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Editorial. Do we *really* want a modern and dependable health service?

Modernism, clinical governance and practice development

'Modern' is one of those terms, like 'quality' and 'evidence-based practice (EBP)', that it seems very difficult to argue against. Who in their right mind would *not* want a modern health service when the alternative would appear to be an old-fashioned or out of date one? Who would not want a cutting edge service based on the latest scientific evidence when the alternative is one based on ritual, hearsay and tradition? Of course, that is the way that the government always phrases the argument. But to set up the modern in opposition to the old-fashioned or out of date plays on only a single meaning of the term. 'Modern', with its roots in the Latin *modo*, meaning 'just now', also has the sense of being *à la mode*, fashionable, trendy, ephemeral, and stands in contrast to what is solid, traditional and enduring. To describe EBP, for example, as modern in this sense is to label it as the latest bandwagon, as merely a passing fad. However, 'modern' has yet another meaning. When historians and philosophers talk about the modern age, they are referring to an historical period that began with the enlightenment project in the 18th century and (some say) ended around the middle of the 20th century. Seen in this way, the modern is already old-fashioned, and has come to be replaced with what some call the post-modern.

Modernism is characterized predominantly by its attempt to order, predict and control the material world through the rational application of the method and findings of science in order to bring about progress. Indeed, a five word summary of the modern might be 'a belief in continuous progress', the idea that, through the application of science, things will continue to get better and better for ever and ever. The modern, as we might expect, leads to the dependable. The application of a rational and well-controlled principle or method results in a predictable and efficient outcome, as Henry Ford demonstrated with his production line cars and MacDonalds has demonstrated with its burgers. Whereas the government would no doubt wish to contrast the dependable with the unreliable and inefficient (and who in their right mind would want an unreliable and inefficient health service?), critics of modernism are more likely to contrast the dependable with the exciting, the revolutionary, or the experimental. A modern and dependable process turns out identical black cars and identical tasteless (in both senses of the word) burgers for the masses in the most efficient way possible. A modern and predictable health service might be best for routine treatment, but there will undoubtedly be occasions where we might prefer a postmodern, experimental, cutting edge (if not completely efficient) service tailored specifically to our individual needs.

When the government outlined its vision of a 'modern and dependable' health service, it apparently had not considered that the terms could have anything but positive connotations. Thus:

> 'the aim is to provide an NHS that *continually improves* the overall standard of clinical care, whilst *reducing variations in outcomes* of, and access to, services as well as ensuring that clinical decisions are based on *the most up-to-date evidence* of what is known to be effective (NHS Executive 1999, my italics).'

This reads as a modernist manifesto which, with a few minor word changes, could apply equally to cars or burgers. A modern and dependable health service therefore holds out the promise of the rational application of the latest scientific knowledge in a reliable and dependable fashion, maximizing the efficient use of existing resources for the benefit of all.

The driver for this modern and dependable health service is clinical governance (CG), which has been described as 'a framework through which the NHS organizations are accountable for continuously improving the quality of their services…' (NHS Executive 1999) through a number of rational and objective mechanisms such as EBP, National Service Frameworks (NSF), the National Institute of Clinical Excellence (NICE) and the Commission for Health Improvement (CHI, now CHAI). We might expect, then, that practice development (PD) would sit well within the overall

strategy of CG, since PD has also been described as 'a continuous process of improvement designed to promote increased effectiveness in patient-centred care' (Hope 2003). However, this presupposes that PD is underpinned by a similarly modernist philosophy of rationality, predictability, dependability, control and continuous progress through the application of the scientific method, and indeed, that 'improvement' and 'development' refer to essentially the same process and outcome.

An uneasy alliance

Each of the papers in this special edition on CG and PD explores, in its own way, what emerges as an uneasy alliance between these two seemingly compatible concepts. In their paper on the Discipline of Improvement, Clarke *et al*. discuss a number of discrepancies between CG and PD. For example, they note the conflict between the emphasis placed by CG on remote 'distal knowledge' from Randomized Control Trials (RCTs) and the preference of PD for local 'proximal knowledge' generated by and for local health care problems. As they observe, the kind of knowledge favoured by PD 'is highly contested as a vehicle for developing knowledge through high-quality research, yet is highly prized as a vehicle for developing practice that is context aware'. Similarly, whilst 'a rational and positivistic approach and associated tools and techniques' may be the favoured problem-solving strategy of CG, PD usually occurs in 'a systemic and pluralistic environment' where such strategies are largely ineffective.

As Clarke *et al*. are quick to point out, these discrepancies are the result of a clash of paradigms. On the one hand is the modernist position that 'sees the process of improvement as… amenable to logically deduced alterations to processes and structures', whilst on the other hand is the postmodern 'emphasis on learning, participation, process and context specificity', which seeks to 'embrace plural voices… and acknowledge the distribution of power amongst respective stakeholder groups'. The importance of Clarke's paper lies in its attempt to unite the modernist stance of CG with the postmodern tendencies of PD through the construction of a new 'discipline of improvement', which 'resides across what have been traditionally seen as binary oppositions'. Furthermore, its promise is that 'as the Discipline continues to evolve, it will be important to knowingly move towards a more or less postmodern position'.

Newbold articulates the same clash of paradigms and the same desire to somehow unite them, albeit from the perspective of research rather than PD. He begins by cautioning us against the downside of the dominant modernist paradigm which views health care as an industrial process with an emphasis on cost-effectiveness and technological innovation. Whilst such an approach has many benefits, 'it is at the price of decreased quality of care and loss of the health benefits of therapeutic interaction'.

From a Kuhnian perspective, the dominant paradigm of health technology would completely suppress any competition such as the therapeutic paradigm (Kuhn 1962). However, Newbold frames his discussion around Lakatos' notion of 'research programmes', which allows for apparently incommensurate programmes to coexist, albeit in competition (Lakatos 1978). The problem is therefore one of balance. At the moment, the 'health care as industrial process' programme is more influential than the 'health care as therapeutic interaction' programme. Or, put another way, the values of the health care governance (HG) agenda of modernization and progress through the application of generalizable science and technology are winning out over the values of the PD agenda of individualized therapeutic interaction, fundamental aspects of human care and the use of emotional labour. For Newbold, both programmes are necessary for effective health care, and his aim, as it is for Clarke *et al*., is a redressing of the balance between the technological and the humanitarian, in order to give the latter a greater prominence.

Wilkinson *et al*. are also concerned with this clash of cultures and the ways in which they might be reconciled, but this time from a learning perspective. They point out that one of the key components of CG is its emphasis on quality, and that quality improvement requires 'the integration and retention of learning [...] both for professional development and for broader service enhancement'. For Wilkinson *et al*., this goal is best achieved through a learning organization (LO), which is concerned less with individuals than with 'collective learning that goes beyond the boundaries of individual learning and can release potential gains both for the individual and for the organization'.

Learning organizations represent a distinctive and effective approach to practice development, and as such, conflict with the CG agenda in ways similar to those outlined earlier by Clarke *et al*. Thus, as Wilkinson *et al*. point out, there are 'significant areas of divergence' between CG and LO in their overall ethos, in their points and context of origin, and in their methods of adoption. The former has been imposed by the government in a top-down fashion and is dominated by external performance review, whereas the latter is a

bottom-up, grass roots initiative that rejects external monitoring and performance measurement. Thus, whereas CG introduces management-driven and closely monitored goals:

> 'organizational learning, in contrast, emphasises individual internalized changes in ways of thinking. It is too much to expect that formalized systems and empowered individuals will always have an easy co-existence.'

The challenge for managers, then, is to 'seek a creative tension' between the modernist technological agenda of clinical governance and the humanist person-centred agenda of learning organizations.

Gerrish and Clayton provide a further attempt at reconciling the technical with the human in the form of an action research project aimed at promoting EBP. The problem which they attempt to address is essentially the same as in the previous three papers, only this time it is couched in the language of knowledge and evidence. As Sackett *et al.* (2000) tell us, EBP is concerned with combining knowledge from research, clinical expertise and patient preference, and yet, as Gerrish and Clayton point out, 'there has been little attempt within the literature to explain how these different world views might be integrated'. The difficulty which their study attempts to address is therefore twofold: how to apply generalizable scientific knowledge to individual clinical cases; and how to generalize experiential knowledge from individual cases to a wider context.

From the perspective of our debate, the most interesting finding is presented at the very start of the study in table 2 (see page 118). Contrary to the fears of Newbold that the technical rationality scientific paradigm has the upper hand in nursing and midwifery, Gerrish and Clayton found that 'nurses tended to draw upon experiential knowledge acquired through their interactions with patients and colleagues to a much greater extent than formal knowledge gained from textbooks and journals'. In fact, knowledge gained from interactions with individual patients was ranked highest, knowledge from experience was ranked second, intuitive knowledge was ranked eighth and knowledge from journals and textbooks was ranked 10th and 11th respectively.

There are at least two implications that can be placed on these findings. The first, traditionally adopted by the modernist research community, is to explore ways of ensuring that research-based knowledge is accorded more importance by practitioners. The second, preferred by postmodernists such as Lyotard (1984), is to celebrate the observation that practitioners appear to value narrative knowledge from their own experience, from the experiences of patients, and from the experiences of colleagues, more highly than they do scientific knowledge from research.

Yet another expression of this schism is articulated by Eve, who outlines a PD project involving eight psychiatric rehabilitation units. The tension expressed here is between the 'organization' and the 'workers'; between the physical setting of the service and the philosophy of practice; between outcome and process. As Eve notes:

> 'The practice development framework of the rehabilitation service has come to view success and improvement in client-centred or person-centred terms. Whilst this is philosophically in line with contemporary policy it is not without the tension that exists internally from health care organisations that need to deliver corporate targets. Whilst benefits of a practice development process may be "felt" or "known" at a clinical level there is not always the quantifiable evidence to ensure that central health care policy targets are being driven through or met by the processes of practice development.'

As in the former papers, there is an attempt at reconciliation. Rather than playing off the corporate against the personal, we should recognize that 'the person-centred paradigm at both clinical and organizational level should not be underestimated in its ability to deliver the corporate agenda at the same time as meeting the needs of the individuals being supported'. The key to this integration of the personal and the corporate, PD and CG, is self-management and self-regulation. Practice development can therefore offer self-governance in place of the current CG system of externally imposed assessment and star ratings.

Warne's paper, which he presents as a 'postmodernist pantomime', further questions the logic of external assessment and evaluation and highlights again the schism between the individual and the organization. At the heart of this pantomime is the argument that the monitoring function of CHI can undermine the good intensions of CG in terms of both process (unwieldy, subjective and ineffective review teams) and outcome (the questionable validity of the star rating system and the questionable equity and efficacy of the rewards and sanctions allotted as a result of the star ratings). As he points out, 'CG is about the culture of the NHS organizations, a culture where openness and participation are encouraged, a culture that facilitates learning and where best practices are shared and incorporated across the whole organization'. However, 'there is a risk that the way in which some organizations may wish to deal with (a CHI inspection visit) is by anticipating and preparing for a review in a way that minimizes the

developmental and change management opportunities that might arise from the review'.

Like Eve, Warne advocates 'a more adult response' that moves away from a star system based on 'childhood culture', which punishes those who are not achieving, towards an 'appreciation and understanding of the people who make up the organization'. In other words, a shifting of the focus from the organization towards a more person-centred approach.

Finally, McSherry brings together many of the schisms identified in the previous papers and offers a 'recipe' for unifying them through modernization. As he points out, the key difficulty is the reconciliation of a modernization agenda (with all of its implications for centralization, uniformity and large scale solutions) with:

> 'the fact that the NHS is such a huge complex establishment incorporating a multitude of diverse health and social care organisations and personnel covering a whole range of settings/specialties across and between community, primary and acute sectors.'

As he rightly points out, the modernization agenda, operating as it does on an organizational and policy level, is not seen by individual practitioners as relevant to their role and responsibility within the context of their daily working practice. McSherry's solution is to introduce a 'whole systems' approach that unites the clinician and the manager under a system of 'HG'. Health care governance is an amalgam of clinical and corporate governance; that is, governance at both the micro and macro levels. Furthermore, HG requires the introduction of 'practice developers' who can mediate between the demands of the organization and the needs of the individual practitioner. Thus:

> 'Practice development is essentially person or client focussed, whilst health care governance is systems based. When harmonised, these provide the potential recipe for modernisation. The recipe for modernisation is essentially associated with focussing on the whole system to achieve excellence. That is, investing in the person (practice development) – staff, public, patients and structures (healthcare governance).'

For McSherry, as for most of the writers here, the modernization agenda is achieved through the successful combination of HG and PD.

Progress and development

Each of the papers in this special edition has something unique and important to say about CG, PD, and sometimes difficult relationship between them. Each, in its own way and using its own terminology, highlights and problematises what appears to be a fundamental schism in nursing and health care. In these papers, we have seen this schism expressed in terms of the corporate *vs*. the personal agendas of health care, the industrial *vs*. the therapeutic research programmes, objective external evaluation *vs*. subjective self-evaluation and distal scientific knowledge *vs*. proximal narrative knowledge. This schism is epitomized by the organizational agenda of technological *progress vs*. the practice agenda of human *development*.

There might appear at first sight to be little to choose between the two terms:

> '**Progress**/noun/forward or onward movement towards a destination, objective or goal… towards an improved, more modern, or more complete state (from Latin *progredi* to go forth)
>
> **Development**/noun/a process of natural growth, differentiation, or evolution by successive changes; a bringing out of the possibilities of something; an unfolding (from Old French *desvoloper* to unwrap) (adapted from the *New Penguin English Dictionary*).'

However, closer consideration reveals some not-so-subtle differences. The concept of progress was a key component of the Enlightenment philosophy of the 18th century, and suggests that the application of the scientific method will ensure a continuing and continuous improvement in all aspects of our lives. As we have seen, this notion of progress is at the heart of CG, which is defined as 'a framework through which the NHS organisations are accountable for continuously improving the quality of their services…' (NHS Executive 1999). The concept of development, on the other hand, has a more organic feel to it. Whereas the etymological roots of 'progress' reveal a forward-moving 'going forth' towards a predetermined external goal, the roots of 'development' suggest a more natural growth, evolution or unfolding of innate potential.

Critics of the modernist Enlightenment project have pointed out that the notion of constant progress through technology towards some ideal state is a myth. History tells us that progress in one area is always accompanied by regress in another; that every advance has a cost. Thus, Lyotard (1992) has pointed out that the promise of the Enlightenment was that:

> 'The progress of the sciences, technologies, the arts and political freedoms will liberate the whole of humanity from ignorance, poverty, backwardness, despotism.'

Although this might well be the reality for some people in the developed world, the cost has been great.

Whilst it might be tempting to see the ills of the world only occurring in places as yet untouched by the Enlightenment project:

> 'It was not a lack of progress but, on the contrary, development (technoscientific, artistic, economic, political) which created the possibility of total war, totalitarianisms, the growing gap between the wealth of the North and the impoverished South, unemployment and the 'new poor', general deculturation and the crisis in education (in the transmission of knowledge)… (Lyotard 1992).'

We can perhaps see parallels in the field of health care. A direct result of progress in the production of more powerful antibiotics is the parallel emergence of yet more deadly and resistant viruses. A direct result of progress towards the increased education and specialization of nurses is an increase in the numbers of unqualified health care staff in clinical areas. A direct result of progress towards increased lifespan is a crisis in care and (sometimes) a deterioration in quality of life for older people.

Development, on the other hand, is more gentle, less invasive. Practice development is concerned with achieving one's potential. Whereas *progress* in one area seems to result in regress in another, my *development* does not impede your development. In fact, it can positively enhance it. If progress is associated with modernism and the enlightenment, then development is associated with postmodernism, with plurality and with diversity.

Towards a postmodern health service

Let us now return to the question posed at the start of this paper: do we *really* want a modern and dependable health service?

The answer has to be a loud and unequivocal 'sometimes'. Modern medicine, with its emphasis on scientific progress, on rationality, on improvement (even with its associated costs), on technological interventions and on intrusive and aggressive monitoring, is exactly what I want for the treatment of routine medical problems. But do I necessarily want modern *nursing* care? Well, I am not so sure. Scientific knowledge from RCTs provides us with statistical information about how populations might respond to medical treatment and nursing interventions. It is therefore useful at a macro level for managers and service planners, as well as for nurses who practice in a task-centred way. However, most writers agree that what distinguishes nursing from medicine is its concern with individual therapeutic interventions with individual patients, and these are hardly uniform or predictable in advance.

Modernist generalizable science is therefore of limited help to the practising nurse, who is less concerned with whether a particular patient fits the population to which the findings of a research study apply than with how this individual in this unique situation might respond to this individualized intervention by this particular nurse at this particular moment. If the patient-centred nurse is concerned with science at all, it is with the 'science of the singular' (Simon 1980), that is, with postmodern science (Lyotard 1984).

A postmodern science is distinguished firstly by its emphasis on narrative knowledge rather than on generalizable scientific knowledge. In other words, the stories that we tell one another constitute a body of knowledge that is of greater relevance to the individual practitioner with her individual patient than is the knowledge of populations afforded us by modernist science.

Secondly, postmodernism is comfortable with its own lack of certainty. Whereas modernism looks for predictability, certainty, generalizability and dependability, postmodern science is concerned with 'undecidables, the limits of precise control, conflicts characterised by incomplete information, "fracta", catastrophes, and pragmatic paradoxes' (Lyotard 1984). It appears to me that these are issues that most practitioners have to face everyday. Nothing is predictable in advance in our individual encounters with individual patients, and it is perhaps foolish and misguided to hope for any sort of certainty.

And thirdly, postmodern science embraces diversity and contradiction as inevitable aspects of the world. Whereas modernist science is constantly progressing towards a single truth by the elimination of falsehood, postmodernists suspend all judgements and attempt to hold several contradictory points of view at the same time (see, for example, Derrida's writing on deconstruction and différance). As the postmodern architect Venturi (1966) stated, 'I prefer "both-and" to "either-or", "black and white and sometimes grey" to "black and white' ". Once again, this would seem to fit with my experience of nursing practice, and indeed, with PD.

Summary

This edition of *Journal of Nursing Management* examines the relationship between CG and PD. Although the two concepts would appear on first sight to have a great deal in common, all seven papers identify incompatibilities, and each, in different ways, attempt to reconcile them. The main difficulty appears to be that CG and PD operate out of different paradigms.

Whereas CG is based on a modernist philosophy of progress through the scientific method, PD has a more humanist foundation which I have associated with organic development and postmodern science. Ultimately, of course, health care and nursing require both paradigms, and I hope that these papers will go some way towards redressing the current imbalance towards the modernist aspects of health care. Do we *really* want a modern and dependable health service? Of course, but we might also at times want a postmodern, uncertain and experimental one.

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