some social 'good' is generated and is distributed. As I will argue at length in the next chapter it was communicative failures between industry and the public that allowed Far Eastern competition to 'kill off' many British industries. Therefore dialogue is indicated, and not debarred, by situational difficulties. It makes strategic sense. Consequently the oblique use of methods should be grounded in dialogue. Ironically, since dialogue is called for by both modernists and postmodernists, dialogue may be the 'ideal' post-critical framework. Within this options for action can be identified hitherto regarded as mutually exclusive but, like homeopathy in the NHS, have been suppressed. Choice would be made on the basis of understanding rather than selfishly in the (often coerced) absence of understanding. The tools of TSI that are being subjected to ever more rigorous critique (see Wilby, 1995) could then be mobilised in the fundamental pursuit of fairness without expert knowledges and skills becoming the sole basis for decisions and action. The NHS quality gap can then be tackled with leading edge technology but on a fairly agreed and broadly understood basis. Dialogue is in, not out. Thus the development of a dialogue framework for intervention is a crucial step in critical systems thinking. I will now summarise the elements of such a framework.

5.7 Elements of a dialogue framework for CST
There are two key elements of a dialogue framework for CST. The first is strategic and the second is communicative. Since dialogue is not a 'natural' state but a special process (unlike communicative action, see chapter 3), and given that it is absent and needs to be created (by definition), it appears that strategic action (or 'oblique use') is the starting point for dialogue. The enriched insider / outsider model may be one starting point for dialogue based CST interventions. It could form an element of the strategic preparation by a research team preceding the start up of dialogue. By reflecting on the insider / outsider relations between the groups (nominally identified) their social action potentials become a focus for critique - for example like the analysis of the NHS at the end of chapter 4. Strategic motives can be identified that, in the right circumstances, might create an insider forum mediating with a low profile between a few or more of the groups. Later the model can be used by the participants to reflect on their social action potentials and of those groups they would like to draw into dialogue.

Notice that this is a local issue - how can you create a strategic motive for the participation of a group in dialogue? Such motives can be looked for and sought out. The users of the NHS want quality services. So strategic motives can be harnessed - but critically. However this analysis may also reveal that localities want to 'war' on each other metaphorically or otherwise. Such intractable strategic relations need to be referred onward and outward to a greater assembly - if one exists. In Northern Ireland for example the non-local is vital if the local are to engage in dialogue rather than war. If it does not then there is no 'solution' to local conflict which may even begin to dominate the non-local. In this way there will always be a strategic dimension to dialogue in which creating and sustaining dialogue is the goal. Arguably this should be a prime goal for CST
The motives for participation in dialogue may become clearer as the technical problems of finding the forum and discussion tools for it are considered. CST is well equipped to provide these tools (as well as others for designing other organisational structures and processes) through, for example, TSI. However the process of dialogue itself provides the critical basis for such an intervention. TSI's new focus on choice, and alternative possibilities, including oblique use of methods seems well suited to a dialogue setting. The dialogue can convene around an agenda in which technical, practical and emancipatory methods are considered in direct or oblique modes. Hence the communicative element of a dialogue framework for CST is the practice of dialogue according to the conditions identified in chapter 3 which are: the option and minimal competence to say 'no' to validity claims, the expectation of a genuine response to this and equal or increasing equality of access to the process.

Devising a means of operationalising dialogue as a process within which to embed the process of intervention represents a profound step out of precommunicative paradigm that is dominated by strategic relations. It is such an attempt, concerning a critical systems intervention on quality in the NHS, that is discussed in the final chapter. However before considering this I will examine the final part of the NHS quality gap jigsaw - the theory of quality, and why 'quality' is proving such a popular variable in the NHS.
As discussed in chapter 4 the term pluralism is also widely used in political science (Grant, 1989) and in natural science (see Popper, 1979).

Dr Madsen Pirie is an economist and has been the head of the right wing Adam Smith Institute. In *Micropolitics* (1988) he transfers the logic of economic arguments about markets to public policy. This is often referred to as political economy. In the course of this he discusses the views of Kuhn and scientific revolutions. I shall be returning to Pirie’s political economy explanations when discussing the emergence of critical systems thinking.

M’Pherson (1974) has argued that so-called ‘hard’ systems thinking (being associated with quantitative engineering type management problem solving) is a subset of ‘soft’ systems thinking (associated with multiple-view, qualitative management problem solving). On the other hand Checkland (1981) has argued the reverse. Either way each is claiming to represent the diversity of the field with a theory that unifies differences of practice at theoretical level - these are theories of pluralism.

What Reed (1985) termed integrationism (meaning a theoretical pluralism) is dropped by Jackson (1987) and Flood (1989). Instead they refer to pragmatism. Jackson (1987) and later Flood (1989) defines pragmatism as a trial and error approach to systems practice lacking theoretical insight and grounding. According to Flood Isolationism can consist of a narrowness of theory (sticking with one theory) or a narrowness of systems practice (sticking with one methodological framework). Imperialism occurs when narrow theory / practice is broadened by adding on bits of theory and practice from other perspectives but always subordinate to, and sometimes completely subsumed by, the original theory / practice view. Scientific medicine can be seen as imperialistic because it defines the criteria by which insights can be acquired from other disciplines e.g. from herbalism or acupuncture. The practice of homeopathy in the NHS may be seen as pragmatism. Complementarism was the expression of fundamental theoretical unity emerging out of a lawless diversity (Jackson, 1987). This view, and subsequent revisions to it, is discussed later in this chapter.

See appendix B.
This is not necessarily true in natural sciences - for example spacecraft regularly navigate the Solar System on Newtonian mechanics without Einstein's theory of relativity being applied. Yet the former is a narrow special case integral to the latter broader (and later) theory. Unfortunately the theory of relativity though mathematically 'simple' is just too complicated for the day to day business of navigating around the globe or the Solar System. In contrast the social world is far more complex than the natural world and this leads to the question about what theoretical grounds there are to believe that integrating social scientific theories 'denatures' them? I suspect that any denaturing occurs because of the drive for what Habermas calls 'cognitive instrumental abridgements' of social complexity (see chapter 3). Denaturing in this view is a distorting simplification of a theory caused through a lack of dialogue between advocates of differing theories who then may act strategically. If dialogue were established then any suspected denaturing of theories and practices could be challenged, the grounds of propositions and areas of agreement or disagreement between participants rigorously established. I will be returning to the issue of dialogue in the social sciences at the end of this chapter.

In chapter 3 I explain that Habermas aims his theory of communicative action at resistance to cognitive abridgement and simplification in the pursuit of instrumental success. This might be termed a 'critical modern resistance' in contrast to 'postmodern resistance'.

A search of the HELMIS database of NHS literature produces some 2000 references to quality. Within these references a large proportion promote the idea that increased participation is good for quality. No reference seems to assert the reverse.

The ISSS conference in 1995 held in Amsterdam was repetitively confronted with the need to increase participation. To my knowledge no-one recommended less participation. Other examples of recent work on participation include Brown (1995) on enskilling, Wexler (1987) on education, and Arce et al (1994) on rural development.

See appendix B.
In chapter 7 I argue that the Trent Quality Initiative provides empirical evidence of a \emph{meta-dialogue}. The records of the dialogue are potentially useful in producing efficient forms of democratic control through dialogue. More about this in the final chapter.

This scenario seems to say there is no point making any effort to be more participative - it just gives strategic control to some other (equally arbitrary) actor.

Coercion does not \emph{cause} diversity but it does cause \emph{inequality} - an inequality can be defined as an unfair and unjust diversity.
Chapter 6

The theory and practice of quality

So far I have discussed how the NHS is characterised by social, political and cultural diversity, and how the lack of dialogue has led to an unfair specification of the boundaries of quality in the NHS services. In the last chapter I suggested that CST can provide a framework for a systems intervention that can be embedded within a dialogue process. It is necessary now to reconsider the simple definition of quality with which I began the thesis. I will propose an alternative communicatively based definition of quality - critical quality - and suggest that achieving critical quality is an appropriate goal for critical systems thinking in the NHS. The concept of critical quality builds upon the theory of dialogue and social action potentials between politically and culturally differing social groups that was developed in chapter 3. Finally it draws upon the social action perspective of chapter 3 and the critical systems thinking of chapter 5 for a critique of contemporary quality methodology and for a practical framework for critical quality.

The chapter begins with an overview of quality definitions. The development and spread of strategic quality within industry is reviewed. The contribution of the so-called 'quality gurus' to this strategic view of quality is assessed. Then I discuss the development and basis of normative quality. Next I review Total Quality Management (TQM) and in particular Flood's (1993) contribution to quality methodology. In the light of the strategic, normative and 'total' views of quality I then examine quality in health care. I examine key differences between
services and physical goods, and I assess the applicability of TQM to the management of quality in the NHS. Finally I set out the elements of an alternative view of quality: critical quality. To begin with then I shall consider the various attempts to define the meaning of quality.

6.1 The meanings of quality

Quality literature like that of Ellis and Whittington (1993), Flood (1993), Munroe-Faure and Munroe-Faure (1992) Hutchins (1990), Shaw (1989), Witcher and Wilkinson (1990) and Oakland (1989) are representative of the huge number of attempts to explain why quality has recently become so important. Quality literature often deals very briefly with traditional views of quality as it has been implicitly defined by producers and consumers in market places in the pre-industrial revolution era. There is often some discussion of the effects of the industrial revolution but the majority of accounts deal mainly with the post Second World War rise in importance of quality. Service industries often appear to be mentioned as an afterthought because most texts deal primarily with manufacturing industry but assume that quality principles are applicable to all industries. Moreover, quality in farming or fishing is hardly ever mentioned, and there is a specific literature on quality in health care that appears in many ways to have developed quite separately. What usually follows the historical analysis of quality is an instruction manual on how to manage quality.

Quality is an old concept implicit throughout the history of civilisation. According to Ellis and Whittington (1993) there were 'traditions of good practice' in the medicine of ancient Egypt, Assyria, China, Japan and Mexico and ancient Egyptian tomb paintings depict brick inspectors. Yet it is only in the late 20th
century that the term has gained a widespread and common use or meaning. The most often cited contemporary definitions are those of the so-called quality gurus.

Quality is a predictable degree of uniformity and dependability, at low cost and suited to the market.
Deming, 1982

Quality is fitness for use.

Quality is conformance to requirements.

Quality is best for the customer use and selling price.
Feigenbaum, 1984.

Quality is the loss imparted to society after the good is shipped.
Taguchi, 1979.

All but the last one of the definitions refer to an individual's use or requirements of the product which is related to the notion of a customer. However, Taguchi's definition differs markedly from the rest in allowing a social and temporal element to the definition of quality. Oakland (1989) and Flood (1993) (with a caveat about cost) amongst others offer what is probably a good summation of all bar Taguchi's definition of quality:

Quality means simply meeting the customers requirements.
Oakland, 1989

It is this summary definition that is the basis of Total Quality Management (TQM) as described by Flood (1993), Munroe-Faure and Munroe-Faure (1992), the Department of Trade and Industry (1991), Witcher and Wilkinson (1990), Oakland (1989), and others. It is interesting to see that many British companies have produced their own definitions of quality, examples of which are listed by
the Department of Trade and Industry (1991), that all reflect the themes of meeting customer requirements or completely satisfying the customer.

There have been a number of attempts to define quality of health services. Maxwell (1984) defines quality in terms of

- Access to services.
- Relevance to need (for the whole community).
- Effectiveness (for individual patients).
- Equity (fairness).
- Social acceptability.
- Efficiency and economy.

A similar formulae was proposed by the Joint Committee on the Accreditation of Healthcare Organisations (JCAHO) (Ellis and Whittington, 1993). Another famous quality formula is that of Donabedian (1980) who defined quality in terms of structure, process and outcome of a health service. The Kings Fund probably come closer to a succinct definition of quality in the NHS: ‘quality’ is accepted as defined by a combination of criteria of service including effectiveness, acceptability (to consumers and providers), equity (of access and distribution) and economy.’ (Kings Fund, 1986). This is really only a restatement of Maxwell's (1984) quality formula.

All of these formulae are used in exactly the same way. They are frameworks that are explicitly intended to guide standard setting, performance measurement and review. They differ considerably from the guru definitions of quality that simply refer to consumer requirements or conformance by attempting to specify some of the attributes of a service. None of the definitions focus on the possibility of individual loss or failures to conform to consumer requirements.
being instead very generalised. In a sense there is a closer match with Taguchi's (1979) definition of quality as a loss to society since a generally inadequate quality of health care implies a similar general loss to the community.

The guru definitions are underpinned by the major assumption, that goes with hardly a qualification from any author, that quality is a tool to facilitate commercial success by improving competitiveness. As Oakland (1989) puts it, competitiveness is measured by price, quality and delivery of a good that simply meets the customers requirements. In public services, such as the NHS, 'value for money' is a proxy for competitiveness that it is the explicit role and goal of the Audit Commission (1992) to assess on behalf of the government and the taxpayer. In the terminology of chapter 3, quality is viewed by virtually all authors as a variable specified strategically to obtain more profits or value for money. The assumption that quality is a variable mediating between the selfish strategic interests of consumers and producers dominate the accounts of Munroe-Faure and Munroe-Faure (1992), Hutchins (1990), Oakland (1989) and other authors. I call this a condition of strategic quality.

Where quality is a variable mediated through the intermeshing of normative entitlements between producers and consumers there exists what might be termed a condition of normative quality. To an extent Shaw's (1986) account of quality in medicine illustrates the rather separate development of quality in health care by dealing predominantly with normative quality.

None of these authors consider the possibility that quality might also be a variable mediating between communicatively acting consumers and producers
in which all the forms of social action identified in chapter 3 might be coordinated. This may be termed critical quality. I now want to enlarge on these meanings for quality, beginning with an overview of strategic quality in which I will assess the contribution of the so-called quality gurus. Then I will explore the concept of normative quality. I will use the notions of strategic and normative quality to analyse Total Quality Management (TQM) which is currently in vogue. Then I will consider quality approaches in health care services with a view to assessing the applicability of TQM to the NHS. In particular I will draw out some of the chief differences between, and difficulties inherent in, specifying services as opposed to the physical attributes of manufactured goods. At various stages in these discussions I will assess the place of communicative action and the role of dialogue in these quality approaches. This leads to a final discussion and definition of critical quality. To begin then, I will consider strategic quality.

6.2 Strategic quality

According to Flood (1993) the quality of foods, animals and goods has, for hundreds of years, been measured by discerning customers buying from producers in markets and shops. Perishable goods brought to market had to to be sold to discerning customers. The produce would be inspected by the consumer and rejected if it did not satisfy their requirements for freshness, firmness, price and so on. Feedback was instantaneous and the producer would strive in future to meet the buyers requirements because unsold produce was a loss to the producer. Flood implies that this process was based upon strategic actions between producers and consumers who were bargaining with each other. Like the majority of writers about quality he does not explicitly envisage the operation of normatively regulated action in traditional markets in which producers and
consumers fulfil obligations and entitlements in their transactions. He does mention the role of feedback in the bargaining process that occurs during the strategic interaction of producers and consumers in a market.

It is possible, however, that feedback in traditional markets may have offered the possibility for degrees of communicative action because of the familiar relationships between buyers and sellers and the potential benefits of longer term collaboration in terms of security of production and consumption. Although traditional markets are often characterised as a focus of idealistic strategic bargaining over price and quality it is likely that this is a gross simplification of the social action relationships between the producers and consumers. The further investigation of the ancient role of quality would be an interesting anthropological, even palaentological, research subject - for example what was the meaning of quality in Viking Jorvik or in flint tool exports to Europe from Britain during the stone age? - but unfortunately these questions are beyond the scope of this thesis!

Flood also mentions traditional crafts, trades and arts in which the producers often formed monopolistic guilds with long apprenticeships for those who wished to learn the master’s rare skills. Ellis and Whittington (1993) regard this as an early form of quality assurance. Buyers perhaps relied more upon the producers reputation than their own judgment about the quality of the goods. This meant for example that woollen cloth from mediaeval Colchester could be marked with a special stamp and be exported for sale in Europe, where it would attract a higher price than other cloth. Interestingly it was monks that seemed to control prices (Ellis and Whittington, 1993). In this way both Ellis and
Whittington and Flood implicitly touch upon the largely one sided normative regulation of quality by professions and other bodies. This is discussed in more detail later.

World wide trade was boosted by such innovations as Harrison's maritime chronometer that enabled ships to navigate precisely in longitude rather than by guestimating (Beet, 1976) and by the exponential growth of railways (Hutchins, 1990). These innovations increased the potential for the mass production and distribution of other goods and in the process altered the idyllically ancient principles of quality. While in small markets the traditional 'inspection and reaction' (Flood, 1993, p4) mode of quality regulation may have continued the mode of mass production and rapid distribution that began in the industrial revolution removed the possibility for an intimate and immediate feedback from the buyer to the producer.

The industrial revolution produced a massive change in the pattern of production and consumption. In Great Britain for instance transport was revolutionised through mass production: Blast furnaces in its Northern towns poured out quality steel at such a pace that in one short ten-year period from 1840 to 1850 its railway lines reached every corner of its shores. Never in the history of mankind had the creative forces of an entire nation been so galvanised to success. Risk-taking, entrepreneurial drive, and creativity moved at an almost unbelievable pace.

Hutchins (1990, p1)

Consequently quality mediated between producers and consumers became more reliant upon strategic action and the possibility for communicative action with consumers was largely eliminated.

In the novel mass markets of the 19th and early 20th centuries the balance of
strategic power lay heavily in favour of the mass-producing entrepreneurs. Producers who were confident they could sell all their mass produced goods at a good profit for the foreseeable future may not have even been (or be!) aware of, or may have simply ignored, the negative reactions of non-buyers. As Ford famously put it: 'any colour you like as long as its black' (Nevine, 1957). Quality in this case was being defined primarily by the producer for the strategic reason of production cost minimisation but in so doing established a normative quality of production that also favoured the producer. Another illustration is more recent and far more cautionary: one might question whether battery egg and intensive poultry farming and butchery would have boomed in the United Kingdom had the public been more aware that these forms of mass-production could spread salmonella throughout the supplies. The public assumed that eggs were free of any such infections. This created the strategic opportunities for the egg producers to increase their sales of cheaper eggs who did so without the intention of spreading salmonella. Yet if the public distaste for salmonella and egg or chicken had been communicated more personally and immediately to the producers during the 1980s egg crisis (leading to the resignation of a junior Minister, (Economist, 1988)) then the crisis would perhaps not have occurred in the way it did.

Visible in these two examples is a limitation in the relationship between strategic action and quality. Classical economic theory which is based on assumptions about strategic actions by utility maximising buyers (Rosenberg, 1988) would deem the egg crisis an unfortunate market failure due to the inadequate feedback of information between purchasers and producers about the quality of produce. The limitations of strategic interactions have already been discussed in chapter 3.
when it was shown that information is a tool that may be strategically distorted by an actor. The egg-crisis is therefore typical of and not incidental to the strategic action relations between producers and consumers in which quality issues may be deliberately ignored or obfuscated.

These examples also typify the changing strategic social action potentials between producers and consumers as mass market goods and services became available. Henry Ford could ignore the demand for green cars because of the strategic strengths of his business (cheap and reliable cars and many buyers) and the strategic weakness of potential consumers (options to buy other cars were very limited). Quality had become a variable strategically specified and normatively regulated by one side - the powerful producer with a market to exploit - and this situation remained in many industries in the United States, Europe and Great Britain until after World War Two when things began to change.

According to Flood, Munroe-Faure and others attention to the quality of mass production through inspection and testing in factories was stimulated by the two World Wars. Control over industrial processes was enhanced by statistical and scientific methods especially involving newly developing operational research skills (Jackson 1991; Flood, 1993). To that extent quality had perhaps also become strategically two-sided with the military consumers demanding outstanding performance from products.

After World War II consumer demand was so great that quality became more one sided again in the producers favour. Arguably it is possible to see the increasing dominance of normatively regulated quality by producers in the post war period
in Britain. According to Hutchins manufacturers in the 1950s and 1960s seemed to believe in making inferior goods as a matter of principle even though the means existed to make better and more reliable goods. For instance car and motor bike manufacturers refused to rustproof their products in spite of 'massive public criticism' (1990, p22). Hutchins argues that this attitude was justified by powerful producers in terms of the 'throw away society' of higher volume and cheaper disposable goods. Producers could make inferior products and sell them all - there was no strategic reason it seemed to make better goods - although as Hutchins points out this lead to the downfall of many British industries with the onset of Japanese competition.

The impression is usually given in the quality literature, for example in Flood (1993) or Munroe-Faure and Munroe-Faure (1992), that Japanese industrial competition was able to exploit the quality weaknesses of British, European and North American industry by obtaining and putting to use the skills of statistical process and quality control acquired by the Americans during the war. Hutchins (1990) heavily qualifies this view by pointing out that the Japanese at an executive level in industry generally already understood the statistical control of processes. What they gained from the Americans were ideas about management which they nevertheless found lacking. This is often obscured by the accolade heaped upon Deming and Juran as 'quality gurus' - they both received the highest Japanese imperial awards for their work in Japanese industry. It may be more logical to treat these awards (and guru status generally) as part of the quality propaganda machine that the Japanese constructed (and others since like the Department of Trade and Industry, 1990).
Meantime British industry, despite being the developmental niche for many inspection and quality control methods during the war, may generally have only became aware of the so-called guru approaches to quality in the 1980s following their promotion by the Department of Trade and Industry. Lately this has been through the 'Managing into the 1990s campaign' that was launched in 1989. It seems ironic that the victorious powers in World War Two, that recognised the military value of quality as a variable of strategic importance to both consumer and producer, failed to recognise or propagate its commercial value. Instead virtually all accounts of quality explain that American and European industrial nations became industrial casualties when Japan and other industrial competitors seized upon and developed quality management.

In particular quality was not seen by the new industrial powers as something the producers strategically or normatively controlled without regard to consumers. As Hutchins (1990, p22-23) explains Japanese producers were able find consumer requirements of common manufactured products like electrical goods, cars and motorbikes which British producers, as argued above, either barely acknowledged or even wilfully ignored - such as rustproofed cars and motorbikes. In other words quality came to be seen as a two-sided variable by the Japanese, defined strategically between consumer and producer, and this enabled their industries to exploit consumer requirements in a way seemingly invisible to British business.

The two-sided strategic view of quality should not be confused with the strategic roles of quality in traditional markets. The Japanese had not reintroduced an ancient notion of quality. Their industry, based on what Hutchins (1990, p22) describes as a 'marketing mentality' did not rely on the intimate two-way
definition of quality negotiated in traditional markets. The 'marketing mentality' of post-war Japanese industry used generalised feedback from consumers to redefine specific attributes of standardised production. Consumers were still not in intimate and immediate contact with the producers and their control over quality was not based on the possibility of longer term communicatively coordinated actions. Rather consumers were able to choose an alternative 'better' product strategically made so in a few highly publicised ways by the producer. So the producers were selectively exploiting the consumer demand for incremental improvements in products by making these improvements available rather than reaching understandings with consumers.

Having become aware of the commercial value of quality as a two-sided strategically defined variable it is currently being promoted as a matter of urgency by the British government. The Right Honourable Peter Lilley MP, while he was Secretary of State for Trade and Industry (DTI), stated in the introduction of a key Department of Trade and Industry publication for British business that '(t)he competitive edge now is with those who manage their resources most effectively in offering a timely response to the demands of the market' (Department of Trade and Industry, 1990). Lilley was voicing the Government's view that British business must strive to produce a superior combination of price, quality and delivery of goods and services during the 1990s in what is perceived to be a fiercely competitive world market by concentrating on four things: design, production, purchasing and supply, and quality. With the help of Peat Marwick McLintock (business consultants) the Department of Trade and Industry proposed what they called a 'complete programme' to improve the commercial performance and competitiveness of businesses. Lilley even added a warning to
his introduction:

This programme can assist you in moving towards the kind of strategy which is at the heart of some of the world's most successful companies. I hope you would agree this an opportunity you cannot ignore.

Department of Trade and Industry (1990)

You certainly cannot ignore the importance the Government attached to this programme and it is perhaps quality (particularly in the form of Total Quality Management) which has generated the greatest public awareness (and cynically speaking the greatest income for management consultants). Again let us refer to the DTI:

Coping with the increasing importance of product quality and greater service content is seen as the No.1 strategic marketing issue for the decade by Europe's top businessmen. And quality is the responsibility of the chief executive who must be personally committed to it.

Department of Trade and Industry (1990)

One of the ways in which the DTI is promoting quality, is by highlighting the so-called 'quality gurus', who are perceived to exemplify the ways in which the strategic value of quality may be commercially exploited. In the next section their contribution to strategic quality is considered.

6.3 The quality gurus

It is interesting to note that British quality literature mainly refers to British, American and Japanese quality initiatives. However, alone of the so-called gurus only Moller is a European the rest being mainly Japanese or American. There is now a long list of quality gurus: Deming, Juran, Crosby, Feigenbaum, Ishikawa, Taguchi, Shingo, and Moller are all listed by the Department of Trade and Industry (1991) and are described as "charismatic", and "deified". Such an outpouring is remarkable. In the following sections I will summarise the
approaches of the most commonly cited quality gurus, concentrating more fully on Deming (1986) and then concentrating on the differences between Deming and Crosby (1979, 1984) Ishikawa (and Lu, 1985), and Juran (1988). All of them make certain recommendations about how quality should be managed. These take the form of various activities that have to be undertaken in a particular way to attain particular goals. The gurus also make implicit or explicit assumptions about the meaning of quality, the purpose and nature of organisation, and the nature of opportunities of difficulties faced by industry. To begin with then I shall consider Deming.

6.3.1 Deming

W.E. Deming worked as a statistician for the US Department of Agriculture and the Bureau of Census. Although it was during the Second World War that he began to develop an interest in methods of statistical control of variability in manufacturing output (Flood, 1993) it was after the war in Japan that his influence on industry in general became significant. Unfortunately the usual accounts about Deming's work in Japan like those of Flood (1993) and especially Munroe-Faure (1992) give the impression that it was he who introduced the Japanese to statistical process control and that it was their adoption of his ideas in toto that largely explains Japanese industrial success. Hutchins (1990) corrects and qualifies these views by pointing out that statistical techniques were in use in Japan before the Second World War. Moreover the Japanese Union of Scientists and Engineers (JUSE) was formed in 1946 and began to promote 'Quality Control' throughout Japanese industry based on various sources including the American Standards Organisation publications Z1-1, Z1-2, and Z1-3, Shewhart's (1932) 'The Control of Quality of Manufactured Product' and so on. Finally before a single
quality guru came to Japan the first major Quality Control training programme commenced in 1949 led by the chairman of JUSE, Ichiro Ishikawa - the father of Professor Kaoru Ishikawa who is an acknowledged quality guru (Hutchins, 1990).

It was in 1950 that the Japanese Government invited Deming to lecture on statistical methods. JUSE followed this by inviting Deming to give eight days of seminars. According to Hutchins (1990) Deming's achievement was to 'cut through' academic theory which was well known to Japanese academics and make it meaningful to production workers. Shortly afterwards the Japanese created an award (the 'Deming Award') to promote Deming's techniques but it was considered necessary by 1955 to launch a massive media campaign of 'self-improvement' programmes to enhance this promotion. Hutchins argues that by this time the Japanese 'had extracted all they usefully could from the statistical techniques, and they needed to take Quality up to the level of upper management' (1990, p78).

It was the statistical control of variability in all processes that was originally central to Deming's approach to quality. Reducing process variability by systematically eliminating causes of variation should improve the consistency of the output, eliminate waste, and enhance the reputation of the product. Deming's initial concern was therefore with the producer's strategic control of quality. The chief tool required to assist the statistical control of manufacturing processes is the statistical process control chart on which are plotted observations of production. If there is a statistically significant deviation from the parameter specifications for a particular process then investigative and corrective action is taken to locate and eliminate the cause of the deviation.
Deming also devised sampling methods for use in door to door consumer surveys (Flood, 1993) thereby attempting to identify the strategic quality requirements of consumers. It is the selection of the consumers requirements for standard production that completes the two-sided view of quality discussed previously that generated the strategic opportunities for Japanese manufacturers to exploit in world markets.

Deming was awarded the highest Imperial honour in 1960 for his contribution to the development of quality in the regeneration of postwar manufacturing in Japan (Munroe-Faure and Munroe-Faure, 1992) which perhaps corroborates Hutchins view that Deming's contribution to quality in Japanese industry was impressive, rapidly exploited but nevertheless quickly superseded. Hutchins (1990) and Flood (1993) seem to differ on this point. Flood (1993) states that Deming's essentially 'machine-like' approaches to statistical process control were well suited to the reconstruction of Japanese post-war industry. Hutchins argues, however, that Deming's techniques had worked well in America during the war but were not suited to Japanese post-war reconstruction. Labour relations deteriorated rapidly and this was traced back to the vogue for American style machine-like management philosophy. Unlike European and North American industries that could sell everything they could make Japanese industry was weak and could not afford poor labour relations. Consequently

They were thus the first nation to become aware of the need to break the mould and avoid the problems becoming entrenched. This was because they had experienced the disadvantages of the Taylor\textsuperscript{1} systems before they had experienced its benefits. For example, if Japan in the early 1950s is compared with Western Europe and the United States at the time, a vivid contrast can be observed.

Hutchins (1990, p49)
So Deming's techniques were valuable but by themselves inadequate modes of management. According to Flood (1993) Deming's 'success' in Japan was not matched in North America. Flood attributes this to Deming's methodological emphasis on the machine-like strategic control of quality which failed to recognise post-war North American workers cultural and political attitudes:

> He encountered major difficulties arising from poor motivation, leadership and training. Difficulties were also found in standards of practice, and too heavy a reliance on technology rather than people. These issues significantly affected the development of his ensuing ideas. Deming became more human orientated in his writings.

Flood (1993, p14)

While Flood correctly identifies the human relations weaknesses in the early Deming approaches to quality management he perhaps overemphasises his role in Japanese management. If Hutchins' view is correct Deming's methods were uniquely adapted by the Japanese to compensate for the cultural and political deficits that Flood argues obstructed the implementation of Deming techniques in North America. What is more Hutchin's argues that Deming developed awareness of the need to encourage some form of employee participation from the Japanese rather than from his failure in North America. The corollary is that anyone attempting to implement Deming's guidelines cannot look to the early or maybe any Japanese industrial success for anything other than the use of statistics as exemplars of Deming quality management.

Deming argued that industry suffered from five 'Deadly Diseases':

1. A general lack of constancy of purpose.
2. Too much emphasis on short term profits.
3. A lack of or unsuitable evaluation of performance, merit rating or annual review.
4. Management are too mobile.
5. Management decision making too readily relies on
quantitative data without paying due consideration to less tangible or hidden factors.

Deming (1986)

These 'diseases' form Deming's 'theory' about what is wrong with industry and they mainly concern strategic social action: Industry generally lacks consistent strategic actions and appropriate validity criteria aimed at longer term profitability. Only the fourth disease is a structural criticism but this implies that management are unable to take and evaluate appropriate strategic actions because they do not stay long enough with the business. However Deming's theory fails to recognise the importance of communicative variables and it assumes that if only strategic action can be improved then all would be well. The theory of dialogue developed in chapter 3 shows this to be a partial view.

Deming's diseases may have some relevance to the NHS. For instance, although the NHS is clearly not (yet) in the business of making corporate profits, the creation of internal markets may have introduced the possibility of a new kind of revenue-based 'short-termism' in NHS Trusts. The lack of performance criteria is often cited with respect to the NHS. Maynard (1992) for example argues that many NHS decisions are made in the absence of any relevant data. To an extent Deming's fifth disease could be rephrased for the NHS as 'decision making is too often based on irrelevant quantitative data'. However Flood (1993), with a much more comprehensive model of business, organisation and social interests, finds Deming's list too short adding nine further diseases to compensate for Deming's lack of structural, political and cultural detail. These include regimented bureaucratisation, coercive organisation, management / worker distinction, excessive individualism, crisis management, ignorant managers, sporadic management and reliance on simple tools (Flood, 1993, pp286-7). In other words
Deming's diseases form an highly partial view about the nature of industry and organisation. To an extent he addresses this inadequacy in the rest of his guidelines which form the 'cure' for the diseases. The guidelines include his famous fourteen 'points for management', the seven points of his 'action plan', and the never ending cyclic management steps: Plan - Do - Check - Action. In addition to Deming's own publications lots of other books summarise Deming's work (e.g. Flood, 1993; Munoroe-Faure, 1992, Oakland, 1989). I will deal with specific issues very briefly here.

While Deming argues that commercial strategic actions must reflect longer term goals in his 'points of management action' he calls for the elimination of 'slogans, exhortations and numerical targets [...] quotas or work standards and management by objectives or numerical goals'. Deming calls for these to be replaced with 'leadership' instead (Deming, 1986). One of the key outcomes of leadership is expected to be effective teamwork and to facilitate this he calls for 'fear' to be driven out 'so that all employees can work together effectively' and for 'barriers' to be removed that 'rob people of their right to pride in their work' (Deming, 1986). In this Deming is trying shift emphasis from narrowly defined strategic and normatively regulated actions to more broadly participative social action. Deming does not clearly explain what is meant by the process of leadership but he is clear that it involves strategic action to implement the guidelines, following the 'plan, do, check, action cycle'. In the 7 point 'action plan' leadership is made a responsibility of management who have to explain everything to the workforce. What is meant by 'explanation'? Deming may be implying a degree of dialogue between employees and management but it more likely refers to an exercise in strategic action (with or without degrees of
normative regulation) in which case explanations may seem to lack sincerity. Far from bring 'driven out' coercion might become necessary in order to implement the plan with sincere explanations being reserved for the issuing of threats and incentives. Given the importance attached to leadership seeing this as a purely strategic skill, rather than being sincere to employees, is a very serious limitation in Deming’s scheme.

Flood (1993) points out that Deming notably prioritises management over technology. These 'people-orientated' steps as Flood (1993) refers to them are complemented in Deming's overall approach by steps involving 'systemic functional analysis' because Deming is also concerned about the structural logic of organisation. Therefore he proposes that all stages of organisational processes be identified and the relationships in customer-supplier terms be worked out and improved through a coordinated team effort (Deming, 1986). This introduces what are now referred to in quality literature (Oakland, 1989; Munroe-Faure and Munroe-Faure, 1992; Flood, 1993) as internal and external customers.

Internal customers are employees of a business who receive some product or service from another employee or department as part of the process of production. An external customer is the person who buys the product of the business. In this way customers and suppliers can be identified at all stages of an industrial process which has clearly defined inputs and outputs. This model is then amenable to statistical control. Deming has not given a name to this organisational model but it is nearly ubiquitous in every current text on quality and every guru approach. It corresponds to the management cybernetic model of organisation discussed in detail by Jackson (1991). A management cybernetic
model is based on the theory that an organisation consists of processes, which may involve human activities, that transform inputs into outputs. The output is measured in some way, for example physical attributes of the good, or the quantity produced or production time lost, and this information is fed back to the process controller which may be fully automatic. This is virtually analogically congruent to the control of a domestic central heating system in a house. However, the simple negative feedback control model is often generalised in quality management to involve the whole organisation with varying degrees of political and cultural amendment to compensate for the un-machine-like tendencies of people. I will deal with criticisms of this model after reviewing the gurus.

These potentially destructive inconsistencies are indicative of the fundamental methodological flaws in Deming's work: that his guidelines are not really an explicit theory of quality management, or of organisation, but simply a set of pragmatic steps. The real theory is hidden as a set of assumptions entering into each polemically stated step. This is why, for instance, a management cybernetic model is visible in Deming's approach but not explicitly defined. As Flood observes quality management generally 'lacks the rigour of established management and organisation theory'.

The social action perspective developed in chapter 3 also reveals some other assumptions in Deming's work. There is a belief expressed in Deming's guidelines that people act as utility maximising agents as is assumed in classical economic theory (Rosenberg, 1988). This belief underpins the maximising of long-term profits through strategic quality. It is assumed that people are on the
whole more likely to buy better quality goods for the same delivery and price if they have a choice. Of course in chapter 3 it was shown that strategic 'utility maximising' action is only one of several kinds of social action and these are largely unaccounted for in Deming's approach to quality management.

It is assumed that the workforce will accept the carefully explained rational goals of the management who are assumed to be entitled to manage the organisation. It is also assumed that business is managed in the interests of shareholders who aspire to the maximisation of profits in the long term and that this is in the general social interest.

Flood rightly argues that Deming's methodological guidelines are too vague to form a 'Deming Method' of quality management. Although he has emphasised the role of people Deming has failed to deal with the meaning and nature of participation, motivation and leadership, a criticism echoed by Hutchins (1990). Moreover Deming's approach is theoretically partial and inconsistent. There is a communicative deficiency in the Deming approach. I now want to consider the other gurus more briefly.

6.3.2 Juran

Juran followed in Deming's footsteps in going to Japan in 1954 where he gave seminars for middle and top executives. He advocated 'Management of Quality' which Hutchins argues was the basis of the current Japanese notions of 'Total Quality'. There are clear differences between Juran and Deming. Juran (1988a; 1988b) emphasises the role of management rather than process variability as the
cause of quality problems. Therefore the management of quality requires starting at the top with his famous 'quality trilogy' borrowed from financial management: quality planning, quality control, and quality improvement.

One similarity with Deming is in the identification of internal and external customers and their needs. However, Juran differs from Deming in making the two-sided strategic view of quality, strategically determined between producer and consumer, into the high profile and crucial starting point for managing quality. What the organisation produces internally or as an end product is based on finding practical ways to satisfy the needs of customers. It is this commitment in social action terms that Hutchins (1990) identifies as the basis of Total Quality in contemporary Japanese industry.

Another similarity with Deming is found in the implicit management cybernetic theory about the nature of organisation. However, Juran emphasises goal setting as a way of gaining control of processes which Deming clearly rejects. This is not a dispute about statistical control of processes. Rather it is a dispute about the nature of employees and social action. Juran is advocating closer and more explicit social control of the workforce through the strategic use of goal setting. This extends the range of machine-like thinking clearly from the machines themselves to the machine and process operators. This is congruent with his belief that management cause quality problems (Flood, 1993) and not the machines (and their operators) whose output may be statistically controlled.

Juran specifies a further ten steps to quality improvement which, like Deming's management points and action plan, specify various conditions, activities and
kinds of social action. These include a call for leadership, training, measurement and monitoring of performance all of which Deming subscribes to. Unlike Deming, however, Juran sees it as essential to set quality goals for all activities and publicise and reward achievement. That is Juran wholly believes in the rational utility maximising actor who will, as an employee, strive harder for strategic rewards or to avoid strategic punishments. This narrow political and cultural view of the workforce is noticed by Flood (1993) who argues that Juran's emphasis on the responsibility of management and leadership for quality ironically fails to account for theories of motivation and leadership. For example Juran makes no reference to removing fear from the workplace perhaps because fear is useful in creating the machine-like conditions he believes necessary to manage quality. Dealing with the workforce in this way overlooks the possibilities for communicative action and dialogue, the potential for which is hinted at in Deming's scheme, relying instead on normatively regulated action (through performance measures, training and publicity) and strategic action in the form of incentives.

It can be seen that many of the criticisms levelled at Deming's approach above may also be levelled at Juran's. While Juran does more strongly emphasise a two-sided strategic view of quality than Deming his view of the workforce and the political and cultural nature of organisation is more primitive.

6.3.3 Crosby

Crosby (1979, 1981, 1984) did not go to Japan and has not received an imperial award! His reputation as a guru therefore originates in a slightly different sphere to that of Deming or Juran. He gained experience in quality management by
working on American missile projects and from being corporate vice president
responsible for quality for fourteen years at ITT (Munroe-Faure and Munroe-

His approach to quality management is more integrated and more succinct than
Deming or Juran and it is based on the explicit consideration of the meaning of
quality, the measurement of quality and organisation for quality. These are
pithily summarised in his famous five (originally four, Flood, 1993) 'absolutes of
quality management':

1. Quality means 'conformance to requirements' and not a
degree of excellence.
2. There is no such thing as a quality problem.
3. It is always cheaper to do it right first time.
4. The only performance measurement is the cost of quality.
5. The only performance standard is zero defects.

Crosby (1979)

Quality is defined in such a way by Crosby that there can only be degrees of lack of
quality. If a product does not conform to the customer's requirements there are
additional costs incurred in using it, replacing it, or reworking it, so that it does
conform to requirements. So lack of quality is costly and measuring the costs of
non-conformance is the only useful measure of quality. If production can be
achieved without errors then conformance to requirements will nearly always
occur, apart from wholly random deviations, and the cost of quality will
therefore be very nearly zero. Consequently Crosby (1979) maintains that quality
is free within an ideal-type process with 'zero defects'. It is necessary therefore to
constantly measure non-conformance and to strive continually for the ideal.
Unlike Juran Crosby does not centre his approach on planning the organisation
and processes from the external customer requirements inward although his
definition of quality is not incompatible with this.

Flood (1993) observes that Crosby has recently added point 2 - 'there is no such thing as a quality problem' - to emphasise that quality problems do not create themselves or exist independently. They are a symptom of a poorly managed process. Again this is idealistic rather than realistic: there may be some processes where uncontrollable errors occur that create non-conformance in a proportion of the end product. A spell of warm weather might shorten food shelf life for example. This might be labelled a quality problem by the end user or even by the producer simply unable to control all the elements of the process. Neither Deming nor Juran opt for this idealism although in terms of goal setting Crosby is closer to Juran than Deming.

Where Crosby differs from Juran is in the greater emphasis that is placed upon managing people with a number of tools that each imply a theory about people and organisation. One such tool is the 'Quality Maturity Grid' which states how the quality 'maturity' of the organisation can be evaluated. This comprises a series of stages beginning with uncertainty characterised by managerial confusion and a lack of commitment to quality and ending with certainty characterised by management understanding why they have no quality problems. Each stage is evaluated in six categories that deal with the degree of managerial comprehension, the position in the company hierarchy of certain employees, the manner of problem handling from prevention to crisis management, the cost of quality as a percentage of sales, the amount of quality improvement activity, and the overall understanding of the nature of quality problems.
Another tool is the 'Make Certain Programme' in which facilitated employee groups identify big problems and by who and how they should be tackled. There is also a 'Management Style Evaluation' tool that measures individual management performance on a simple scale on such issues as listening, teamwork, helping, transmitting, being creative, leading and so on.

The final tool is the 'Quality Vaccine' which is a preventive programme. The vaccine requires commitment from everyone to conformance with requirements, the presence of systems to undertake various functions like costing of non-conformance, education programmes and so on, the communication of information, the continuation of operations in smooth cycles, and lastly clear and unambiguous policies.

Crosby's approach is more accessible than Deming or Juran. Like them Crosby implicitly applies a management cybernetic model of organisation. The workforce is expected to produce machine-like activities that are controlled by measures of deviation from conformance. There is an emphasis on strategic action in which the employees are regarded as rational utility maximisers who will respond to rewards (or punishments).

There is an emphasis on the development of normatively regulated action in the workforce, through training and education, so that the management are entitled to the cooperation of employees in achieving zero defects. There is a call for a degree of dialogue but only between groups of employees so that they can identify the cause of problems originating in another department. This information is then used strategically and not as part of communicative action between those
claiming to be victims of error and those 'blamed' (as Flood, 1993, p27 puts it) for causing it.

Like Juran Crosby does not reject the use of fear as a strategic incentive to create the utterly cohesive team effort demanded in a quality driven organisation although Flood argues that Crosby intends to 'free workers from externally generated goals' and wants then to work together in an 'open and conciliatory way' (1993, p28). This inconsistency can be explained in that, like Deming and Juran's quality approaches, Crosby's lacks theoretical rigour. For instance Flood (1993) rightly points out that political divisions are not addressed. The simplistic management cybernetic model at the heart of each guru approach presented so far is criticised for facilitating authoritarian control of organisation (Jackson, 1991) and this contradicts Crosby's purported intention.

These three gurus largely represent the American establishment. The last guru discussed is Japanese, Kaoru Ishikawa, and he arguably offers a strikingly different approach.

6.3.4 Ishikawa

Hutchins (1990) regards Kaoru Ishikawa as the exemplary Quality guru and as going beyond Deming and Juran by developing 'Total Quality'. This is also variously called 'Company Wide Quality' (Flood, 1993), 'Company Wide Quality Control' (Ellis and Whittington, 1993) and 'Total Quality Control' (Ishikawa and Lu, 1985). Ishikawa does not provide a step by step recipe like Deming, Juran and Crosby for quality success. As Hutchins puts it 'there can be no 'paint by
numbers' guide to implementation and for different companies the route will be different' (1990, p53).

In Hutchins view the chief contribution of Ishikawa is essentially to make the planning, doing, checking and acting elements of Juran's quality management approach into a group responsibility. In this way people are required to be less individually machine-like - a key characteristic of Deming, Juran and Crosby approaches - and more autonomous. To an extent Hutchins sees this as reintroducing at a group level the ancient principles of craftsmanship that are fragmented and lost with Tayloristic modes of management while retaining the benefits of a machine-like corporate whole (1990, p50).

Flood (1993) describes Ishikawa's approach as requiring vertical cooperation between managers, supervisors and workers with horizontal cooperation between departments and functions. This horizontal component is to an extent understated in some quality literature (see Flood (1993), Munroe-Faure and Munroe-Faure (1992) or Hutchins (1990)) because Ishikawa sees the marketing function as the principle reference point with which all other functions must coordinate (Ishikawa and Lu, 1985). In other words as Oakland (1989) argues (taking the lead from Ishikawa) marketing is the business both of finding out what are feasibly and most-profitably satisfiable customer requirements and then delivering that satisfaction. In fact marketing becomes the principle strategic function of the business (and it is where the chief executive should have an office) rather than being a 'bolted on' corporate function that is often in conflict with finance: a common problem noted in British industry by Witcher and Wilkinson (1990). Ishikawa therefore extols the two-sided strategic view of
quality par excellence.

The main tool for implementing Total Quality are Ishikawa's celebrated 'Quality Circles' (sometimes also referred to as 'Quality Control Circles' see Flood, 1993). Quality circles have become a very widespread approach to implementing quality management in industry generally and in the NHS where there have been numerous implementations\(^2\). Hutchins discusses these in great detail. He describes them as the only way in which genuine craftsman-like 'self control' may be achieved by groups of workers in their work place (1990, p108) but he adds a caution that there 'is a great variety of types of group operating in the West all using the term Quality Circle. This is regrettable, because when such groups fail, the impression is that the Quality Circles concept itself is invalid' (Hutchins, 1990, p111). In the light of this Hutchins specifies the defining attributes of quality circles quite precisely. These refer to the size of group, the nature of participation, the compatibility of members, the regularity of meetings, the activities undertaken. Broadly a quality circle will consist of 3 to 12 individuals from a workplace voluntarily meeting for an hour a week in paid time. They are trained to identify, analyse and solve work-place problems, present them to management, and implement the solutions where this is feasible (Hutchins, 1990, p111).

Hutchins argues that quality circles go through several stages of maturity. Newly formed quality circles have to acquire the skills through training to undertake problem solving. After a while quality circles develop a simple degree of self-monitoring and feedback control. Eventually a degree of innovatory flair emerges at which time the quality circle members attract a degree of acceptance...
and respect from other non-members including management. The final degree of maturity is self-control. At this stage the organisation is making available all the resources that the quality circle members demand to maintain their autonomous development and innovatory activities. Members undertake self-development outside of the place of work.

Unfortunately quality circles need not operate a process of dialogue. Instead of being free insiders, quality circles could have 'prisoner' status or be 'outsiders' to some dominant circle, department or authority, in which case strategic and not communicative actions would dominate interrelationships. At this point quality circles may only remain intact because of the coercive strategic actions of management, who may issue threats and incentives, or because of normatively regulated action making the group cohesive but of low value. Additionally, there may be potential for the outsider quality circles to become ideological outsiders. At this point, the quality circle may be viewed by management as a dangerously independent group against which strategic action would be taken, such as the dismissal of members.

Interestingly, Hutchins (1990) argues that no quality circles in western Europe have yet reached the ultimate self-control stage of development. It may be that self-controlling quality circles are viewed as a strategic ideal, which will probably never be attained, and there is a consequent lack of effort. However, Hutchins appears to reject this, and argues that it is a Western management fault for failing to go to visit Japan to see self-controlled quality circles in operation. On the other hand, it may that Hutchins has not grasped the possibility that what he terms self-controlling quality circles are really strategically controlled. In any case, like
Hutchins, Flood (1993) also seems to feel that management may fail to implement quality circles properly by not listening to the ideas generated and facilitating the implementation of solutions. This would undermine the groups, and make them into outsiders, with respect to the dominant management group. It is possible that this may be a normatively regulated reflex action of British managers who cannot contemplate the creation of autonomy at work. It may be symbolic of a deep seated lack of trust or respect from those who 'own' resources for those who are employed to use and create resources. Flood (1993), Hutchins (1990) and Witcher and Wilkinson (1990) all argue that there are profound attitude problems in British industrial management that seriously and adversely affect the potential success of quality implementations. Hutchins (1990) blames management for the perceived lack of quality in much British industry. Witcher and Wilkinson argue that failures in quality implementation arise through boardroom 'short-termism', sectionalism and managerial leadership that 'directs' rather than 'facilitates' (1990, p18). Some of these points have been made for decades. For example Deming identified 'short termism' as a 'deadly disease' in the 1960s.

There is also a counterpoint to the benign view of quality circles as self-controlling forums for dialogue. Although Ishikawa's quality circles allow a much broader view of people than the rational utility maximising actors of Deming, Juran and Crosby, quality circles are nevertheless tools of two-sided strategic quality. Quality circles must gear their efforts towards achieving the narrowly defined corporate profit goals. Moreover, although mature quality circles may be fluid and autonomous organisations, they may have been highly selective of members, in which case it is moot to ask what happens to those not
selected or ousted? Finally, quality circles operate an industrial process which is still viewed as essentially a simple feedback control process, the output goals of which flow from marketing decisions, and not quality circle decisions. Ishikawa's approach is, Flood (1993) argues, much more people orientated and holistic than the previous three guru approaches reviewed. Moreover, Flood argues (briefly!) that the notion of quality control circles is more easily applicable to service industries - perhaps one of the reasons why quality circles are tried so often in the NHS. He also argues that Ishikawa's approach lacks systemic logic because it does not incorporate a view of feedback and interrelationships between the causes of errors. However, this may largely depend upon the way that quality circles operate. Self-controlled quality circles may function analogously to the white cells of the immune system in the human body, by identifying and eliminating errors, in the way that white cells identify and eliminate invading organisms. Similarly they perform functions that contribute to the survival of the whole - and of course their own survival - in this way Ishikawa's approach potentially operationalises what has been identified as an organic view of organisation and this, arguably, carries a more powerful systemic logic than that of the other gurus whose approaches tend to reflect mechanistic thinking (see Burns and Stalker, 1961; Morgan, 1986). Nevertheless Ishikawa's approach is, as the social action analysis of quality circles above indicates, politically and culturally deficient. In respect of these Flood (1993) argues that Ishikawa's ideas would struggle in the politically divided situations that are typical of Western organisation.

Each of the gurus above are widely regarded to have significantly contributed to the development of notions of quality. They each espouse a set of views about the meaning of quality and how it should be managed. They all accept in some
way a strategic two-sided view of quality that is determined between internal and external customer/supplier relations. They all support the identification of errors and their elimination from the process of production. They all advocate the systematic control of errors through various statistical and problem solving tools. They differ in their approach to managing people with Juran and Crosby (despite his philosophy) stressing a strategic goal setting and deterministically manipulative view of people. Ishikawa and Deming contrast with this by stressing the voluntary nature of cooperation between groups of people and leave open the potential for dialogue. None of them discuss how to deal with dissenters and employees who disagree with the corporate goal: they all assume that awards, information, training and leadership can deal with political differences and create a coordinated machine-like team effort.

Although strategic quality has undoubtedly been highly influential it is necessary to consider another view of quality that has been referred to above: normative quality which arguably has had a greater role in health care.

6.4 Normative quality

Normative quality means that the specification of what is produced is regulated through quantitative of qualitative standards of expectation. Failing to meet these standards leads to some rule guided sanction rather than a simple loss of benefits or performance bonuses. The traditional market notion of Flood (1993) may be a locus for normative quality because of the longer term benefits accruing to a community, that avoids the uncertainties of strategic action. In this case bargaining may still occur in the market, and this may appear to be the traditional two sided strategic mediation of quality, but boundaries of entitlement may
become established. Amongst these are issues of who has the right to sell in a particular market, what currency is acceptable and so on.

The advent of mass production also led to standardisation, which is perhaps the clearest sign of normative quality. Woodward (1972), in his account of the establishment of the British Standards Institute, argues that it was distribution of mass produced products, through better transport worldwide on railways and ships, that acted as a driving force toward standardisation. The American Civil War was also a driving force behind late 19th century standardisation. It was the incentive behind the first example of product inspection by measurement of dimensions rather than gauging by eye alone. This technique was adopted later by Singer sewing machines and McCormick harvesters (Ellis and Whittington 1993, p38). Ellis and Whittington (1993) observe that the manufacture of components for the 'new' technology in manufacturing industry meant that different sources of parts were incompatible. Replacement parts for industry had to be customised at great expense. Similarly manufacturers in iron and steel had to hold large stocks of raw material to their unique specification. So there were incentives to standardise production which would reduce costs and ease manufacture. This led to degrees of normative quality being established in all sorts of intermediate and end products including Whitworth's standard screw thread and iron and steel specifications (Ellis and Whittington, 1993). Once standardisation of various products was achieved it was probably nearly irreversible. For instance there would be no question about the dimensions of pipe to make or buy - it became an industry standard. Failing to produce the entitled attributes of product might lose customers to other standard producers. Exceeding these attributes simply wastes money - as Crosby observes in his
approach to quality management.

During the 1960s some big British manufacturers destroyed their strategic competitiveness by failing to recognise that British consumers felt entitled to purchase better (Japanese) specification goods (e.g. rust-proofed cars). Otherwise, as Hutchins (1990) argues, Wolsey and Fairy might now be market leaders selling their vehicles in the USA and Europe along with Nissan and Yamaha. The issue is that the 'low-quality' norm was structurally unchallengable. British car and bike manufacturers were able to produce and attempt to sell inferior goods because they had the means to do so without regard for dissenting views. A possible way to save these industries was seen to be the strategic intervention of government as indeed occurred in British Leyland. Unfortunately Government strategy perhaps only preserved the flawed norms of the industry and therefore failed to deal with the problems that remained structurally unchallengable. The Thatcher era from 1979 onwards dealt with nationalised industrial problems by removing the governmental structural support that sustained the industries against foreign competition. Surviving industries then had to compete on price, quality and delivery and had to acquire competence in the strategic management of quality. Consequently there was a massive loss of uncompetitive British heavy industries (Hutchins, 1990).

One of the key actors in the strategic propagation of standards in Great Britain was, and is, the British Standards Institute (BSI). This began as a civil engineers committee devising standard specifications for heavy industrial goods in 1901. Later the committee worked during World War One on the standardising of weapons and munitions. In 1929 it received a Royal Charter and became the BSI
in 1930 (Woodward, 1972). In this way a single committee became crucial in the spreading of normative quality in British industry.

Inspection became a key mode of managing quality and became central to Taylor's so called 'Scientific Management' (Ellis and Whittington, 1993). As Ellis and Whittington note the responsibility for inspection in the munitions industry gradually became the purchaser's which in the late 20th century is now also a common retailer practice - retailers now often inspect a proportion of the product rather than relying on the producer. Inspection is dedicated to the normative regulation of quality, because comparison is made with a constant standard, which may be defined wholly outside of the organisation's control. Inspectors are usually entitled to take certain actions if more than a particular amount of product is produced that does not meet specification. In 1992 I visited a factory in Lahore, Pakistan, that makes garments for a major American 'blue jeans' company. This company permitted only 10% non-conforming production at the time of my visit and arranged random inspections to assure this. Interestingly the output was 100% inspected by factory quality controllers. This is probably only possible in a low-pay, hard-labour, 'sweatshop'. According to a former manager at the factory 'vagabonds' are employed to bring back any absconding workers who are therefore virtual slaves.

In contrast to this end of the line inspection, as Flood (1993) explains, since World War Two quality management has involved progressive steps back, from concern only with the quality of the end product, to concern with the design before it is fabricated - this is exemplified by Taguchi (1979) who advocates designed in quality. Although these changes have occurred for strategic
competitive advantages, both the inputs and the outputs of manufacture will conform to a whole range of standards, defined *externally* in ISO 9000 and so on. So normative quality is incorporated into the design of products. When the process of manufacture has settled down it becomes, to an extent, a process based *internally* on normative regulated quality.

Normative quality in manufacturing has had a significant impact on manufacturing. Arguably it may have had a much greater impact on health care, and on the NHS. Health care professions, such as doctors, nurses, pharmacists and so on, usually regulate quality by licensing members if certain standards have been achieved in examinations, worktime has been spent in a particular environment and so on (Wilding, 1986; Ellis and Whittington, 1993). Continuing membership often depends upon demonstrating continuing competence with theoretical and practical development. This is especially so in the health care professions where continuing registration of nurses for example is now linked to a demonstration of constant professional education and practice (Ellis and Whittington, 1993).

The professional regulation of quality is often based upon legally enforceable entitlements by the public and the profession to work carried out according to certain explicit principles. These principles may even be codified, published and often put in public places such as the code of conduct for nurse, midwives and health visitors (UKCC, 1994). Shaw (1986) and Ellis and Whittington go back to the 1518 Royal Charter of the Royal College of Physicians of London for the earliest British example of a code which required that doctors uphold the standards of medicine for professional and public benefit. At this time only the
guilds and crafts referred to by Hutchins (1990) and Flood (1993) would have similar control over members but it is interesting to note the public centred value expressed in the code. The Greek Hippocratic oath despite being some 2000 years old remains amongst the most well known ethical codes governing the quality of medical practice (Seedhouse, 1988). The 1518 Royal Charter of the Royal College of Physicians of London might be construed as an attempt, by the King, to gain strategic control over the quality of medical care for the community, but it also formed a new basis for normative quality: the Royal Charter was the institutionalisation of Regal and public entitlements and expectations.

Codified practice resembles the attempts, characteristic of strategic quality management, to create corporate cultures around mission statements. However, professional codes apply to individuals who must take legal and professional responsibility for their actions. This is not the case if an employees fails to conform to the corporate mission statement which in any case are usually very general without any legal precedents to clarify the detail of its commitments. Professional codes are usually far more complex and they constitute legal as well as professional obligations far in excess of industrial mission statements.

The usual reason that a guild or profession is created is probably a strategic one: They are often seen to confer power over the public to the professional body and its members (Wilding, 1986). However, the Royal Charter referred to above and the ancient Hippocratic ethics of *beneficence* (do good) and *non-maleficence* (above all do no harm) (Seedhouse, 1988) imply a degree of altruism - a willingness to self-sacrifice. This might still be interpreted as the effect of the socially valuable long-run benefits of normatively regulated action (Habermas,
However it might also reflect a non-strategic value or motive that might be expressible as dramaturgical action. Yet the sincerity of this might only become visible in special circumstances - such as in dialogue processes.

Now that the strategic and normative meanings of quality have been discussed I want to consider the implications of these in the most publicised and prolifically written about form of quality management: Total Quality Management (TQM).

6.5 Total Quality Management

Not only is TQM the most promoted form of quality management in industry, there have been numerous claims that it has been implemented in the NHS (Sewell, 1994; Ovretveit, 1994; Spackman, 1993; Munroe-Faure and Munroe-Faure, 1992; Holloway, 1991). Munroe-Faure and Munroe-Faure (1992) are typical of the TQM genre in having no doubt about the current totality of TQM's solution to quality management: 'Total Quality Management' is a proven, systematic approach to the planning and management of activities. It can successfully be applied to any type of organisation' (Munroe-Faure and Munroe-Faure, 1992, p136). Flood, aware of shortcomings in other TQM guides as we shall see, sees TQM as genuinely beneficial for business but only if it is developed, hence his manifesto tone: 'Beyond TQM'. However in this section I want to raise some important questions about TQM that may be overlooked or misunderstood by those implementing TQM. I will give a special consideration to Flood's (1993) version of TQM since this represents an attempt to deal with some of the serious shortcomings of the traditional total quality approaches.
TQM is frequently based on eclectic and pragmatic compilations of guru and other approaches. Typical of this are the accounts of Munroe-Faure and Munroe-Faure (1992) and Oakland (1989). In part the analysis of TQM that follows is a response to the under-theorised state of the art. Witcher and Wilkinson argue that research is needed to determine TQM’s status as a theory for or of organisational behaviour (1990). Nevertheless TQM is regarded by its protagonists as the state-of-the-art approach to quality. The DTI promotional videos, in advocating TQM, go to great lengths to illustrate the practical differences between a ‘quality’ organisation and ‘non-quality’ organisation from being greeted at the door to the finished job. Even Flood (1993) eulogises:

TQM is sweeping the industrialised world, with good reason. TQM is helping to remove unnecessary and costly waste, to locate and eradicate sources of error, and to provide the consumer with reliable products that they actually want. It also makes people’s jobs more meaningful. TQM makes common sense.

Flood (1993, pxi)

In Ackoff’s (1992) ironic words TQM is a panacea. It is important to ask, however, whether there are any other consequences or effects of using the TQM approach besides the claimed improvements to industrial competitiveness or value for money in the NHS?

To help answer this question let us begin with an account of the principles of TQM that have been usefully summarised by Flood (1993). He identifies ten main principles of TQM. These are:

1. There must be agreed internal and external customer requirements.
2. Customer’s requirements must be met first time, every time.
3. Quality improvement will reduce waste and total costs.
4. Prevention of problems is better than cure or crisis management.
5. Quality improvement can only result from planned management action.
6. Every job must add value.
7. Total involvement of all employees from top to bottom and across functions is required.
8. There must be an emphasis on measurement to help assess and to meet requirements and objectives.
9. There must be a culture of striving for continuous improvement involving breakthroughs as well as incremental steps.
10. An emphasis should be placed on promoting creativity.

(Source: Flood, 1993, p48)

Witcher and Wilkinson (1990) provide a model of TQM that draws on Oakland (1989) in which TQM is viewed as the holistic interaction of teams, methods and internal markets facilitated by leadership. This is broadly similar to the approach taken by other authors on TQM such as Munroe-Faure and Munroe-Faure (1992) or the Department of Trade and Industry (1991). It can be seen that TQM involves all the elements already introduced previously in the discussion of the guru approaches. There are special emphases, however, on the 'market' nature of organisational processes involving customers and suppliers in long chains and on the costs of non-conformance in the chain.

The 'quality chain', which is emphasised by Oakland (1989) and the DTI literature (parts of which Oakland may have written), is one of the key unifying strands within TQM. It is explicitly based on the view of an organisation as a series of interconnecting processes which have inputs and outputs. Every member of the workforce is understood to be undertaking some process. Internal suppliers produce an output for someone else. Internal customers are defined as those who receive as an input to their process something that a supplier has produced as an output. Everyone is regarded as someone's customer and someone's
supplier in long interconnecting chains through the whole organisation and beyond.

While internal customers requirements are being met, first time every time, there is no problem. However, when a supplier fails to meet a customer's requirements then it is more difficult for that customer to meet the next customer's requirements. In this way a defect at a point in the quality chain can create defects all along the chain. What is more defects can cascade along branches. In extreme cases a single defect, such as a missing spare part, may stop an entire business because everyone is wholly dependent upon the manufacturing process. In health care a late consultant doctor can tie up a large variety of staff who have independent commitments elsewhere. Therefore one defect may create dozens of other defects creating 'non-conformance to requirements' in many other places.

A major justification in the literature for the TQM approach is that it helps to reduce business costs by the elimination of such 'non-conforming' output. Output which does not conform to the requirements of the customer, internal or external, at the very least wastes their time in handling and disposing of it. It also involves wasted effort and materials on the supplier side. The Department of Trade and Industry (1990) and Munroe-Faure and Munroe-Faure (1992) give various examples of industries that have calculated the potential financial savings on costs of non-conformance. For example the National Westminster Bank in 1988 claimed that 25% of their operating costs was due to non-conformance. 
TQM authors, like the gurus, always focus upon the ways in which these defects can be eliminated. Usually, as Flood (1993) observes, authors of standard TQM texts describe one particular toolkit for 'problem solving' and this is exemplified by Oakland (1989) or Munroe-Faure and Munroe-Faure (1992) who advocate such tools as Ishikawa fishbone cause and effect diagrams and a flowchart 'problem solving method'.

One of the central claims of TQM is that it is total or holistic. However what does this mean? Upon what theory does this stand? Does this help in deciding whether or not TQM should be implemented in industry in general and in the NHS in particular?

6.5.1 TQM: total or partial?

Witcher and Wilkinson (1990) emphasise that TQM is an holistic form of management, rather than simply a goal of management, but they do not justify their argument. More helpfully, Flood (1993) describes TQM as 'total' because it seeks to involve everyone, everything and all issues in the management of quality. However, the involvement of 'everyone, everything and all issues' is a large claim to make of any method of management. How is this claim justified? It is through the practical application of the idea that every employee is involved in a process with inputs and outputs. The simple definitions of customers and suppliers (that I introduced earlier when discussing Deming) are operationalised by applying the management condition that 'quality' output is the goal of every process of the business thus applying the familiar management cybernetic model.

In one sense input-process-output, as observed by Jackson (1991), is an extension of machine-like thinking (see Burns and Stalker, 1961 and Morgan, 1986). That is,
organisations are expected to work 'like clockwork'. Well-oiled, timely and utterly single-minded. However while management cybernetics is stuck with this limited model, organisational cybernetics, according to Jackson (1991), goes far beyond it with brain-like thinking (Morgan, 1986), which as we shall in a moment see has been utilised by Flood (1993). TQM, however, usually relies upon the simple machine-like model for organisation.

This model is arguably so limited that it is reliant for sophistication upon a variety of tools, including for example Ishikawa's quality circles, his famous fishbone diagram for identifying the causes of errors in production, and, for controlling workplace activity: control charts and graphs, histograms, scatter diagrams, and Pareto charts. Other tools include Best Practice Benchmarking for quality improvement (Holloway, 1995; Oakland, 1989), or more complicated tools such as Quality Function Deployment (see appendix C and Munroe-Faure and Munroe-Faure, 1992). In the end, however, no matter how big the tool kit or intricate the feedback controls, standard TQM remains a very late 20th Century application of mid-20th Century management cybernetics. If TQM has any methodological claim to holism then it arises from these rather old cybernetic ideas carrying the single-minded philosophy and tools of TQM into every aspect of the organisation and its market.

Yet this has a cost. The major criticism of management cybernetics is that it is clearly open to authoritarian organisational applications: 'Models that treat organisations as simple input-transformation-output systems, with an externally defined goal, clearly lend themselves to autocratic usage by those who possess power' (Jackson 1991, p122). This is reflected in TQM and the guru approaches.
previously discussed where strategic action is seen to dominate over dialogue as the dominant mode of social action. It is the reduction of error in the output of a process that TQM teamwork is directed towards without allowing the goal of the process to be substantively challenged. Flood expresses it this way:

> In this machine-like cybernetic structure people become cogs operating without freedom. There is no room for freedom, not even to make local relevant decisions. Mindful people must become mindless parts. Creativity is suppressed by restricting commands and extrinsic control, originating or operating from the outside.

Flood, 1993, p130

Deming and Ishikawa each appear somewhat aware of these limitations of machine-like organisation, hence their proposals to 'break down barriers' or facilitate self controlling quality circles\(^9\). However it might be counter argued that a TQM organisation is orientated to the satisfaction of its external customers by delivering products and services that conform to their requirements. Therefore the substantive goals of a TQM organisation, are strategically defined by its external customers, who therefore guarantee the legitimacy of the corporate goals. So long as the business succeeds strategically, society benefits from more productive industry, and more effective delivery of satisfaction to consumers.

This is a standard economic argument for the maximisation of social welfare through efficient markets (Rosenberg, 1988). It does not reflect the strategic control over quality exerted by the producer nor the ignorance of the consumer both of which reduce the efficiency of markets. Strategic action will involve the distortion of information in a way that will affect consumer decisions by making it less possible to make a rational buying decision. In this way the machine-like limitations of TQM organisations affect social welfare in a potentially negative way by (more efficiently) achieving the wrong social welfare goals - such as the
creation of a 'short term profit' economy.

The coordination of effort in a TQM organisation to achieve corporate goals requires a machine-like commitment from a team whether this be departmental or in a quality circle. Hence the need for such TQM paraphernalia as cultural cohesion to prop up the simplistic cybernetic model of organisation. TQM culture serves the cybernetically (and externally) defined goal of the organisation and is, naturally, reproduced wherever there are supplier-customer relations. It is the creation and reproduction of the TQM culture, or in other words certain kinds of values and normatively regulated action, that is made a strategic management goal by virtually all TQM authors. This is done largely through propaganda disseminated through so-called leadership, training, facilitated groups and so-called 'explanation'. It is propaganda because it is a strategic exercise: as we have already seen dialogue simply does not on the whole appear to be supported in quality management although Ishikawa and Deming offer a chink of light. The political question about dissenters who will not cooperate with the TQM regime is never addressed explicitly: it is implicitly left to the organisation's disciplinary processes and the control of personnel through contracts.

TQM in social action terms, or in systems terms, must be seen as highly partial and unreflective, perhaps even dangerously simplistic in its standard form. The upshot of this is that the adaptability of organisations implementing TQM may be limited rather than enhanced. Deming recognises the dangers of rigidity and advocates the abolition of slogans, targets and so on, which is contrary to the spirit of TQM as it is being practised, according to Oakland (1989), in the UK.
Not surprisingly, given the serious methodological shortcomings in the standard approach, TQM has encountered difficulties in implementation in British industry. Witcher and Wilkinson (1990) claim that nearly all TQM implementations they know of in the UK fall short of being 'holistic' and 'total'. According to Flood (1993) there are largely unexpected problems being experienced by those implementing it. However, the problems faced TQM implementation are not all due to general theoretical weaknesses. The 'partial' implementations of TQM are, argue Witcher and Wilkinson (1990) due to the dominance of particular values and structures in industry. For instance, short-termism is seen to be the consequences of banks and big investors demanding short paybacks in conjunction with the numerical domination of accountants on boards and in senior management. This leads to 'quick-fix' TQM. The 'reluctant manager' problem arises because participative teamwork with middle management leaders is based on little more than 'exhortation' (1990, p14). Middle managers are often assigned roles without consideration of their ability, attitude or propensity for the teamwork tasks. The culture creation strategy based on identifying 'core values' often expressed as a 'mission statement' leads only to agreements on vague and meaningless corporate objectives with even these remaining subject to dispute (1990, p15). Leadership under these conditions naturally is difficult and highly pressurised with ever closer monitoring by performance targets (1990, p14). The limitation or absence of participation, by definition, means that performance is determined by a senior manager according to the short term requirements of the board. The machine-like team is therefore created and sustained by strategic action and not through dialogue.
Witcher and Wilkinson (1990) recommend that firms should be more market orientated, a finding familiar from the gurus above, and that it is the two-sided strategic mediation of quality that should drive the TQM implementation programme. In this way it would be the strategic selection of longer term plans to deliver satisfaction to external customers from which would be derived the specifications of requirements throughout the rest of the internal quality chain. Witcher and Wilkinson (1990, p15) argue that commitment may not be necessary in order to achieve this but merely compliance. In their view by revising the implementation strategy, and securing compliance from the workforce, TQM would become an holistic success. Central to the securing of compliance is leadership which, they argue, 'is about quality committed senior management which must ensure that the principles of quality management are implemented continually' (Witcher and Wilkinson 1990, p6).

What Witcher and Wilkinson have done is little more than state that leadership means securing compliance from everybody (including 'top management') about the way activities are undertaken. What they imply by this is that strategic action, in the form of threats or incentives, is required. Yet their root argument as to why TQM implementations fail is that the existing threats and incentives are inadequate and so they have contradicted themselves. This is a pity because they recognise the structural and value problems that usually foil strategic actions and appear to prevent successful TQM implementations. It must also be said they completely overlook the general theoretical shortcomings of TQM.

A better response to the problems Witcher and Wilkinson identify would be to set up dialogues that permit the problem structures, goals and values to be
challenged. Participants in dialogue would not find disagreement over corporate goals to be a problem, since genuine dialogue values dissensus as much as consensus in coordinating actions. The only compliance required is that participants do not resort to strategic action because this may destroy a dialogue. Moreover leadership in a dialogue then takes the form of facilitation and not the strategic posturing advocated implicitly by Witcher and Wilkinson.

Witcher and Wilkinson's criticism of TQM implementations and their definition of leadership leads us back to the dominance of strategic action as a British management modus operandi. However, like Hutchins (1990) they view the problem as an inadequate strategy by management in the pursuit of commercial success rather than as a lack of dialogue between workers. It seems bizarre that TQM is, in Flood's words, 'sweeping the industrial world' given the problems discussed so far. Flood's (1993) version of TQM is an attempt to redress these problems and realise the potential of TQM by theoretically strengthening it. This is discussed next.

6.5.2 Flood's theory of TQM

The distinct limitation of the reliance of TQM on a limited cybernetic model has been recognised in other literature. Both Flood (1993) and Holloway (1991) each respond to TQM limitations by proposing the implementation of TQM through the Viable System Model (VSM) which is the main organisational cybernetic method (Jackson, 1991) par excellence. Flood's arguments deserve a very close look, because he claims to have largely overcome all the drawbacks of the traditional modes of quality management, in a theoretically rigorous and socially and politically superior version of TQM.
Flood's theory of TQM is explicitly based on Habermas's (1972) knowledge constitutive human interests, the original theory of complementarism developed in critical systems thinking, and anticipates post-critical complementarism. It makes use of three perspectives - machine-like traditional management thinking, brain-like cybernetic systems thinking and socio-cultural systems thinking. Each of these perspectives are deemed to imply each other in a complementary interrelation that Flood argues is not recognised in the general quality literature. Instead industry Flood argues is dominated by traditional machine-like quality thinking which is contradictory and neutralises the value of quality ideas. What is central to Flood's argument is that emancipation, in the form of disimprisoning and freedom, can be secured for both workforce and society only by debate and design of organisations for quality.

The design of organisation that Flood forcefully advocates is Beer's (1972, 1979) Viable System Model (see appendix B). Flood views quality as a functional requirement of the VSM rather than seeing the VSM simply as a superior means of implementing TQM as Holloway (1991) implies. By applying the VSM, Flood is attempting to overcome the serious methodologically un-total and unholistic partiality of TQM. Moreover, the VSM is a key part of his explicit social and political manifesto: 'Practising freedom' (1993, p127).

Flood argues that the VSM is politically and socially superior to management cybernetics - a view also taken by Jackson (1991) - and that Beer (1973) 'preempted and smashed the arguments to be levelled by the critics of his organisational cybernetics who still fear autocratic dimensions to his work' (1993, p128). The
cybernetic element of Flood’s TQM is claimed to be more robust than in the standard version of TQM.

The premises of each argument are summarised in the following paragraphs with a discussion at the end of each brief section.

The design premises are that gaining knowledge and expertise is necessary in order to overcome the social ills of the modern world such as unemployment, starvation, poverty and so on. Being inefficient, as a way of guarding against the autocratic use of cybernetically excellent design, does not overcome these ills. The older machine-like approaches to management reduce freedom because they are inefficient and coercive. In contrast organisational cybernetics potentially enables all human activities to become more efficient by sacrificing only just that amount of locally agreed individual freedom, within an organisation, that is needed to maintain a viable whole into the long term. This produces more freedom for everyone than it consumes (a 'Liberty Machine': Beer, 1973). Anarchy, argues Flood (1993, p131), may represent the ultimate individual freedom but is self-destructive because social life needs organising to deliver social goods like food, drink and leisure. Consequently autonomy which is essential for creative and free human life is finely balanced against regulation which is necessary for achieving social goals. The VSM is proposed as the flexible design that can achieve these fine balances.

Beer (1973) argues that social ills are caused to an extent by a lack of cybernetic efficiency. This assumes that VSM organisations cannot operate to profit from creating social ills, and also that everyone is agreed about what a social ‘good’ or
‘ill’ is. Moreover he and Flood (1993) appear to assume that anarchy is the opposite of total regulation\(^{10}\) and that it is a question of finding a balance point between the two. If this balance is right and locally agreed then the organisation is viable and it will produce social goods rather than social ills.

However VSM organisations have corporate and subcorporate goals that together define the purpose of the organisation. Whether the organisation produces a social good depends upon the nature and means of definition of the corporate goal. If the process of corporate goal definition is a strategic process, undertaken solely by the board of directors, then they will want to be completely confident that the locally agreed sacrifice of freedom by an employee serves the predetermined goal of the organisation. If Witcher and Wilkinson are correct in their analysis of British industry then local agreements will only serve short term goals. In a purely strategic mode the VSM is no different to any other mode of quality management discussed previously. It simply gives the board better control and maximises autocratic power - a criticism levelled by Ulrich (1981).

However if debate is mobilised, as Flood (1993) suggests, then the VSM can be implemented in a more critical process of quality management. Flood argues that dialogue and debate as crucial to the 'freedom' design of viable organisations (Flood, 1993, p133). Debate is seen by Flood to be essential to reveal what Vickers describes as a 'mind trap' which is 'only a trap for creatures which cannot solve the problems that it sets' (Vickers, 1970). Escaping from one mind-trap leads inevitably to another but experience builds up and increases individual and social freedom. Debate contributes to trap-solving because participants may each have part of the 'combination' that others can learn and understand (Flood, 1993,
p134). Flood therefore proposes the use of a variety of methods that facilitate debate. These include the use of Quality Circles (discussed earlier), Strategic Assumption Surfacing and Testing (Mason and Mitroff, 1981), Ackoff's (1974, 1978, 1981) Interactive Planning and Soft Systems Methodology (Checkland and Scholes, 1990)\textsuperscript{11}.

However Flood identifies a limitation in debate, and argues that design and debate are in themselves insufficient to create freedom, because they are often used as tools to serve narrow interests by structurally powerful groups. Powerless or subjugated groups are effectively imprisoned (prisoner insiders or outsiders by necessity in the terms of chapter 4). The agenda for debate is given and inflexible. This echoes the criticism made earlier, that quality management in industry is dominated at the corporate goal level by strategic quality, in which the producers favour their own short term interests. Flood argues that it is vital to empower people 'at least with the knowledge that they are subject to the interests of others' (1993, p137) following which appropriate changes may be made. Unfortunately though, unlike 'designing and debating, however, disimprisoning is not flush with models or methods. Very little practical work has been done on disimprisoning' (Flood, 1993, p137-138). The only approaches to disimprisoning that Flood can identify are Ulrich's (1983) Critical Systems Heuristics (CSH) and one of the elements of Flood's (1990) Liberating Systems Theory (LST) that deals with freeing knowledge suppressed by dominant institutions\textsuperscript{12}. Neither of these are deemed by Flood to be highly developed and effective ways of disimprisoning. Yet without development in these areas Flood argues that 'practising freedom' will remain only a 'good idea' (1993, p141). Disimprisoning is therefore very high on Flood's research agenda. Post-critical complementarism
(Flood and Romm, 1995a) and the oblique use of methods (Flood and Romm, 1995b) appear to be contributions to that agenda.

This is perhaps the big crunch moment in Flood's TQM. How can freedom be attained if strategically powerful groups are able to do what suits them? What force can be identified with which to equip a disimprisoning method that will neutralise strategic (or normative) superiority? What is required according to authors such as Habermas, Giddens and Ulrich (and Bauman whose postmodern agenda is notwithstanding) is that dialogue processes are structurally bound into modern living. Through this, imprisoning structures would be revealed, and it would allow participants to coordinate their actions to counteract them in ways otherwise invisible or impossible. It is through the democratic process of dialogue and not simply the incidental tools through which disimprisonment may be achieved. Habermas's theory of communicative action is specifically directed toward stating the democratic conditions under which the rationality of the force of the better argument can begin to operate in public life. The next chapter outlines an attempt at operationalising dialogue in the Trent Quality Initiative (Gregory, Romm and Walsh, 1994) and this can also be seen as an attempt at disimprisoning.

Flood's argument is by far the most comprehensive and radical of any quality approach yet published. He regards the implementation of TQM through the use of Total Systems Intervention (TSI) as a way of encapsulating the design, debate and disimprisoning elements within an intervention. He does attempt to address the theoretical issues that underlie the pragmatism of the guru and other quality approaches. He rightly criticises the neglect of individual and social life
although his TQM pathway of design, debate and disimprisoning is still communicatively underdeveloped. If dialogue principles can be incorporated into it and spelled out then this may be the seed for a new movement in quality that I have termed critical quality. Before I introduce this idea however I want to review the approaches to quality found in health care services and consider more fully the status of quality in the NHS.

6.6 Quality in health care

Perhaps the acrimonious and anecdotal atmosphere of discontent about the NHS that I described in chapter 2 is one of the motives behind the burgeoning of quality schemes in the NHS during the 1980s. Yet as I have already argued quality in health care generally or in the NHS is not a new consideration. Probably the most famous influence on the quality of health care in the Western world, is that of Florence Nightingale, whose actions had practical significance in the Crimean War in the mid 19th century. Although her efforts are seen as the epitome of caring they were guided by 'a cycle of standard setting, observation, review and improvement' (Ellis and Whittington, 1993, p11). She demonstrated that improvements in outcome, measured on a scale of 'relieved, unrelieved, died' (Shaw, 1986), were possible by improving caring practices. In these activities Nightingale was displacing the existing normative quality of care with strategic improvements in quality. In the process she was establishing more dynamic expectations and entitlements: the 'Lady with the Lamp' created a new normative quality of hospital care\(^\text{13}\). According to Ellis and Whittington (1993) the next step in the international development of quality was E.A. Codman's systematic review of medical practice at the turn of the century in Boston (USA). Codman called back his patients after a year to check the accuracy of his diagnoses,
the degree of benefits and side effects of treatment. Codman even founded the 'End Results Hospital' after his ideas were rejected by colleagues (Ellis and Whittington, 1993, p11). Ellis and Whittington claim this was the first example of assured quality in health care being marketed.

Codman's innovation is an early example of two-sided strategic quality in health care focussed upon the output of the service. Ellis and Whittington observe that most developments in health care quality were directed at the process by influencing and controlling the 'education and licensing of practitioners' (1993, p11). For example in the USA the Flexner Report (1910) on theoretical and practice standards in medical education stemmed from evaluation in medical schools commenced by the American Medical Association and the Carnegie Foundation. The Royal Colleges in the United Kingdom undertook the inspection of hospitals, departments and training programmes to check their suitability for medical student training. Other health related professional organisations followed suit. In this way normative quality of health care began to spread. Recently this has included moves to introduce regular relicensing as a way of maintaining strategic pressure on practitioners to maintain their standards of practice (Ellis and Whittington, 1993).

Ellis and Whittington argue that the emphasis on practitioner training demonstrated great confidence that this guaranteed the quality of the output of health care. The normative and strategic quality of output was believed to be assured by the normative quality of medical input. This is markedly different to Codman's strategic quality emphasis on output evaluation that can be seen to have exploited his colleagues' reliance on normative quality.
According to Ellis and Whittington it was the period from the 1930s onwards where outputs of care gained in importance in the UK and the USA as a variety of studies produced useful data. Many of these studies are continuing to the present day. They are mainly concerned with one particular kind of outcome - death - in a variety of settings: maternity (Hooker, 1933; Maxwell, 1984); Anaesthesia (Lunn and Mushlin, 1982); deaths under 50 years of age (Royal College of Physicians, 1978) and peri-operative deaths (Campling, Devlin, Hoile, and Lunn, 1993). Other outcomes of health care have been studied such as the success of cardiac surgery, diagnostic testing and caesarean sections (Ellis and Whittington, 1993, p12).

These studies correspond to attempts at statistical process control and are analogous to the cybernetic feedback controls in quality management reviewed earlier but at the stage of retrospective inspection of the output\(^\text{14}\). The feedback of a limited range of outcome measures that began in the 1930s is complemented by an informal tradition of clinical meetings in hospitals to discuss unusual or difficult cases (Shaw, 1986; Ellis and Whittington, 1993). Ellis and Whittington point out that this usually begins with a review of medical records which also corresponds to a methodological bias toward retrospective inspection (1993, p12). However, another analogy may be made: unusual or difficult medical cases are analogous to the errors that most quality management methods in manufacturing seek to eliminate at source. Clinical meetings can be seen in strategic quality terms as a problem-solving approach\(^\text{15}\).

Amongst the first and most well known explicit theoretical attempts to tackle
quality consistently were those of Donabedian (1980) and Maxwell (1984). They each designed quality assessment schemes which have been of great influence in NHS quality management. Since then activity in quality intensified constantly. Ellis and Whittington identify 13 varieties of quality initiative (table 2 - see appendix C) that they classify as 'quality specific techniques' (because they were devised as means to manage quality) (1993, p66-154) and 'generic techniques' (because they were devised for management generally) (1993, p155-188). They then discuss over 40 examples of quality initiative drawn from these categories that have emerged mainly in the 1980s. Kitson, Harvey and Guzinska (1987) produced a directory of nursing quality assurance, including long lists of quality related activities, cross-referenced with health authority locations. For example they list 29 health authorities in which quality circles were being used, 5 health authorities in which patient satisfaction surveys were being used and so on. Monitor, a checklist of hospital quality items was the most widespread and frequently used quality initiative in District Health Authorities. 'Patient satisfaction systems', which means patient questionaires, suggestion and complaints procedures and opinion polls, were a small proportion.

There was also a boom in 'medical audit' which is a term defined by Shaw (1986) to mean the evaluation of quality of NHS services. Shaw states that medical audit was not widespread at the time he was writing. He argues that this was because the medical profession was confident that it was self-critical in practice for instance through case conference meetings. Nevertheless he states that 'it has
been shown many times that... (via systematic analysis)... unexpected findings and improvements are possible' (Shaw, 1986). He therefore argues that medical audit should be a part of clinical practice. Ellis and Whittington, in contrast to Shaw, argue that the reason for the slow spread of audit is because the medical profession 'has been notably unwilling to participate in quality assurance, and once persuaded of its value, has been very creative in setting up separate systems in which its ownership can be clearly established' (Ellis and Whittington, 1993, p195). They further argue that these 'separate systems' are important for the preservation of medical professional power. They believe it is no accident that the term 'medical audit' is used frequently since this is a sign of medical power. Shaw's remarks about medical audit seem to leave out the majority of activity related to quality in the NHS which is dominated by nursing and the 'professions allied to medicine' (Ellis and Whittington 1991). This has been a source of confusion and dissension and so the phrase 'clinical audit' is sometimes used to denote a much wider scope of quality interest than that of the medical profession. For example Normand, Ditch, Dockrell, Finlay, et al (1992) undertook a government commissioned comprehensive survey of 'clinical audit' in the

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<td>Professional standards systems</td>
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Table 2: NHS approaches to quality management
Shaw (1986) argues that clinicians in groups, or individually, have organised systematic analysis with a view to improving the quality of practice, in spite of limited resources, because of a tenacious commitment to provide services of the highest possible quality. Here perhaps again can be seen something of what appears to be a caring altruism which, in health economics, is often termed the 'caring externality' (Mooney, 1993). This is the the sense of satisfaction (or 'utility') associated with caring for others. Putting it this way throws into relief both the mysterious nature of human agency and the inadequacy of economics to account for caring: If the need to care (and obtain satisfaction) was as imple strategic action then, on the whole, nurses and doctors would pay to work in the NHS rather than the other way around. Yet otherwise caring is an economically bizarre behaviour. Dawkins (1989) explains apparent altruistic behaviour as the consequence of natural selection at the level of genes within what is essentially a prisoners dilemma\textsuperscript{16}. The alternatives in social action terms are that caring is a normatively regulated action that is supported, amongst other ways, by dutiful ethics (Seedhouse, 1988) or that it is a subjective phenomena corresponding to dramaturgical action (Habermas, 1991a). Or finally perhaps it is a way of reaching understandings with those cared for, or with others.

Whether it is called altruism or a caring externality (or love?) there is a behaviour expressed in caring that confounds the logic of strategic quality. The market reforms of the NHS introduced the strategic motives of revenue gains, and threats of revenue losses, in order to drive up quality, drive down price and demonstrably improve value for money (Gregory and Walsh, 1993). Has this
created a new tension between strategic imperatives and altruistic motives amongst NHS employees? Nurses in the NHS have always attracted the sympathy and gratitude of the general public. However, if altruism is being replaced by strategic bargaining in the NHS will the public remain sympathetic to a workforce that only cares for as much as it is paid? The likelihood is that caring will continue and will merely be exploited, perhaps as it always has been, by the employers whether these be NHS trusts or directly managed NHS units through the underpayment or over working of staff. It is precisely this sort of tension that could be managed were the reformed NHS based on the principles of critical quality rather than on what are explicitly principles of strategic quality.

Other interprofessional tensions and struggles can be seen in Adam's (1987) comments that community doctors, already monitoring 'quality' implicitly along Maxwell's (1984) lines in 1974, have been marginalised by other groups who seized the initiative including nurses and General Managers. Adam goes on to complain about the superficial 'shop-window' quality approach emerging from the emerging NHS business orientation, for example emphasising hotel services, rather than what the patient is really interested in - the outcome of medical and nursing care (1987, p18). In Adam's view quality in the NHS suffers from a 'partial approach'. This is echoed by Donabedian (1991) and Ellis and Whittington (1993) who argue that there is professional fragmentation of quality which is clearly visible in the way a multitude of separate records are kept for an individual patient. It is difficult to pin down who can or should be responsible for improvements or developments in quality. There is a lack of 'dialogue' between the NHS professions (Ellis and Whittington, 1993, p196) a view similarly expressed by Normand, Ditch, Dockrell et al (1991) on inter-disciplinary
communications in the professions allied to medicine. Far from NHS management being able to overcome these fragmentation problems Ellis and Whittington believe that they are more likely to tackle the seemingly easier issues of throughput, efficiency and hotel services (1993, p196).

Audit of medicine and surgery (perhaps this could be called 'medical audit') has become a statutory requirement with the 1989 NHS reforms. This is because a crucial element in the operation of the internal market of the NHS is the specification of services in what are euphemistically called 'contracts'. Quality is something that must be implied by these service specifications because an imperative of the Government was to measure and improve value for money - a proxy for competitiveness.

Specifying services in the quasi-contracts of NHS providers can only be done if the specifications are measurable either qualitatively or quantitatively. Since much of the effort expended during the 1980s on quality in the NHS focussed upon standard setting (Ellis and Whittington, 1993) this activity probably proved useful in the creation of the internal market. The assessment of value for money or provider performance in the NHS internal market is reliant upon the auditing of performance against specifications. Consequently there are now a vast range of quality initiatives throughout the NHS that are directed at the 'observation, review and improvement' (Ellis and Whittington, 1993, p13) of NHS services. Inquiring into the breadth of involvement of NHS practitioners and other staff in quality initiatives in Trent Region was a survey element of the Trent Quality Initiative (Gregory, Romm and Walsh, 1994). This found that many staff at all levels from domestics to senior consultants were often involved in several
quality initiatives, such as quality circles and standard setting for example, but that possibly only a minority of initiatives were considered to be 'working well' (Gregory et al, 1994, p29). This may reflect a problem that the 'efflorescence' of quality initiatives, as Ellis and Whittington (1993, p13) put it, may be at a very superficial level an observation echoed by Dalley and Carr-Hill (1991) in a country wide survey of NHS quality assurance. It may also reflect a general lack of theoretical and practical insight. All this leads to the reasonable question as to why, with all the specifications required for contracts, the quality of NHS production remains so contentious? To answer this it is worth comparing the nature of a service with that of a manufactured good.

Problems with specifying NHS services
Some NHS products take the form of manufactured goods, such as medicines, spectacles, hearing aids, prostheses, dentures and so on. However most NHS products are not physical objects because they are predominantly services. Even obtaining physical goods from the NHS requires that a mainstream service be delivered to the consumer first. This is usually in the form of primary care (a medical consultation that offers access to treatments) through general practitioners or through accident and emergency or some special clinics such as genito-urinary medicine.

Services differ from physical goods in a variety of ways. Nelson (1970) differentiates between search goods which may be investigated prior to purchase and experience goods that have to be consumed before they can be more fully known. While as K. Walsh (1991) points out most goods have an element of either characteristic NHS services may be regarded as primarily as experience
Services, unlike physical goods, cease to exist at the moment of their creation according to Marshall (1947). They are intangible, instantaneously consumed as they are produced, involve the actual maker of the service intimately in a close relationship which might itself be the product, and only exist if the consumer uses them (Bowen and Schneider, 1988).

Not only physical intangibility but mental intangibility may characterise a service to the extent that it may not be possible to determine whether it has been received at all (K Walsh, 1991, p507). This is most clearly understood with respect to preventive services like immunisation where it can be difficult to convince parents of the need to protect their children against 'rare' diseases like measles or polio.

It is the combining of time and effort with the produced service by the user that completes the production of the service (K Walsh, 1991, p507). Yet while a degree of control over the production of the service is usually attained by the producer there may be no control over the simultaneous consumption. Recently there have been disputes about whether smokers should be entitled to heart surgery (Independent, 1993). This could be construed as an attempt by clinicians, or by resource managers, to gain strategic quality control over the way surgery services are consumed.

Services, unlike physical goods, are not stored prior to consumption, but often
consumers are stored on waiting lists, to minimise the waste of the producers time (K. Walsh, 1991). This became a focus for the government when it ring-fenced budgets to deal with the NHS back-log of work in 1989. Unfortunately what may have occurred is the perverse rewarding of poor producers (Holloway, 1991) and the strategic reshuffling of waiting lists\textsuperscript{18}. All of these characteristics make it difficult to specify the attributes of services. It also leaves the door open to the temptation to specify the measurable trivia of a service because the important things are too difficult. This arguably occurred in the Caring Principles project (Trent Regional Health Authority, 1991) which deliberately avoided conflict by identifying ‘broad’, ‘non contentious’ standards for a wide range of health services including primary care (GPs) and hospital care.

Perhaps the key issue in the production of services is the role of the user especially in the face of the socio-cultural complexity of the community served by the NHS. Ironically Maynard (1992) comments that the role of the consumer is one of the unresolved issues of the 1989 NHS reforms and yet this is at a time when there has been increasing professional consciousness about the importance of the consumer's judgment. Yet the very nature of NHS services places a constraint upon a prospective patient's ability to make a knowledgeable decision about the nature and means of any treatment. However K Walsh (1991) points out that this does not stop an experience good, such as NHS care, being reasonably evaluated even if the consumer is unable to say precisely why one service is preferable to another - it simply becomes ‘a matter of judgment and an exercise in practical wisdom' (K Walsh, 1991, p505). Hirshmann (1983) argues that because people become used to a service, it no longer yields pleasure but simply comfort, and this may differ from the consumption of physical goods.
Consequently expectations rise. This assumes, however, that all people are always strategic utility maximisers who experience a diminishing degree of additional satisfaction (or marginal utility). This is simply too simplistic when viewed from the multiple-social action perspective of chapter 3. The premise inherent in dialogue is that expectations can be attenuated to a rational level.

Another problem with controlling the quality of a service is that since largely unspecifiable services cannot be assessed until they are used, then non-conforming product cannot be eliminated prior to delivery. Yet it is attempts to eliminate non-conformance with procedures and controls that has dominated performance measurement in public services (K Walsh, 1991, pp505). Indeed the audits extolled by Shaw (1986) and by Ellis and Whittington (1993) have attracted criticism because they are often seen to be aimed at the political control of expenditure and employee activity (Pollitt, 1988).

Since service quality is a matter of judgment K.Walsh argues that any decision at all where there is a group of individuals probably involves the denial of an aspect of someone's values. Since 'there is no single value base' (1991, p508) this leads to the difficulty over whose values should determine the quality of services (Mooney, 1993). Often in the case of services decisions have been heavily weighted by professional values (K.Walsh, 1993) which corresponds to the dominance of normative quality in the NHS seen earlier.

This situation has been changing somewhat with the increasing political and professional recognition that NHS service users have a legitimate and practical role in the determination of quality. Towell (1987) argues for a 'pluralist'
approach to the assessment and assurance of quality because of the differing emphases of various interest groups. Sanderson (1987), a physician in Wessex Region, remarks that:

The role of the consumer in quality assurance is important and generally underrated. Their alleged ignorance of the true value and quality of services has been used to deny their rights and prevent their involvement in setting standards of quality... (but there are)...general changes in society... (and therefore)... QA (quality assurance) programmes should take the opportunity to work with consumers and help change attitudes to their involvement.

Sanderson (1987, p6).

The NHS Management Executive (NHSME) published a consultation document that expressed the need for a 'move away from one-off consultation towards ongoing involvement of local people in purchasing activities' (Department of Health, 1992a, p1). They supported the publication of research method guidelines for Health Authorities to facilitate research into the views of local people about the purchase of NHS services (Sykes, Collins, Hunter, Popay, Williams, 1992).

This 'listening' initiative is part of the increasing awareness of the patient-consumer role with respect to NHS services. James in a report to the Department of Health on social services states that the 'primary definition of quality should be that of the service user' (1992, p5).

These calls for feedback from consumers may affect normative and strategic quality in the NHS but do not correspond to a call for dialogue. The Sykes, Collins et al guidelines on listening to views about purchasing are very similar to basic marketing approaches (Collins is a Professor of Marketing at City University). However, marketing approaches like those recommended are
aimed at providing producers with information of strategic value and not at reaching understandings with consumers. Moreover a marketing survey tool is often conceptually and theoretically fixed as to what is inquired into - the conceptual models on which they are based are presumed to be adequate. Similarly 'patient satisfaction instruments' (Ellis and Whittington, 1993, p151) and tools such as the survey by the Health Policy Advisory Service (1993) (HPAU) also possess limited domains of validity. For example although the HPAU survey provides comparative data with NHS services nationally, so that an NHS provider can 'bench-mark' service performance, this does not accommodate local issues and local values. Nor do these tools permit a balancing of the national and the local issues of NHS quality - that can only be undertaken in some forum where choices are made. These can only be critical choices if strategic and normatively regulated action is not allowed to dominate decisions. In other words without permitting the users of services to challenge the claims to validity, implicit in quality tools, there can be no grounds to regard NHS users as rational determinants of quality. While the 'listening' initiatives certainly serve well the notions of strategic quality that characterise the market reforms of the NHS it is the purchasers who are really the NHS customers (Gregory and Walsh, 1993). Any feedback about NHS users viewpoints will be interpreted in the light of the strategic interests of purchasers and providers. The providers strategic interest in surviving and prospering is paramount in the reformed NHS. It is their struggle and striving under the influence of strategic imperatives that is supposed to improve value for money. Yet it was shown in chapter 3 that the predominance of strategic action limits the possibilities and options for coordinated action between stakeholders.
Only to the extent that there is congruence between the interests of the user and interests of the NHS purchaser will contract specifications suit the user. Yet, such congruence cannot be demonstrated without the operationalising of dialogue since communications will be dominated by strategically employed information - or in other words propaganda. Propaganda is employed continually. For example in the media the constant scare stories about the NHS are counter-balanced by reassuring statements by the government.

A dialogue process in contrast permits any participant proposition to be comprehensively challenged thus opening up ranges of possibility and domains of validity that are completely missing from strategic or normative quality. This sort of challenge requires fundamentally democratic structures and processes to facilitate but, in accordance with Government policy discussed in chapter 2, local counciollor membership of health authorities was ended with the 1989 reforms (Department of Health, 1989a). While the presence of an elected counsellor on a purchaser does not in itself produce critical quality in the NHS, the absence of such a representative may weaken feedback to consumers. Perhaps symptomatic of the communicative failings of the NHS, both in the past and currently, are the increasing number of self-help user empowerment groups (for example see Winn, 1990).

**Organisation for quality in the NHS: will TQM do?**

Quality approaches in the NHS are increasingly viewed as best implemented within some organisational framework that confers a supposedly comprehensive approach like those of the gurus reviewed earlier. This almost without fail consists of borrowing ideas such as TQM from business and industry (e.g. Ellis
and Whittington, 1993) and other management cybernetic based patterns (eg: O'Leary, 1991). Ellis and Whittington are cautious, however, about the appropriateness of industrial models of organisation for the NHS. They argue that NHS costs unlike manufacturing industry are difficult to account for, the effectiveness of NHS output is often disrupted, the NHS is also one of the largest and most complex conglomerate organisations, and there is less managerial control over its professional workforce than the case in commercial industry (1993, p193). Nevertheless Ellis and Whittington tend to overlook the inherent difficulties of specifying a service but Harman (1992) points out that flexibility is often needed in the NHS. Attempts to specify NHS services may therefore reduce rather than enhance quality.

Given the intangible nature of services compared with physical goods, the contentious role of NHS users, the professional fragmentation of quality, the difficulties faced in TQM implementations in simple industries, and the nature of the NHS quality gap (see chapter 2) it might be thought that TQM would be ineffective in the NHS. Yet, despite their caution Ellis and Whittington support Oakland's (1989) version of TQM as a suitable mode of NHS quality management. Holloway (1991) similarly argues that there is no basic incompatibility between the NHS and TQM. Indeed the NHS Management Executive budgeted £4 million in 1991/1992 for the support of quality initiatives including TQM (Department of Health, 1992a). Holloway (1991) lists various quality initiatives from 1985 until 1989 of which she describes some as 'relatively comprehensive'. She also assesses the possibility of a VSM version of a TQM implementation at St. Mary's hospital Luton.
Munroe-Faure and Munroe-Faure (1992) give two examples of 'Quality Improvement Initiatives' which they regard as 'TQM in practice' at the East Birmingham Hospital outpatients and at Doncaster Royal Infirmary and Montague Hospital Trust. On closer inspection these simply comprise elements of TQM such as setting mission statements. The Trent Quality Initiative survey revealed claims to TQM implementations mainly in radiology and non-clinical areas in hospitals within Trent Region but these were certainly not coordinated initiatives within the whole organisation (Gregory, Romm and Walsh, 1994).

There are many other claims that TQM has been implemented in the NHS (e.g. Butler, 1993; Spackman, 1993; Sewell, 1994). However, the critique of TQM already carried out finds it lacking politically, culturally, communicatively and structurally. This has caused unease that perhaps TQM is not appropriate for the NHS (Ovretveit, 1994). There is simply no basis to accept that TQM in its standard form is suitable for the comprehensive quality management of the NHS. What is required instead is the implementation of critical quality.

6.7 Critical quality
If quality is regarded as a variable mediating between communicatively acting consumers and producers, in which all the forms of social action might be coordinated in the long run, there exists a condition that may be termed critical quality. In other words, critical quality in a situation is achieved when dialogue is institutionalised. Several conditions can be stated on the basis of this definition to guide the implementation of critical quality.

One structural requirement of critical quality is that participants in the dialogue
must have the means to implement communicatively coordinated actions including coordinated strategic action. The adequacy of such structure can be revealed in the course of dialogue. The lesson to be drawn is that critical quality can only be achieved where structural requirements can be satisfied.

Another structural requirement means that everyone involved or affected (to use Ulrich's, 1983 terminology) by the management of quality in the situation must also have an equal opportunity to participate in the dialogue. This may appear to be an onerous condition but it does not mean that everyone has to be simultaneously involved. Rather it means that the boundaries of the dialogue must be open to challenge. If the boundaries of dialogue are structurally fixed by a small membership as is characteristic of industry then it would close itself off to the diversity of differing views that might challenge it. This is quite clear in the NHS where Normand et al (1992) argues that multi-disciplinary working, though supposedly widespread, is more often talked about than accomplished. Giddens (1994) argues that political reform is needed to overturn the destruction of welfare in the 1980s and to achieve this requires that democracy should reach both up and down, from nations to individuals. Critical quality might then be seen as an element of this kind of political restructuring.

The other conditions for critical quality are those relating to dialogue itself as were specified in chapter 3. Briefly these are that participants have at least the mimimun communicative competence to be able to deny a validity claim while being committed to redeeming any claims when required.
6.8 Critical quality and the NHS
Standard TQM cannot cope with the complexities of the NHS, however, combining dialogue processes with a framework such as Flood's TQM (which is itself an expression of critical systems thinking) may offer a mode of critical quality management for the NHS. This would differ radically from any existing mode of NHS management. The task of the final part of the thesis therefore is the elaboration of methodological guidelines for the implementation of critical quality in the NHS in the light of the practical research into dialogue undertaken in Sheffield in 1994 - the Trent Quality Initiative.
Notes

1. The architect of machine-like 'scientific management' (Flood and Carson, 1993).

2. In a survey of employees of the NHS in Trent Region during 1992, more than half of respondents claimed to be involved in a 'quality circle' (Gregory, Romm and Walsh, 1994). One of the participants in the Trent Quality Initiative (see chapter 7) was thinking about starting a quality circle as a way of trying to overcome seemingly insoluble problems of conflicting requirements of nurses, doctors, paramedics, patients and pharmacists, in a hospital outpatients in a major Sheffied hospital. The rationale for this plan was broadly that it seemed like a good idea. I suggested that a better idea would be to begin a process of creative thinking, in which other options are also considered, including reframing what the problems are supposed to be. Sadly we had no time to continue our conversation.

3. However white cells are systemic and can eliminate pathogens from any part of the body supplied by blood. Likewise quality circles would need to be able to 'circulate' around all parts of the organisation, or at least to have some overlap, otherwise they cannot be systemically functional. This an example of an organic metaphor of organisation (Morgan, 1986).

4. The various standards include BS 5750 (equivalent to ISO 9000), and others.

5. And in America there are 'more panaceas than problems' (Ackoff, 1992).

6. Avoiding the costs of non-conformance is one of the commonly perceived incentives to implement one or other form of error-eliminating quality management. However, the valuation of non-conformance is usually simplistic. It is usually seen simply as a cost on the profit and loss account.
In health care, however, the cost of non-conformance to all the participants in a situation may not be reflected in NHS accounts. Taguchi (1979) recognises this failing in the usual approach to defining the costs of non-conformance and so he defines quality as a loss to society. Yet the practical problems in measuring loss to society may be insurmountable in the vast number of simple but vitally important situations that characterise the activities of health and social care. A little flexibility may be of advantage because the costs of non-conformance must be estimated originally in non-monetary units. In the hospital ward in Sheffield that I managed for a period of time there were frequent instances of non-conformance that might usefully have been investigated simply for the learning to be gained. For example, curtains would often fall from the windows. The curtains could never be replaced immediately for structural reasons of job demarcation, budgets, safety and so on. Instead nurses would improvise by hanging drawsheets up at the window. Clearly there are issues of non-conformance here relating to the substitution of inadequate materials, the use of nurses time on non-clinical duties, the loss of goodwill, and so on. These would carry a monetary cost in the hospital accounts although it would be subsidised to an extent through the act of caring that resulted in the improvisation. However, the most significant cost of non-conformance would be very unlikely to appear in the accounts: that of the person whose bed was by the window. The damaged curtains posed serious social implications for the dignity, privacy and autonomy of life for the individual who more often than not required assistance even to move or communicate. Most examples of non-conformance are probably much less dramatic but unless there is some attempt to account for the losses to other participants in the situation then
any monetary valuation will remain partial. It could be argued that eliminating the monetary cost of non-conformance would also eliminate the other less tangible social costs. It would not be necessary to attempt a more comprehensive valuation. However, this means that the institution would prioritise monetary values over social values where it might be the latter that are ultimately more significant. In a private hospital, for example, neglecting a cheap and obvious cost of non-conformance while pursuing the elimination of seemingly bigger ones might overlook the loss of reputation and of clients.

7. See appendix B for details of organisational cybernetics and the VSM.
8. The interested reader can refer to Ishikawa and Lu, (1985) or Flood (1993) or Oakland (1989) for more information about any of these
9. Hutchins (1990) remember argues that Deming developed his people orientation from observing the Japanese problems of implementing Deming techniques with machine-like management.
10. Anarchy is the opposite pole to perfect collaboration. Somewhere in between are economic competition which requires just that amount of collaboration in order to make it work.
11. See appendix B
12. See chapter 5 on post-critical complementarism which has developed in the same vein.
13. Her reputation for this is such that her statue can often be found outside hospitals all over the world: for example Laguna Honda, San Francisco, USA.
14. All of these outcome studies comprise collections of data over periods of time that measure a few elements of health care process outputs and compare the output from one service producer with another. This
demonstrates a similarity between the production of an health care service and the production of a manufactured good. Process outputs in manufacturing are often sampled and the information is fed back to control the production. Sometimes this feedback is based on the proportion of consumer complaints or guarantee claims relating to product failure some time after manufacture - often up to a year. Similarly the healthcare outcome studies mentioned also measure the proportion of failures - for example death or readmission - over periods of time. For example the National Confidential Enquiry into Perioperative Deaths (NCEPOD) includes in the study deaths in hospital that occur within 30 days of surgery (Campling et al, 1993, p17). This information is fed back to improve the control over the production of health care in the form of recommendations.

15. The normative regulation of quality in health care is perhaps being established further and further back even to the design stage of human life through genetic engineering and control. However, this is not new. 'Design' of people for zero defects has been a major political concern throughout the UK, Europe and the USA since the turn of the century under the influence of social Darwinism and eugenics (Alaszewski, 1988). Whereas genetic control through sterilisation of 'mental defectives' in the population was not acceptable because of moral and political opposition, incarceration in special hospitals to stop people with learning disabilities reproducing was an explicit British government policy in the Mental Deficiency Act, 1913. Even World War Two has not expunged such prejudices even if the opposing of Nazism made discrimination against portions of the population politically unacceptable. Today people with learning or other disabilities in many cases face being eliminated before
birth through abortion. Tomorrows boundary judgments have yet to be resolved.

16. The prisoner's dilemma is discussed in chapter 3.

17. These so-called contracts are not legally binding (Department of Health, 1989a).

18. The concept of 'Just In Time' management that emerged in Japan (Oakland, 1989) is a way of reducing the stored quantity of physical goods that are intermediate to the manufacture of the end-product. Each intermediate good is produced 'just in time' for its utilisation in the next stage of manufacture. This reduces costs and, in a way, makes 'just in time' operations more like services that are consumed as they are produced. However a just-in-time operation supports mass production unlike a service. If a 'just in time' good is produced 'too late' then mass production is lost. This is usually unacceptable and swift action to eliminate the error will follow. However if a service is delayed the queue gets longer and may be unacceptable to the consumers and be deplored by management but the error may still be tolerated for strategic reasons such as the control of costs.
Chapter 7

Implementing critical quality

This final part of the thesis presents an overview of an attempt at implementing a dialogue on quality between NHS users, purchasers and providers, in Sheffield in 1994 - the Trent Quality Initiative (TQI) (Gregory, Romm and Walsh, 1994). In chapter 3 I identified five key varieties of social action. These provide a convenient framework with which to evaluate the TQI. These include:

- Aspects of strategic success or failure of the dialogue. Were the preconditions for dialogue satisfied? Chiefly: did dialogue occur during the Trent Quality Initiative?
- Issues of acceptability. To what extent were issues of acceptability raised in the dialogue and how were they dealt with?
- Issues of sincerity and genuineness. In what ways was sincerity challenged or claimed?
- Extent of communicatively coordinated actions. Were any actions coordinated through dialogue?

I will deal firstly with the background to the project. Then I will discuss the strategic aspects of the project including the design. Then I will consider examples of substantive issues raised during the project - empowerment and participation - and how these were handled at what may be termed a meta level of dialogue. I will explore some of the implications of a meta level dialogue process. After this I will give a resume of the answers to the above questions. Then finally I will move on to consider how dialogue can begin to transform the NHS and begin to overcome the inequality inherent in the NHS quality gap.

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Flood's (1993) use of an organisational cybernetic structure and Hutchins (1990) use of quality circles are briefly examined as alternative approaches to the mobilisation of dialogical processes in deciding the boundaries of quality in the NHS.

In chapter 6 I argued that if quality goals are strategically or normatively given ('take it or leave') then, by definition, they are uncritical. Consequently the implementation of critical quality can only begin with the creation of the structural possibility of dialogue out of which can emerge genuine commitments to consensus goals and genuine disagreements over goals. Dissensus is not an indication for the expulsion of one or other (weaker) dissenter but for dialogue and only then can the nature of a commitment be properly assessed. The key questions therefore are: what is a pragmatic structure for dialogue on quality in the NHS and how can it be created? The only example so far of an attempt at creating a rigorous multi-agency dialogue in the NHS is that of the 'Trent Quality Initiative' (Gregory, Romm and Walsh, 1994) which I will now review.

7.1 The Trent Quality Initiative

The Trent Quality Initiative (TQI) was an uncommissioned research project that nevertheless attracted funding from Trent Regional Health Authority. It involved representatives of NHS purchasers, providers and visually impaired users in Sheffield over several months from late 1993 to early 1994. There were more than thirty participants directly involved in the dialogue at various times.

In the following sections I will outline the design of the structure and process of the TQI and then evaluate the project according to the framework given above. A caution is necessary. What follows is my interpretation of the design, process
and outcome of the TQI. For clarity I am giving my thematised account rather than my chronological ‘blow by blow’ version of ‘what actually happened’ in the creation of the TQI. My co-researchers (and other participants) almost certainly differ in their interpretations but this should not be taken as sign that either I or they necessarily have ‘got it wrong’. Rather my account should be regarded as my attempt to enrich my understanding of the TQI and draw from it those (disputable) things that suit my purposes. This is a contribution to dialogue. Other versions of the TQI may be written, by others, in the future and be subject to dialogue.

7.1.1 Aspects of strategy - the design of the TQI process

The TQI was designed to facilitate dialogue between stakeholders of differing levels of communicative competence, with differing interests, and unequal power. In chapter 4 I presented an embryonic analysis of the social action potentials in the situation involving the Royal Sheffield Institution for Blind people (RSIB), the Visually Impaired People’s Group (VIPs) and the major NHS purchasers and providers. The two NHS user groups became involved as a result of previous contacts between the research team and the RSIB whose executive management are keenly interested in quality issues of health and social care.

![Diagram of the design of the Trent Quality Initiative](image)

**Figure 11** The design of the Trent Quality Initiative

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The problem the researchers were tackling was how to create a 'level playing field' so that the purchasers, providers and users of the NHS could come together in away that constrained the distorting influences of strategic and normatively regulated action, and allowed dialogue to occur. What was proposed was an iterative series of peer group and multi-agency group meetings (figure 11).

Peer groups were proposed because it was thought that the forum had to be one in which participants would feel more secure and able to speak openly on issues they considered important. While no forum can perfectly control all external factors it seemed that a peer group offered the possibility of normative support and reduced hierarchical influences on the formulation of viewpoints.

This is borne out to an extent by the participant evaluation forms filled in at the end of the last TQI meeting and again after several months. Nevertheless there seemed to be greater tensions in multi-agency groups than in peer groups. The majority of respondents who were multiagency representatives commented that peer group meetings differed from multiagency meetings in style and content. So it is clear that both kinds of meeting indeed contributed distinct kinds of output which is some vindication in itself of the design which was intended to reveal and deal with diversity of viewpoints. By arranging meetings for a range of peer groups it was anticipated that these would function as independent sources of viewpoint formulation along the lines suggested by Midgley (1992). During peer group meetings the participants could practice the principles of dialogue and improve their individual levels of communicative competence.

A multi-agency group appeared to offer the possibility of validity checking of peer
group propositions as well as the generation of creative insights not available to peer groups. The way forward seemed to be to alternate between peer group meetings and multi-agency meetings as shown in figure 11. Peer groups could be formed from all those individuals who wished to be in a dialogue.

Representatives from these peer groups could then form multi-agency groups as shown in figure 12.

Figure 12 The formation of multi-agency groups from peer groups

So it was envisaged that dialogue would occur both within peer groups and multi-agency groups and also between groups. In this way it was hoped that the intensity of viewpoint formulation and validity checking would be enhanced to a greater degree than if the dialogue occurred in one bigger forum.

This arrangement also means that whatever propositions are formulated in the security of a single peer group can be examined by several multi-agency groups. Similarly whatever is formulated in a multi-agency group can be examined in several peer groups. Consequently every point recorded at any stage is subjected
to a greater and more diverse assembly for further consideration. It is the ability to refer a point of dissensus onward to a greater and more diverse assembly that gives dialogue its potential as a locus of creative and systematically validated thinking. It is out of this perpetual reflexivity of discourse that critical quality may begin to emerge.

The details and ramifications of this are discussed below but in summary dialogue did take place both within and between groups.

7.1.2 The procedure for meetings
Each meeting was facilitated by a university researcher who guided and prompted the participants on the use of the guidelines (table 3). The meetings began with accounts of the last meetings given by the representatives that attended them. This allowed a systematic dialogue to occur on the validity of the consensus/dissensus points raised at the other meetings. Some points were resolved without further reference but other points of consensus or dissensus were clearly recorded. It is the recirculation of these consensus/dissensus points around the other groups that offers the potential for insight or action that would otherwise be hidden.

| Table 3: Summary of guidelines for project meetings |
| We ask that each participant be prepared to:- |
| 1. Read all documentation prior to each meeting. |
| 2. Accept the direction of the facilitator during the meetings. |
| 3. Listen attentively. |
| When listening to what others have to say, please think carefully about four things: |
1. Do you understand what has been said?
2. Is the speaker being sincere?
3. Is the speaker's point acceptable to you?
4. Do you agree with the speaker's use of information and/or experience?

If the answer to any of these is "no" please ask for clarification.

Issues that remain without agreement in any meeting will be discussed further in a subsequent meeting.

(Gregory, Romm and Walsh, 1994, p153)

7.1.3 Peer group viability
There were six places allocated to each peer group in the TQI which was deemed to be a practical number of participants in a discussion. Other numbers were feasible and could have been selected. Fewer numbers would have reduced the diversity of viewpoints in a meeting and would also have meant that absence for any reason would have had a proportionately more deleterious effect. A group reduced from four to two by sickness is less viable than a group reduced from six to four. Greater numbers potentially increase the diversity of viewpoints but allow less time both for making propositions and answering questions. Furthermore increasing diversity increases cognitive stresses on individuals with limited attention spans (Baddeley, 1990). The pragmatic maximum of 12 members of a quality circle suggested by Hutchins (1990) is probably a good guide to the maximum ideal size of a dialogue group.

Peer groups sizes in the TQI were not all the same. The NHS user group looked
as though it might have seven members at the start but two members for health and social reasons were unable to take part. Another member also could not attend all the meetings due to deteriorating health. The mixed professionals peer group had only two members at first and later grew in size to five.

Each peer group differed considerably from all the others and each was called upon to contribute something original to the dialogue. Within peer groups participants were able to learn how to apply the dialogue guidelines, practice the process of dialogue, and refine the issues surfaced into a series of consensus and dissensus viewpoints on NHS quality. The goal was to emerge from a peer group meeting with a summary of viewpoints, collectively owned by the peers, which a delegate would then take into a multi-agency meeting.

The collective ownership of viewpoints in a peer group taking part in a dialogue, whether consensus or dissensus viewpoints, is important because it increases the security of individuals participating by alleviating social pressures. Participants are then more likely to contribute to meetings if the output is collectively owned. Individuals can avoid the responsibility of being identified personally with a particular view which may be strategically damaging to them. Unless this protection is built into a dialogue there is a strategic distortion occurring that might prevent some individual from taking part or raising an issue.

7.1.4 Scheduling meetings
The meetings schedule commenced on November 1st 1993 and ended on February 28th 1994 with a commitment at the beginning from each individual member to attend up to six half-day meetings.
The practical difficulty of the time constraints of the NHS members meant that only 3 multiagency meetings were scheduled in each phase rather than the 6 originally intended. The availability of time to participate in dialogue is a major structural factor and it is worth reiterating that doctors seemed not to get involved in the TQI mainly for lack of time rather than simple unwillingness. In contrast Trusts appeared unwilling to create the time necessary for any doctor to be able to participate.

7.1.5 The TQI agenda

The marginalisation of NHS users through political and cultural distortions of NHS services had already led to the conclusion that dialogue on NHS quality between stakeholders was needed (Gregory and Walsh, 1993). The introductory meetings for the TQI conducted with the NHS users and a preliminary survey of NHS staff in Trent Region confirmed that a variety of conflicts of interest existed between all those stakeholders who were eventually to take part.

It would have been possible to begin the dialogue with a blank agenda - carte blanche - and to begin a critical systems problem solving exercise from that point according to the dialogue guidelines. However, there was also a need to satisfy the funding requirements of Trent Regional Health Authority with a clearly structured agenda. This seemed to impose a potentially terminal distortion on the dialogue but fortunately Ulrich (1983) has provided a method that is both part of TSI (see appendix B) and Flood's (1993) TQM (see chapter 6). This is critical systems heuristics (CSH) (Ulrich, 1983).
Table 4: Critical systems heuristics, questions 1, 4, 7, 10 in the IS mode

1. Who is the beneficiary of the NHS quality systems design?
4. Who is able to change the measures of success?
7. Who is involved in the design of the systems?
10. Who, from those affected by the systems, are involved in its design?

Table 5: Critical systems heuristics, questions 1 to 12 in the OUGHT mode

1. Who should benefit from the system's design?
2. What should the purpose of an NHS quality systems be?
3. What should the measure of success be?
4. Who should decide on changes to the measure of success?
5. What resources should they control?
6. What resources should they not control?
7. Who should be involved as designers of the system?
8. What expertise should be used in the design process?
9. Who should be able/expected to guarantee the design?
10. Who (from those affected) should be involved?
11. How should they be involved?
12. Which point of view should determine the design?

(Adapted from Ulrich, 1983)

Critical systems heuristics asks up to 12 questions about 'what is' and 'what should be the case' on a variety of issues in any planning situation. By using these questions to focus on quality systems the dialogue would produce a structured output that promised to satisfy the common basis for participation. Phases 1 and 2 of the project concentrated on answering 4 questions (Table 4) to reveal what the participants thought corresponds to the current arrangements for quality in the NHS.
Phase 3 of the project concentrated on answering the same questions in the ought mode but with the other 8 questions in mind (table 5).

### 7.1.6 Recording and reporting

There were communication and coordination issues to be considered in the design of the dialogue. There had to be an effective way both of recording and reporting the output from each meeting which had then to be passed onto the next meeting. Since any individual or group of people are limited in terms of the volume of data and variables that they can handle (or *variety* as Ashby (1956) puts it) the meetings were intended to produce summaries of points of consensus or dissensus.

In the end with the consent of the participants a comprehensive record was made of the discussions in meetings on flip charts, notes and audio recordings, with summaries of the conclusions circulated to all participants prior to their next meeting. Copies of the summaries were produced in print, large print and braille so that all the peer group members could read or listen to the summaries being read before each meeting. This allowed the participants the opportunity to consider what points of validity they would like to clarify at the next meeting. These arrangements worked extremely well in so far as everyone seemed to receive material in a timely manner. However in the evaluation questionnaires there were a few comments about the summaries failing to reflect the content of the meetings (Gregory, Romm and Walsh, 1994, pp157-8).

### 7.1.7 Confidentiality and anonymity

It was regarded as essential for the protection of participants, and others, that
anonymity and confidentiality be respected during the project and everyone was asked to avoid naming specific individuals and organisations. Yet this potentially constrains and distorts dialogue since it limits the specific nature of some issues being fully addressed. Therefore there was no 'rule' imposed that forbade any names being mentioned. This allowed the possibility of existing procedures being used by participants for pursuing complaints or other action in the NHS.

The dialogue was arguably well equipped for doing this having CHC and NHS members present who had access to existing mechanisms for complaint/suggestion making although these were largely regarded as inadequate and generated much discussion (e.g. see Gregory, Romm and Walsh, 1994, p91). It may be that this aspect of the dialogue was under-utilised as a way of implementing coordinated actions on behalf of the participants since very few participants directly controlled the supply of resources to NHS services - there were no very senior managers or consultants involved.

7.1.8 The identification of participants: stakeholders, volunteers and peer groups

The research team were already aware of the interest of the management of the Royal Sheffield Institution for Blind (RSIB) people in research into quality in the NHS. Following contact with them it was decided that verbal invitations would be made to the 150 or so visually impaired users of the RSIB day centre to come to introductory meetings. The RSIB management had also identified another local organisation called the Visually Impaired People's Group (VIPs) with a membership of around 60. A small group of the VIPs hold a regular meeting at the RSIB and they were also verbally invited to attend an introductory meeting.
The introductory meetings which each lasted approximately 45 minutes, involved approximately 80 visually impaired people and took place in June 1993. Participants at the meetings were asked about their experiences of using the NHS and to tell any anecdotes or stories. Story telling has been used as a tool with evaluative potential in its own right (Kadiri, Midgley and Vahl, 1993) and the output from these meetings was used to identify other possible stakeholders in the dialogue. This data has also been referred to in chapter 3 of the thesis to illustrate the complexity of quality management in the NHS.

The output from the meetings has been published in full in the research report (Gregory, Romm and Walsh, 1994). These personal accounts revealed a wide variety of issues and concerns, reflecting not only the personal experience and values of the speaker, but also the quality of their information, and sometimes disinformation.

In the week following these meetings individual approaches were made by me to virtually all those people who attend the day centre and VIP meetings and I identified seven volunteers (on a first come first served basis) who formed the first peer group: the "NHS users".

In this way the first two stakeholders, the RSIB and the VIPs were identified. They constituted a convenient sample of willing volunteers and were not the only NHS user stakeholders that could have been involved. However, visually impaired people also to some extent typify a group potentially marginalised by NHS decision making although this is a very low level of generalisation. For instance the ‘VIPs’ are younger often professionally employed people while RSIB
day centre users are typically around eighty years old. Consequently participants from the RSIB are more often than not people whose eyesight has declined in later life and in many ways are more typical of older people in Sheffield in general than of visually impaired people. RSIB staff made the point several times that there is an 'ice-berg' of visually impaired older people of which the RSIB users are the tip.

The other stakeholders that emerged are listed in Table 6. These were approached in a variety of ways seeking voluntary representation from them in order to fill 6 places in each peer group. Approaches were made formally by letters to chief executives and departmental heads and personal approaches were made to contacts within each broad stakeholder.

Table 6: Stakeholders in the Trent Quality Initiative

| The Local Authority          |
| Sheffield Family Health Services Authority |
| Sheffield Health Authority   |
| Trent Regional Health Authority |
| Central Sheffield University Hospitals Trust |
| Northern General Hospital Trust |
| Sheffield Community Health Council |
| Royal Sheffield Institution for Blind people |
| Visually Impaired People Group |

The participants might have been 'peer grouped' in a variety of ways although the peer groupings finally chosen were the simplest as listed in Table 7. The groupings matched the current policy implementation divisions of the NHS into purchasers, providers and users of the NHS.
Table 7: Peer groups in the Trent Quality Initiative

Purchaser management
Provider management
Provider - nurses
Provider - mixed professionals
Community Health Council
NHS users

The "mixed professionals" peer group was created as a result of the difficulties in finding volunteers to represent separate "paramedical" and "medical" peer groups. Gaining the support of paramedical and medical staff was difficult according to senior NHS management, doctors and paramedical staff, because of the workload of the staff concerned. In addition, feedback from medical staff who refused to volunteer indicated a reluctance to participate in "yet another quality initiative". It was at this stage that personal approaches succeeded with the professions allied to medicine where formal approaches had failed.

The researchers believed that a consensus about the requirements of representation might lead to some coordinated action to change the membership in a group and this occurred. During the dialogue in Sheffield, independent action by the "mixed professionals" led to another paramedic volunteer, from an hitherto unrepresented stakeholder, joining the peer group because of their consensus about under representation.

The action was possible because of the information available to an already participating paramedic. The research team had previously been unable to find a volunteer for any peer group from the stakeholder concerned. Response from
stakeholders in identifying representatives was patchy, varying from excellent to complete inertia. Ultimately all stakeholders had some representation in at least one peer group. The final composition of the peer groups is listed in Table 5.

<table>
<thead>
<tr>
<th>Table 8: Representatives in peer groups by source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purchaser management</strong></td>
</tr>
<tr>
<td>Local Authority (1)</td>
</tr>
<tr>
<td>Sheffield health authority / family health services authority (2)</td>
</tr>
<tr>
<td>Trent Regional Health Authority (2)</td>
</tr>
<tr>
<td><strong>Provider management</strong></td>
</tr>
<tr>
<td>Northern General Hospital Trust (2)</td>
</tr>
<tr>
<td>Sheffield Central University Hospitals Trust (3)</td>
</tr>
<tr>
<td><strong>Provider - nurses</strong></td>
</tr>
<tr>
<td>Northern General Hospitals Trust (1)</td>
</tr>
<tr>
<td>Sheffield Central University Hospitals Trust (1)</td>
</tr>
<tr>
<td><strong>Provider - mixed professionals</strong></td>
</tr>
<tr>
<td>Sheffield Central University Hospitals Trust (2)</td>
</tr>
<tr>
<td>Northern General Hospital Trust (1)</td>
</tr>
<tr>
<td>Trent Regional Health Authority (2)</td>
</tr>
<tr>
<td><strong>Community Health Council</strong></td>
</tr>
<tr>
<td>Community Health Council (6)</td>
</tr>
<tr>
<td><strong>NHS users</strong></td>
</tr>
<tr>
<td>Royal Sheffield Institution for Blind people (3)</td>
</tr>
<tr>
<td>Visually Impaired Peoples Group (2)</td>
</tr>
</tbody>
</table>

7.1.9 Strategic success or failure?

In chapter 3 certain practicalities emerged as preconditions for dialogue including the opportunity to examine and reject the validity claims of each viewpoint expressed, the expectation that a genuine response will be made to such denials, and equality of access to the process. These conditions inevitably imply that
there must be sufficient resources (time, place, transport, materials, people etc) in order to undertake the process, commitments by participants to dialogue, the possibility for independent or coordinated action between parties involved, and sufficient communicative competence to deny a validity claim. Were these conditions fulfilled in the TQI? Creating a systematic opportunity to examine validity claims was the purpose behind the design, method and facilitation of the TQI. As a precondition for dialogue it was felt to be an adequate design. The rest of this chapter is to some extent an evaluation of the efficacy of the design in practice.

There were clearly sufficient resources for the project to proceed to the extent that it did but as stated already the participation of some groups such as doctors was minimal. This may have affected the substantive content of the dialogue - or else there would probably have been no call for medical involvement - but perhaps had little impact on the process itself. Facilities were provided by the RSIB, the VIPs and the CHC. Funding for refreshments, transport and documentation was made available by Trent Regional Health Authority. A considerable amount of time and effort was given by the researchers and all the participants.

The explicit motive for commitment to, and participation in, the TQI was a concern for the quality of NHS services, though it is impossible to know what the personal reasons were for any individual joining in. Yet given the varied backgrounds and current roles of the participants we can assume that personal reasons and the nature of concern over quality (the 'interest') differed from stakeholder to stakeholder.
For instance the NHS user participants were people with visual impairment and registered as such with the local authority. None of them had previously been involved in a research project of this type although one NHS user was retired from a senior post in the NHS and was very knowledgeable about health services research in general. All NHS user participants were interested in the quality of NHS services and each had views on this that they aired originally in a series of preliminary interviews (Gregory, Romm and Walsh, 1994).

More speculatively the NHS purchaser representatives were presumably following up an interest in NHS user involvement and empowerment in quality initiatives as called for by the Department of Health (1992b; 1992c). From personal comments made to me at least some NHS provider representatives were interested in quality management approaches per se reflecting the current high activity in NHS quality initiatives. Feedback at a pre-project publicity meeting indicated that the CHC participants were perhaps fulfilling an interest in user empowerment.

In the terms of chapter 4, each of the stakeholders were outsiders by necessity with some low-profile insider relationships. The strategic task faced by the researchers was to create a forum of insiders from the stakeholders so that their knowledge could be mutually shared and actions coordinated in a way that could possibly draw each of the stakeholders into more committed insider relations. Everyone was warned beforehand that there was no certainty of agreement. On the other hand it was stressed that the whole point about dialogue is that differences of interest and purpose can be resolved or further researched as a
concomitant of coordinated social action.

During the course of the dialogue the nature of participants commitments to the process were clarified. For example, it became clear that visual impairment *per se* was not an overriding issue for the NHS users. Rather their concerns were mainly expressed as ordinary patients of the NHS (Gregory, Romm et al, 1994).

Commitments altered during the course of the dialogue. At the final meeting, for example, no NHS employee spoke as a representative of a multiagency group. This interesting fact is examined later because it may signify a constraint on the commitment of the NHS professional participants because the dialogue had a formal endpoint.

There were difficulties in gaining commitments initially from certain groups. As is discussed below there were no doctors involved at first and only two representatives of the professions allied to medicine. Eventually the 'mixed professionals' peer group had five participants. Changing commitments notwithstanding there was sufficient commitment from a large number of participants to attend the majority of meetings. Although a register of attendance was not kept from the other records attendance seems to have exceeded 75% for the entire project of those who made commitments.

The referral of points of dissensus to the next meeting as indicated in the guidelines was the procedure for handling dissensus. This was crucial: without this opportunity the dialogue itself would have been meaningless. A potential problem of the use of systematic validity checking during meetings is the creation
of confrontation which could disrupt the process. This could take the form of
tactical repeated challenges to the validity of some propositions by other
participants. This might be designed to intimidate, distract or baffle the speaker.
In order to prevent the facilitation of such confrontation during meetings the
guidelines were kept in the background rather than explicitly employed after each
statement - the effectiveness of the dialogue was seen to be vested more in the
overall process than in individual communicative performance.3

However, there are signs that this tactic was used in at least one meeting
(Gregory, Romm and Walsh, 1994, pp118-122) though perhaps not as an explicitly
planned use of the validity claims. This occurred during what I regard as the
most challenging multi-agency meeting of the series I facilitated. It was the final
one in which the peer group schemes for reforming the CHC and representation
on NHS Trust boards were challenged mainly on grounds of impracticality.
Being a limited research project there was no further opportunity to redeem any
validity claims or counter-challenge the validity of the criticisms being made.
Nor were any alternative practical suggestions made despite at least a superficial
acceptance of the inadequacies of existing arrangements. In other words there
was a strategic silence. For example,

there was no disagreement, and some support for the point, that
the CHC needs to be publicised amongst the public and NHS
staff. However of the seven actions proposed by the NHS users
peer group none received general agreement or disagreement.
There was no agreement about implementing any actions.
There were no suggestions about who should implement, how
to implement and where to implement each action.
Gregory, Romm and Walsh (1994, p119)

There may even have been changes in the dynamics of participation as delegates
began to act strategically with respect to the end of the project - for instance to
avoid any further commitments. The meeting ended on clear points of
dissensus that could not be taken forward to a further meeting because there were
none. This was unsatisfactory and stressful for the participants and limited the
possibility for coordinated action.

This was significant in several respects. On the one hand the dialogue seemed to
have failed at this point because no coordinated actions seemed to emerge from
the meeting. However, on the other hand the analysis of the content of the
meeting using the validity claims allows a precise determination of what points
would have required further clarification had there been another meeting.
These consisted in part of sweeping generalisations such as the view that local
people are apathetic as a justification for not attempting to create local
representation on the CHC (Gregory, Romm and Walsh, 1994, p120). The fact
that such propositions were made and were rejected (either by challenge or non-
response) is a positive finding for the dialogue process because the (lack of)
grounds for the rejection was stated clearly.

The validity of this particular generalisation was challenged by the facilitator but
not redeemed - it was simply repeated by some other participants at the meeting.
Interestingly enough at the 'final encounter' one of the participants who had
supported this generalisation at the previous multi-agency meeting claimed that
other participants were making 'unwarranted generalisations' (Gregory, Romm

In each case the participant was acting strategically perhaps to defend territory
rather than acting consistently and the dialogue reveals this. The participant was
effectively trying to prevent any discussion of issues that had not been statistically qualified to some notional degree of significance. This challenge to the validity of many of the experiences brought into the dialogue was itself challenged and not redeemed. In other words it did not stand up.

That such inadequate reasoning is recorded and reported - especially given its origin in senior NHS staff - creates an opportunity for independent action even if this opportunity is not immediately taken. Moreover since the dialogue involved NHS users their social networks will have new information. While this may only be at the level of stories passed around the social peers of participants, these may be significant in altering the interactions the public have with the NHS. In the theoretical terms of chapter 3 such stories become part of the lifeworld of previously present experiences on which NHS users, purchasers and providers draw in making decisions and evaluating the quality of services.

Lastly the situation at the end of the multi-agency meeting referred to would not be mirrored in an institutionalised perpetual dialogue where the possibility for further referral would always exist. All the challenges raised to the peer groups proposals would have been further reviewed and the generalisations would themselves have been challenged. The lesson to be drawn from the Trent Quality Initiative then is that the key to critical quality is in the continuing opportunity to discuss issues and raise and redeem validity challenges. Otherwise a strategic opportunity is created that will doubtless be exploited.

While in practice there will often be time horizons on the relevance of an issue - and therefore the opportunity to act strategically by filibustering - this need not be
a general problem. This is because the potential strength of a dialogue process is in successful dialogue between groups rather than simply within groups as part of a perpetual series. This point is exemplified by the multi-agency meeting referred to above.

7.1.10 Options for action

During the process it was originally envisaged that action might result from both peer group and multi-agency meetings. Anticipated examples included the need of a peer group to do research by gathering more information or expert viewpoints in order to clarify an issue or to resolve a point of dissensus. In another instance there may have been campaigning (as suggested by Midgley, 1992). This might have occurred completely independently of any other group. Action may also have been taken after a multi-agency meeting that was coordinated amongst the peer groups. It can be seen that the possibilities for coordinated and independent action were highly varied and are increased by diversity.

In the TQI the purchaser management peer group (including the local authority) and the provider management peer group each had executive officers or their representatives. In theory all these individuals commanded or helped command NHS and community resources with implications for action resulting from the TQI dialogue. In practice there were perhaps very few significant resources commanded by these representatives (or that they admitted to) that were of concern to the other participants. This was a structural problem in the TQI that would need to be addressed in a critical quality forum.
The dialogue did create other opportunities for action of which the simple passing on of information proved more significant than may have been previously suspected by some of the participants. A key finding was that the CHC was virtually unknown to the mixed professionals, NHS users and nurses peer groups with patchy knowledge dominating the NHS manager peer group. As one would expect, those with reason to be in regular contact with the CHC knew about it and vice versa (Gregory, Romm and Walsh, 1994, p133). This became important to an NHS user peer group member whose sudden illness also coincidentally led to the first occasion that he claims to have received poor quality care from the NHS. He was able to contact the CHC for assistance to make a complaint which his peer group agreed is generally very difficult due to their visual impairment.

7.1.11 Measuring dialogue - did dialogue occur?
Previously it was stated that the dialogue guidelines were kept in the background. This immediately begs the question as to whether the TQI guidelines had any effect on the dialogue? It may also be reasonably asked whether it is possible to determine if any dialogue took place at all? How can the process of dialogue be measured?

It is feasible to go back over the audio records of the TQI meetings and undertake a linguistic analysis of pragmatic utterances (see appendix D). This would involve examining in fine detail what occurred at each moment of discussion. This may be done in terms of the quantity of consensus or dissensus propositions made that were formally recorded or otherwise 'lost' (before they ever went into the written record) with the corresponding quantities of validity claims.
challenged, redeemed or unredeemed. This analysis could assess what validity claims appeared to lead to the termination of propositions or whether a recorded proposition was accompanied by any unrecorded challenges to validity. The main use of these analyses would be to inform the participants of the results so that their meaning could be evaluated in the course of dialogue to help in the selection of agenda items. It should be possible to observe systematic distortions of the dialogue - appearing as silences or repetitions. While dialogue occurred to the extent that validity claims were checked both within and between groups what I shall now discuss some of the substantive issues raised by the TQI process beginning with empowerment and representation.

7.2 Empowerment and representation
Earlier it was stated that one of the ways in which commitment to dialogue was gained was through the focus on the quality of NHS services. Yet, NHS user commitment to the dialogue would not have been forthcoming were there a lack of confidence in the process. Moreover, this confidence had to be sustained. For this to be there had to be a degree of what is sometimes termed empowerment. Empowerment literally means giving power to someone, making them stronger in some way for example physically, politically, socially or economically. A central premise of the TQI was that creating what might be termed a communicatively 'level playing field' is, by definition, empowering. One of the key purposes of the dialogue was to empower those NHS users who might otherwise be marginalised in NHS decision making (Gregory and Walsh 1993). Dialogue, it was thought, would create an opportunity for an otherwise absent equitable critique of, and participation in, social action in the NHS.
To be empowering in a wider sense though, the participants have to be representative of others and they must be effective in their communication. Yet the logic of dialogue does not depend directly upon *quantity* of representation, as does a majority voting system, but upon the *quality* of representation. The two key issues therefore concern whether the dialogue participants are able to handle efficiently the self-generated or imposed variety created by the dialogue and whether some participants are able to effectively represent themselves and their communities.

The first issue may be regarded as a cybernetic design problem which has some relation to the second issue which concerns the communicative competence of the participants. Clearly, representation in dialogue is only adequate if the representative is not overwhelmed by the data being produced. It is usually assumed that NHS users are not equal to NHS professionals in terms of communicative competence and would therefore be at some considerable disadvantage in a cross-table discussion.

However, although the use of the validity claims has, arguably, demonstrated that communicative differences between participants may be reduced - which is equivalent to empowering - *facilitation* remained indispensable in guiding and encouraging the use of the guidelines (Gregory and Romm, 1995).

It is interesting, therefore, to observe that at the final meeting of the TQI no NHS professional had volunteered to speak on behalf of their multi-agency group. It remains therefore that one NHS user and two CHC members were the final representatives for groups in which NHS professionals outnumbered them four to one. There may have been hidden strategic or other reasons for this, although
no opportunity to reveal them remained at the end of the project. Speculatively it may be thought that, on the whole, the professionals had lost interest within the TQI. This might have been because there was a degree of empowerment of NHS user viewpoints occurring that was contributing to a degree of disenfranchisement of the NHS professionals toward the end of the project. In other words some of the NHS professionals' commitment was waning since they were not winning the arguments and they were nearing the end of the project. This could not occur in a perpetual dialogue where uncommitted participants would drop out to be replaced by those willing to sustain the process.

A clearer indication of empowerment occurred when the NHS users peer group produced their own detailed set of proposals for a publicising and recruitment body for the CHC - a task delegated for their consideration by one of the multiagency groups in the previous phase of the project. Although these particular plans were challenged in the subsequent multi-agency meeting it was only the absence of further meetings that prevented counter challenges being made to produce better proposals given the near total consensus that the CHC was a virtually anonymous body. The views of NHS users were therefore formulated, heard and challenged, which exemplifies their relatively high degree of social empowerment.

The empowerment of NHS users in the TQI was arguably partly the result of structural planning to manage the variety produced during the process. As well as guidelines about the logic of dialogue there was prompt reporting, filtering at every meeting by the participants to summarise and prioritise issues of concern, referral of points of dissensus onward, selection by groups of the issues they
wished to discuss, and delegation of issues to other groups for discussion. Each of these options enabled the variety produced to be attenuated to levels amenable to management by the groups concerned without losing important details. Where variety increases there is no reason in principle why additional groups could not form to deal with it.

7.3 Participation and the role of lay people in NHS decision making

In the second series of peer group meetings - relatively early in the dialogue process - the role of lay people and patients in NHS decision making became a focus for debate. Critical questions were asked about 'who' should benefit from or change the measures of success of or be involved in designing quality systems in the NHS. So explicit consideration of the identity of decision makers and beneficiaries was forced on the participants. The provider-managers suggested that audit was the mechanism through which NHS patients could be involved in decision making, implicitly favouring the employed professional, expert approach to NHS decision making (Gregory, Romm and Walsh, 1994, p80). To a lesser extent the mixed professionals peer group followed this line. It was being claimed implicitly either that broader participation in NHS decision making is undesirable or not feasible but it can be 'proxied' through audit and other consultative tools.

In contrast the NHS users suggested that patients should be represented in decisions in a way 'that overcomes disability' (Gregory, Romm and Walsh, 1994, p82). The nurses peer group followed a similar line to the NHS users while the CHC peer group explored ideas about democratic patient involvement and representation (Gregory, Romm and Walsh, 1994, p85). The purchaser’s peer
group commented that the framework for decision making should be based upon 'consumer led' outcomes and upon broader participation (Gregory, Romm and Walsh, 1994, p86). These groups claimed that genuine broader participation in NHS decision making is acceptable and feasible while conversely claiming that narrow participation in NHS decision making is unacceptable. So, very crudely, at this stage the broad line was drawn between those supporting broadly participative 'lay-led' decision making in the NHS and those supporting more narrowly participative 'expert-led' decision making.

All three subsequent multi-agency meetings prioritised the issue of participation to greater or lesser degrees and delegated the issues to specific peer groups for discussion at the next meeting. Of the 17 issue areas specifically itemised in the written record (Gregory, Romm and Walsh, 1994, pp89-94) 11 directly refer to the mechanism or conditions of participation of patients and lay people in NHS decisions.

The purchasers were twice delegated approximately the same issue. For example Multiagency group (M/A) A delegated the consideration of 'patient involvement: who are they? what do they want?' (Gregory, Romm and Walsh, 1994, p90) while M/A group C delegated 'How should users' voices become involved in terms of planning?' (Gregory, Romm and Walsh, 1994, p93). The mixed professionals were twice delegated less explicit but nevertheless related issues ('informed consent' (Gregory, Romm and Walsh, 1994 p90, issue 3) and 'receptive forums' (Gregory, Romm and Walsh, 1994, p92, issue 3). The CHC were delegated the user involvement issue three times and 'the selection of Authorities' referring to NHS purchaser and provider Trust boards (Gregory, Romm and Walsh, 1994,
Nurses were delegated a 'receptive forum' issue. NHS users were delegated the issues of the role and profile of the CHC.

Provider-managers were not delegated a participation issue at this phase of the dialogue. Since delegation was done on the basis of the multi-agency group's consensus as to a peer group's expertise or need to confront an issue it may be that provider managers were regarded as either less able or willing or interested to deal with participation than the other groups. It should be recalled that there were provider-managers (from separate Trusts) at the simultaneous multi-agency meetings and none registered an objection to the delegation of participation issues to other peer groups. Simple caution is one possible explanation of this. It is easier to wait and see what others say about how you should make decisions and then criticise rather than the other way around.

The dialogue process at this stage had achieved a consensus about the need to discuss further the issue of participation in a variety of forms that had been filtered and selected. The challenges to the acceptability and feasibility of broader participation in decision making were to come when the easily stated principle was being fleshed out with proposals for action in the subsequent peer group meetings.

The third and final phase peer groups each had an agenda to consider with a list of issues delegated to them by the multi-agency groups. Again there was a task of filtering and selection occurring which meant that not all issues on the agenda were discussed. Of the 17 issues delegated to peer groups 12 were discussed in depth. 7 of these were participation issues. So from the second phase to the
third phase, 7 out of 11 participation issues survived the processes of filtration and selection. All the peer groups apart from the provider managers had at least one participation issue on their agenda while three (half) had no other kind of issue.

The issues that did not survive related to the broadening of purchaser/provider relations to include middle management, staff and patient viewpoints (not pursued by mixed professionals / nurses), the involvement of 'users' voices' in planning and specification of services (not pursued by purchasers) and the use of 'receptive forums' in effective use of resources (not pursued by mixed professionals). The latter issue was also delegated to the nurses peer group who did consider it.

The peer groups had to suggest what activities were necessary to produce an outcome in keeping with the principles (including genuinely broadened participation) of the issue on the agenda. The nurses peer group managed only to state that 'receptive forums' had to be 'set up' (Gregory, Romm and Walsh, 1994, p100). Similarly the mixed professionals dealing with the same issue only mentioned 'talking through policies with stakeholders' (Gregory, Romm and Walsh, 1994, p106). However they also dealt with informed decision making and suggested 11 linked activities that they believed would enhance patient decisions.

The NHS users dealt with enhancing the profile and representiveness of the CHC and produced more than 20 detailed activities that might help achieve this. The CHC peer group dealt with enhancing the design and monitoring of health care in the community and the selection of Authorities. Again more than 20 activities were proposed to increase 'lay-led' decision making. The purchasers dealt with patient involvement and complaints handling in terms of the user
definition of criteria. For example they refer to 'question-card and evaluation form design - users and professionals?' (Gregory, Romm and Walsh, 1994, p106) indicating a proposed document that travels with each patient to record and report their individual requirements and evaluations of service. This was a concrete proposal on user participation that potentially goes further than mere consultation and is certainly more clearly ‘pro’ broader participation in terms of individual and local decisions. In contrast the CHC peer group proposals for representation on NHS Trust boards were more concerned with executive decisions in a way not dissimilar to the Labour Party’s manifesto (Labour Party, 1994) announced at that time. This was not unexpected given the strong Labour hold on South Yorkshire and the presence of Labour Councillors on the CHC. It would have been more surprising to find the CHC advocating a closing down rather than opening up of Trust board meetings.

At this stage of the dialogue the participation issue had been raised, filtered and selected for detailed discussion and was handled in two broadly differing ways. There seemed no doubt from the NHS user and CHC peer group meetings about the acceptability nor even feasibility of lay involvement in NHS decision making. The question was one of how it should be organised. The ‘lay-led’ model was in full flow. In contrast the three NHS professional groups that were also dealing with participation issues, in terms of the written record, tended to pursue the ‘expert-led’ model even where they were discussing consultation. On the whole the NHS user and lay person was seen as someone to be consulted - but not as a strategic decision maker. At an individual level at best the patient had to be assessed for competence prior to information being supplied to them on which they were to make a more ‘informed decision’ (Gregory, Romm and
Walsh, 1994, p104, para 8.2.5, point 6). At an organisational level managers were to employ 'user agreed criteria' in evaluation on the basis of which NHS services were to be programmed and specified (Gregory, Romm and Walsh, 1994, p106). This is very much in the vein of the Department of Health's Local Voices initiative (Department of Health 1992b,c). My concern is that, although the professionals were discussing user involvement, this was responded to strategically and not with the conviction that users are discerning and potentially competent decision makers. The evidence for my (contentious) view is contained in the final meetings.

All of these proposals on participation had to go on to the more diverse assembly - the final M/A meetings - where approaches to implementation were to be considered. However details could be challenged, qualified, modified or rejected. It could have been expected that there would be strong challenges to the 'lay-led' activity proposals from the minority 'lay' representatives given that NHS professionals outnumbered them two to one in the M/A meetings. What the final multi-agency meetings had to deal with then was the possibility of confrontation on issues of substance in the context of the end of dialogue. I have already explained that the professionals may have been acting strategically with respect to this point in time and process. So what did happen to the participation issues?

It appears that consensus and coordinated actions on participation, to find ways of implementing the peer group proposals, were not forthcoming. In M/A group A there was no acceptance by the professionals involved that they could contribute to implementation on participation issues either directly or even indirectly (Gregory, Romm and Walsh, 1994, p117). What occurred was a series
of implicit challenges to the claim to feasibility inherent in the participation activities proposed by preceding peer groups rather than a challenge to acceptability. However, M/A group A only dealt with proposals made by the mixed professional, nurse and purchaser peer groups - the most 'expert-led' dominated proposals.

In contrast M/A group B dealt with proposals made in the NHS user and CHC peer groups but fared no better in terms of consensus on participation issues and in terms of coordinated action. In this meeting the challenges were more pointed and explicitly aimed at the inherent claims of participation proposals to feasibility and to acceptability. For example, as discussed previously, it was claimed that the public are too apathetic to become more involved in the CHC or to pursue complaints (Gregory, Romm and Walsh, 1994, p121).

M/A group C seems to have been more constructive, with greater consensus on the principles and activities of participation issues but again no signs of commitment by any professionals to implementation or how to implement. For instance 'receptive forums' and '3-pronged discussions' were deemed to be an urgent issue for action (Gregory, Romm and Walsh, 1994, p125) but there was no coordinated action agreed at the time in respect of this. There is the possibility that some independent action may have been undertaken since but there is no mention by any respondent of anything specific in the second evaluatory questionnaire.

So the participation issues raised and debated during the course of the dialogue largely fizzled out in terms of coordinated action and were subject to a great
degree of challenge in the absence of the possibility of reconsidering or discussing the issues further. The principle of lay-led decision making was challenged by those with power to redeem its implicit claims without the genuine opportunity to do so in a subsequent meeting. Expert-led decisions began as the status quo of NHS decision making and remained so - through the failure of the groups to agree ways of implementing participative proposals. These points are echoed in some of the participant evaluations of the dialogue that probably come from lay persons, for example:

_has the project influenced any of your attitudes or actions in relation to health care issues? If so please elaborate._

(b) No difference in actions. I have not changed my views. I still think the ‘top’ want more and they’re not willing to make changes for the benefit of society.

(d) Sadly yes - a loss of confidence in the whole thing from the top down. I think that managers are interested in earning a lot of money. How many managers visit the centres and how frequently?


Conversely, the point made by an NHS professional that the lay participants were unable to appreciate ‘practicalities’ (Gregory, Romm and Walsh, 1994, p172) also emphasises the dominance of the expert-led perspective in terms of implementation. So dialogue occurred on the issue of participation in NHS decision making in terms of propositions being made, challenged and qualified, but without leading to coordinated implementation of actions.

There are two perhaps rather subtle points arising from this about the nature of dialogue itself. Firstly the dialogue succeeded in empowering NHS users to a
point short of coordinated implementation of their proposals. As argued previously, in a perpetual dialogue one might expect genuinely coordinated action to emerge from such empowerment. Secondly reflection upon the dialogue reveals a richness of detail and a degree of debate that does not seem to have been fully visible to all the participants (including the research team) at the time. This second point warrants some discussion.

7.4 Meta-dialogue
It is possible to see in the TQI that there was a flow of thematic argument from meeting to meeting that was not controlled by any particular individual or group except possibly (but not necessarily) the facilitators. The dialogue was designed so that the agenda of each meeting was determined at the previous meeting and also that issues could be delegated as I explained above. Moreover it is an essential characteristic of dialogue that issues can be raised freely. What was perhaps not so obvious to many participants during the project is that the individual propositions made in the TQI in quite separate meetings were often also thematically linked across meetings - for example propositions on participation issues - perhaps reflecting participant lifeworlds. Even the facilitators were not necessarily aware of all the themes that the participants themselves might have identified with hindsight had they the opportunity.

Examples of other retrospectively identifiable themes include those of resources, motivation, and patient rights. Doubtless other themes can be identified by other observers, such as other participant representatives, and these may not necessarily agree with each other. Suddenly it seems as if it is possible to hold another dialogue between observers about the thematic content of an original
dialogue. Likewise my interpretation of the dialogue content and of what occurred is disputable (and I expect it to be challenged).

Such a dialogue might be termed a *meta-dialogue* (following Flood’s and Carson’s 1993 definition of a *metalanguage*) and it deals with the flow of argument *between* meetings rather than simply *within* them. Yet participants in the TQI were not necessarily aware that such themes could be identified. The two evaluation questionnaires filled in immediately after the project and then after some months had elapsed asked for participant opinions on, amongst other things, personal learning, desirable consequences, and improvements to the project. The responses are given in full in the research report (Gregory, Romm and Walsh, 1994, pp155-188). These offer some insights into the richness of the discussion as perceived by the participants and also into their awareness of the whole process in which they took part - it is this latter issue which is most concerning.

There are a range of answers to every question broadly varying from optimistic responses to pessimistic responses and often contradictory between respondents. This is to be expected given that the context for the project was deliberately chosen to for its possible diversity of attitudes and opinions and that expression of this was promoted as desirable. So, for example, pessimistically speaking some participants claimed to have learned little if anything from the project while optimistically others claimed to have learned lots. Some respondents found the facilitation of meetings to be generally poor while on the contrary others found it very good. Some found the meetings muddled while others felt they were a good way of promoting dialogue, and so on.
What is most striking about the responses, however, is the general lack of awareness of meta-dialogue. This is visible in the pessimistic responses claiming that there was muddled thinking and lack of a recognisable framework, in the many responses that identify that specific issues were discussed but without an 'outcome', and in the near total absence of reported awareness of the broader nature of some of the issues raised; the participation issue is an exemplar of this. No participant seems to have been aware at the time, for example, that the dialogue was processing the thematic participation issue in the way that it did which, as demonstrated earlier, was in dialogue between groups rather than simply within groups. So what are the implications of this?

Although the participation issue was dealt with in great detail even in the absence of knowledge of the overall flow of argument (i.e. of the meta-dialogue) participants simply did not have access to this information. Consequently the impression of dis-satisfaction with the process which arises in some of the evaluation questionnaires may be due in part to this lack of awareness. More so perhaps than the apparent lack of rational argumentation in some individual meetings (according to some participant evaluations) or even the general lack of coordinated actions for implementation.

This possible lack of awareness of the meta-dialogue may be thought of as an efficiency problem. Individual actors whether facilitating or otherwise have to be very talented individuals if they are to be able to assimilate and synthesise all the important thematic elements of a multi-stakeholder dialogue, as well as deal with a large number of individual propositions, in a strange setting. Practice and
familiarity with fellow participants should improve the ability of participants to grasp themes and make judgments.

Firstly, participants will become more intelligible to one another as they learn the jargon, terms and concepts used by the others. Subsequently, they will obtain more data upon which to form judgments about sincerity of other speakers, and judgments about information or experiences offered in support of propositions. Dialogue efficiency should improve, then, with participant practice. One of the evaluation questions (Gregory, Romm and Walsh, 1994, p176) asked whether the respondent’s ability to contribute improved during the course of the dialogue. Again, this was responded to in the diverse and ambivalent way mentioned previously, although many participants claimed to be as talkative at the end as at the start (e.g. (Gregory, Romm and Walsh, 1994, p177). However, the CHC peer group members were obviously familiar with each other and the respondents that identified themselves as CHC members appeared to find the process easier to ‘get into’.

Participants in dialogue need a view of the big picture to make sense of the individual arguments which they conduct. In the TQI the facilitators who were dealing with a very broad range of project details were probably not able to provide the degree of clarification that might have enabled the majority of participants to comprehend the meta-dialogue of personal interest and to go on to produce meaningful commitments to coordinated action.

The significance of this is that dialogue in a TQI type project might be enhanced by providing a special feedback on the meta-dialogue on the identity of the issues
raised and the type of validity claims that have been raised or redeemed between meetings. This might raise dialogue efficiency by an order of magnitude over a process where meta-dialogue awareness is left to individual development and facilitator judgment. How could such a meta-dialogue be operationalised?

One approach would be to allow stakeholders (i.e. those groups who are represented in the peer groups) to analyse the thematic output of TQI style meetings and feedback summarised information into the subsequent meetings. The participants can then filter, prioritise and select agenda issues for the next meetings in the light of these summaries. This might enhance argument and prioritisation and increase the productivity of meetings.

Another approach would turn the TQI process on its head. Instead of representatives from various stakeholders in the community forming peer groups in the dialogue, they would form groups in the meta dialogue. The detailed dialogue itself would be conducted by full time official representatives who advocate stakeholder positions which may be formulated in peer group meetings. Alternatively officials may brief themselves on detailed issues through other modes of research rather than imposing a burden of several meetings on a particular group in the community which, for example, might be short of resources. In other words the viewpoints put forward might be largely expert rather than directly lay formulated. Stakeholder peer groups, with the help of their chosen advocates and experts, would analyse the output of the multi-agency meetings which would be part of a perpetual series. These groups would then feedback their views on the themes of the dialogue to the next multi-agency meeting. In this way the dialogue would consist of more articulate and
more effectively prepared propositions, validity claims, and redemptions than if groups with highly differing competencies faced one another directly.

Nevertheless the dialogue of chief interest to broad groups in the community would be the meta dialogue in which general principles and themes are articulated. These general viewpoints would become part of the detail of the dialogue in the usual way. Crucially though, the articulation of these meta-viewpoints would help to guide representatives in the filtering, prioritising analysis and selection of propositions.

The official representatives in the multi-agency groups would be entering into systematic communicative action in the usual way including making arrangements for coordinated action for which they need access to and control over resources. Like Hutchins quality circles these multi-agency groups would be fed with the resources to make them executively independent but within the overall framework of dialogical control. This seems to mean that the representatives would be de facto purchaser and provider managers and what amounts to solicitor advocates for NHS user groups.

There are objections to this approach. It implies a reduction of the diversity of viewpoint formulation, an increase in expert domination, reduced participation of the community with the loss of the opportunity to deal with fine details which might be more important at times than the overall flow of argument, the loss of the chance to directly learn about the 'practicalities' of the NHS and to have prejudices challenged from a variety of perspectives, and the loss of the opportunity for those who actually do the work of, or use, the NHS to check the
genuineness of each other's positions. However, it is possible that these objections can be overcome to some extent with practical benefits to the community as I shall now argue.

### 7.5 Diversity, marginal groups and advocacy

Firstly, diversity might still be generated and dealt with even in the absence of dialogue peer groups. The key to diversity of viewpoint formulation is that there is a dialogue structure which even very small groups of minimally competent and resource-poor individuals can easily join to begin contributing. To do that probably requires an agent or researcher to go out and make contact with such groups in a way that is socially feasible and culturally appropriate.

Such an 'outreach' idea was floated during the TQI (Gregory, Romm and Walsh, 1994, p102: the word 'outreach' is not in the summary but it is on the audio record). This in itself is an important way of beginning to advocate for groups in the community that are the most marginalised and least likely to be heard. Travellers, homeless people, certain ethnic groups, children in particular situations, learning disabled or brain injured people, prisoners, older people, people with mental health problems, people in remote areas and so on are all examples of such groups. These may never be able to form a peer group able to engage in formal dialogue but they can be contacted. Their views on the existing output of dialogue and their ideas for further dialogues can sought and stated. They can at the very least participate by proxy through an advocate. There are examples of existing schemes (e.g. A.S.C, 1995) but these advocates do not usually have access to a dialogue forum in which to make their views known.
Advocates may be appointed by a local office, perhaps the CHC, either because someone has discretely proposed a marginal group, or as a result of a direct approach from the marginal group. It is worth noting that if the CHC did have this role they would have to be very high profile in contrast to their current remarkably low profile status as observed in the TQI (Gregory, Romm and Walsh, 1994). One way of raising profile (again as observed in the TQI) is perhaps with prime time advertising and the appointment of ‘marginal group’ research staff. Naturally this service has resource implications but the costs are the price of democracy and management in the egalitarian interests of the whole while the benefits are improved use of resources - an increase in efficiency and effectiveness.

Where groups do have the resources and competencies to form distinct peer groups they may recruit their own advocates. Even wealthy groups may be marginalised, business people from ethnic minorities for example.

7.6 The effects on participation - finding a constituency

The handing over of dialogue to expert advocates does not necessarily entail creating a new mode of expert domination so long as they are directly related to a ‘constituency’ stakeholder that legitimates their role. Where stakeholder members are concerned about an advocate’s conduct of the dialogue they can ask for another advocate to be appointed by the CHC or recruit one independently. If for some reason the existing advocate manages to ‘stay on’ it will soon become obvious on what basis as any claims that are made may be challenged by the new advocate. It may then become a question of an advocate demonstrating that they do have a constituency to represent since the genuineness of their role can be
7.7 Dealing with the ‘small print’

The great potential benefit of an expert dialogue is that peer groups would not be confronted with a mass of fine detailed argument and would not be forced into defensive positions by more communicatively competent professionals. Instead a more leisurely view of the dialogue itself can be taken concentrating on the emergent issues. They can check that their advocate is producing the right details in the dialogue, they can also contribute proposals, but they can also take an overview of what is being produced in other dialogue meetings. If they don’t trust their advocate they can replace her/him. Those who like dealing with the small print can apply to be an advocate.

The one thing that is lost, however, is the possibility of learning directly through having personal prejudices challenged by other stakeholder participants. This is replaced with the indirectness of an advocacy system. Put another way there is a loss of immediate critical appreciation at the individual level but an increase in reflexivity between groups and society.

The corollary is that dialogue and meta dialogue each need to be considered and perhaps structurally serviced in a dynamic balance so that participants are aware of their overall progress but are undertaking as much critical appreciation as they can individually.

Having dealt with issues of substance arising out of the dialogue I will now
briefly summarise the answers to the evaluatory questions posed at the start of the chapter.

7.8 Resume: did dialogue occur in the TQI?
Dialogue occurred within meetings but also between meetings. There was a degree of empowerment of the NHS users that led to user defined proposals being fielded and challenged. It was only the end of the dialogue that prevented user defined issues being taken further forward. However once the dialogue forum had dissolved there was no sign afterwards that longer term insider relations had been created between any of the stakeholders, although there may be some 'low profile' inside relations of which I am not aware.

7.8.1 To what extent were issues of acceptability raised in the dialogue and how were they dealt with?
There were frequent expressions of concern over the acceptability of the current arrangements of the management of the NHS especially relating to lay-participation in strategic NHS decision making. However as well as the dialogue on these matters within meetings it is clear that issues were dealt with at a meta-level of dialogue of which there was little awareness.

7.8.2 In what ways was sincerity challenged or claimed?
In some ways this is a difficult category to evaluate. Sincerity tended to be dealt with in a general polite way in the meetings themselves. Indeed the structure of the dialogue was aimed at producing jointly owned proposals in order to diffuse away from individuals the possibility of being identified with a specific
viewpoint. There were challenges made to the sincerity of NHS management in
general (for example claiming that they were more bothered about money than
patients) and this seemed to lead to some territorial responses from managers
particularly in the final meetings.

7.8.3 Were any actions coordinated through dialogue?
Options for action on a wide range of issues were generated and were specified in
detail by the peer groups. However there seemed to be no agreement over these
courses of action between peer groups at the end of the project although it is quite
possible that some of the ideas may have been taken forward. There were some
occasions of independent action taken for example when an NHS user went to
see a senior nurse with some special crockery or the commitment made by a
member of the CHC to put the profile of the CHC onto the agenda of the next
meeting. It is possible that participants wanted to avoid commitments beyond
the end of the dialogue and this may have constrained the coordination of
actions.

7.9 Dialogue and the NHS quality gap
In chapter 2 I suggested that the NHS is characterised by a gap between the quality
of what is provided by the NHS and what is required by the public. This I
illustrated with an hypothetical map of the NHS ‘quality gap’. The problem with
this gap is that it is unfair because there is unequal access to the process in which
the boundaries of quality are specified. I propose that the process of dialogue is an
appropriate way of reducing the unfairness and the size of this gap because it can
reveal hidden options for action on quality in the NHS by empowering
participants within a democratically framed, communicatively level, ‘playing
field’. The Trent Quality Initiative provides empirical evidence that dialogue can occur both within and between meetings amongst widely disparate peer groups in terms of their social, political, cultural and physical states and abilities. The TQI can be seen therefore as a step toward creating critical quality in the NHS in which the boundaries of quality become subject to a lay-critique and are perceived to be more acceptable to the general public. What I will now do is discuss two broad approaches for implementing critical quality in the NHS and suggest that methods might accomplish this.

7.10 Transforming the NHS: incremental versus radical methods for implementing critical quality

Approaches toward the implementation of critical quality in the existing NHS can be divided into incrementalistic and radical methods. Incrementalistic methods can be defined as those that promote gradual change and presume that this is the only feasible and desirable approach. My use of the term differs slightly from the notion of incrementalism in policy analysis which is seen as ‘muddling through’ organisational decision making (Lindblom, 1959). Incrementalism is often seen in policy terms to be the ‘actual’ way that organisational and governmental decisions are made and implemented (Smith and May, 1980). In contrast rationalistic decision making is regarded in the policy literature as having ‘predominated in the study of organisation’ (Smith and May, 1980) and to be the model of not only analytically how but normatively how ‘ought’ decisions be made (Etzioni, 1967). This model presumes that decisions require a search for goals, the formulation of objectives, the selection of alternative strategies, and the evaluation of outcomes (Scott, 1971). These ideas also underlie the rationality of strategic systemic and other management interventions discussed and criticised in chapter 5.
My use of the term *incremental* takes something from both policy concepts and adds the crucial ingredient *critical* through the process of dialogue. By incremental I mean gradual change that often will amount to muddling through day to day NHS decisions pending the resolution of issues through dialogue. In terms of the revised insider-outsider model developed in chapter 3 incremental change does not alter the identity of groups in a situation but it does involve the creation of at least some insider relations amongst outsiders by necessity and ideological outsiders. It also involves the weakening of prisoner insider relations perhaps along the lines of Flood’s disimprisoning (1993).

Radical methods of NHS transformation I define as sweeping changes produced in a short period of time. Referring again to the insider-outsider model this radical change alters the identity of groups in a situation and revises all the relations in the situation. Everyone has to look to see how things have changed and how they are affected. For example no one can take for granted that their preexisting insider relation still pertains. Or groups previously ideologically outside might have become thresholders or high profile insiders. A change of government might be the harbinger of one such radical change. Privatising the NHS by floating it on the international stock markets would be another example. The governments creation of the internal market in the NHS is possibly another. The creation of general management in NHS decision making may perhaps be regarded as an attempt to be radical that was arguably less so (Klein, 1989).

In policy terms radical simply means rationalistic decisions that produce big changes. Incrementalism is, by definition, not radical although there is no reason
why many incremental changes over a long period of time cannot also lead to complete transformation. In this section I shall look at incremental approaches to implementing critical quality first, and radical approaches next.

7.11 Promoting incremental change - NHS Quality Forums

The structural linking of dialogue groups with points of access to existing NHS decision making mechanisms is one potentially easy incremental way of beginning the 'public-sphere' transformation of the NHS. An organismic perspective shows how this transformation might be seen as the reproduction of 'commensal' self-organising dialogue groups throughout the body of the NHS, that reflexively mediate between it and the community, wherever the conditions are suitable. These conditions include the availability of resources - as in self-controlling quality circles (Hutchins, 1990) - and dialogue conditions, especially commitments, specified earlier. Looked at in terms of the insider-outsider model it is equivalent to creating insider relations between NHS management groups and erstwhile outsider community groups such as the CHC which would become 'NHS Quality Forums'.

In the TQI the possibility of a similar role being undertaken by suitably reformed Community Health Councils was discussed at length although without a consensus on practical proposals (Gregory, Romm and Walsh, 1994, pp119-121). It goes beyond the simple restoration of councillor presence on the boards of NHS Trusts and Health Authorities although the exact arrangements of the dialogue process and the number of groups involved would vary from place to place according to local circumstances.
The evolution of self-controlling NHS Quality Forums based on dialogue would offer an efficient means of bringing together the 'lay' requirements, expectations and beliefs of local sections of the community into contact with expertise in the NHS. At a local level the output of the NHS can be more closely attenuated to the customer requirements of the community with a corresponding elimination of waste.

Where local requirements differ from national policy requirements there is generated a point of dissensus that can be referred onward to a greater and more diverse assembly - the wider community of outsider-by-necessity peer groups. Additionally this could involve the advocates for marginal groups feeding back to the NHS Quality Forums. In this way local communities may communicate and coordinate according to the requirements of the whole for efficiency.

Another way of seeing this incrementalistic policy and structure change is as a recolonisation of the lifeworld of the NHS (see chapter 2). This is much more far reaching than merely managing the NHS in a new way as has been attempted many times since its creation. Rather, it is a gradual transformation over many years of the whole norm-time-space framework on which those individuals who purchase, provide and use the NHS draw to define their perceptions of the situation. This is transformation at an anthropological level where the dynamic creation of diverse but narrow viewpoints about what the NHS should be doing are communicatively revised. This can also be viewed from the discordant pluralism perspective of Gregory (1992) in which there is a a process of critical appreciation facilitated which ripples outwards through society from the individuals directly involved in the dialogue groups.
It has to be emphasised again that it is the way that dissensus is handled that will chiefly determine the success or otherwise in the democratic regeneration of the NHS. NHS Quality Forums would be confronted with potentially large amounts of dissensus and therefore there will be requirements for consensus on how to 'muddle through' while the dissensus issues are dealt with. Often there is unlikely ever to be an absolute consensus on a issue. For example on abortion or euthanasia. However dialogue provides the rational process for dealing with such dissensus which might otherwise be resolved irrationally or through power.

7.12 Incremental steps to critical quality in the NHS
Practically speaking the responsibility for creating and facilitating NHS Quality Forums could be delegated to local CHCs or a quasi-autonomous government organisation such as the NHS management executive. Legislation would be needed so that participation by NHS authorities is mandatory but the terms of reference of that involvement need not be spelled out. Over the course of many years executives would be preferred by the Department of Health that favour and successfully practice high quality dialogue over executive autonomy. In this way executive commitment to democratising the NHS could be acquired and accumulated strategically.

The role of the CHC or the QANGo would need to be promoted. Such promotion could coincide with such campaigns like that of the World Health Organisation's Health For All 2000. Marginal Group research staff would need to be appointed.

The dialogue process would be convened in the first place as a perpetual calendar
of NHS Quality Forum meetings (say 12 a year) between NHS authority board executives and the community representatives who would be recruited locally. These could be local people who put themselves forward and may even be elected as suggested in the TQI (Gregory, Romm and Walsh, 1994). They could be expert advocates put forward by the local CHC or by some community group. If a prospective participant is insufficiently communicatively competent then they should be able to gain expert advocacy via the CHC. Many existing self help groups and community support ventures like those mentioned by Winn (1990) might be able to link into the meta-dialogue.

The agenda would be the one already locally pertinent and in use by the Executive of each individual NHS organisation. However the outputs from the dialogue would be distributed to any stake holding groups or marginal group advocates who require them. These would fulfil the community peer group functions and feedback their views into subsequent NHS Quality Forum meetings.

The dialogue guidelines themselves would be identical to those in the TQI.

It is quite possible that the Community quality forum meetings could make full use of critical systems thinking with suitable training. In this way the dialogue could become full host to the complementary but critical application of powerful methods such as the discussion and systemic intervention tools reviewed in chapter 5 (e.g. CSH, or SSM). This could be an explicit critical systems intervention. TSI for example might be used in such a setting. In many ways this kind of intervention might resemble a community operation research project.
Although the above structural changes might sound radical in fact the changes would take many years to put into effect. Many of the meetings held around the country might not seem much different to the meetings that have occurred in the past at least until there has been a useful level of communicative competence achieved by participants. On the other hand some Community quality forums might 'take off'. Over decades critical quality would emerge. Alternatively a radical 'Big Bang' approach could be taken to achieve critical quality possibly within a single decade which I shall now outline.

7.13 Radical steps to critical quality - the 'Big Bang'
A radical approach to implementing critical quality would involve going a crucial but momentous step further than above. This programme of reform would create democratic structures within an organisational design noted for its articulation of notions of balanced efficiency, effectiveness, control and autonomy. Such redesign could be undertaken strategically along the lines implied by Flood (1993) and involve the broad restructuring of the NHS into a viable system; dialogue processes would commence within the NHS and between the NHS and those it affects in all the communities in which it operates (or should operate), and dialogues across communities including between professions, politicians and the public. This kind of restructuring would call into question all the preexisting insider-outsider relations of the NHS and would deserve to be termed radical. This should only be done through an act of government that had already won an election on this basis and it would be a response to Giddens call for democracy to extend upwards and downwards from institutions to individuals (Giddens, 1994).

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The existing NHS structure of an internal market populated by Health Authority purchasers and NHS Trusts would be reformed into democratic bodies that would determine service specifications and agreements by dialogue with each other, with the communities they serve, and with the professions and employees that work in them.

Although the broad NHS would be planned as a viable system the detail of its operations - the viable system S4's (see appendix B) which are currently identifiable as NHS Trusts - might be dealt with through a series of critical systems interventions within dialogue processes. Dialogues could be facilitated with a variety of discussion tools. Key issues on the agenda of NHS dialogues would be derived from Ulrich's CSH and would deal with, amongst other things, the meaning of Beer's efficiency measures in the local context, the degree of autonomy against regulation in local NHS implementations and so on. Eventually these planning issues would be regarded as the routinely considered parameters applied to each new issue put on the agenda by a stakeholder. In other words they would constitute taken-for granted categories for critical appreciation.

The NHS management executive would probably be the main body delegated with the job of implementing the reform through dialogues which would be resourced so that meaningful coordinated actions could be taken. These resources would not be small - dialogue groups in Hull might affect budgets of the order of several hundred million pounds. Overall the NHS budget of £31bn would be directed by dialogue groups. Naturally executives would be recruited to
replace those unable to commit themselves to the process of dialogue.

Once more the guidelines for dialogue would be similar to those used in the TQI. Dissensus would be dealt with by referral of an issue onward to peer groups in the community.

At the start of such a reform the dialogue groups might be confronted with massive areas of dissensus although the effect of this should not be overestimated. There would be no paralysis of action as is feared by Grant (1989) because the interest groups would be insiders engaged in dialogue. There would still be consensus about the continuation of many existing basic NHS functions while dissensus points are worked out. For example hospitals would continue to deliver their services as before in the short term. However their executives would be engaged in local dialogues on appropriate development and change. Eventually such change would filter through within a coordinated whole.

The operation of dialogues would be essential in coordinating and directing change. Rather than reliance upon 'blind steering' (Habermas, 1991b) the meta-dialogues would add a dimension of conscious and rational steering to the determination of quality in the NHS.

7.14 The prospects for radical change in the NHS

There has been an history of radical change in the NHS. As I explained in chapter 2 it was created at of one of the most radical moments in history - the end of World War Two. Subsequently it has been reformed (or 'redisorganised' to use
a Maynard phrase, see chapter 2) several times. The 1989 reforms of the NHS were not undertaken as part of a specific manifesto commitment but as the act of a strong government. It cannot be ruled out that radical changes will be made to the NHS in the future such as its total commercial privatisation. On the other hand it might be that such future radical changes are essentially egalitarian but only if the arguments in favour are made and backed up with appropriate practical methods.

Democracy is a keystone principle of egalitarianism - the ethical commitment to equality (Seedhouse, 1988). Dialogue is the keystone process of egalitarian democracy. CST can play a pivotal role both in facilitating dialogues and arming the democracy with complementary methods for coordinated action. There is no compelling reason to presume that critical quality in the NHS cannot be achieved early in the 21st Century. However can critical quality be achieved in other services and industries? In this penultimate section I shall briefly deal with public services and industry in general.

7.15 Critical quality and public services
If dialogue can work in the NHS it can work in other public service industries also. The NHS is the main purchaser and provider of medical and hospital based nursing services but community care is largely the province of social services. Since the White paper ‘Caring for People’ (Department of Health, 1989) market approaches have been facilitated in the provision of home care and residential services for virtually all client groups requiring them.

Care management is the principle method for organising community care and
consists of assessors with budgets who can purchase a package of services from the private sector tailored to the individual requirements of the service user e.g. older disabled people: - at least that's the theory. In practice this only works if the private sector is able to produce the right services at the right price, the budget is big enough, and the assessor is expert. However there are instances of catastrophic failure of community care, such as the murder of Jonathan Zito by Christopher Clunis (Ritchie, 1994), where communicative failures led to action coordination failures. Taking child protection as an example of a very special community care service communicative failures have been prominent in very many of the child abuse inquiries such as those reviewed by Reder, Duncan and Gray (1993) and are simply not addressed by any existing market reforms.

Yet the recommendations and exhortations from these many inquiries which often extol multi-disciplinary working seem unable to prevent new crises occurring. In these circumstances there would be much to be gained from introducing dialogue processes at least as an incremental step toward realising critical quality of community care. Indeed unless such processes are introduced into community care, and full recognition is given to systemic complexity, Walsh, Alaszewski, Harrison and Manthorpe (1995) argue that there will continue to be unexpected and damaging crises such as that marked by the Cleveland Inquiry (1988).

Health and social care are one sphere of public service but there are many others. However since 1979 the Conservative government has introduced markets and quasi-markets into virtually all service industries that were previously publicly owned. Water, gas, electricity, telephones, refuse collection, community care,
hospital care and so on comprise large sectors of industry blindly governed to some extent by market forces. However it has been argued in chapter 3 that the theory of market forces is underpinned by a notion of only one kind of social action. It is not surprising then to find that all of these markets are explicitly regulated to some extent - market forces alone clearly do not produce what economists would call efficient solutions to resource allocation, service specification and delivery in any of these markets. Nor do they produce what Seedhouse (1988) would call egalitarian solutions. However does regulation correct this? Can OfTel, OfGas, OfWat or the Community Health Council make the specification and delivery of these services *sufficiently* efficient to satisfy capitalists and 'buy off' wavering socialists of Britain in the late 1990s? Or is regulation a misleading and bogus idea?

An insider - outsider analysis is revealing: All the industries mentioned are composed of strategically independent units. Notionally these industrial units - British Gas, the water companies, power companies and so on - are each competing in a market but in practice they have for the moment near total monopoly status. This means that they are able to define quality of service in a strategically one sided way within certain regulatory limits. These limits reflect certain public entitlements and comprise a degree of normatively regulated quality of service.

With respect to the majority of those to whom they do or could supply a service each industry is an outsider. Moreover, so are the regulators who are also outsiders with respect to the public. There is little basis for systematic communicative action between the groupings. There is no basis for critical
quality leaving only a regulated market and a political economy of quality. Consequently there will be crises which seem unexpected - but only if you have the narrow market view of public services.

The recent pay scandals are a moot point. These industries will undoubtedly attract at least some competition into their arena. Therefore newly privatised industries are never ever likely to be as profitable as in the first few years after privatisation. Those who manage these industries will never have such an opportunity for short term profit. Given the infamous British short termism discussed in chapter 6 it has to be questioned whether future well being is being sacrificed in selfish short term interests.

Only when serious competition does enter the markets for water, gas, electricity, and telephones will a fully two-sided strategic approach to quality of services in general develop in these industries. Nevertheless the regulators could take on a new role as dialogue centres in which they performed their functions as insiders with the industry and with the community rather than being outsiders-by-necessity. In this way quality would become a communicatively mediated variable rather than wholly a strategic variable. Competitors to the main providers can still enter the market but on a specification determined through dialogue in which the interests of the wider community are expressed and coordinated.

Finally the community and industry in general would benefit from beginning dialogue processes. Traditional interest groups such as the Confederation of British Industry and the Trades Union Congress could well perform pivotal roles in the facilitation of dialogue. Since dialogue is inevitably about taking a longer
run view than that usually attributed to industry the 'short termism' that characterises British industry would be gradually replaced by longer run views. Greater stability of price, quality and delivery of goods and services could be achieved within an increasingly egalitarian national structure.

All that remains now is to review the content of the thesis, assess to what extent the goals of the thesis have been met, identify what contributions to knowledge have been made, and set out what further research and development might emerge from the thesis.
Unlike juries dialogue groups are intended to be systematic in reviewing the evidence before them according to communicative guidelines. Also unlike juries what the dialogue group members advance as reasons for reaching their collective agreements and disagreements may be cross-examined by other participants in the dialogue. Juries themselves are not required to give reasons or be challenged on their viewpoints. The size of a jury is considered to be very important in influencing verdicts (Carson, 1994) but the process of dialogue purports to overcome the distortions introduced by group dynamics. If this is so then juries should perhaps be reconstituted along the dialogue guidelines suggested here.

In a conversation that I had with a senior executive from a major NHS Trust when trying to canvass support especially from doctors I was asked if the Regional Health Authority was making participation compulsory. I responded by stating that participation was voluntary. Subsequently no doctors from the Trust participated probably because the Trust could see no strategic value in making any medical staff available. I had a similar experience with several Trusts.

Checking the records carefully does enable the dialogue to be evaluated post hoc in terms of validity claims raised, redeemed and failed but not in terms of the intrinsic value to the participants.

For example in child care there are frequent calls for empowerment e.g. Bond and Keys (1993); Gannon (1993); Gibson (1993); Lindsey (1993).

The parliamentary model of the House of Commons is interesting because, following an ancient protocol, the Speaker is elected from and by the members to maintain 'order' and nominate in an equable manner who should speak. Similarly if a dialogue group has become sufficiently robust it will become self-organising if, like Hutchins (1990) self controlling quality circles, they are fed with sufficient resources.

The House of Commons arguably does not support dialogue since propositions, questions and answers are produced for strategic purposes and not the communicative purposes of reaching understandings. The 'select committees' perhaps contribute more to the communicative action of parliament than the sittings in the Commons.
This debate between what Hood (1992) terms broad participationism and narrow participationism is a hot topic in the risk literature which has many parallels with the quality literature.

Note that there is some double counting because some issues were delegated to more than one group at an M/A meeting. Similarly the issue of NHS user involvement in design and planning was duplicated in M/A groups B and C and was delegated by both groups to the CHC peer group. The latter were clearly regarded at the separate M/A meetings to have the interest or the expertise on this issue.

Out of the 17 issues there was one duplicate referred to already - the design issue which was delegated twice to the CHC by the independent M/A groups. Grant (1989) comments that there is often confusion over analytical and normative theories in politics a view supported by Smith (1980) on policy.
Chapter 8
Conclusion

In this thesis I have brought together the theories underpinning critical systems thinking, dialogue and quality and related these together to form a new view of quality that I have termed critical quality. In the course of this I have highlighted the diversity of stakeholder perceptions of quality in the NHS, defined dialogue as a special conditional process of mediation between actors, explored the way that social action potentials can be identified between actors in diverse situations, considered how critical systems thinking can assist in the creation of dialogues, analysed quality in terms of social action, and finally reviewed the Trent Quality Initiative, a practical research project on dialogue in the NHS.

What I will do in this final chapter is to summarise to what extent my thesis has met the original objectives that I had when setting out on my research, what contributions to knowledge the thesis makes, what recommendations the thesis supports and what further research on dialogue can be undertaken.

8.1 The original objectives of research
When I embarked on this research I had been specialising as a nurse in the care of older people. I worked as a charge nurse in a hospital ward with clients some of whom were individuals who 'lived' at the hospital on the wards where I worked, others for whom rehabilitation from strokes and other illnesses were not deemed possible and who came in from rehabilitation units and waited while a nursing home bed was found, and others who were admitted in the expectation that they would die sometime very soon. In winter when pressure on beds in the city began to grow we would sometimes accept younger patients with
other medical problems including, once, a middle-aged woman who had had a coronary less than 24 hours previously but was transferred from coronary care to the ward on which I worked because of demand for beds.

The hospital was built as an isolation unit for people with infectious diseases so it was remote from the city, certainly one of the highest hospitals in England and way above the smog and smoke of industry with keen fresh air, and it was designed to minimise the spread of respiratory diseases with very long corridors. Yet this function was obsolete, it was crumbling and it was being used for other purposes of which the most bizarre was probably the nursing of older people. There was a great deal that was unsatisfactory with those wards but how could it all be expressed in a simple, pithy way? How could the inadequacy be measured? Quality seemed to me then, in 1991, a good way of beginning to deal with it. I was convinced that by arguing for quality and criticising the obvious failures around me that I was acting in the interests of my patients. I thought I needed a surefire formula to identify those who were 'marginalised', and arrange to consult them in some way, so that their views could be taken into account. This was my first idea about 'pushing out the boundary' of decision making in the NHS. I soon outgrew this arrogant idea however.

My personal research objective changed from the search for an ultimate (and universal) scientific quality formula to the search for a way of bringing together diverse actors because the 'problem' was more complex than I first appreciated. In my new view the NHS quality 'problem' is not directly related to any particular shortage / excess of any resource - human, physical or fiscal - or to the use of any particular formula for combining these. Rather my understanding of quality in the NHS is that it is problematic because of the dilemmas arising out of
differences of beliefs, means and ends of those producing, using or not using the NHS. This means that my original aim of finding an (indisputable) quality formula could not be achieved. Instead I strived to find a way of mediating between individuals and groups with alternative views.

This change in my research path is one of the clearest signs of my personal development - I have changed from wanting always to find the single 'true' path (consisting mainly of assertions that this or that should or should not happen) to wanting to open up options for action. In terms of the NHS this means that formulas are still useful but only to the extent that they are used critically and fairly. Fairness I have defined communicatively - crudely social action is fair when those it affects can challenge effectively the claims to validity inherent in it. Social action is unfair when those affected cannot challenge it. Again crudely my commitment to 'fairness' is partly based on a wish to care for others (a sincere value that I cannot wholly explain away as a manifestation of selfishness) and my perception that cooperation is strategically vital for the longer term viability of organisation (whether local or global) because it allows other options to be developed. Nevertheless my new perspective is only beginning to unfold. I have not 'arrived' - I am simply in transit (and enjoying the trip).

As I mentioned above a major research objective that was part of my remit was to think critically about how to 'push out the boundary' of NHS decision making. This objective has been achieved to the extent that NHS users were engaged in dialogue with purchasers and providers in the NHS. What is more the potential of dialogue has only begun to be explored. This thesis has helped to elaborate and link the process of dialogue (a sociologically grounded theory) empirically with the goal of quality (a pragmatically grounded ideal) through the medium of
critical systems thinking (linking theory and practice systemically and critically). These contributions to knowledge can be spelled out more fully:

8.2 An increased understanding of dialogue
An increased understanding of dialogue has been achieved in two ways. On the one hand empirical evidence has been provided of dialogue - indeed that it can occur at all. This is sociological data of interest to those who support or dispute Habermas's theory of communicative action. On the hand other dialogue has been shown to be a flexible practical process that may possibly be modified at a meta-level to achieve increased efficiency and effectiveness of mediation between actors. This is management systems and science data of interest to those who wish to manage organisations and to those who support or dispute practical social interventions whether locally or globally. These conclusions can be confirmed or challenged through the examination (in terms of the communicative validity claims identified by Habermas) of a full data set that has been recorded in written and aural media kept in the Centre For Systems Studies at the University of Hull.

8.3 A new understanding of quality
Quality is usually defined in a pragmatic way and it is widely acknowledged to be an under-theorised field. However the social action perspective of dialogue that I have applied to quality allows quality to be understood in three broad sociologically grounded ways - as strategic quality, normative quality and critical quality. By defining critical quality it has become possible for critical systems thinkers to say how cooperation through understandings can form the basis for the provision of goods and services where previously quality has been understood as resulting from a mixture only of dutiful and/or competitive goal
directed actions. Critical quality links practical management interventions through critical systems thinking with an abstract sociological theory. This strengthens the ground for quality management as a democratic process.

8.4 The communicative development of critical systems thinking
The direct use of Habermas's theory of communicative action as a sociological grounding for defining the process of dialogue has enriched critical systems thinking in several ways: critical systems thinking can move on from the older hackneyed and idealistic notions of 'ideal speech' and 'communicative competence' to more practical notions of 'ideal seeking' and 'level playing fields'. The consideration of communicative variables in any intervention can be seen now as inevitable and therefore their consideration can become part of the 'front-end' of critical systems interventions - especially those applying Total Systems Intervention. Dialogue offers a framework within which to embed critical systems interventions and one of the explicitly strategic goals of CST becomes the creation and continuation of dialogue between stakeholders - this latter point supports and develops other post-critical work in the CST movement that has arrived at similar conclusions through differing routes: that of oblique interventions. The modelling of social action potentials between individuals and groups in terms of insider/outsider relations develops the ability of critical systems thinkers to consider communicative variables explicitly.

Having outlined the contributions to various fields of knowledge I will now consider what further research on dialogue and critical quality can be undertaken.
8.5 Opportunities for further research: dialogue in the NHS

Further research is required to repeat the format of the Trent Quality Initiative in similar settings in order to verify or challenge or extend the conclusions reached in this thesis. Other formats can also be experimented with in order to maximise the efficiency of the dialogue process for example making use of meta dialogue. At some stage it would be vital to begin a dialogue project in which there was credible executive involvement but such a project might only be organised in the NHS with the support of the Department of Health.

8.5.1 Dialogue in other public services

If dialogue can work in the NHS it should work in other public service industries also. Since the White paper ‘Caring for People’ (Department of Health, 1989) market approaches have been facilitated in the provision of home care and residential services for virtually all client groups requiring them. Care management is the principle method for organising community care and consists of assessors with budgets who can purchase a package of services from the private sector tailored to the individual requirements of the service user e.g. older disabled people: - at least that is the theory. In practice this only works if the private sector is able to produce the right services at the right price, the budget is big enough, and the assessor is expert. However there are instances of catastrophic failure of community care, such as the murder of Jonathan Zito by Christopher Clunis (Ritchie, 1994), where communicative failures led to action coordination failures. Taking child protection as an example of a very special community care service communicative failures have been prominent in very many of the child abuse inquiries such as those reviewed by Reder, Duncan and Gray (1993) and are simply not addressed by any existing market reforms.
Yet the recommendations and exhortations from these many inquiries which often extol multi-disciplinary working seem unable to prevent new crises occurring. In these circumstances there would be much to be gained from introducing dialogue processes at least as an incremental step toward realising critical quality of community care. Indeed unless such processes are introduced into community care, and full recognition is given to systemic complexity, Walsh, Alaszewski, Harrison and Manthorpe (1995) argue that there will continue to be unexpected and damaging crises such as that marked by the Cleveland Inquiry (1988). Consequently community care is a priority area for research into the creation of dialogues. This will inevitably focus especially upon the necessity of approaching some less accessible groups including homeless people, travellers and so on.

Finally the community and industry in general would benefit from beginning dialogue processes. Traditional interest groups such as the Confederation of British Industry and the Trades Union Congress could well perform pivotal roles in the facilitation of dialogue. Since dialogue is inevitably about taking a longer run view than that usually attributed to industry the ‘short termism’ that characterises British industry would be gradually replaced by longer run views. Greater stability of price, quality and delivery of goods and services could be achieved within an increasingly egalitarian national structure.

8.5.2 Disability and dialogue
The Trent Quality Initiative involved people with visual impairment, but with ordinary levels of communicative competence, in meetings with NHS
professionals. However dialogue potentially provides a way that individuals with the barest minimum of communicative competence - the ability to deny a validity claim - can engage others in debate. There are two broad aspects to this relating to the role of intelligibility and to efficiency and effectiveness of dialogue processes. Firstly a denial of a validity claim can be made by somebody with a limited command of language (e.g., a young child) or severe language impairment (arising from injury or an innate learning disability). This is potentially empowering because there are many individuals whose language (and other) disabilities currently means that they are not recognised as competent decision makers. The law, for example, even accepts an IQ level of below 50 as indicative of mental deficiency (Carson, 1994). For practical purposes of care this has never been accepted as the limits of an individual’s ability to make choices but the ability to deny validity claims has never been considered as a decision making tool. Within a dialogue framework in which a denial is entitled to a response it may be that this provides another way of disimprisoning some of the most vulnerable members of society. Critical systems research from a post-critical perspective would use the denial of a validity claim as the starting point for the generation of options for action.

This research would usefully consider how language-disabled individuals can communicate a denial and what methods can be used to generate options for action. These options might involve finding ways of making the response to such a denial intelligible to the individual concerned. Or, if this is impossible, as to how a communicative advocate can be employed. How would such a person facilitate their client’s interaction with their social environment in shops or with public services for example? To what extent can autonomy be created for such an
individual? This could be a profoundly emancipative project. There is another corollary however of this. An objection that might be raised to the inclusion of the less communicatively able in dialogue is that they would slow the process of decision making down by raising unnecessary challenges to validity claims. The burning question therefore is: what structures for dialogue can be created to enable efficient and effective decision making but which is also accessible to peer groups and which balances the local and non-local? I have already suggested possible 'organismic' (quality circle) and 'brain' like (organisational cybernetic) solutions but what other possibilities are there? How would they be operationalised? In this thesis I have dealt with quality but it seems to me (recently!) that it is possible to go not only 'beyond' TQM but beyond quality itself.

8.6 Beyond quality - risk?

Quality and risk are clearly linked. Risk defined as possibility of an undesirable situation (Alaszewski and Manthorpe, 1991) applies to quality: there is a risk that quality may not be achieved. There is the possibility that what was agreed about quality may be ditched by one of the parties, or that what has been promised and previously assured, may not actually be delivered. A high quality nursing home for example may deny certain choices to residents in the interests of health and safety. What are the consequences of this? While this may conform to the requirements of health and safety it may deny the vital characteristic of human life which is expressed in purposeful risk taking. In other words the claim to quality may be denied. This is one way of beginning to think about risk. Unlike quality, risk relates directly to the short and long term choices that individuals make. As a concept it has a status in sociology and economics that quality does not have (it has been written about by Giddens (1991) and Luhmann (1991) for example). It is a far more dynamic variable because it deals directly with choice,
decision and action. Yet the relation between risk and quality has not been explored despite the inference that lower quality may mean higher risk or that quality is sometimes evaluated in terms of risk. One question then is how is risk related to quality in practice? For example how is accountability operationalised for risk and quality within the same organisation? What constraints does this impose on options for action? This is a fertile ground for development particularly from the perspective of choice within the post-critical paradigm. Critical systems thinking has the basic framework and tools to conceptualise the domain of risk in welfare organisations. Surely it is only a matter of time before the task is undertaken!

It can be seen that this thesis only scratches the surface of possibility for dialogue yet dialogue is not a fashionable contender for political supremacy. However thinking about the possibilities for dialogue, about the structures required to make it operate, is a step toward realising dialogue in practice. An ideal egalitarian society may never be achieved. Yet, since there is no known steering mechanism that can overcome inequality, a fairer society will only come about by arrangement - through dialogue. Thus dialogue is a vital research topic.

8.7 Summary: dialogue, quality and critical systems thinking

In chapter 2 I explained that the NHS 'quality gap' is not an easily circumscribed issue. It is 'caused' by political, cultural and social diversity of health beliefs, practices and interest both within and without the NHS, and internationally. It is a conundrum of how to mediate between these differences to achieve goal successes, that are acceptable to those whose diversity is reflected fairly in the quality gap. Or, how to accept the principle of inequality and the futility of
attempts to mediate such diversity.

The argument for the egalitarian management of the quality of NHS services began in chapter 3. Firstly I elaborated the elements of dialogue derived from Habermas’s theory of communicative action (Habermas, 1991; Habermas, 1991). This theory shows how strategic, dramaturgical and normatively regulated varieties of social action can be evaluated and coordinated through communicative action which occurs when individuals are attempting to reach a mutual understanding of a common situation. Dialogue I defined as the systematic opportunity to enter into communicative action between individuals and groups. The NHS quality gap is therefore a problem of achieving strategic success, that is dramaturgically genuine, normatively acceptable and communicatively coordinated through an egalitarian and democratic process of dialogue.

In chapter 4 I elaborated a theory of interest group relations, characterised as insiders and outsiders, derived from Grant (1989) which I combined with the theory of dialogue. I argued that it is possible to model the potentials for social action between individuals and groups in a way that summarises relations in terms of insider-outsider group status. I argued that the analysis of the NHS in Sheffield provides one view as to the social action potentials of the groups that between them define the local boundaries of quality.

In chapter 5 I introduced critical systems thinking (CST) and explained how this framework can contribute to the fair renegotiation of the boundaries of quality in the NHS. I justified the appropriateness of CST as a framework for the
management of quality in the NHS, rather than the many other often apparently conflicting alternative theories and methods in the organisational literature, in terms of the critical and complementary themes in CST. I argued that in general CST can be enhanced by embedding interventions in dialogue processes. Another significant conclusion was that CST can increase its emancipative potential, and may be undertaken in more widely varied situations, by the analysis of the social action potentials of situations for example in terms of the insider / outsider model. I argued that other recent developments in CST, particularly the oblique use of systems methods proposed by Flood and Romm (1995), also imply the need for dialogue processes.

In chapter 6 using the theory of communicative action I defined three modes of quality management - strategic quality, normative quality and critical quality. I argued that strategic quality traditionally dominates in post-war commercial industries while normative quality is more strongly associated with health services. Critical quality I defined as the determination of service quality through dialogue. Various approaches to quality management were reviewed including some of the so-called quality 'gurus' and total quality management and I argued that these mainly support one or two sided strategic quality in industry although Flood's TQM does, in the spirit of critical systems thinking, methodologically integrate debate and disimprisoning into quality management and organisational design. I argued that Flood's TQM can be enhanced through the use of a dialogue framework. However I also argued that services are fundamentally more difficult to specify than the production of physical goods and that this emphasises the need for dialogue on them boundaries of quality in the NHS.
In chapter 7 I gave an account of a critical systems intervention to create a rigorous dialogue on the boundaries of quality in the NHS between purchasers, providers and users in Sheffield - the Trent Quality Initiative. I evaluated the TQI in terms of the social action framework according to its degree of strategic success (including the empowerment of NHS users), the way that issues of acceptability were dealt with, in terms of the way sincerity impinged on the dialogue, and finally as to the extent that actions were coordinated through the dialogue. I argued that the TQI demonstrates that dialogues can be conducted both within and between groups through alternating series of meetings and that this empowered NHS users to a considerable degree but that there were few clear signs of coordinated actions arising directly from the dialogue. I argued that this was perhaps because the TQI was a limited series of meetings and that many of the professionals involved avoided commitments towards the last meeting. I argued that in a perpetual series of meetings that this difficulty would be overcome. I further argued that the professionals involved in the dialogue may have been acting more strategically than sincerely on the issues of user involvement in deciding the quality of NHS services.

The dialogue process occurring between meetings I defined as a meta-dialogue and argued that it is crucial to give feedback to participants on this so that they can filter and select dialogue issues more effectively. This led to the suggestion that peer groups formed from members of the public might participate directly in a dialogue or, alternatively, they might participate mainly in the meta-dialogue and use advocates to represent their viewpoints in the main dialogue.

I then argued that critical quality can be achieved in the NHS either through an
incrementalistic path or a radical path to change. The former I argued involves improving efficiency and effectiveness through the creation of local NHS Quality Forums without massive structural changes to the NHS. The latter I argued involves a massive reform of the NHS possibly into an overtly organisational cybernetic design but with dialogues occurring within and between all stakeholders locally and nationally. Finally I argued that public services in general could become critical quality services.
Notes

1. Unlike juries dialogue groups are intended to be systematic in reviewing the evidence before them according to communicative guidelines. Also unlike juries what the dialogue group members advance as reasons for reaching their collective agreements and disagreements may be cross-examined by other participants in the dialogue. Juries themselves are not required to give reasons or be challenged on their viewpoints. The size of a jury is considered to be very important in influencing verdicts (Carson, 1994) but the process of dialogue purports to overcome the distortions introduced by group dynamics. If this is so then juries should perhaps be reconstituted along the dialogue guidelines suggested here.

2. In a conversation that I had with a senior executive from a major NHS Trust when trying to canvass support especially from doctors I was asked if the Regional Health Authority was making participation compulsory. I responded by stating that participation was voluntary. Subsequently no doctors from the Trust participated probably because the Trust could see no strategic value in making any medical staff available. I had a similar experience with several Trusts.

3. Checking the records carefully does enable the dialogue to be evaluated post hoc in terms of validity claims raised, redeemed and failed but not in terms of the intrinsic value to the participants.

4. For example in child care there are frequent calls for empowerment e.g. Bond and Keys (1993); Gannon (1993); Gibson (1993); Lindsey (1993).

5. The parliamentary model of the House of Commons is interesting because, following an ancient protocol, the Speaker is elected from and by the members to maintain 'order' and nominate in an equable manner...
who should speak. Similarly if a dialogue group has become sufficiently robust it will become self-organising if, like Hutchins (1990) self controlling quality circles, they are fed with sufficient resources.

6. The House of Commons arguably does not support dialogue since propositions, questions and answers are produced for strategic purposes and not the communicative purposes of reaching understandings. The 'select committees' perhaps contribute more to the communicative action of parliament than the sittings in the Commons.

7. This debate between what Hood (1992) terms *broad participationism* and *narrow participationism* is a hot topic in the risk literature which has many parallels with the quality literature.

8. Note that there is some double counting because some issues were delegated to more than one group at an M/A meeting. Similarly the issue of NHS user involvement in design and planning was duplicated in M/A groups B and C and was delegated by both groups to the CHC peer group. The latter were clearly regarded at the separate M/A meetings to have the interest or the expertise on this issue.

9. Out of the 17 issues there was one duplicate referred to already - the design issue which was delegated twice to the CHC by the independent M/A groups.

10. Grant (1989) comments that there is often confusion over analytical and normative theories in politics a view supported by Smith (1980) on policy.
Appendix A

A chronology of Habermas's texts cited in the thesis


Appendix B

A resume of Total Systems Intervention and associated methodologies

Total Systems Intervention

Total Systems Intervention (TSI) is the brainchild of Flood and Jackson (1991a) and has since been further developed by Flood (1995a,b). Flood and Romm (1995a) give a neat synthesis of TSI. They describe it as a ‘metamethdology’ that ‘works with the assumption that all problem solving methods are complementary’ (p379). The process of TSI involves a three phase iterative process of creative thinking, choosing, and implementing a method or methods to deal efficiently, effectively and fairly with problem situations.

In the original version Flood and Jackson (1991a) suggested that creative thinking about problems could use systems metaphors (likening complex organisational systems to more common conceptions e.g. to machines, brains, organisms and so on (see Morgan, 1986)) ‘to help managers think creatively about their enterprises’ (p50) and to identify dominant and subordinate metaphors. An enlightened choice could then be made about which method(s) to use to deal with the situation by bringing together a critical understanding of systems methods gained through the system of systems methodologies (SOSM) with creative thinking through metaphors. In the later version (Flood, 1995a,b; Flood and Romm, 1995a) the emphasis on metaphors and the SOSM has been dropped. Instead there is an emphasis on how choices can be made to use any method critically, either obliquely or directly. This follows creative thinking using a broader range of tools than metaphors and the critical understanding of methods is being developed in terms of a critical review mode (Wilby, 1995).

Flood and Jackson (1991a) reviewed 6 methodologies in detail out of 13 they placed within SOSM. Three of these I have referred to at various points in the
thesis. Critical Systems Heuristics I have dealt with in chapter 7. I will describe briefly below the viable system model (VSM) (referred to chapter 6 and 7) and soft systems methodology (SSM) (referred to in chapter 6).

The Viable System Model

The VSM is claimed to be a general model of any persisting kind of organisation (see Espejo and Harnden, 1989). It is closely identified with a ‘brain-like’ view of organisation (Morgan, 1986; Flood and Jackson, 1991a). A viable system comprises five subsystems that each carry out what Flood (1993) terms functions that are related to one another in specific ways. System 1 (S1) is the implementation subsystem. This is where the organisation actually produces the product or service that sustains it ‘in business’. System 2 (S2) is the coordination system between all the five parts. System 3 is the control system. System 4 is the intelligence gathering and analysis system and System 5 is the strategic policy making and decision system. Each of these systems are related to one another through specific channels for passing information and commands. Every system 1 contains all five subsystems so that the VSM is recursive. It can be magnified so that particular jobs can be specified or magnification can be reduced so that the whole organisation itself is seen as an S1 within a much bigger viable system.

Perhaps the most interesting element of the VSM from the viewpoint of dialogue is that the VSM articulates and specifies the necessity of balance between autonomy and control. An organisation cannot be viable if its S1s are not sufficiently autonomous. However viability is threatened by the loss of control. The VSM therefore problematises the balance between autonomy and control. In the terms of this thesis that balance should be struck through dialogue. As Flood put’s it ‘quality management can only happen when people have autonomy, responsibility, can participate and are not subject to coercive forces - i.e. when
they are free' (1993, p126). The viable system model is discussed in depth by Beer (1979a,b and 1981) and Espejo and Harnden (1989).

**Soft Systems Methodology**

The SSM is a structured process of inquiry through which participants in a problem situation can come to understand their situation better, and suggest culturally feasible and systemically rigorous ways of improving it by modifying existing systems. One of the key principles of the SSM is the distinction between the real world and systems thinking. The systems thinking in SSM produces conceptual models that are compared with the ‘real world’. Through this comparison differences become clear that can be used to suggest changes in real world organisation. The process of SSM begins with creative thinking or *finding out* by building a *rich picture* to express the problem situation - a profile of the real world. Another element of the process is to produce ideal *root definitions* of systems using the famous CATWOE mnemonic. This involves identifying (C)ustomers (those who will benefit or suffer from the activity), (A)ctors (those who do the activity), the (T)ransformation process (through which inputs become outputs), the *(W)eltanschauung* (loosely speaking a world view or big assumption about how/why the system works), the (O)wners (who can stop the activity) and finally the constraints of the (E)nvironment as they are given. Conceptual model are then produced from these root definitions which specify the actual activities involved in the system and finally there is a debate about how reality compares with the conceptual models and what desirable and feasible action can be taken to improve the situation. Full details of SSM are given in Checkland and Scholes (1990).
Appendix C

1. Common health service quality approaches

Standard Setting
This has been one of the most widespread and key activities in NHS quality management. There are professional standards originating in professional organisations. For example the College of Occupational Therapists, the Chartered Society of Physiotherapy and the Royal College of Nursing have all been active in standard setting. Usually a working party is convened to identify and at least provisionally specify standards that the workers are supposed to fulfil. Ellis and Whittington (1993) note that these standards are sometimes very general. For example the College of Occupational Therapists Standards (1989) refer to the need to consider 'resources' when discharging a patient to the community. Broad based non-contentious standards were the explicit goal of the working party that produced 'caring principles' for Trent Regional Health Authority (1991). A typical caring principle often used the phrase that the patient 'will have confidence' in some quality of the service such as the professional conduct of staff. Standard setting has also become the focus for what Ellis and Whittington term 'comprehensive review systems'. An example of one of these is the Dynamic Standard Setting System (DySSSy) developed by the Royal College of Nursing (1990). The broad process of DySSSy is for staff in a clinical area to identify some matter for quality improvement, determine criteria for measurement using Donabedian's structure, process and outcome, and agree a standard to measure against. What follows is refinement and evaluation. Ellis and Whittington feel that the widespread 'ground level' involvement of staff in using DySSSy might help to create a quality culture. I would argue that it is likely to create a DySSSy
Audit

Various tools have been devised to measure and evaluate records. For example the Phaneuf Audit (Phaneuf, 1976) uses 50 statements (e.g. ‘cause and effect is understood’) grouped in 7 categories of care (e.g. the observation of symptoms and reactions) to which yes/no answers can be given. Note that reviewing records is not the same as auditing social action. In contrast QUALPACS relies on two observers (whose inter-rater reliability has been determined) who discretely and confidentially observe periods of care. Feedback is given to the clinical area on performance (Pearson, 1987).

Ellis and Whittington also list a large variety of techniques under other headings. For example they refer to the use of general health indicators, quality of life scales, disability measures, and pain measures under ‘outcome appraisal’ (1993, p257) and quality circles and a quality improvement plan under ‘local problem solving techniques’ (1993, p254). Interested readers can refer to their volume for further information.

2. Quality function deployment

This is described by Munroe-Faure and Munroe Faure (1992). The approach facilitates a trade off between customer requirements and design and manufacture constraints. This is done through a ‘house of quality’ which specifies on the same chart the customer requirements, engineering variables, engineering characteristics that affect customer requirements, the interaction between the latter, the target engineering characteristics, the importance of each
requirement, and finally the customers perception of competitors. In this way quality function deployment produces a picture in which judgments can be made as to what tradeoffs can be made but always from the perspective of customer requirements and always in comparison with competitors. This model assumes therefore that such information is available.
Appendix D
Measuring dialogue

It is feasible, on the basis of Habermas (1991a), to undertake a linguistic analysis of pragmatic utterances to determine what statements were made, what validity claims were raised, what validity claims were challenged or denied, what validity claims were redeemed, and which validity claims were forgotten or dropped. The following is an abbreviated extract from the audio record of the NHS users phase 1 meeting of the Trent Quality Initiative (Gregory, Romm, Walsh, 1994) which is analysed according to the guidelines given in chapter 7:

Ms B

The complaints system is not benefitting visually impaired people because they cannot write.

Mr R (challenges information / experience claims of the above)

The above does not entirely apply because a lot of people do not help themselves even though they could.

Mr H (attempts to redeem information / experience claims made by Ms B)

'I telephoned' (at least some people try to help themselves but without success because of the difficulties involved)

That was the end of that particular exchange. The proposition that visually impaired people find the complaints systems difficult to use which was made by Ms B did not become part of the written record. When propositions disappear from the dialogue this can be observed and become subject to the dialogue.
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