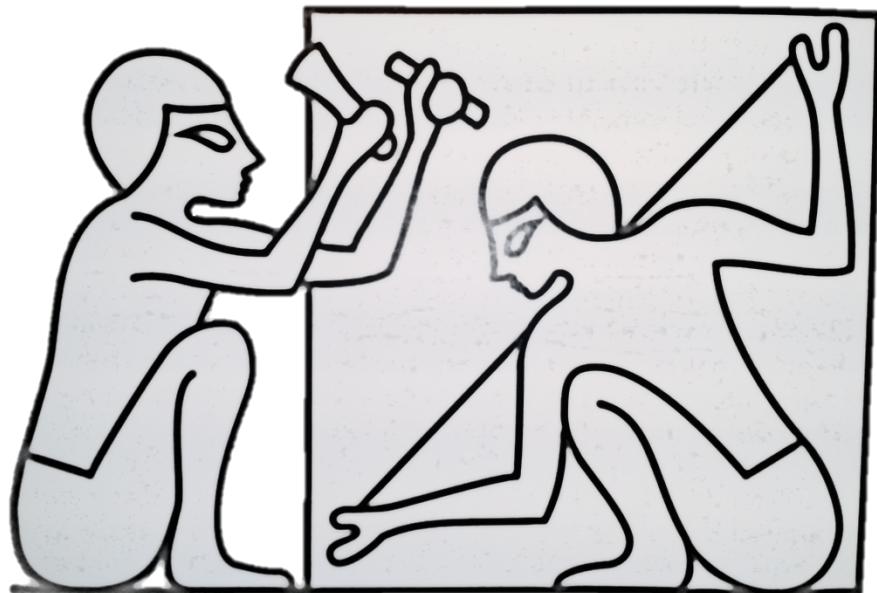


The London School of Economics and Political Science

Accounting for Quality: The emergence and significance of managing for quality in healthcare

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Adapted from: 'Quality inspection', Thebes, C 1450 B.C. in J.M. Juran, *A History of Managing for Quality* (1995, p. 612).

A thesis submitted to the Department of Accounting of the London School of Economics for the degree of Doctor of Accounting, London, September 2013

Declaration

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Abstract

This thesis investigates the emergence and significance of the phenomenon termed the *contemporary promise of quality* in healthcare. This phenomenon is shown to be part and product of a historically extraordinary set of movements that have remade quality in a form that is explicit, calculable, expressible as accounting numbers, and amenable to management ideas and ideals. It is also shown to be closely inter-twined with the emergence of a distinct way of contemplating and undertaking reform of the healthcare sector; a politically attractive means of continually responding to failures by calling for the import of the newest improvement interventions. This thesis documents the historical specificity of these movements and tracks their international reach. It also investigates what the phenomenon entails for healthcare systems, organizations, professionals and patients as it is variously operationalized. Investigating the USA and UK health reforms, and experiences with reform, in detail, this thesis shows that this phenomenon is closely connected with a movement of care activities ‘onto the balance sheet’ and toward representational activities rather than the activities that historically constituted the practices of caring. It also shows this phenomenon to be closely connected with changing forms of expertise, knowledge and professionalism in healthcare. It identifies, for example, the emergence of knowledge about managing *experiences*, and a certain style of engaging with numbers and acting in an outwardly entrepreneurial way, as closely intertwined with this movement. This thesis as a whole, by attending to the wider movements of which quality and its calculations are part and product, contributes to our understanding of accounting, quality, healthcare, professionalism, and government reforms. It shows the way that a calculable quality emerged and moved between time and place, and in the process reconfigured the very nature of policy-making and caring.

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Chapter 1

Accounting for Quality: An introduction

About a century ago there emerged the massive movement that came to be known as scientific management. Its major focus was on improving productivity, and its influence was felt throughout the twentieth century. We are similarly in the early stages of a massive movement, this time in managing for quality. It began in recent decades, but still has far to go before becoming widely effective among world economies. The likelihood is that it will take the entire twenty-first century to digest this change. As a result, the twentieth-first century may well become known to historians as the Century of Quality. (p.xii)

- J.M Juran (1995) *A History of Managing for Quality*

1.0 The contemporary promise of quality

Quality is becoming the new catchword of government-led reforms.¹ As in the manufacturing sector of the 1980s and 1990s (Juran, 1993; Miller and O’Leary, 1994a; McNealy, 1993; Hackman and Wageman, 1995), the solution to the perceived failures of health and social care (Pfeffer and Coote, 1991), education (Cameron and Whetten, 1996; Frazier, 1997), policing (Rosenbaum and Lurigio, 1994; Home Office, 2010) or even the welfare state is increasingly argued to be one of measuring, accounting for, comparing, and improving the ‘quality’ of the services and products that they offer (Kirkpatrick and Martinez-Lucio, 1995).² As authors such as Pollitt and Boukaert (1995) note, government-led reforms in the name of quality increasingly hold out the promise of solving a wide variety of preoccupations and concerns—among other things, they promise to “restore the morale of staff, reassure citizens anxious about the

¹ No a priori distinction between the private and public sector is made in this thesis because, as a consequence of reforms in the 1980s and 1990s, the distinction between these types of organization is often unclear. In the jurisdictions studied here, healthcare delivery organizations are often described as “hybrid forms” (Kurunmäki and Miller, 2011), exhibiting characteristics associated historically with both forms of organization (Brunsson and Sahlin-Andersson, 2000). The distinction made is between government reforms that are initiated by government authorities (i.e. in contrast to self-regulation), and those initiated by semi-autonomous organisations and sectors, while acknowledging that this distinction is also sometimes blurred (Higgins and Hallström, 2007). The term “reform” is used to denote “an intentional, sustained and systematic process of structural change” (Saltman and Figueras, 1998, p.86).

² Scare quotes are used throughout this thesis to highlight the use of words’ or phrases’ commonly-invoked but historically-specific meaning, rather than an underlying reality of the thing to which it might correspond.

threatened decline of their basic public services, and provide politicians with a new set of rallying cries" (p.7).

Such a proliferation of quality discourse is no more apparent than in healthcare, where quality has become the primary discourse through which to contemplate and undertake reforms since 1985 (Øvretveit, 2000; Ferlie et al, 1996). As in other fields, where previous reforms were articulated and undertaken on the basis of a wide range of promises, including that of "quantity", "efficiency", "effectiveness", "professionalism", "education", and "access" to care (Starr, 1982; Porter, 1999), a current PubMed search of the Public Policy medical subject heading (MeSH) database shows clearly that the term "quality" has come to dominate discussions of healthcare policy in recent years (Figure 1.1 below). This does not mean that these other constructs have been dispensed with altogether. Rather, they have typically been subsumed within a broader, seemingly more optimistic, and (as we will see) more politically appealing discourse of quality.³

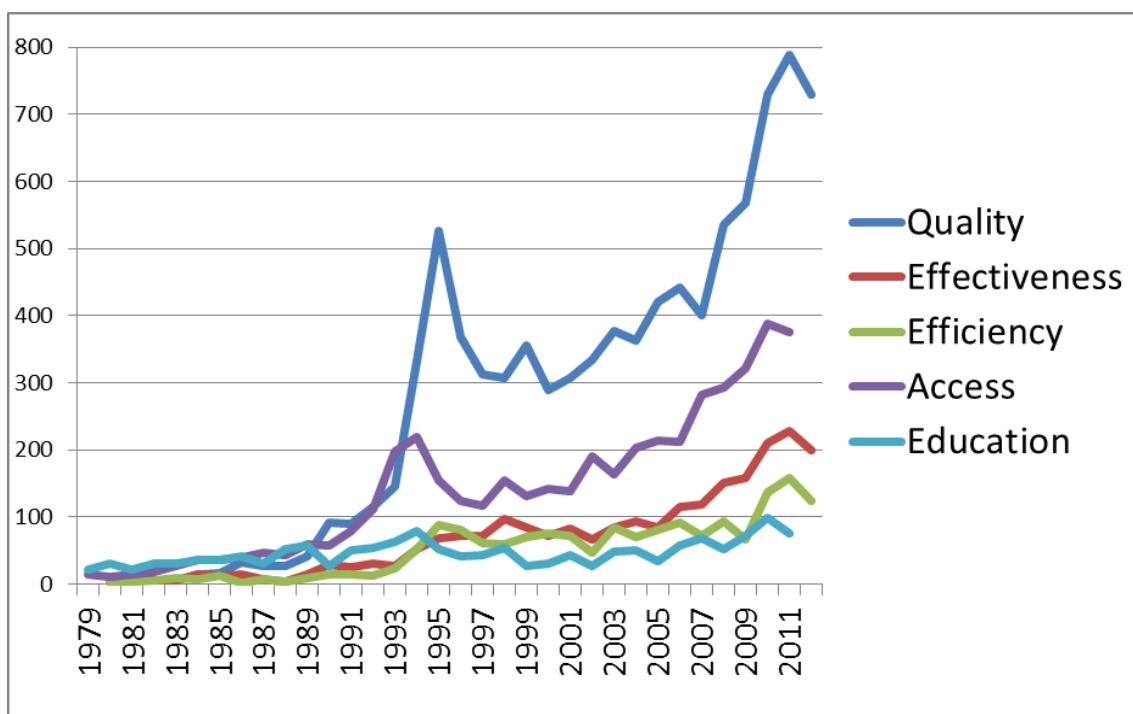


Figure 1.1: Number of papers published in the Medline Public Policy MeSH database with the terms above in their title or abstract

³ In the case of the movement from economy to quality Pollitt and Boukaert (1995) note that, "quality improvement did not *replace* the drive for economy but rather complimented it. It held out the promise of squaring the circle: with these new techniques, perhaps the cost of public services could be lowered whilst at the same time the satisfaction of the users could be raised" (p.7-8).

This quality explosion (c.f. Power, 1996) is in large part a matter of discourse. However, by attending closely to multiple movements of which this discourse is part and product, this research shows the quality explosion to be closely intertwined with much else. This thesis shows this discourse to be part and product of a set of significant movements related to quality, accounting, the delivery of healthcare, professionalism, policy-making, and much else, summarized and differentiated in time as *the contemporary promise of quality*.

The contemporary promise of quality, this thesis shows, is closely related to the emergence and stabilization of four historically distinct characteristics of quality and quality improvement—a particular way of thinking and talking about quality. Firstly, this is a notion of quality conceptualized strictly as an *accounting concern*; as something which can only be accurately perceived and improved upon through formal measurement, commensuration and comparison. Secondly, it is a notion of quality that aims explicitly and formally to include the *consumer's perspective* of the product or service. Thirdly, the contemporary promise of quality articulates the ideal that improvement must be *bottom-up*, and led from the front line. Fourthly, it suggests that improvement can only be achieved by equipping everyone to *experiment* with quality, and learn what works through active engagement with their own tests of change.

Each of these four preoccupations and ideas operate in spheres that extend beyond the topic of quality as such. The concern to attend to the consumer's perspective, for example, is a management discourse and aspiration that operates at a global scale and across domains (DuGay and Salaman, 1992). This research shows, however, that such preoccupations are not just constitutive of but in part constituted by the contemporary promise of quality. It shows that through the packaging of these aspirations into the optimistic promise of quality, and their operationalization into the specific interventions and programs of improvement that this promise of quality requires, these preoccupations are given a concrete and consequential expression. It illuminates, for example, the way that the customer's view, when entangled with aspirations to measure quality, come to provoke and embody the customer as a person with 'experiences' that need to be attended to and improved with the help of new forms of expertise and intervention. As such it shows the contemporary promise of quality to extend and in part enact these preoccupations and concerns.

The contemporary promise of quality is also shown to be closely connected with the emergence of increasingly international norms of contemplating and undertaking reform. This research shows that the emergence of quality as a distinct and often repeated promise of government is closely connected with the historical packaging of quality within the four characteristics mentioned above and a certain trajectory in the development and operationalization of New Public Management (NPM) reforms, which make the contemporary promise of quality a reform solution “for all seasons” (c.f. Hood, 1991). As intimately connected with these reforms, the contemporary promise of quality is shown to be a deeply programmatic phenomenon (see Miller and Rose, 1990; Miller and O’Leary, 1990), characterized “by an eternal optimism that a domain or a society [can] be administered better or more effectively, that reality is, in some way or another, programmable” (Miller and Rose, 1990, p.4).

The contemporary promise of quality is thus also shown to be indissociable from the distinctive ambitions, and tools and technologies, to act upon organizations and people in quality’s name. As this research will show, these ambitions, tools and technologies participate in the meticulous but imperfect construction of dense networks of different elements and whole new worlds of quality and healthcare, in which new distinctions are provoked, new terms of performance are constructed, and new possibilities, even new professionals, are made (Callon, 1991, 1998; Miller and Rose, 2008, p.53-83; Thrift, 2000; Vaivio, 1999).

In summary, the contemporary promise of quality is a phenomenon that takes place simultaneously at multiple and overlapping levels and locations, and that is at once discursive and programmatic, material and social, transnational and even personal. It is a movement of multiple but connected changes and relationships; simultaneous movements in both what quality is and ideas about how it can be improved upon *and* how and in what ways all of the heterogeneous ideas and ideals to which quality is attached come to be expressed, made operational, and extended into the lives of providers and recipients of services in the name of quality. It is a movement, therefore, not just of a changing form and function of quality but indistinguishably of movements at the “margins of accounting” (Miller, 1998), changing terms and arrangements for calculations (see Callon and Law, 2005), the re-presentation of the consumer and her

view (see Mold, 2010), the re-configuration of the terms of performance and improvement (see Timmermans and Berg, 2003), movements in the form and location of policy-making (see Miller and Rose, 2008), a performance culture in the making (see Strathern, 2000; Power, 1996), and much else besides.

While this thesis documents the emergence of a phenomenon with distinctive characteristics, boundaries, and consequences, it also highlights the “elusiveness” (Wilkinson and Willmott 1994, p.1) and fragile composition of quality more generally (Xu, 2000). While the contemporary promise of quality is shown to be inextricable from the constitution of new things (c.f. Miller and Rose, 1997; Power, 1996; T. Porter, 1994), and even performative in the sense of imperfectly constructing ideas and ideals into reality (Callon, 2006; Butler, 2010), it is nonetheless shown to generate new opportunities and possibilities—“overflows” to use Callon’s (1998, p.149-51) terms—for quality to change and to become something new. These overflows are shown not just to be a matter of the imperfect fit between our theories of quality and programmatic ambitions to govern it and the messy realities of professional practice (see Callon, 1998; Kurunmäki and Miller, 2006), but also to be distinctive to the concept of quality itself. As something with a long history of associations and that, at least theoretically, can be made to be “almost anything anybody wishes it to be” (Donabedian 1966, p.167), quality remains only a promise—an aspiration or, to paraphrase Miller and Rose (2008, p.17), a “congenitally failing” but “eternally optimistic” enterprise.

It is this tension between the elusiveness and tenuousness of quality on the one hand and its concrete stabilization on the other that provokes and even guides this research.⁴ Indeed, the underlying questions guiding this research are: how does quality come to be given a more or less distinctive form and function at particular points and locations in time, and what are the distinctive effects of its particular form? These are questions that are provoked by quality’s elusiveness and that investigate quality as a historically contingent and essentially mutable object—a “quasi-object” to use Latour’s (1991, p.116, citing Serres, 1987) terms.

⁴ It is an investigation, as such, of achievements of varying degrees; an investigation of the emergence, to borrow and adopt Callon’s (1991) description of a different sort of assemblage, of “a coordinated set of heterogeneous actors which interact *more or less successfully* [italics added] to develop, produce, distribute, and diffuse methods” (p.133) for doing something about quality.

1.1 Quality in healthcare

This research investigates the emergence, operationalization and consequences of the contemporary promise of quality in the domain of healthcare, primarily in the USA and UK, over roughly the past 25 years. In addressing these issues, it is suggested that we can begin to better understand the broader significance and consequences of such movements, and differentiate between their different variants or incarnations.

In healthcare, as is likely in other fields, quality is often described as a timeless preoccupation—a concern, one author notes, that is “as old as medicine itself” (Maxwell, 1984, p.1470; Wilkinson and Willmott, 1994; Pollitt and Boukaert, 1995). It is also commonly described as an inherently malleable concept or ideal; it can be, we are often told, “almost anything anybody wishes it to be” (Donabedian 1966, p.167; Pfeffer and Coote, 1991). This research suggests, however, that such descriptions of quality overlook the important aspects of quality that matter: namely that quality is enacted differently and is thought of in very particular terms throughout place and time. As indicated in Figure 1.1 above, and as this section will briefly highlight, while quality of care may in one sense be an age-old worry, it has only become a matter of explicit and programmatic concern since the mid-1980s. Far from being anything anybody wishes it to be, moreover, it has during this same time come to be conceptualized and operationalized in a quite specific and historically distinct manner, embodying the distinct and seemingly irrefutable characteristics of quality as expressed in the contemporary promise of quality.

Prior to the mid-1980s, quality was a term rarely invoked in public debates about healthcare (Boaden et al, 2008), it was seldom explicit in healthcare reforms (Scrivens, 1995), and it was not overtly and systematically attended to at a national and programmatic level (Smith, 1994). As will be illustrated in detail in Chapter Two, quality was in fact something that could not be precisely defined, accurately measured or programmatically addressed; to do so, one author reflected, was thought “to somehow belittle or denature its essence” (Donabedian, 1988, p.1743). However, from the mid-1980s onwards, and as part and product of the activities around quality in the USA and UK, which are documented in the chapters that follow, quality began to be

articulated in the international discourse as something that is central to a world-class healthcare system, a right of healthcare consumers, and a requirement of successful healthcare modernization more generally. The Council of Europe (COE), for example stated, “Receiving health care of good quality is a fundamental right of every individual and every community” (in Shaw and Kilo, 2002, p.5), and the Organization for Economic Cooperation and Development (OECD) similarly stated that “Policymakers need to measure, evaluate and compare the quality of care systems for three main reasons: to promote accountability, to inform effective policy development, and to help health care providers learn from one another” (2010, p.3). Moreover, a number of international quality rankings began to emerge to formally compare healthcare systems (eg. OECD, 2006; World Bank, 2006, p.168; USAID, 1999).

Such international exhortations to place quality at the heart of care, and the development of infrastructure to make quality synonymous with health system performance, emerged hand in hand with new programmatic aspects of quality—with the formation, that is, of frameworks, plans, calculations, and tools for somehow expressing, documenting, classifying, comparing, and then doing something about that which had hitherto gone largely unexpressed. While aiming, for example, to avoid “suggesting that ‘one size fits all’ and that there are ‘magic bullets’ for quality” (WHO, 2006, p.vii), international standard setters such as the World Health Organization (WHO) nonetheless increasingly state that “the principles of quality management are largely identical across all countries, as they build on optimal use of scarce resources, client orientation, and sound planning as evidence for improved quality of services” (*ibid*), and articulate procedures, protocols, standards and frameworks for nations to act upon quality. On the basis that quality is a “fundamental right”, the Council of Europe (COE), for example, has required its members since 1997 to:

[Create], where appropriate, policies and structures that support the development and implementation of ‘quality improvement systems’ (QIS), that is, systems for continuously assuring and improving the quality of health care at all levels. (COE, p.90)

Similarly, the WHO recommends a series of best practice and minimum standards around quality and quality improvement, (see WHO 1992, 1999, 2003a, 2003b) including that:

- a) Quality assurance should be incorporated in national health policies, programmes and strategies

- b) Governments should create or strengthen existing bodies in ministries of health to act as an advocacy or advisory body on quality assurance in health care. This body should include representatives from other sectors, nongovernmental organizations, teaching and research institutions, and professional groups
- c) Core groups should be formed at the national, regional and local levels to provide leadership and to ensure that quality assurance becomes an integral part of all health care programmes, particularly those in district health systems based on primary health care, as well as to ensure that each programme manager is responsible for identifying action points and developing specific indicators and standards for their individual programmes [...]. (WHO, 1992, p.135)

Such programmatic aspirations at the international level have, not surprisingly, gone hand in hand with a proliferation of national healthcare legislation with specific quality requirements, the development of national healthcare strategies, an increase in the number of national healthcare quality agencies and regulators, a growth of government-led activities to collect and disseminate information about quality performance, and many other such systematic efforts to act upon and improve the quality of healthcare since 1985 (WHO, 2003c). Appendix 1.1 documents many examples of such activities undertaken in a range of countries since the 1990s.

Despite the stated flexibility of such exhortations, and the different tempos at which national programmes have been unfolding (see Appendix 1.1), these discursive movements and programmatic aspirations are nonetheless inseparable from the development of complex networks and associations that operationalize a distinctive notion of what quality is and how it can be addressed. Indeed, as already noted, the calls to do something about quality do not suggest quality to be “almost anything anybody wishes it to be” (Donabedian, 1966, p.167), but instead demand quality to be thought about and acted upon in a particular way. They call, for example, for “continuous” quality improvement (COE, 1997, p.17), for “responsible [...] programme managers” (WHO, 1992, p.135), the development of “specific indicators” (*ibid*) and other such historically-specific terms for doing something about quality.

These are subtle but important distinctions. For it is in the content and specificity of the multiple associations of these diverse discourses, ambitions, frameworks and mechanisms of quality, as they are made operable at a range of locations, that the contemporary promise of quality comes to be formed. As suggested above, the

operationalization of the contemporary promise of quality in healthcare has four distinctive characteristics. Each of these characteristics, as will now be summarized, is historically distinct, and presents new challenges, opportunities and dilemmas for healthcare in the name of quality.

First, the discursive articulations of quality equate quality foremost as an *accounting concern*.⁵ They suggest that quality is something that can and must be precisely defined, accurately measured, summed up, made visible, and reported publicly in order to be sufficiently understood, assured, and improved upon (e.g. Brook et al, 1996; Shekelle and Roland, 2000; Arah et al, 2003). In order to act upon quality, it is argued, it must be made calculable, commensurable, and amenable to scorecards, balance sheets and performance indicators, much like other contemporary concerns (see Kaplan and Norton, 1996; Edenius and Hasselbladh, 2002; WHO, 2008). As an indicative 1999 consensus statement from the Institute of Medicine (IOM) states:

During the next few years, as change continues, we cannot lose sight of the urgent need to monitor and improve the quality of health and the effectiveness of health care within our society [...] *Quality can and must be measured, monitored, and improved* [italics added]. Policymakers [...] must insist that the tools for measuring and improving quality be applied. These approaches require constant modification and reassessment—that is, the continual development of new strategies and the refinement of old ones. Furthermore, credible, objective, and non-political surveillance and reporting of quality in health and health care must be explicitly articulated and vigorously applied as change takes place. (IOM, 1999, p.1)

This movement of quality from the depths of professional judgment to formal and explicit calculation is a marked event in the history of quality and indeed healthcare (Donabedian, 1988, p.1743). It is a movement, as we will see, synonymous with the emergence of an accounting ideal in the science and practice of healthcare, and a reconceptualization of “what it means to be a good doctor, patient, manager, and even healthcare system” (Zuiderent-Jerak and Berg, 2010, p.32; see also T. Porter, 1996, 1992; Timmermans and Berg, 2003).

⁵ Quality is described as an accounting concern, rather than one of measurement to emphasize that this quantification of quality has emerged, similarly to accounting (see T. Porter, 1992, 1995), on the basis explicitly of a defense against so-called mere judgment, that it shares a close relationship to representations of performance, and that it is seen and described commonly as a practical affair or technical (Timmermans and Berg, 2003).

Second, quality is defined as something that must be understood at least in part from the *perspective of the patient*, as a consumer of healthcare services. Reforms in the name of quality note that, “to earn the label ‘good enough’, care must meet standards expected by consumers” (Grol et al, 2002, p.110).⁶ As such, quality and the perspective of the patient are described as closely and necessarily linked (eg. OECD, 2006; Legido-Quigley et al/World Bank, 2008, Ch.1). It is stated, for example:

If the patient is to be served then he or she must have a voice in the process of medical care. Satisfaction has therefore come to be seen as a legitimate and desired outcome in itself, not solely as a means of improving compliance. It has become an attribute of quality, a legitimate health care goal. (Williams, 1994, p.510)

This interrelationship between quality and the patient’s view means that the promise of quality has become part of efforts to define, measure, improve upon, and even standardize the patient’s point of view, as exemplified in the rise of the patient experience survey.⁷ This standardization, as we will see, has consequences and effects in diverse fields.

Third, the contemporary promise of quality posits that successful quality improvement—often referred to under the title of “continuous quality improvement” (see Berwick, 1989; Tuckman, 1994; Blumenthal and Kilo, 1998)—requires a *bottom-up process* of change. Drawing from many industrial-sector improvement models and differentiating itself from the management-driven target culture of NPM, this conception of improvement suggests that quality must be enmeshed in the culture of the organization and become everyone’s concern. The WHO, for example, states:

Visible senior management leadership, commitment to quality, and staff involvement are essential. Quality should be central to business plans and

⁶ All national rankings of health system performance include measures of quality from the patient’s perspective. The metric of “responsiveness” has been included in the WHO’s world health systems performance assessment framework since 2000, the OECD’s Health Care Quality Indicators Project, included “safety and responsiveness/patient centeredness” as a core quality dimension since 2002, the National Scorecard on US Health System Performance (undertaken by the Commonwealth Fund in 2006 and 2008) includes “patient-centred, timely care” as a core performance indicator (see Schoen and How, 2006), the WHO HSPA initiative includes a core chapter on patient-centeredness (Valentine et al, 2003), and the Dutch Health Care Performance Report seeks to measure “care of a high standard that is provided in an effective, efficient, and patient-centred way and that meets the patient’s actual needs” (Westert et al, 2010; Nolte, 2010).

⁷ International bodies emphasize, and national legislation increasingly require the development of national standardized survey programmes to measure, rank, and reward performance on health surveys. Indicatively, a literature review conducted in 2008 identified 55 national and international patient experience survey programs (Kunnskapsseneret, 2008).

the management agenda: *it is everybody's business* [italics added]. This attitude is often referred to as a quality culture. (2003a; p.85)

This emphasis on “culture” (ibid) means that improvement is seen to be about the “critical need to empower [the] workforce to learn and participate in continuous improvement” (Blumenthal and Kilo, 1998, p.627; see also WHO, 2003a).

This model of bottom-up and numbers-driven improvement to be embraced by all presents distinct new requirements for healthcare professionals (c.f. Kurunmäki and Miller, 2006). It corresponds with the continually emphasized need for the development and institutionalization of a specific way of talking about performance and quality (Øvretveit, 2000). Developing a “shared language of quality improvement” (Macfarland et al, 2013, p.16) or a “quality culture” (Davies et al, 2000; Roberts and Perryman, 2007, p.155) is advocated as an essential part of *doing* quality. As the WHO, for example, states:

Quality assessments have little or no practical benefit unless their conclusions are translated into an agreed, defined plan of action that is subsequently implemented and then shown to have achieved the intended results by repeating the assessment. These methods should become standardized, transferable and shared with colleagues, for example through professional and organizational networks at local and national level. (WHO, 2003a, p.85)

Quality improvement therefore increasingly centers on equipping all staff with the language, methodologies, metrics and models that allow them to think about, undertake, and communicate their improvement activities.⁸ As we will see, it is through such equipping and equipment that the ideals of improvement take part in constructing new distinctions among organizations and professionals and new requirements of care (c.f. Thrift, 2000; Callon, 1998).

Fourth, the contemporary promise of quality also maintains that change and quality improvements are difficult to achieve, and as such require active and *continual experimentation* from those on the front line (c.f Willmott, 1993). The principles of “Continuous Quality Improvement” (CQI), first elaborated by Donald Berwick in the

⁸ Equipping staff typically means spreading (often through so-called cascade teaching) standardized improvement methods or methodologies, like the PDSA cycle, LEAN, Statistical Processes Control and ‘Six Thinking Hats’ that are seen to be central to the production of the right quality culture, and therefore essential pre-requisites to doing quality and service improvement generally (Boaden et al, 2008; WHO, 2003a, p.86). These are all quality improvement tools developed in industrial manufacturing sectors (see NHS Innovation and Improvement, 2013; see details in Section 4.4).

healthcare sector, maintain that failure should not result in blame but that in fact failure is an integral part of any successful improvement programme (Blumenthal and Kilo, 1998; Berwick, 1989, 2008). As a number of authors state:

The implementation of CQI programs in hospitals is undertaken in successive steps; many of them will not result in successful outcomes. The difficulty is to have hospital managers recognize and accept failures and to consider them as part of the implementation process. (Maguerez, 1997, p.6)

As such, it is argued, improvements require equipping those at the front line with the right tools and the right motivation to undertake their own local experiments, so as to engage in every-day tests of change. This requires:

[Data] collection and analysis to diagnose problems; the formulation of hypotheses for improvement; the conduct of experiments; the collection and analysis of data on the results of those experiments; and the revision of interventions based on these data. (Blumenthal and Kilo, 1998, p.633)

As we will see, these reforms seek to transform the healthcare organization, like the American factory in the 1980s and 1990s, into a “laboratory *par excellence*” (Miller and O’Leary, 1994b, p.472). This is a space deeply connected with far reaching political ideals and improvement dreams and the material and personal transformations that they require. They also are shown to be closely related to the enactment of a particular type of healthcare organization and professional (Miller and O’Leary, 1987; Callon, 1998).

The specific characteristics of the contemporary promise of quality, outlined above, are summarized in Figure 1.2 below as an accounting concern, as patient-centered, as bottom-up, and as experimental. Together, it is suggested that these four components constitute a newly stabilized way of thinking about healthcare and how it is to be acted upon. It is this assemblage of distinct and possibly competing elements that gives contemporary quality initiatives the distinctive dynamics and effects that will be illuminated in detail in the chapters that follow.

Characteristic/Doctrine	Meaning	Justification
An accounting concern	Must be defined, measured, commensurated, ranked, and reported to be sufficiently understood or improved. Favors comparability and impersonality over representational accuracy.	We can only improve what we can measure. Professional judgment is fallible. The patient knows best.

Patient or customer-centered	Discussions of quality must include some form of formal (ideally quantitative) patient representation.	The patient knows best. The customer is King.
Bottom-up	Improvement must become personal and individual to everyone in healthcare; it is 'everyone's business'. Improvement must be led by the front line.	Top-down and management-driven reform does not produce lasting improvement. Physicians and nurses really care about quality.
Experimental	There is no one right way to do improvement. Staff must be equipped with the skills and motivation to figure out what changes will result in improvement.	Improvement is difficult to achieve. Knowledge about improvement is imperfect There are ways of thinking about improvement that are applicable throughout healthcare.

Figure 1.2: Characteristics of the contemporary promise of quality

While this thesis highlights the emergence and stabilization of a particular and relatively enduring conceptualization of quality, it also documents the continual challenges of the contemporary promise of quality to live up to the dreams and schemes of which it is a part. It shows that, as the whole world of healthcare is being transformed in the name of a seemingly-irrefutable notion of quality, at the same time, this work generates challenges, “overflows” to use Callon’s (1998, p.244-270) terms, and possibilities for new ideas about what else quality might be, and how else it might be improved, to emerge.⁹ As such, it highlights that quality remains an unfulfilled promise, even while it takes part in the transformation of so many things.

1.2 Research design

⁹ The ongoing elaboration and stabilization of the contemporary promise of quality is shown to take place alongside the emergence of evidence of almost continual quality failures and scandals. In the UK, these include the emergence of details of high death rates during cardiac surgery at the Bristol Royal Infirmary in the 1990s (see Kennedy, 2001), the conviction for serial murders of the physician Harold Shipman in 2000 (see Kinnell 2000), reports of abuse perpetrated by the gynecologist Richard Neale (see BBC, 2000), findings of repeated abuse of elderly patients at the Garlands Hospital in 2000 (Kmietowicz, 2000), the unauthorized removal of organs from 893 dead children at Alder Hey Hospital and others (see Hall, 2001), documentation of physical and psychological abuse of patients with learning difficulties at Winderbourne View Hospital in 2011 (DH, 2012b) widespread neglect and mistreatment of patients at the Mid-Staffordshire NHS Trust (see Francis, 2013), public admissions of the “potential for the events in Mid-Staffordshire to be repeated in any hospital in Scotland or in the UK” by the Royal College of Physicians (see BBC, 2013, n.p.), and the identification of fourteen hospitals with major and continued failings in quality (Keogh, 2013).

The research for this thesis has been undertaken principally in the UK and US healthcare jurisdictions, although reference is made to other international developments to the extent that they emerge from and impact on these two locations. Focus on these jurisdictions stems from both empirical and theoretical considerations.¹⁰

Empirically, the two countries are international leaders in the quality movement and tightly interwoven, thus making them important places to study the contemporary promise of quality. The two have developed and pioneered many aspects of the increasingly international movement (Darzi, 2008a; Scaly and Donaldson, 1998; Berwick, 2003; Woodhead and Strobl, 2011), including the “continuous quality improvement movement” (Blumenthal and Kilo, 1998), the “science of improvement” (Berwick, 2008), and “modern quality improvement methods” (Brennan, 2002, p.976; see also Chassin and O’Kane, 2011).¹¹ These movements are closely connected with the activities of specific reformers in the USA (such as Donald Berwick and Avedis Donabedian) and UK (such as Archie Cochrane and Ara Darzi) and institutions (such as the Institute for Healthcare Improvement, Picker, and Institute of Medicine in the USA, and the NHS Institute for Improvement in the UK). Even while the US healthcare system performs poorly compared to its peers on a number of core aspects of performance (Davis et al, 2010), and the UK National Health Services faces many challenges and care scandals domestically, they are both seen internationally as the leading authorities in quality and quality improvement and models for reform elsewhere, and therefore primary locations in which the contemporary promise of quality is, in part, made (The Economist, 2013).¹²

¹⁰ This thesis does not aim to formally compare the two jurisdictions. Rather these sites have been chosen to gain a better understanding of the movements around quality that they differently experience and contribute toward.

¹¹ These movements have longer histories with different geographical connections. Kirkpatrick and Martinez-Lucio (1995), for example, note that the “quality revolution” that inspired some public sector reforms in the early 1990s, “started in Japan and has since spread to the United States and Europe” (p.2). While these movements are closely connected to the emergence of the contemporary promise of quality outlined here, they are distinct from the more specific packaging of quality improvement ideas and ideals (as an accounting concern, patient-centered, bottom-up and experimental) that is of primary concern throughout this thesis, and that were constituted specifically in the UK and USA.

¹² Benefiting from a health system that is more amenable to wholesale programmatic reform than that of the USA, it has been able to advance quality ambitions described as early as 1990 as the “most ambitious, comprehensive, systematic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation’s health care system” (Leatherman and Sutherland, 2003, p.1).

There have also been consistent interactions between the USA and the UK healthcare reforms throughout these years, making it difficult to understand the elaboration of the contemporary promise of quality in one jurisdiction without analysis of the other.¹³ The US healthcare reforms and reformers have not only had a consistent influence on the UK reforms (through the work, for example, of the American economist Alan Enthoven) but the quality agenda and quality improvement reforms have, this thesis shows, been significantly inspired by the American experiences and “best practice” (Woodhead and Strobl, 2011). Donald Berwick, the founder of the IHI, for example, was actively involved in the crafting of NHS quality programmes, among other things, publishing a number of articles in prominent UK journals with titles such as “What can the UK learn from the USA about improving the quality and safety of healthcare?” (Tomson and Berwick, 2006) and “A primer on leading the improvement of systems” (Berwick, 1996).¹⁴ Beyond the conceptual or intellectual influence, this thesis also shows many situations in which British regulators, hospital administrators, and even doctors and nurses seeking to do something about quality, looked to their counterparts in the USA for guidance, tools, and support.¹⁵ These interactions between the different jurisdictions and their so-called “star” status (Kmietowicz, 2007, p.181) on the international stage makes them ideal locations to investigate the historical constitution of the contemporary promise of quality and then to begin to understand the practical consequences and social significance, while acknowledging that other jurisdictions may have yet to embrace the contemporary promise of quality to the extent seen here.

Theoretically, the choice of study sites presents the opportunity to witness the dynamic by which the standardization ambitions inherent in the contemporary promise of quality are driven, mediated, and transformed through their translation and operationalization into local programmes and realities. The contemporary promise of quality, as suggested above, is to an important degree an international standardization movement, concerned

¹³ This investigation was originally confined to the UK experiences with quality and quality improvement. However, research in the UK quickly illuminated an overwhelming number of historical and contemporary connections with the USA, making it clear to the researcher that no study of the promise of quality could be undertaken without a thorough inclusion of the US history and developments.

¹⁴ In 2005 Berwick was awarded an Honorary Knight Commander of the Most Excellent Order of the British Empire for his work and in 2013 he undertook a systematic review of NHS quality and safety for the government.

¹⁵ Many of the quality improvement leaders in UK hospitals that we follow in Chapter Three have been IHI Fellows, and one hospital even undertook weekly conference calls with its partner hospital in the USA as it operationalized its quality improvement interventions.

to elaborate one right way of thinking about quality and doing quality improvement, like many such programmatic ambitions with accounting at its core (Espeland and Stevens, 2008; Timmermans and Berg, 2003). However, as more micro-studies of the movement of standards have shown, the process of translating standards into local realities is always one of negotiation, unexpected permutation, overflows, and even innovation (see Mennicken, 2010; Czarniawska and Sevón, 2005; Lounsbury, 2008). As such, standardization programmes and the ideals that circulate at the international level are seen to be driven, in part, through the messy interactions, the conceptual overflows, and the complex negotiations that take place as they are operationalized across different and ever more localized locations. Because the two jurisdictions are different in terms of their healthcare systems, political and economic contexts, and other such well-documented variables (Pollitt and Boukaert, 2011), but also highly interactive and closely connected with the international standardization process itself, we are able to witness this process by which the contemporary promise of quality comes to be elaborated, modified, and changed at different national and international levels over time.

Research within each jurisdiction has also been carefully designed to capture this ongoing and recursive process of the elaboration of the contemporary promise of quality. In addition to the reference points already noted, it has been designed in part with loose inspiration from Deleuze's (1988/2006) comments on Foucault's research method, in particular his remark that:

One must pursue the different series, travel along the different levels, and cross all thresholds; instead of simply displaying phenomena or statements in their vertical or horizontal dimensions, one must form a transversal or mobile diagonal line along which the archaeologist-archivist must move.¹⁶ (p.20)

In order to travel along such diagonal lines and to explore quality as a multiplicity, this research has attended to the temporal unfolding of quality's many discursive, conceptual and material manifestations across multiple levels in a small number of cases.¹⁷ Instead of investigating, for instance, multiple quality initiatives at only one

¹⁶ Deleuze, quoting Boulez, continues: Foucault "created a new dimension, which we might call a diagonal dimension, a sort of distribution of points, groups, or figure than no longer act simply as an abstract framework but actually exist in space" (1988/2006, p.20).

¹⁷ While this thesis takes loose inspiration from Foucault's work, it does not engage in debate about the difference between Foucault's 'early' and 'late' or later writings.

level or location, this research draws upon a small number of cases and looks at the way they interact dynamically with other levels and location over time. For instance, it investigates the ways in which quality activities in a small number of hospitals are related both to the national discourse and demands, as well as the interpretive efforts of the individual hospital staff. This design allows us to witness the dynamic multi-level interaction between changing international and national discourses around quality, national and organizational reforms undertaken on the basis of the promise of quality, the various ways in which these reforms are made sense of and experienced by organizations and professionals, and also the way that the “overflows” (Callon, 1998, p.244-270) created at these levels contribute to the creation of yet new discursive formations and reform dreams and schemes.

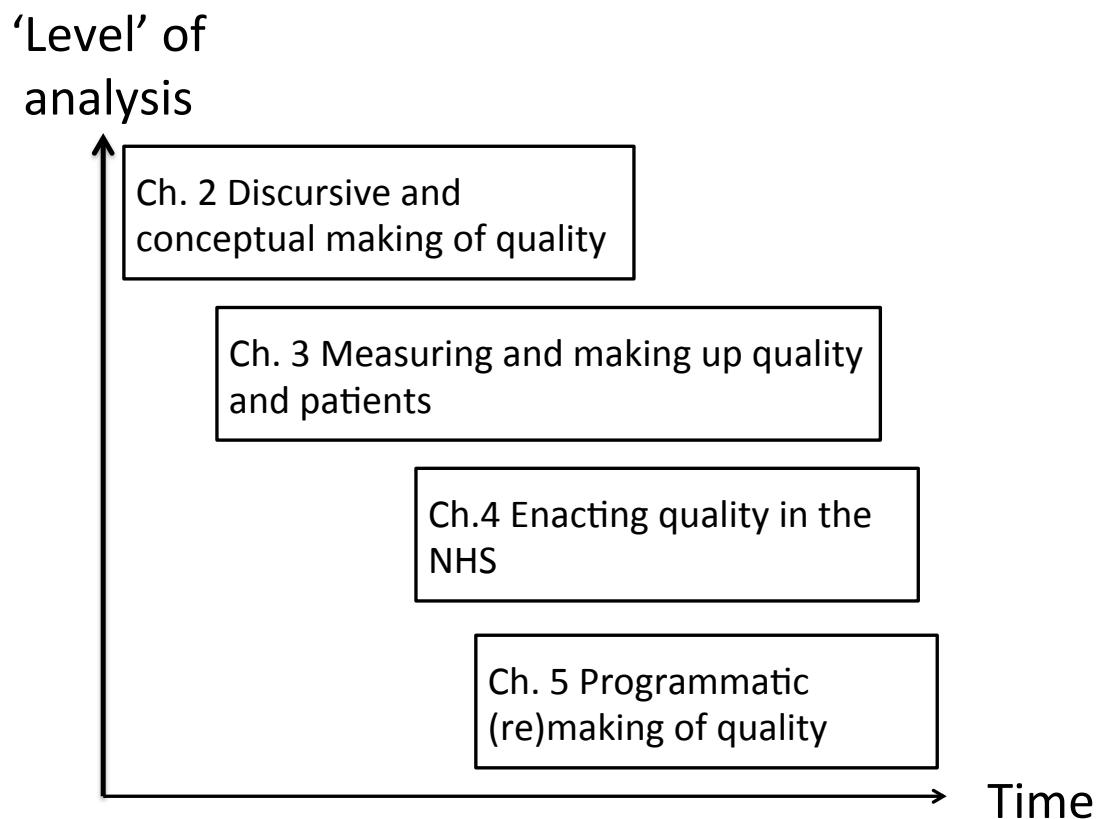


Figure 1.3: Multi-level research design

The product of such a design is to paint a multi-level and continually unfolding picture of the contemporary promise of quality. Indeed, each chapter of this thesis, represented schematically in Figure 1.3, intersects to form a diagonal line between the unfolding of time and the experiences with the quality promise at different but intertwining and

recursively interacting levels or locations.¹⁸ By aligning the investigation in such a way, this research is able to investigate quality not as some permanently stable or derived thing but as a continually emergent phenomenon (Pickering, 1995) constructed through the messy and unpredictable interaction of multiple technological, personal, and even aspirational or ideational elements and desires, unfolding in different locations throughout time (Callon, 1991; Latour, 1988; Miller and Rose, 1990). As we will see, it is through the investigation of these multi-level interactions, which this research is designed explicitly to access and address, that the contemporary promise of quality can be seen to derive its distinctive form and function, and its distinctive and potentially significant consequences and effects.

1.3 Making up quality: methodological considerations

Quality...you know what it is, yet you don't know what it is. But that's self-contradictory. But some things *are* better than others. That is, they have more quality. But when you try to say what quality is, apart from the things that have it, it all goes *poof!* There's nothing to talk about. But if you can't say what Quality is, how do you know what it is, or how do you know that it even exists? If no one knows what it is, then for all practical purposes it doesn't exist at all. But for all practical purposes it really *does* exist...What the hell is Quality? What *is* it? (p.187)

- Robert Pirsig (1974) *Zen and the Art of Motorcycle Maintenance*

As this quote from Pirsig suggests, quality is a potentially elusive object of study. It is at once proclaimed to be the “key to a customer’s heart” (e.g. Bernoff and Parrish, 2013, n.p.) and simultaneously “the latest in a long line of management fads” (Wilkinson and Willmott, 1995, p.2), to be “an amalgam of relatively unremarkable ideas” (Grint, 1994 in DeCock and Hipkin, 2003, p.670) and also a “radical answer” to core organizational problems (DeCock and Hipkin, 2003, p.662), to have “subjugating and totalitarian implications” (Willmott, 1993, p.515), while being advocated as the essence of the artisans’ craft (Sennett, 2009, Ch. 9). Not surprisingly, therefore, it occupies a fragmented academic space in healthcare and other fields. In this space, there is a huge quantity of literature but surprisingly little by way of discussion or analyses that “address its actual meaning or reflect upon its practical implementation or social

¹⁸ This explicit use of the idea of “levels or locations” is not intended to suggest that they are mutually exclusive or empirically separate. Rather, these distinctions (which are almost always implicitly and often un-problematically made) are explicitly noted and attended to in the research design so that we can more closely investigate and appreciate their dynamic and ongoing interactions.

significance" (Wilkinson and Willmott, 1994, p.1).¹⁹ In the face of this relatively polarized field, a specific methodological approach to the study of quality is advanced.

The first methodological proposition of this research is that *quality is made up* and that to understand what quality is and what quality does, we must enquire into the terms and processes of its making. What being "made up" means in this research is quite specific. It does not denote its colloquial meaning, as being conjured out of thin air or imagination (like a child's made up friend). Nor does it suggest that it is something pre-existing whose features and properties are simply given a new significance (like a make-up artist might prepare an actor). Nor, even, does it suggest that quality is merely constructed materially (like a pennant chiseled out of a piece of wood). This research suggests instead that quality (like the friend, the character, and the pennant) is made up and made into a more or less concrete reality through a continually emergent and ongoing process of the interaction, mutual construction, and stabilization of all three of these processes. Rather than seeing these senses of 'making up' to be unrelated and distinct, they are conceptualized here as constitutive pieces of the more significant process in which they are all continually adjusting to fit together in order to construct a mutual stability and reality.

Making up quality, to state it another way, is argued to be a process of ongoing and mutual co-construction of three things. Firstly, it is made up by a set of ideals about quality: the purposes it might serve, the forms that it might take, the terms that it might be improved upon, etc. Secondly, it is made up by a set of properties or characteristics that can be more or less agreed to have something (ideally everything) to do with quality. These properties are not merely imagined but provoked, and they maintain some connection to the realities and things of the past (Miller and Rose, 1997). Thirdly, it is made up by a set of material and conceptual arrangements that stabilize these characteristics, relate them to the ideas and ideals, and constitute them not just theoretically but into reality as qualities themselves—as things that can be seen, worked

¹⁹ Wilkinson and Willmott (1994) explain: "leading advocates of quality management are disinclined to refer to previous management literature—or, indeed, to reference anything outside of the quality management field. Critical of such failings, management academics who are not themselves busy promoting 'the quality revolution' (Oakland, 1989, x) have been inclined to be contemptuous of its triviality [...]" (p.2). Callon similarly notes that in the area of economic sociology, the "repeated and multiple uses [of the notion of quality] in very diverse approaches and investigations show that it is still a under-conceptualised and fragile notion" (Callon, 2005, p.S94).

with, and acted upon (Miller and Rose, 1997; Callon and Law, 2005). None of these things alone, this research argues, make quality what it is, but are instead pieces that, through their relation, interaction, and stabilization, give quality a particular and distinctive reality. This means that making up quality, despite its rather flippant colloquial connotation is a significant “achievement”; it takes place at multiple and overlapping locations and involves the stabilization and careful calibration of all sorts of parts, be they ideational, conceptual, material, or even personal (Çalışkan and Callon, 2009, p.370). This also means that making up quality is a process of exclusion as much as creation: it is an achievement of creating connections, stabilities and even singularities, and this is at least in part through the severing of alternative connections and making alternatives uncertain and unstable (see Callon and Muniesa, 2005; Callon, 1986; Karpik, 2010).

Two distinct yet overlapping strands of research inspire this conceptualization of quality. It takes inspiration, firstly, from Ian Hacking’s work on “making up people” (1986). Concerned with the effects of naming and classification, Hacking suggests that in certain cases—cases like homosexuality, multiple personality, and hand gloves, but not planets²⁰—the terms we use to describe things co-emerge with the things themselves. In these cases, he suggests, the seeming correlation between the objects and the names cannot be explained on the basis of naming alone (nominalism), nor the existence of the objects (realism), but on the basis of a historically-specific process of mutual fitting: a process of names and things “emerging hand in hand, each egging the other on” (p.165). Hacking’s conception of construction, which he calls “dynamic nominalism”, suggests quite simply that if things fit reasonably well with their names, this is because we have made each to fit the other (Hacking, 1991).²¹ Applied to the case of quality, his work suggests that quality is what it is at any point and time neither because we have found out more about its true essence nor because we have simply agreed to describe it in a particular way, but because we have made quality as a thing (a

²⁰ The distinction Hacking makes is between the objects and things that can respond to, and recursively interact with, the ways they are categorized and made knowable, and those things (like planets) that exist independently of our understanding and categorizations of them.

²¹ “The claim of dynamic nominalism”, he explains, “is not that there was a kind of person who came increasingly to be recognized by bureaucrats or by students of human nature but rather that a kind of person came into being at the same time as the kind itself was being invented. In some cases, that is, our classifications and our classes conspire to emerge hand in hand, each egging the other on” (Hacking, 1986, p.165).

set of properties, for example) and quality as a name synonymous at a particular place and time. The mutual-construction of names and ideas and the realities of things is core to the notion of making up quality advanced here.

This perspective also takes inspiration from a body of literature that focuses more specifically on the mechanisms, processes, and materials which are put in place to establish, contain, and constrain the mutual construction that Hacking describes. Advanced most recently in the areas of the social studies of finance and economics, a number of studies investigating the constitution and reconstitution of economic goods (Callon and Muniesa, 2005; Callon et al, 2002²²), singularized items (Karpik, 2010), pricing systems (MacKenzie and Millo, 2003), markets (Callon, 1998), and even utility-maximizing individuals (Callon, 1998; see also Thrift, 2000) illuminate complex and distributed processes by which people and things are literally built into reality ever more (or less) concretely. They illuminate the constitution of such economic things to be inseparable from their naming and the ideas and ideals that such naming entails, but more specifically they illuminate the meticulous and often material crafting of such things into a specific and more or less stable reality or singularity. Highlighting the work of multiple and overlapping experts and intermediaries and all of the material devices they employ (Miller and Rose, 1997; Slater, 2002), they describe processes of “equipping” and “habilitation” (Callon 2006, p.45; Callon, 2008, p.33) to be central to the construction and mutual stabilization of the people and things and their names.²³ As such, they highlight important variables in the making up of quality. They show that calling something quality isn’t enough to make it respond; more than that, and drawing on the notion of performativity, they show that what something is called needs to be carefully and more-or-less exclusively crafted and constructed in such a way that it corresponds with its name (Cochoy et al, 2010).²⁴ This is done in large part through material movements and actions of many diverse and seemingly intermediary agents that connect ideas and things. This material making or joining-up of theories or names

²² Provocatively they describe an “economy of qualities” that underlies and constitutes economic action (Callon et al, 2002; see also Musselin and Paradeise, 2005).

²³ This line of analysis led to Callon’s famous statement that “yes *homo economicus* does exist, but is not an a-historical reality: he does not describe the hidden nature of the human being. He is the result of a process of configuration [...]” (1998, p.22).

²⁴ These studies helpfully highlight the marginality and tenuousness of making things up, showing that assemblages only persist to the extent that the equipment and arrangements that hold them together withstand the overflows that they generate and shocks that emerge (Butler, 2010).

and people and things is thus also central to the idea of making up quality advanced here.

Methodologically, this concept of making up quality entails a shift in focus and enquiry from what quality *really* is to how it is, at any place and point in time, made thinkable in a particular way, enacted in a particular form, and constituted as a specific feature of social, organizational, and professional life. Much like Çalışkan and Callon's (2009, 2010) call for studies of the economy to move from questions of the economy as such to questions about the processes of "economizing"—by which they mean "the processes that constitute the behaviours, organizations, institutions and, more generally, the objects in a particular society which are tentatively and often controversially qualified as 'economic'" (2009, p.370)—this research suggests the need to locate questions of quality in similar ongoing processes of *qualitizing*.

This means conceptualizing quality not as a pre-existing thing, but as historically-constituted *assemblages* of ideals and ideals, mechanisms and things, and persons and subjectivities, that are arranged in a particular way to specify, enact, construct, or more generally qualitize quality in particular ways.²⁵ "Assemblage" here denotes not just elements that have been made to overlap and interact with each other, but also the endogenous and recursive mutual-adjustments taking place among the elements to establish the unique arrangements that are achieved. As Callon explains, drawing from Deleuze and Guattari (1998), these are "arrangements endowed with the capacity of acting in different ways depending on their configuration" (2006, p.13)—arrangements of elements, in other words, in which there is no divide between elements that arrange and assemble, and those that are arranged. These are elements of various forms which each has a capacity to interact with and act upon the other.

This first proposition, that quality is made up, however, only gets us so far. While it has moved the debate and points of enquiry regarding quality from questions of what quality is to those of the processes of qualitization, it has not helped us to conceptualize and investigate how qualitization is done. To do this, a second methodological

²⁵ While much research drawing upon the notion of assemblages focus almost exclusively on the material arrangements or "microstructures" (Callon et al, 2002), this research does not privilege these material and technological forms over the less-tangible ideas, mentalities, and ideologies (see Latour, 1987).

proposition is advanced: that there is no contemporary assemblage of quality without accounting, and as such, to study the contemporary promise of quality and its qualification it is necessary to study *accounting for quality*.

This proposition is advanced in part for empirical reasons. This research shows that the emergence of the contemporary promise of quality goes hand in hand with it being made into an accounting concern. It shows, to state it differently, that the forging of a connection between the activities and ideals of accounting, and ideas about what quality is and how it can be improved, are central movements in the contemporary processes of qualitization. As such, we cannot begin to understand the qualitization of quality without enquiring into the processes and configurations through which means of accounting for it were rendered and made stable.

This proposition is also advanced due to our evolving understanding of how accounting and its expertise are transformed at its margins (Miller, 1998). A significant body of literature has come to investigate and illuminate accounting as far more than neutral tools and expertise that arise to meet functional demands. Instead, authors such as Chapman et al (2009) conceptualize accounting broadly as “[...] all of those spatially and historically varying calculative practices—ranging from budgeting to fair value accounting—that allow accountants and others to describe and act on entities, processes, and persons” (p.1; see also Desrosières, 2002). In doing so, they have articulated and demonstrated accounting to be a set of changing practices and ideals that are fundamentally intertwined with, and even constitutive of, both the aspirations toward which they are attached and the very domains in which they are elaborated and applied (Power, 1996; Hopwood, 1984). They have illuminated a “dualistic character” of accounting (Burchell et al, 1985, p.385) in which it is always implicated in on-going processes of becoming, to use Hopwood’s (1983, p.289) terms, “what it was not”, while simultaneously operating to produce new organizational forms, new programmes of government, new shop floors, new subjectivities, and much else (Hopwood, 1987; Chapman, et al, 2009, p.10). This body of work thus shows changing accounting practices to constitute one of the very processes by which ideas and things are made the same, ideals and people are connected, and more generally, assemblages are formed (c.f. Espeland and Stevens, 1998; Fourcade, 2011).

This conception of accounting thus extends and helps to clarify the process of making up quality: to analyze accounting for quality, and to understand historically and in practice how quality has been made into an accounting concern, tells us not only about how accounting has altered but also how quality has been qualitized in its unique way. Such studies of accounting and calculation also provide us with a number of heuristics and concepts for understanding and studying the emergence and operation of assemblages.

Firstly, a number of studies in the field referred to as “new accounting history” (Miller, Hopper and Laughlin, 1991; Hopwood, 1987; Burchell et al, 1985; Robson, 1991; Hoskin and Macve, 1986) have highlighted particular ways in which we might conceptualize and study “the processes through which accounting achieves a connectivity with its environment” and helps to constitute a particular assemblage (Robson, 1991, p.551). They highlight that we must look for the “outcome of the past, rather than the origins of the present” and that we must “emphasize the re-directions, transformations and reversals that time instantiates”, rather than investigating the forming of accounts as “as an unbroken continuity” (Miller and Napier 1993, p.632). In order to do this, these “genealogical” studies have attended closely to the multiple and overlapping discourses that attribute accounting its different meanings throughout time, the “problematizations” that have variously constructed accounting as having some function or functionality, and to the “translations” that are involved in connecting ideas and ideals and the mundane techniques and classifications of accounting (Chapman et al, 2009). This work has emphasized elaborate, complex, and historically-contingent processes of fitting, whereby accounting and its assemblage become what they were not through a complex alignment or mutual-stabilization of heterogeneous elements distinct to a time and place.

Secondly, a number of studies of accounting and calculation have conceptualized and demonstrated specific routes or mechanisms through which accounting comes to be allocated its productive or constitutive potential. Many studies highlight that accounting is “profoundly institutional” in the sense that the seemingly neutral instruments of calculation “presuppose and recursively construct the spaces that actors inhabit within organizations and society” (Miller and Power, 2013, p.559; Carruthers and Espeland, 1991). Through its seemingly neutral association, accounting is shown to occupy an

intermediating function, connecting ideas and ideals with ways of thinking and possibilities for acting, thus helping to make up the contemporary world (Miller and O’Leary, 2007). Crudely categorized “governmentality studies” in accounting have elaborated on this point (Rose and Miller, 1992; Foucault in Burchell, Gordon and Miller, 1991). Highlighting accounting’s relationship to objectivity and neutrality, they have shown accounting to be fundamentally interwoven with programmatic aspirations and subjectivization. They have shown accounting to be an important mechanism of government, and as such a primary way through which people can think about and act upon each other—even while presupposing their freedom to choose. Summarizing this work, Mennicken and Miller (2012) state:

By linking decisions to the supposedly impersonal logic of quantification rather than to subjective judgement, accounting numbers configure persons, domains, and actions as objective and comparable. This, in turn, renders them governable. For the objects and subjects of economic calculation, once standardized through accounting, are accorded a very particular form of visibility. (p.7)

Through its programmatic elaboration and extension, accounting is thus shown to be highly productive, even if it often produces actions, reactions, and activities that are far from those envisioned (see Miller and Rose, 2008, p.17).

By examining this constitutive aspect of accounting we are able to explore not just the technical changes of the accounting craft, but the changing social realities of which they are a part. This allows us to better understand the full significance and effects of a quality made calculable. While it has been noted that the notion of quality comes to impact upon “what it means to be a good doctor, patient, manager, and even healthcare system” (Zuiderent-Jerak and Berg, 2010, p.32), these approaches allow us to specify the mechanisms through which the abstract notion of quality comes to take this normative and highly personal form. They highlight that calculations and accounts of quality are not merely derived from quality but in part constitutive of its specific dimensions and terms. Quality, like the characteristics of an economic good, can thus be seen not as “properties which exist and on which information simply has to be produced so that everyone can be aware of them”, but realities that have to be defined, or objectified, through heavy investments in equipment, such as accounting (Callon et al, 2002, p.198).

Bringing together this literature on accounting and calculation with that on “making up” people and things (Hacking, 1986) provides a distinctive approach to the study of quality and its calculation. Framing the investigation in this way leads to an investigation, throughout this thesis, of the changing configuration of the *calculative assemblages* in which quality, accounting, and any other number of associated elements are made up throughout time and place.²⁶ This entails investigating processes of qualitization; the processes through which a variety of (human and non-human) agencies and agents come to claim a “legitimate knowledge” of quality and its calculation and to the “interests of those entities, how these interests came to be formed, out of what materials and to what effects” (Miller, Hopwood and Laughlin, 1991, p.396). It also entails investigating the constitutive relationship between these diverse elements and the verdicts that are produced, the accounts that are rendered, or the judgments that are leveled. Following Callon and his colleagues (Callon and Muniesa, 2005; Callon and Law, 2005; Callon et al, 2002), who use the term “qualculation”, rather than the notions of calculation and qualitization as used here, this idea of a calculative assemblage draws attention to the mutually-constitutive processes by which assemblages and the new things that they take part in producing are held together, and in so doing more or less successfully deny other connections and renderings.

This specific approach, as we will see in the chapters that follow, allows us to sidestep some of the competing and polarized claims about quality that were noted at the introduction to this section, and to begin to take stock of quality’s “practical implementation or social significance” (Wilkinson and Willmott, 1995, p.1). It allows us to avoid the common and polarized views of quality as either attributed to the heroic work of “quality gurus” (eg. Rodkey and Itani, 2009, p.S3), as merely socially constructed (e.g. Nordgren, 2004), or an automatic functional response to demand (e.g. Ruiz, 2004, p.323-4).²⁷ Without dismissing any of these perspectives entirely, investigating quality as something that is made up allows us to highlight that quality requires far more than changing times, social construction, or clever gurus. It instead draws our attention to the historical processes, which are both social and material,

²⁶ “Calculative” is used here instead of accounting in order to highlight that accounts of quality can take many forms, be they closer to judgement or formal and standardized accounting, yet serve a similarly constitutive role in the formation and stabilization of assemblages (c.f. Callon and Law, 2005).

²⁷ These dualistic perspectives mirror the subject-object divide highlighted by Pirsig (1987, p.285).

which relate quality to a particular time, constitute people as gurus, and take part in constructing their pronouncements into the world that they envisioned.

This approach also provides us with a new set of terms through which to investigate and better understand the ways in which notions of quality and ways of accounting for it move between time and place. Instead of assuming that notions of quality are sustained because they are either the most effective in meeting some set of external demands (e.g. Ruiz, 2004; see Chapter Two), or the closest representations of quality's underlying reality (e.g. Epstein, 1995; see Chapter Three), the approach adopted here encourages us to attend to the specific material and discursive movements that invent and transport ideas about quality, and construct them as more or less stable and permeable.²⁸ This illuminates a specificity and historicity that existing approaches to the study of quality tend to ignore: it shows the forging of relations between external demands and solutions of quality and calculation to be historically distinct and contingent, and it shows the relationships between representations and realities to be constructed in historically and geographically-specific terms.

Finally, this approach allows us to investigate the consequences and effects of the contemporary promise of quality in illuminating ways. It means we can extend our analysis beyond the “implementation studies” paradigm (Barrett, 2004) that makes up a majority of the quality improvement literature. Such studies take the historically dominant conception of quality and models of quality improvement for granted, and investigate the extent to which sectors, organizations and individuals fail or succeed in operationalizing these models (eg. Shortell et al, 1998; Bummental and Kilo, 1995; Øvretveit and Gustafson, 2002). As such, they portray the significance of quality as simply one of success or failure of individuals or organizations to achieve these historically constituted goals (see Zuiderent-Jerak, 2007). The approach adopted here, by contrast, focuses attention on the constitution of these goals themselves and the far-reaching and consequential movements entailed in establishing these goals as taken-for-granted realities regarding what high quality care requires (c.f. Power, 1996), thereby weaving a middle line between polarized perspectives on what quality does.

²⁸ Mansfield (2003a, b) is one of the few researchers that has adopted such an approach to understand the movement of notions of quality.

These broad strands in accounting and social science research motivate and are operationalized throughout the chapters that follow. However, none of these themes are applied or operationalized unproblematically. Rather, they interact with the empirical data that inform each of the chapters in order to build explanations of changes that have been made visible and also critique and inform the theories and approaches themselves (see Chapter Six). Although no data is ever independent of the theories and methods that provoke it, the aim throughout this research has been to gather, in as open-minded and theoretically agnostic manner possible, rich sets of data from the field and archives, and then to discover inductively the sorts of theories and concepts that aid a more general understanding of the processes which are studied. The success of these methodological and theoretical concepts and approaches can only be demonstrated in relation to the empirical substance of the chapters that follow.

1.4 Outline of the thesis

Each chapter in this thesis addresses the research ambitions advanced in Section 1.0 above. Together, they aim to describe and help us better understand the emergence of the contemporary promise of quality, how it has been made part of social, professional and organizational life, and what consequences and effects this might have. A brief description of each is provided below.

Chapter Two, *Making Quality Calculable*, investigates the mainstream discourse surrounding quality, its regulation, measurement, management, and handling more generally in the USA and UK from 1945 to 2010. By systematically collecting and analyzing the most cited papers in the top-impact health journals in each jurisdiction with “quality” in their title or abstract, alongside historical accounts, this chapter documents the emergence in both jurisdictions, since 1985, of a distinctive notion of quality in healthcare constitutive of the four characteristics highlighted above—as an accounting concern, patient centered, bottom-up and experimental. In tracing this development, this chapter illustrates the processes and foundations upon which quality and accounting move between time and place. It shows that quality is driven between time and place not by some timeless and progressive logic, but by the contingent constitution of a mutual stability formed between unique intersections of ideas, people and things. This highlights the need for a critical and reflexive investigation and

treatment of quality in order to develop improvement ideas and ideals about quality that come closer to the ambitions that are espoused.

Chapter Three, *Knowing Patients, Doing Quality Improvement*, investigates one aspect of the process of making quality calculable in more detail. It investigates the process by which the patient's perspective on quality became something that could be defined, accurately measured, and used to understand the performance of provider organizations and their staff. To follow this process, the genealogical roots of the nationally-standardized CAHPS (Consumer Assessment of Health Providers and Systems) patient experience survey tools in the USA are followed back to their post-war roots using bibliometric techniques, loosely conceived (c.f. Latour and Woolgar, 1979). Following the changing form and function of the surveys throughout time illuminates a complex, contingent, and recursive interaction between measures and ideas about quality. They are shown to interact with a diversity of other elements to produce a specific type of survey that asks about discreet "experiences" with care in order to capture the patient's view and measure the quality provided by healthcare organizations. This particular rendering of quality and calculation is shown to go hand in hand with the emergence of Chief Experience Officerships in US healthcare organizations and their particular design-based expertise and interventions.

Chapter Four, *Remaking in the Name of Quality*, investigates some of the ways in which the historically-constituted characteristics of quality illuminated in Chapters Two and Three, come to be given programmatic expressions and practical forms and effects. It does this by following the UK's most recent programmatic articulation of the promise of quality in the 2009 *Darzi Review* as it is made sense of and operationalized throughout the NHS. It draws from a series of interviews and observations undertaken with regulators, commissioners, healthcare provider executives, managers, doctors and nurses between January 2010 and July 2013 as they interpreted, responded to, and reinterpreted the quality reforms and other preoccupations in the healthcare sector in order to illuminate distinctive consequences and effects. These multiple and overlapping enactments of quality are shown to take part in the reconfiguration of organizational and professional identities and conceptions of performance and care. These movements entail the production of more representational or balance-sheet activities around quality, and the production of a particular way of being a high-impact and quality-focused

medical professional, summarized as homo-Ara Darzicus. These movements simultaneously, however, are also shown to provoke alternative conceptions of what quality and quality improvement might be, and to generate questions about, and resistance to, this new world of quality.

Chapter Five, *Quality Improvement for All Seasons*, seeks to better understand the extent to which, and the dynamic through which, the contemporary promise becomes a more general model and aspiration for government-led reform. It does this by analyzing in detail the official language, motivations, and associations of the healthcare reforms in the UK from the emergence of programmatic articulations of quality in 1985 until the most recent reforms in 2012. It highlights a trajectory by which the existing doctrines of reform known as New Public Management (NPM) promise, problematize, and then prove unable to address quality, and the way in which, in this situation, the characteristics of the contemporary promise of quality come to provide a foundation for conceptualizing and undertaking reforms. It illuminates the way in which the characteristics of the contemporary promise of quality provide, in this situation, a politically attractive means of responding to the continued failure. This suggests that the contemporary promise of quality might persist and offer a set of improvement doctrines *for all seasons*, much like those offered by NPM previously (c.f. Hood, 1991).

Chapter Six, *Making Up the Contemporary Promise of Quality*, reflects on the ways in which the distinct approach to the study of quality and its calculation pursued here (outlined in Section 1.3 above) has allowed us to illuminate significant aspects and dynamics of quality and its calculation. It also reflects on some of the challenges and limitations of the approach that emerged throughout the course of the study. It shows the benefits and challenges to be interrelated and to revolve around key tensions, namely the ambition: to forego assumptions of stable units interacting with each other, while at the same time aiming to document something particular and distinctive about the world; to move beyond functional explanations of change, while at the same time aiming to explain specifically how one thing acts upon the other; and to illuminate the existence of multiple paths and possibilities, without reducing such multiplicities to a matter simply of historical contingency. This thesis, it is hoped, contributes not just to the illumination, but also to the partial resolution of such tensions.

Chapter 2

Making Quality Calculable: A history of the concept of quality in healthcare in the UK and the USA, 1945 to 2010

2.0 Introduction

On 11 January 1988 Avedis Donabedian delivered a lecture to the American Medical Association (AMA) in which he reflected on the changing definition of quality in healthcare that he had helped to bring about. Following his title, “The quality of care: How can it be assessed?” he remarked:

There was a time not long ago where this question could not have been asked. The quality of care was considered something of a mystery; real, capable of being perceived, but not subject to measurement. The very attempts to define and measure quality seemed, then, to denature or belittle it. Now, we may have moved too far in the opposite direction. Those who have not experienced the intricacies of clinical practice demand measures that are easy, precise, and complete—as if a sack of potatoes was being weighed. (Donabedian, 1988, p.1743)

Indeed, in America in 1988, the concept of quality in healthcare was in the midst of a historically remarkable transformation, moving in directions that even the “founder and father of modern quality improvement” (Mainz and Bartels, 2006, p.79) did not fully anticipate (see Donabedian, 2000 in Herteloh, 2003, p.259).

Quality was being reconstituted along historically unique and consequential lines. Quality was becoming an *accounting concern*. From something that was once seen to eschew formal definition and precise measurement, and yet seen to be assured by an implicit professional guarantee, quality was being re-described as problematic and understandable in terms primarily of measures themselves. It was also becoming something that extended far beyond its traditional bio-medical boundaries to include, at least in part, *the patient's perspective*. From something once confined to the rituals of the medical profession, the management of quality was coming to require new and specific things: as something that was everybody's business but difficult to achieve, it was being articulated as something requiring *bottom-up* processes of change in which everyone is empowered and equipped to undertake their own *experiments* of how quality improvements are achieved. It was this specific repackaging of quality that could and

would be extended and reaffirmed as the foundation of the *contemporary promise of quality* that was outlined in Chapter One.

This chapter seeks to document quality's contemporary making—to unpack the way in which the notion of quality moved and became intertwined with these specific preoccupations and ideals, and to begin to chart the social significance of such changes. This investigation focuses not just on the technologies, regulations, or the operations that materially constitute quality, nor simply the rhetoric about what quality might or might not be, but on the *concept of quality* more generally, or the discourses of quality and the material movements with which they are intertwined, which draw from and intersect between various forms and locations.

In order to conceptualize and follow the changing concept of quality, and the multiple movements and manifestations of which it is constituted, this research draws upon the notion of a *calculative assemblage* that was briefly described in the preceding chapter. An assemblage, derived variously from the work of Deleuze and Parnet (1977/2007), and later Latour (1988), Callon (2006), and Miller (2011), denotes in the simplest sense a grouping of elements—conceptual, material, or whatever they may be—which overlap and intertwine in such a way as to produce a momentary stability, consistency, or coherence among and between elements at a particular place and time. A calculative assemblage is an assemblage that is constituted by, and constitutive of, arrangements of elements that render calculations—be they closer to formal accounting or judgment—of the thing of which it is part and product. Quality, conceptualized in this way, is treated as what Latour (1991), citing Serres (1987), calls a “quasi-object”: “An object of variable geometry” that enters into a relationship with “a group of variable geometry” to negotiate and translate the identities of the actors involved (p.116).

Consistent with the methodological starting points for this thesis outlined in the preceding chapter, this approach makes no claim to the nature of quality itself. Rather, it suggests that one can investigate and follow the form and function of quality through a sort of historical morphology. By attending to the changing elements that take part in assembling quality and its calculations over time—the forming of interrelationships between the various ideas and debates, aspirations and schemes that are articulated and the technologies, calculations, regulations, and accounts—this chapter investigates

movements in the concept of quality, as such relationships form into more or less stable and constitutive wholes.²⁹

Calculative assemblages, as used here, share three important characteristics that facilitate historical analysis of the concept of quality. First, the notion accommodates and emphasizes transformation. In the forming of assemblages, authors such as Callon (2006, 1986) emphasize that no element is ever stable or alone; rather, the unity that defines an assemblage is always paid for by the mutual-enrollment of each element in a number of distinct hopes and dreams. As such, the costs of membership, so to speak, in any assemblage are that the elements are always in part changed. Moreover, the assemblage as a whole is fragile, never permanent, and always taking part in, to use Deleuze and Parnet's terms, "an immanently revolutionary process" (1977/2007, p.71). Employing the notion of assemblage thus allows us to speak not of a singular 'quality' or even 'patient' or 'the medical profession' as if they were the same entities throughout time. Rather, each element of the assemblage as well as 'quality' itself can be seen to become part of new worlds and in the process to transform who they are and what they mean (see Callon, 2006, p.14).

Second, this notion or unit of a calculative assemblage draws our attention to the material and conceptual assembling that must take place in order to produce the momentary stability or consistency that makes the assemblage a whole. Indeed, as authors such as Miller (2011) highlight, assemblages and their constituent parts do not arise from and cohere as a result of some existing logic or superstructure, but because they have been made to fit each other (c.f. Hacking, 1986). Assemblages never pre-exist the elements that map them out and bring them together, and as such, the notion requires that we attend to and account for the various hard work and crafting which is undertaken in order to enrol allies, forge ties, solidify relationships, and ultimately produce a stable but fragile unity (see Callon, 1986). In much the same way that genealogical studies of accounting highlight the need to attend to the conditions of possibility of the emergence of accounting change (Miller and Napier, 1993), the notion of an assemblage highlights the need to attend to the long processes of configuration;

²⁹ This approach is very similar to Latour's investigation of the European hotel key, wherein he follows the addition and substitution of ever more elements that are required to stabilize the key as something that must be left in the hotel reception upon leaving the building (Latour, 1991).

the “redirections, transformations, and reversals” that constitute the “outcome of the past, rather than [...] the origins of the present” (ibid, p.632).

Thirdly, the notion of assemblage is particularly well-suited to an exploration of the dynamic relationships between the rhetorical, ideological, conceptual, even fanciful on the one hand, and the material, technological, and technical on the other. Indeed, assemblages never place any element or elemental form a priori to or derivative of any other (Latour, 1991, p.108). As Deleuze and Parnet explain:

The collective machine assemblage is a material production of desire as well as an expressive cause of utterance: a semiotic articulation of chains of expressions [...] Not representing a subject—for there is no subject of enunciation, but, on the contrary, preventing them from toppling under the tyranny of supposedly significant combinations. (1977/2007, p.59)

They suggest, in other words, that each element provides a sort of fragile context for the other, which then provides the foundation for yet a new context to emerge and act upon all the others (see also Pickering, 1993). As such, this approach allows us to consider the dynamic way in which the discursive and conceptual elements of quality are interwoven with, and inseparable from, the material and technical elements as well.

Taken as a whole, this approach offers a distinctive perspective on agency in the field of healthcare quality, and the relationship between quality and the accounts and calculations of quality that are rendered (c.f. Callon, 1987). This chapter eschews the common functionalist explanations of the movement of quality that argue that changing conceptions of quality are the immediate product of new social or macro demands. Such common explanations of change, argue, for example, that:

Traditionally the technical knowledge of medical and nursing professionals has been considered sufficient for assuring quality and safety for the health care provided to the citizen [...] However, today's health care centres are complex organisations where appropriate medical care requires administrative and managerial support to get the patient safely discharged. (Ruiz, 2004, p.323-4)

It also eschews the long line of what might be called heroic accounts of changing conceptions of quality, which suggest that such movements are the product of the breakthroughs and hard work undertaken by specific individuals. Such explanations for example state:

Three individuals receive credit for laying down the foundation for the evaluation and measurement of quality of care in modern surgery: Ernest Amory Codman, Avedis Donabedian, and Shukri Khuri [...] They shared

the traits of tremendous determination in the face of many challenges and adversities and a sense of enthusiasm in a belief that resulted in improved and safer care. (Rodkey and Itani, 2009, p.S3)

This chapter also highlights that we cannot account for movements in conceptions of quality between time and place on the basis simply of some combination of these terms, as more thorough histories of quality sometimes suggest (i.e. Chassin and O’Kane, 2011).

Instead, this chapter draws attention to wider assemblages of historically-specific and changing elements which bring together social or macro preoccupations, the hard work of the specific individuals commonly mentioned in the heroic accounts, and a variety of other elements so as render into existence and co-construct a notion of quality and a means of its calculation (c.f. Latour, 1988). In doing so, it shows that quality and its calculation neither derive from nor operate in isolation from the other, but in fact are part and product of the same set of diverse movements that constitute them into a particular and more or less stable way.

This chapter thus challenges teleological conceptions of quality that by describing movements in quality as matters of “conceptual advancement” (Maxwell, 1984, p.1470), “the gathering of appropriate data” (Loeb, 2004), “advancements in measurement science” (Epstein, 1995, p.57), or “evolution of medical audit” (Lembcke, 1967, p.7), suggest that quality always moves in a linear fashion toward its fullest and pre-determined expression. This chapter highlights instead a less linear, recursive, and even tautological movement. By illuminating quality’s historical contingency and the reversals, transformations, and co-constitution of this contingency, this chapter also critically questions the inherent goodness and progressive associations that are commonly related to quality (Pfeffer and Coote, 1991; Wilkinson and Willmott, 1994; Kirkpatrick and Martinez-Lucio, 1995). It highlights that if changing conceptions of quality are different from, but no more *true* or *accurate* than, its infinite alternatives, then we must highlight and critically question the distinctive things that are done in the name of quality as it is constituted in a particular way at a particular place and time—an ambition that is pursued throughout the chapters that follow.

In order to provide data for this wider analysis of quality in a consistent manner, the dominant and mainstream discourses as well as the regulations, calculations, and

legislation surrounding quality and healthcare throughout the UK and USA between 1945 and 2010 were collated and analyzed.³⁰ To do this, the most cited articles in the top impact health journals in the UK (the *British Medical Journal* (BMJ) and *The Lancet*) and USA (the *Journal of the American Medical Association* (JAMA) and the *New England Journal of Medicine* (NEJM)) with “quality” in their title or abstracts during every five-year period between 1945 and 2010 were collected. A more general Google scholar search was then undertaken using the similar terms (with “AND health OR healthcare” added), and highly cited and potentially relevant articles were added to the timelines. All of these articles were then added to NVivo software, where key themes, concepts and associations were coded as they were identified in the text. Where articles made references to other relevant people, events, or documents these were located or researched, added to the database, and coded. This snowballing process went on for three or four iterations. It allowed the researcher to identify and track themes in the material, and the matrix function was used extensively to better understand their jurisdictional and temporal significance. These historical materials were also considered alongside a more general review of the literature of quality and the history of healthcare and medicine.³¹

This data collection process aims to capture only the dominant and most over-arching assemblages that emerged throughout this period. It aims to capture, in other words, the assemblages that matter the most, that are invoked when reforming and rethinking healthcare systems, that lend support to certain activities and make others unthinkable, and that win out when other assemblages present themselves by suggesting some other course of action. This choice means that the different, seemingly idiosyncratic, and more localized assemblages which are forged are not given explicit treatment here. This research does not explicitly address the fact, for example, that alongside the assemblage described here as operating from 1945 to 1975, wherein only the physician was deemed

³⁰ This starting date was made largely for practical reasons. Histories of the period illustrate this to be one of consolidation and continuation of emerging trends rather than great upheavals (e.g. Starr, 1985). There is no indication, from preliminary investigations, that the analysis would change if the date selected were ten years different in either direction.

³¹ This decision to include both primary and secondary data was made on the basis that historical facts are never pure or free from historically constituted interpretation and re-interpretation. Drawing from Latour (1988), this approach posits that it is important to understand both how the world was envisioned and constituted at any one point in time, *and* the way that the past worlds were re-envisioned and re-constituted into the present. It suggests in other words, that we must “accept the lessons”, histories and re-conceptualizations, “that the actors themselves give us” (p.51).

capable of making judgments of quality, there were also some wealthy families and communities that conceptualized quality in a different way and built their own infrastructure for rendering judgments about quality themselves (e.g. through word of mouth) (Tomes, 2001). This choice does not deny the existence of such localized assemblages, but highlights that they had not gathered the strength necessary to take part in fundamental changes in the ways in which reforms are contemplated, the way that care is delivered, and other such activities that are important here.³²

From this analysis emerged three overlapping but largely discrete periods of time in which unique assemblages and specific notions of quality were stabilized, disrupted, and reconstituted along distinctive terms. They are addressed in the following sections. Section 2.1 demonstrates the emergence and stabilization in both jurisdictions between 1945 and 1975 of distinct but very similar assemblages and notions of quality. This is a notion of quality that cannot be fully articulated, defined or measured but that the appropriately selected and accredited physician can accurately perceive and assure. Section 2.2 then shows, between 1975 and 1985, these assemblages breaking down, various elements in the assemblage failing each other, and the emergence of a situation in which no stable rendering of quality could be produced. It is a period, to quote one commentator, in which the only indisputable point about quality is that “patients and physicians understand it differently” (Dorman, 1969, p.921-2). Section 2.3 then documents the emergence of an international assemblage and notion of quality and its calculation in both jurisdictions between 1985 and 2010. This is a distinctly contemporary notion of quality, which is calculable, understood in part from the perspective of the patient, and that needs to be managed and improved through specific improvement ideals.

Section 2.4 concludes by reflecting on these changes to highlight the way in which quality and its calculation move between place and time. It shows that the foundations of quality, as part and product of the assemblages in which it is constructed and

³² This data collection process might seem to privilege medical discourse. However, empirically, this research and others (Porter, 1996) suggest that dominant discourse of healthcare quality has been primarily constituted within medical domains. Moreover, as we will see, the category of the medical domain is one that changes to incorporate other such discourses as they gather strength necessary to become part of the dominant assemblage of quality. Indeed, as we will see, the worries and discourses of quality that are seemingly external to the medical establishment come, in many ways, to be internal throughout time (c.f. Callon and Rabeharisoa, 2008).

reconstructed throughout time, to be based on the emergence of self-referential terms rather than the common linear ones. Drawing on Callon and Law's (2005) investigation of the mutual construction of calculation and non-calculation, it also highlights the inseparable link between calculations of quality and the notions and possibilities of what quality is and how it can be expressed.

2.1 Quality in healthcare, 1945 - 1975

Between 1945 and 1975, ideas about quality and its calculations emerged and were undertaken in the USA and the UK in similar but nonetheless distinctive ways. While the assemblages took different forms in the two jurisdictions, drawing upon local preoccupations and ideas to form their unique stability underlying these differences were common genealogical roots that reached in many cases back into the late 1800s. These discourses or logics that were prominent in both jurisdictions, and the West more generally, contributed powerfully to the framing of debates about healthcare and the concept of its quality and its calculation.

These roots consisted of three mutually supportive discourses surrounding the medical profession, the role of science, and the craft of medical care. This section briefly illustrates the way in which these intertwined to “generate a powerful momentum largely independent of its efficacy as a rational social approach to good health” (Porter, 1996, p.199) which, through its enrollment of more and more elements, would become central to the terms of the assemblages which existed in each jurisdiction between 1945 and 1975. In the section that follows, these historical movements and their connections are briefly outlined, then the way that these interact with the local conditions in each jurisdiction to help render specific assemblages and notions of quality is investigated in greater detail.

2.1.1 An emerging assemblage: The medical profession, science, and craft

Roy Porter's (1999) history of “medicine and mentalities” illustrates the way in which science, medicine and its craft grew up together in the West (p.1). His global perspective highlights a “radically distinctive trajectory” to understanding health and illness that was undertaken (Porter, 1999, p.7). Porter writes:

To reduce complex matters to crass terms, most people and cultures the world over, throughout history, have construed life (birth, death, sickness and health) primarily in the context of an understanding of the relations of human beings to the wider cosmos [...] Modern western thinking, however, has become indifferent to all such elements [...] the western medical tradition explains sickness principally in terms of the body itself—its own cosmos [...] everything that needed to be known could essentially be discovered by probing more deeply and ever more minutely into the flesh, its systems, tissues, [and later] cells, its DNA. (ibid, p.7)

This specific trajectory, which isolated illness to the confines of the bio-medical model, Porter shows, was part and product of a coupling of the uniquely Western faith in science of the 18th and 19th centuries, together with the medical profession's insistence to differentiate and define itself and its knowledge base on these scientific foundations.

Porter and others show a variety of medical authorities seeking to “set their discipline on scientific rails” (ibid, p.248) through symbolic association and changes in practice (Hardy, 2001). On an associative level, Porter describes practitioners urging their colleagues to amaze their patients with scientific jargon and the latest scientific tools.³³ He also documents significant movements in the practice and theory of medicine to better align the two through the incorporation of clinical medicine, epidemiology, and bacteriology. Even though advancements in medical knowledge in the twentieth century only occasionally translated into substantive improvements in medical practice and clinical outcomes (McKinlay and McKinlay, 1977), the cultivated scientific association of medicine appealed successfully to a “public on both sides of the Atlantic” that were, throughout the early 1900s, increasingly “sold on scientific medicine” (Porter 1999, p.679).

This scientific aura was, however, maintained alongside a parallel craft-based conception of clinical care. Although science was the foundation of the profession's knowledge base, medical leaders throughout the nineteenth and twentieth century repeatedly defended medical practice as both a science *and* an art (Shattuck, 1969; Whitby, 1951; Saunders, 2000). Although some physicians occasionally argued that medical care could and should be made into a science itself, it was, particularly in the

³³ Illustratively, Porter quotes the physician Daniel Cathell reflecting on his experiences in 1924: “Working with the microscope and making analyses of the urine, sputum, blood, and other fluids as an aid to diagnosis, will not only bring fees and lead to valuable information regarding your patient's condition, but will also give you reputation and professional respect, by investing you, in the eyes of the public, with the benefits of being a very scientific man” (Porter, 1996, p.132).

UK, more often than not defended as too messy, too individualized, and too multidimensional to fit into the rigid world of science (Porter, 1999, p.533). “Too much science”, it was thought, “might distract from the true art of healing” (Porter, 1999, p.697).

As such, and to varying degrees, medicine did not simply merge with science, but relied upon its social status, while also maintaining the need for the individual physician to be more than a mere scientist. Rather, the physician was consistently described as requiring non-scientific faculties, be they the pedigree of a gentleman or a classical education. Indicatively, Rosner states that in the 19th and 20th centuries there was “not much dispute” that a good physician required “a good liberal arts education, followed by three of four years of university medical lectures, and a year or two of hospital clinical experience” (Rosner, 1996, p.153).

These craft and scientific elements provided a sturdy foundation for the medical profession: it could rely for its social prestige on a body of knowledge which was at once socially validated and prized, yet accessible only to the individuals within its clan. This relationship afforded the medical profession a primary position in the social and cultural order for much of the twentieth century (Starr, 1982; Battista et al, 1995). Up until the 1980s, the medical profession was consistently granted, either by the necessities of war or the requirements of a healthy population, the ability to “define and interpret the nature of reality and human experience” (Starr, 1978, p.177; Conrad and Schneider, 1992; Porter 1999, p.645, 652).

This status translated into legal and political power and control. As Starr notes of the USA:

As the main emissaries of science, physicians benefitted from its rising influence. The continuing growth of diagnostic skills and therapeutic competence was sufficient to sustain confidence in their authority. And with the political organization they achieved after 1900, doctors were able to convert that rising authority into legal privileges, economic power, high incomes, and enhanced social status. (1982, p.142)

Indeed, framed within a public interest perspective, a series of reforms in both countries established statutory arrangements for “scientific medicine” (Porter, 1999, p.8) to differentiate and regulate itself. In the UK, the 1858, 1886, and 1950 Medical Care Acts

and the founding of the NHS in 1948 all solidified the ability of the medical profession to regulate itself, restrict entry, and establish medical education standards, on the basis of the implicit assumption that progress and protectionism went hand in hand with the triumvirate of the medical profession, science, and craft (Roberts, 2009; Smith, 1994).³⁴ In the USA, although each state proceeded at its own pace, similarly favorable legal privileges were granted, bolstering the profession's prestige and scientific associations yet further (Starr, 1982).

Alongside these power-granting and regulatory changes, hospitals and medical education were also being increasingly enrolled toward these ends. In both countries, medical education and research became inextricably intertwined with each other and the hospitals, establishing a mutual coherence and stability. As a result of changing economic realities and the Flexner Report (1910) in the USA and the Althone Committee (1921) in the UK, medical education and research became increasingly synonymous with high-tech hospitals overseen by research scientists.³⁵ Such a transformation again added to the stability of medicine and its science. As Granshaw and Porter note, these hospitals “played their part in the transformation of the image of the specialist from a quack to consultant; of the care for the sick in the home to care in an institution; from doctor as peripheral in medical care of the majority to the doctor as central” (1989, p.10) thus reinforcing the triumvirate that was so associated with the twentieth century.³⁶

Throughout the first half of the twentieth century in the USA and the UK, the triumvirate of the medical profession, science, and craft took part in the co-elaboration of an increasing array of elements. By 1945, and as the World War Two was drawing to a close, an increasingly dense arrangement of elements was fitting together into a

³⁴ Smith notes that this public interest assumption was so pervasive at the time that the power granting clauses were “buried in a half dozen inconspicuous lines”, and that those who framed the legislation “gave the rationale for this power scant attention” and almost no discussion (Smith, 1994, p.1). Similarly, the self-regulation of the medical profession is described as a “sacred tenant of the NHS faith” (Salter, 2004, p.12)—something that has been upheld as central to the delivery of high quality care at least until the 1980s (Klein, 2010).

³⁵ Starr states: “Medical education and research advertised their moral responsibility in ways congruent with the cultural standards of an age that increasingly revered science” (1982, p.122).

³⁶ Brook and Avery (1976) state, similarly “a non-critical fascination with technology of modern scientific medicine prevailed, one which did not encourage questioning the value of these procedures” (p.226).

functional whole. A variety of elements, with the triumvirate at its core—the biomedical model, science, trust, medical technologies, hospitals, the medical profession and education, etc.—was, moreover, increasingly dictating the terms under which each other and healthcare more generally was being interpreted, defined and transformed. These elements defined and sustained each other as a functional whole from the middle of the century right through the 1970s in both the USA and the UK.

In both cases, and to the question such as what are hospitals or what should they be, many commentators answered, “incomplete without a school of medical technology” (Houston and Foraker, 1963, p.250), “the physician’s workshop”, providing him “with the tools and facilities so that he can do his job well” (Gundersen, 1954, p.917). To questions about medical professionals, commentators would respond, “the nurse was selfless, humane, generous, warm, motherly; the surgeon was a fearless warrior, the physician was wise and dependable (Porter, 1999, p.693). To questions about the role and benefits of science, commentators responded, “never has the benefits of science and technology been greater” (Allen, 1959, p.2150). Medical education, similarly, was about “striving for technical perfection or for total knowledge within a particular field” (Prior, 1959, p.290). Technology, similarly, was argued to be “a truly integral part of clinical practice, and its impact probably as significant as that of the highway or telephone” (Barnett and Robbins, 1969, p.436).³⁷

As we will see, this broad historically and geographically circumscribed set of discourses and relationships also provided the foundations for questions of quality and its calculation to be envisioned and voiced in a particular way between 1945 and 1970. Although these elements powerfully framed and sustained each other, and generated a bounded framework in which quality could be understood and discussed we will see that they were enrolled and in part transformed into distinct assemblages in each jurisdiction. It is to these national manifestations that we now turn, beginning with a consideration of quality and its calculation in the USA.

2.1.2 Quality and its calculation in the USA, 1945-1974

³⁷ This dense and dominant assemblage led historians to describe the early and mid-20th century as “the Golden Age of Doctoring” (McKinlay and Marceau, 2002) and “the Era of Professional Dominance” (Pescosolido et al, 2001).

In the USA, between 1945 and 1975 these historically constituted set of elements interacted with specifically American preoccupations and concerns to establish a strong and enduring assemblage in which a distinct notion of quality could be rendered. As we will see, this was a notion of quality that was confined within bio-medical boundaries; it was seen to be activated and addressed primarily at the level of medical education and accreditation; and, as such, it was seen to be assured by the beneficence and actions of a strong medical profession. Within this distinct arrangement of quality, we will see that only certain calculative possibilities were afforded and that these calculative activities in turn gave rise to new arrangements in the assemblage of quality itself.

Quality, throughout the period, was conceptualized within three overlapping dimensions. It was, firstly, understood almost entirely as a clinical matter, its outcomes and objectives defined as the extension of the benefits of medical science to every American, and therefore confined to the bio-medical model. To understand and to quantify the “great improvements in the quality of medical care” (Dickinson, 1953, p.1030) that were evident in America throughout the period, authors would cite statistics of maternal and infant mortality and life expectancy. Considerations of ‘non-clinical’ aspects of care such as patient experience were beyond consideration. Indicatively, the incoming President of the AMA in 1968 told his colleagues that, “having gained the leadership in scientific achievement,” the greatest barrier between themselves and “high quality medical care for every American”, is the public's “ignorance of what medicine has to offer” (Wilbur, 1968, p.82). Any deficiencies in quality, it was reasoned, were a result of patients themselves, government encroachment, or cost barriers that failed to allow every American to take part in the miracles of clinical progress (Emerson, 1952; Dickson, 1953).³⁸ For this reason, the relatively few quality concerns that surfaced during the period were conceptualized in terms of the “irregular or uneven distribution of physicians” (Emerson, 1952, p.41), barriers to nationwide coverage, failures in education (Quality of patient care, 1965),

³⁸ Indicatively, a study undertaken in 1932 by Dr. Emmett Bay to compare the medical care at Chicago clinics found all quality problems to be down to the actions of patients. In this in-depth qualitative study, he notes three reasons for less than adequate care: “(1) Patients felt well and thought return unnecessary; (2) patients felt they could not afford to return; (3) patients misunderstood clinic procedures” (Bay, 1932, p.1453).

and (as reviewed later in detail) government interference and incentives for hospitals to cut costs.

Secondly, quality was seen to be controlled and addressed almost entirely at the point of the individual physician, who merely needed the right education and environment in which to work. As long as the self-regulated medical profession was provided with the working environment that it needed, and Americans were afforded full access to care, it was intuited repeatedly that high quality care would result. For, as the President of one American hospital explained it:

It is the physician who controls the quality of the product hospitals provide. He is the hospital's most effective public relations counselor, is responsible for vast educational responsibilities, is the user and controller of the largest part of our hospital's budget, and, most importantly, is the conscience which dictates the kind of treatment patients receive and the lengths of stay. (Danielson, 1966, p.1062)

With the individual physician as the locus of quality, and with the presumed beneficence of the physician, debates about its assurance centered on issues around the right selection, education, and accreditation of physicians. Indicatively, the first AMA *Principles of Medical Ethics* (1903) stated that to protect the public, the academy needed only to ensure the “character and extent of [the physician’s] medical education” (ibid, p.18). With appropriate education, “the only tribunal [needed] to adjudicate penalties for madness, carelessness, or neglect is their own conscience” (ibid, p.5). These sorts of claims carried forward implicitly to the middle and end of the 1900s.³⁹ Indeed, the claim that medical professionals were, by education, the “most self-critical of all professionals” (Quality of medicine is strained, 1967, p.1122) was held up as a barrier to any other form of assurance (except perhaps recertification). As Brook and Avery, for example, note in 1976; “since the process of medical education was assumed to be adequate after Flexerian reforms, the need to measure the result of care delivered

³⁹ Indicatively, the AMA Chairman of the Council on Medical Education and Hospitals stated in 1955: “[The] quality of medical care rendered to the American public is dependent upon the standards of medical education maintained by the medical schools and the adoption of these standards by the licensing authorities of the individual states. These medical standards are basic to any consideration of the socioeconomic conditions under which medical care is rendered and must have constant attention” (Weiskotten, 1955, p.254).

by physicians trained in the new schools may have been considered unnecessary" (p.225).⁴⁰

Thirdly, relatedly, quality was seen to be synonymous with strong medical control of its profession and domain. As based on largely inaccessible medical knowledge and the appropriate selection, education and accreditation of the individual medical professional, it was a strong and well-funded profession that was seen to be central to quality. As one editorial, defending the high costs of medical education and the restrictions to accreditation, explained:

Many of the hurdles [to entry] have been created, or their creation encouraged by the AMA. On that account, the Association has been called by ill-informed critics selfish and protective of the interests of established practitioners. In fact, the opposite is true. All the barriers to the practice of medicine are for the purpose of assuring the highest possible quality of health care and are strictly in the public interest. (Quality of Medicine is Strained, 1967, p.1122)

Quality was, in summary, understood as a matter of the individual physician's judgment, and this judgment was supported by the provision of an appropriate working environment, education and accreditation, overseen by a strong medical profession.

With these arrangements in place, it was noted that hospitals simply "did not consider it their duty to see that good results are obtained in the treatment of their patients" (Codman, 1917 in McIntyre et al 2001, p.9). Illustrative of this point, Harry Stephenson wrote in 1960 of the responsibility for quality that he had during his six-years on the Board of Trustees of Greenville General Hospital as follows:

The subject [of physician quality] gave me great concern. It gave me concern, because I did not understand the problem in general and in particular, what the trustee should do to ensure this great responsibility. There was plenty else to do as a trustee to keep my mind off of this problem, or perhaps to procrastinate it. We have an excellent professional staff in Greenville, and, frankly, no chickens ever came to roost to bring us face to face with the problem. (Stephenson, 1960, p.287)

While perhaps a personal "concern" upon reflection, his comments indicate the extent to which there was a generalized and consistent assumption of physician beneficence throughout the period, which provided implicit assurances of the quality of medical care.

⁴⁰ The Flexner reforms contributed to an overhaul of medical education and medical school accreditation that substantially reduced the number of accredited schools, and ensured that they had better funding, facilities, and teaching, and severely restricted entry as a result (see Barzansky, 2010).

The public and government maintained a similar assumption for most of the period. Although there was occasional public upset about a particular medical failing and as Tomes (2001) highlights, certain physicians and medical institutions had different reputations among those few patients that could afford to discern between them, there was a general assumption on behalf of the American public for most if not all of the period that quality was simply a matter of professional action. As Flexner noted even before his reforms in 1910—and as seemed to remain true until at least the 1960s—“as a rule, Americans, when they avail themselves of the services of a physician, make only the slightest inquiry as to what his previous training and reparation have been” (Flexner 1910, p.x). It is as if, he suggested, “the public has in large measure forgot that it has any interests to protect” (*ibid*, p.xv).⁴¹

This particular arrangement through which quality was conceptualized and ensured was illustrated in a 1949 report produced by a committee of the American Public Health Association (APHA) tasked with envisioning a national health system. It stated the following “essentials” necessary to deliver the “high quality care” that was so important to the health of the nation:

1. Able, well trained, and efficiently functioning personnel.
2. Facilities and equipment which meet high technical standards.
3. Health services which encompass the best knowledge of modern medical sciences, and which ensure availability and continuity of care.
4. Adequate financial arrangements, making possible the timely provision of all indicated services, without economic deterrents for patients or practitioners.
5. Sound administrative organization and operation designed to promote efficiency and economy of services. (APHA, 1949, p.899)

Consistent with the period, the report emphasized the “first component of good quality” to be “the selection and education of doctors [and …] the need to keep curriculum under review” (The Quality of Medical Care, 1950, p.589). Beyond these essentials, it was suggested that there was little more needed to ensure high quality care. Indicatively, where the report suggested “the periodic review of the qualifications of licensed practitioners”, this was seen by commentators as an “unusual suggestion” (*ibid* p.590), such affordances seemingly being unnecessary. This report exemplifies the way that various elements—able and well trained physicians, their scientific associations, trust,

⁴¹ The major pieces of legislation up to the 1970s similarly, such as the Hill-Burton Act (1946), conceptualized quality as something that could be assumed as long as barriers to access, a shortage of funds, and antiquated facilities could be eliminated.

and rising costs—were assembled throughout the period into a well-functioning and mutually symbiotic whole, in which quality was but one element.

These elements did not simply associate in one direction, so as to render quality in a particular way. They also gained and maintained their identity on the basis of the notion of quality that was rendered. As authors such as Scott et al (2000) show, the high costs of the medical technologies and professional control, which helped to sustain the notion of quality, were also defended and sustained on the basis of their contribution to quality.⁴² They argue:

[The] central logics, stressing quality of medical care, provided guidance to the structuring of activities as well as an important legitimating frame to support professional hegemony. They even provided a rationale for medical costs, which began to rise as early as 1945, linking it with improvements in quality of care. (Scott et al, 2000, p.194)

Such associations were seen throughout the period. Invoking quality to define those elements that rendered it, for example, one commentator argued:

The medical care of today is quite different from 25 years ago, and I am inclined to believe that you will agree that its present high quality is due to the principles that this Association has insisted on in the past, namely to *advance the boundaries of medical knowledge, to elevate the standards of education, and to base the practice of our art on scientific principles and sound experience* [italics added]. It is proper therefore that the Association should continue to support scientific research, to examine the standards of medical education, and to further its development. This is the foundation on which the high quality of medical care rests. (Keefer, 1953, p.1531)

Other articles from these years suggested similarly that if America was to have “high quality care”, then the medical profession “must remain free, unshackled, a profession and not a group of technologists” (Wilbur, 1968, p.94; see also Weikotten, 1953; Bauer, 1945), and must have “conviction strong enough to [...] fight government encroachment” (Appel, 1965, p.114). They argued similarly that quality required “complete coverage of [the] nation with local health services, professionally directed, adequately supported, and with trained personnel in sufficient proportion to the population” (Emerson, 1952, p.44; see also Dickinson, 1953), and that the government must “authorize the federal assistance for surveys and hospital construction”, and “replace a large number of existing hospitals” (The Commission on Hospital Care, 1946, p.789).

⁴² Scott et al (2000) similarly identify the “quality of care as determined by physicians” as “a distinctive primary logic” in American healthcare between 1945 and 1965 (*ibid*, p.182).

An increasingly dense assemblage thus emerged in which quality and the elements that surrounded it defined, stabilized, and supported each other. In the simplest (undoubtedly oversimplified) sense, the assemblage that existed from 1945 to 1975 in the USA was one in which *quality was what the physician deemed it to be*. The physician, moreover, was he who delivered high quality care. In this case as in others, this was an assemblage in which it was impossible to understand the things that defined quality without reference to quality itself. The elements constituted quality and quality constituted the elements. As such, quality cohered in a stable and mutually constitutive arrangement; one in which each element was defined in part on the basis of the other.

Within and as part of this specific arrangement, moreover, only certain calculations and calculative objectives could be envisioned and undertaken. In medical hands and assured through accreditation and education, calculations of quality were not directed, at least until the 1970s, at the medical professionals themselves. Indeed, the medical professionals, as they had been constituted in the assemblage, were the guarantors and measurers rather than the objects of quality and its measurement. For, with the right education, all that was needed to ensure their quality was their own conscience. As such, efforts to differentiate by formal calculation the quality of care delivered by the physicians themselves were unthinkable and seemingly illogical.

This lack of calculative possibilities was due not to a lack of computational capabilities or hardware—in fact we will see that this was quite developed in America at the time. It was due rather to the logic intrinsic to the historically distinct assemblage within which quality resided. This can be seen with reference to the largely failed efforts of an energetic reformer, Dr. Ernest Codman, to provide a documentary and quantitative manifestation of the profession's quality guarantee throughout the 1920s and 1930s.⁴³ Codman developed the idea, which he presented initially as “so simple as to seem childlike” (Codman 1916 in Christoffel, 1976, p.8), that “every hospital should follow *every* patient it treats, long enough to determine whether or not the treatments has been successful, and then to enquire ‘if not, why not?’ with a view of preventing a similar

⁴³ Today, however, Codman is consistently described as one of the early pioneers of the quality revolution. Lembcke (1967), for example notes, “We are indebted to Codman for emphasizing the importance of terse case summaries to facilitate the systematic evaluation of large numbers of cases in a medical audit” (p.4).

failure in the future" (in Donabedian 1989, p.238). "By grouping cases into series large enough to favor comparative study and by observing definite previously determined points" he argued, "a rational clinical science can be established" (Codman, 1917/1995, p.12). Believing that great hospitals "have a duty" to undertake such exercises, he worked tirelessly throughout his lifetime (1869-1940) to advance the 'end-result system' which he had developed toward this end.⁴⁴

Although Codman rarely spoke directly of quality, preferring instead "standardization" or "end-results", the incompatibility between his calculations and the existing assemblage of quality were immediately clear. His end-result systems, its findings, and the ideas or questions that inspired it were met with severe hostility from his colleagues and the profession as a whole. In response to his proposition that the hospital introduce his system and make reforms based on its results, he was forced out of Boston General Hospital and the medical mainstream.⁴⁵ The night that Codman introduced his ideas to his colleagues at the Boston medical Library in 1915 was explained by an attendee this way: "if one single night can effectively ruin a surgeon's career, it is likely that this happened to Codman on a Boston winter's eve in 1915" (in Brand, 2009, p.2764). As Donabedian recounts, in the aftermath "there was to be disgrace, a loss of friends, resignation as a chairman of the local medical society, separation from his post as instructor of surgery at Harvard, and a noticeable dip in income" (Donabedian, 1989, p.235).⁴⁶

When the seemingly strong social assurances of quality provided by the profession are contrasted with the hostile reaction to Codman's efforts to provide a calculative manifestation of this same guarantee, the relationship between the arrangements of the assemblage and calculation becomes clear. Seeking to understand this hostility, authors point out that perhaps the notions of imperfection and improvement, which were

⁴⁴ Codman is quoted in Sharpe and Fadens (1998) as stating: "Will we put the methods of science to work in the evaluation of our own practices [...] or must we admit that no matter how much we read, study, practice and take pains, when it comes to a show-down of the results of our treatments, no one could tell the difference between what we have accomplished and results of some genial charlatan [...]" (p.29).

⁴⁵ Berwick notes, that "Codman met in his time the resistance of arrogance, the molasses of complacency, the anger of comfort disturbed" (1989b, p.263).

⁴⁶ Returning from war duties to the end results clinic that he founded on his own, Codman wrote in 1919, "I returned to my closed hospital, in debt, with no borrowing capacity, and somewhat disillusioned as to the possibility of altering the ways of human nature by my intellectual efforts" (in Donabedian, 1989, p.238).

implicit in Codman's framework, were overridden by the blinding benefits of scientific progress. One historian postulates:

Codman's most active crusading years fell between the introduction of the x-ray technology and of antibiotic treatment—a period marking some of the most significant advances in medical history. It does not seem unreasonable to view this remarkable progress as the cause of a kind of professional headiness which, despite episodes such as the first hospital survey [showing the opposite], led to the perception of medical practice as being nearly 'perfect'. (Christoffel, 1976, p.87)

Indeed, within the realities about quality constructed in the assemblage, there was little conceptual basis for calculations of the physicians themselves.

The extent to which Codman's failures were what might be called an assemblage problem rather than a calculation problem (that is to say, a problem not of the tools and the ideas themselves, but of the way in which the world around them was constituted) is made even more explicit in the fact that Codman's tools and ideas later became central to a program led by the American College of Surgeons to measure, improve, and assure the conditions under which they worked. While maintaining strictly that calculations of the individual physicians' performance was unthinkable, the College sought to standardize, record, and compare every aspect of the hospitals.

Asserting its obligation to ensure healthcare of the highest quality—the “burden of professionalism”⁴⁷ as one doctor called it—the American College of Surgeons established its Hospital Standardization Program in 1917.⁴⁸ The program, inspired by the work of Taylor and Gilbreth as well as that of Codman⁴⁹, sought to determine specific and increasingly meticulous standards in the care environment that would allow

⁴⁷ As Dorman described the “burden”: “[...] through many generations, people have endowed the physician with qualities of superior wisdom, of unshakable trust, and of surpassing understanding. In their own minds, they have elevated the physician above themselves and above others. Only in so doing could they bring themselves to place in this man the faith and trust they give to him [...] That is not only the greatest and most humbling advantage we have as physicians. It also is our heaviest and most demanding penalty as members of a profession that ministers to the spirit as well as to the body of mankind. As the penalty of being in our profession, we must willingly accept not only the respect it brings us but also the obligation to be deeply and actively concerned with every facet of health and health care [...]” (1969, p.921).

⁴⁸ It should be noted that historians rarely see this beneficence today, describing it as an effort by “the American medical elite to assert its claim to control the systems in which its members work” (Scrivens, 1995, p.17).

⁴⁹ While there was hostility to Codman's End Results Idea, he incessantly cultivated a close relationship with Edward Martin over the following years, who would become a founder of the American College of Surgeons and appoint Codman to the Hospital Standardization Committee (Mallon, 2000, p.50-55).

physicians to practice in optimal conditions. Controlled by professional prerogative, the standards focused on hotel aspects of care and the hospital environment, and resulted in an increasingly detailed and extremely costly laundry list of physician demands, which most hospitals failed initially to deliver.⁵⁰

Reformed in 1952 as the Joint Commission on the Accreditation of Hospitals (JCAHO) when the two million dollar annual inspection costs overwhelmed the college, the system had slowly expanded to assess a huge range of care aspects; “medical staff organisation, qualifications for medical staff membership, rules and policies governing the professional work in the hospital, medical records, and diagnostic and therapeutic facilities” (Lembcke, 1967, p.546). And, with pressure from the profession, hospitals were forced to make substantial investments in technology and workforce in order to comply.

The success of these calculations, and what differentiated them from Codman's efforts, was their consistency with the logic of the existing assemblage. Most importantly, the calculations did not question the quality of physicians themselves—who were by definition nearly faultless. Rather, they were seen, within the logic of the assemblage, to contribute to the professional burden of delivering the benefits of medical science in an ever more challenging environment. Indeed, the logic of the program was explained this way:

No hospital will ever be stronger than its medical staff. It then becomes the administration's duty to obtain as much equipment and sufficient assistance that is necessary for the staff to obtain the highest professional aims. (Smith, 1924, p.975)

As long as hospitals complied with these ever more rigorous standards (and thus provided the medical professionals with the working environment and technologies that they demanded), it was argued that “there [could] be no reasonable doubt” that “medical care of a good quality” would not result (Lembcke, 1967, p.114). Although *prima facie* inconsistent, this dual standard (of assuming the quality of the physician, while calculating aggressively that of his environment), was in fact wholly consistent with the calculative imagination afforded by the assemblage in which quality resided.

⁵⁰ Lembcke (1967) states; “It is known that only 89 of the 692 hospitals of 100 beds or more could meet any reasonable standard, and it has been said that the facts elicited by the first survey were so shocking that the survey committee ordered the individual survey reports destroyed forthright” (p.545).

These calculations, however, also afforded new possibilities for the stability of the assemblage. The necessity of defining optimal standards for hospital administration and organization encouraged statistical manipulation and increasingly promiscuous calculation. In this spirit, a variety of small-scale efforts were undertaken in the wake of the hospital standardization movement to develop indexes of hospital quality from existing hospital statistics (Lembcke, 1956; Myers, 1954; Eisele, 1954). However, even the strongest proponents found much of the output “virtually meaningless” because of population differences and the more general issue of quality being so thoroughly assembled as inseparable from individual physician judgment (Lembcke 1956, p.647).

In the 1950s and 1960s there were other efforts from clinicians to undertake the sorts of calculations that Codman had suggested. However, they remained very much small-scale, experimental, and problematic. Seeking to “make certain that the full benefits of medical knowledge are being applied effectively” (Lembcke, 1956, p.654) and to place review processes on a “scientific basis” (ibid, 655), efforts were directed at defining standard care processes for specific diseases or interventions and comparing these with indicators on patient notes (Doyle, 1953; Payne, 1963).⁵¹ The calculations rendered were cautious and non-judgmental. Although they produced tentative conclusions about the care activities provided by physicians themselves, the authors found it necessary to supplement these measures with the more typical indicators of the education, character, and training of the physician, indicating that the calculations alone could not be believed (Morehead et al, 1958; Morehead, 1967; Fitzpatrick et al, 1962). Such efforts were also stymied by questions about the ability to define acceptable standards for clinical work, which was uncertain at the time (c.f. Timmermans and Berg, 1997).

Building on the momentum of the standardization program and the findings of some of these small-scale medical standardization activities, the JCAHO began to suggest that perhaps the medical world and the individual physician might be subject to the sort of

⁵¹ Lembcke (1967) was one of a small number of doctors that argued for the profession to continue with clinical standardization and measurement. He argued for his colleagues, in the name of science, not to resist such methodological advancements, reminding his colleagues; “There is nothing particularly scientific about excessive caution. Cautious explorers do not cross the Atlantic of truth” (p.550). He was also one of the first to recognize that such a movement could (and he may have even supported that it should) extend beyond the bio-medical model of care. Indicatively, his 1947 investigation calculated that blood transfusions, rates of x-rays and a few other clinical events were “directly correlated with subjective impressions of good quality hospital care” (1947, p.28).

scrutiny previously reserved for their working environment. In 1952, it required that participating hospitals undertake some sort of clinical review process, stating that as part of accreditation:

Hospital medical staffs must ‘review and evaluate all surgery in the hospital on basis of agreement or disagreement among preoperative and pathologic diagnoses and on acceptability of the procedure undertaken.’ (Payne, 1967, p.536)

With few generally accepted medical standards or clinical process guidelines for evaluating the acceptability of procedures⁵² this requirement was largely an invitation for experimentation, and its vagueness meant that existing judgment-based forms of evaluation would satisfy the requirement. However, faced with the explicit task of reviewing and evaluating clinical care, physicians were forced to examine whether these care practices might be standardized, made calculable, and comparable, or whether indeed the reference to accreditation and education was still justifiable.

In practice, almost all physicians opted for the latter (Payne, 1967; Scrivens, 1995; Rosenberg, 1977, Lembcke, 1967). Although some leading hospitals used crude calculations and comparisons of quality as part of the peer review process, most evidence suggests that calculations were used sparingly and inconsistently throughout the USA as a whole (Rosenberg, 1977; Payne, 1967; Kusserow, 1988). Where a quantitative approach was adopted, and where unusual statistical variations could be discerned, it was typically the case that medical teams would investigate, and come to their own conclusion, usually in the favor of the physician (Payne, 1966, p.1071; Kusserow, 1988). Similarly, up until the late 1960s, there was evidence that the “leaders in medical and hospital administration” still chose to address “betterment of care” through education, improving facilities and procedures, and organizing hospital staff and boards, rather than leveraging the peer review calculations (Lembcke, 1967, p.546-7; Scrivens, 1995).⁵³

However, these peer review technologies took on new meaning, while preserving the existing assemblage, with the introduction of a government-funded health programme

⁵² Weisz et al (2007, p.706) notes twenty “guidelines published between 1945 and 1959 and thirty-five between 1960 and 1974” spurred on by the creation of ever larger health systems (such as the Veterans Association) and demands of insurance companies in the USA.

⁵³ Lacking any objective and external measures of clinical quality, regulators and accreditation agencies were required to work within these boundaries, and limited themselves to the goal of rooting out bad apples and the worst offenders right up to the late-1970s (Brennan, 1998).

for the elderly, Medicare, in 1965. Even though the government remained largely uninvolved in healthcare decision-making, commentators in the medical profession noted that the new program would draw attention to the products that taxes were now purchasing. “People are aghast at the current daily hospital charges and rightfully demand that a commodity so dear is used with the utmost discretion and wisdom,” one commentator noted (Payne, 1967; p.536). Another stated:

The ever-present threat, of course, is that if physicians fail to check their colleagues and establish standards which must be met, then others will do the job for us. And nobody knows for sure what criteria they might use, or how closely related they would be to what we consider valid measurements of medical excellence. (Dorman, 1969, p.922)

Against this background, peer review was given a new meaning within the medical profession. While previously such calculations were seen to be a possible threat to the assemblage, in this context, they became a possible means of maintaining the profession’s privileged interpretation of quality (see Timmermans and Berg, 2003).

Peer review also offered the government a potential means of tempering the overprovision of care, which was incentivized by Medicaid’s cost-based reimbursement system. Unable to determine on its own what was and was not medically necessary, government administrators suggested that peer review might offer some assurance of acceptable levels of provision. With such overprovision concerns in mind, legislation in 1972 established a regional peer review process, encouraging groups of practitioners to voluntarily form Professional Standards Review Organizations (PSROs) to “review independently the use of medical services” (Jost, 1989, p.239). This exhortation left the form of review, however, entirely to locally-assembled medical professionals, thus institutionalizing as much as challenging the existing assemblage.

Although “created primarily [...] to lower public expenditure of patient, especially inpatient, care” (Lohr, 1985, p.5), it was clear at the time also, according to an observer, that “the legislators were certainly aware of the potential role PSROs would have in quality assurance” (*ibid*). And indeed, peer review took on a central role in quality assurance with the introduction of standard costing (the Prospective Payment System) for Medicare and other federal health programs. Incentivized to cut costs as a result of this new reimbursement scheme (rather than over-provide), it was argued that hospitals might discharge before medically necessary and select patients into treatments in which

profits were highest while rationing those that were loss making. Quality was seen to be a product still of the application of medical technology, and as a result, all of these new provider incentives were seen to be a major threat to the delivery of quality care.

The peer review model and existing PSRO groups were seen, almost immediately, as the new guarantors of quality in this situation.⁵⁴ As Welch noted in 1975, the “preservation of high-quality medical care in the future will depend in an important way on the standard set by local [PSROs]” (p.47). Indeed, the PSRO mandate was soon explicitly extended to calculate and maintain quality, and the standardization process was given renewed interest and funding (Jost, 1989). In 1980, as PRSOs were being consolidated as Peer Review Organizations (PROs)⁵⁵, it was ordered that *Quality Review Studies* supersede Medical Care Evaluation Studies and that “more emphasis be placed on improving the quality of care, that a broader set of topics be considered, and that methods other than medical record audit be developed” (PSRO Transmittal No.100, in Lohr, 1985, p.6). The medical profession, who now saw this process as less of a threat than a means of protecting their medical knowledge from cost-cutting and administrative efforts, moreover, were now increasingly ready to specify and codify clinical process standards, even if it meant sacrificing some judgment at the point of delivery (see Timmermans and Berg, 2003, 1997; Weisz et al, 2007).

It was thus from roughly the mid-1970s that quality moved from a matter of medical judgment to a matter *potentially* of formal quantitative calculation. The process of peer review, now mandated as part of the Quality Review Studies, had established the process of setting specific care process standards, and reviewing case files or other data against these standards, as a means of assessing quality of care delivered by physicians and more generally. But instead of threatening the assemblage, it supported (if slightly altered) it, in the face of cost pressures and commercial imperatives. As such, quality still had many of the same conceptual dimensions as it did in 1945. Although the individual physician’s judgment might, theoretically, be formally critiqued on the basis of a more specific calculation, the quality that these calculations attended to, was still

⁵⁴ These similar concerns and solutions were also developed in response to Health Maintenance Organizations (HMOs) (Brook and Avery, 1976).

⁵⁵ The 1982 PRO mandate was designed to ensure that services provided under Medicare and other federal auspices were “medically necessary, conformed to appropriate professional standards, and were delivered in the most effective and economical manner necessary” (Kusserow, 1988, p.2).

something medically-defined,⁵⁶ that sat alongside physician judgment, and that was based on bio-medical terms. Yet, the incorporation of quality into this calculative form would provide an opportunity for the assemblage to be made visible, critiqued, and eventually replaced.

2.1.3 Quality and its calculation in the UK, 1945-1975

In the UK, and across the same three decades, an assemblage emerged with similar characteristics to that in the USA. Although “quality” was much less frequently mentioned—Capstick (1974, p.278) notes “a general attitude of complacency [...in which the...] profession and public alike have been remarkably silent about the quality of medical care”, when it was invoked it was in much the same terms as in the USA. It was intuited to be a professional concern: a matter of the application of medical technologies, and the appropriate education and accreditation of the professionals involved. This arrangement was enshrined with the founding of the National Health Service (NHS). Indicatively, Bevan’s message to the British Medical Association (BMA) at the NHS’s inauguration was:

In this comprehensive scheme—quite the most ambitious adventure in the care of national health that any country has seen—it will inevitably be you, and the other professions with you, on whom everything depends. My job is to give you all the facilities, resources, apparatus, and help I can, and then leave you alone as professional men and women to use your skill without hindrance. (Bevan, 1948, p.4565)

This message—that the government role would be to provide professionals with the right facilities, resources, and apparatus—so that they alone could provide high quality care, was a powerful “implicit concordat” that, Klein (1995, p.47) argues, was carefully maintained through to the 1980s, even in the face of pressing cost concerns.

Efforts to improve quality in the years that followed the founding of the NHS “concentrated [mostly] upon the provision of an adequate range of facilities accessible to people who need them” (McLachlan et al, 1976, p.37), while provision of quality care was ensured by the underlying, though largely implicit, mechanisms of selection and training of medical professionals. Indicative of this implicit treatment, the main

⁵⁶ Consistently “designed to accommodate professional interests” (Scott et al, 2000, p.215), PSROs and PROs were, like efforts before them, organizations of professions that “should not be considered an entity separate from the physician community or from the medical institution” (Goran et al, 1975, p.3; see also Scrivens, 1995; McIntyre et al, 2001; Jost, 1989).

regulator, the General Medical Council (GMC), gave little consideration to potential failings. As Gould writes, the GMC concerned itself throughout this period, not with questioning physician quality and competence but primarily with “crimes such as adultery with patients (or some allied sport), of being drunk in charge (of a car or a customer), or advertising, or knocking on a competitor” (1991, p.112). Moreover, the sanctioning powers granted to the GMC by legislation in 1969 specifically limited the remit to matters of “serious professional misconduct”, thus intuiting that making subtle inferences about medical professionals’ capabilities was wholly unnecessary (Gould, 1991).

In contrast to their hospital counterparts, general practitioners (GPs) in the UK were subject to a number of high-profile investigations into potential quality failures as early as the 1950s (i.e. Collings, 1950; Danckwerts, 1952; Hadfield, 1953; Taylor, 1954). While these reports disagreed enormously on their assessment of overall quality of care being delivered, they all conceptualized quality in the same terms, citing selection and education, accreditation and training as the fundamental building blocks of high quality care.⁵⁷ As Taylor (1954), for example, noted:

In the final analysis, the quality of the service depends on the men and women who are actually doing the job [...] good general practice begins with the good GP. So most of the conclusions are suggestions for self-help. (in Rivett, 2013, n.p.)

Throughout the period, these points were emphasized when seeking to improve the quality provided by GPs. Indicatively, even in 1974, Acheson writes that a new GP would be “as capable as anyone else of being blind to his own failings”, but, “this [was] less likely to occur when the scientific habit of self-criticism is maintained” (Acheson, 1974, p.453).⁵⁸

Within this assemblage, the outputs of care were measured primarily in bio-medical terms.⁵⁹ As Rivett states, “death was the clearest measure of outcome” (2013, n.p.)

⁵⁷ Rivett notes a similar set of discourses following the Hadfield report: “every profession, said the BMJ, has its quota of unsatisfactory practitioners; that a few should be outstandingly bad was only to be expected. *The remedy was in better selection of students* [italics added]” (Rivett, 2013, n.p.).

⁵⁸ The Royal College of General Practitioners was founded in 1952 in order to improve the quality of care through the development of medical education, stricter training standards, and pay awards that would allow the most rigorous selection (Hunt, 1957; Minister of Health on future of general practice, 1954).

⁵⁹ In the BMJ during this period it was not unusual to find statements such as, “The close and intimate relationship between the advancement of medicine and the advancement of human civilization needs no comment” (Mallick, 1953, p.462).

throughout the period, and even probing papers as late as 1972 declared standardized death rate, late foetal death rate, infant mortality rate, and maternal mortality rates to be the “most sensitive indicators” of overall performance (Honigsbaum, 1972, p.429). Despite the occasional references to qualitative factors in many of the reports of GP quality, such as the length of queues, quality was nonetheless described as synonymous with clinical outcomes, and it was stated as a matter of fact that “the reactions of patients [to care] are a poor guide” of “improvements in quality” (Honigsbaum, 1972, p.433).⁶⁰

A notion of quality thus emerged in the UK during the period that was consistent with that in the USA; it was a medical concern and confined to the bio-medical model, activated and addressed at the level of selection, education and accreditation of physicians, and assured through the provision of a sufficiently technological working environment, whilst leaving the physicians in charge. At the same time, similarly, the elements that supported the particular notion of quality were themselves supported by the notion of quality which they helped to produce and stabilize. On the basis of providing the appropriate environment for the physician to deliver high quality care, for example, both political parties, notes Klein (2010, p.46), were “rival salesman” for the construction of new and expensive hospitals.

However, in the UK some of the elements in the assemblage had been historically understood rather differently from their American counterparts. Perhaps the most significant difference was the primacy given to the craft (vis-à-vis science) of the medical profession and medicine generally. The British medical profession developed in a way that was distinctly reliant on its association to craft, winning its privileged social position and legal rights through its willingness not to press its scientific association too far (Roberts, 2009; Starr 1982, p.42). Similarly, the profession’s social appeal was one based on its more learned and aristocratic, rather than scientific, association. As such, it was emphasized throughout the period that, “it is important that the medical profession, while being technically competent, should also have such intellectual and social prestige

⁶⁰ The unwillingness to consider the patient view was espoused well into the 1970s: “Certainly hospitals should have a simple, straightforward system for handling complaints [...] beyond that point, however, dangerous precedents may be set. Just as there is no limit [...] to the demand for medical care so may there be no limit to the numbers of complaints from patients and their relatives [...] The defence of ‘clinical judgement’ has provided doctors with a legitimate shelter [...] (Challenging clinical judgment, 1977, p.1498).

and such unquestionable integrity as to command respect in the councils of the nation, the province, and the community" (Whitby, 1953, p.452). Another author, writing in 1985, continued to maintain similarly: "clinical medicine embodied science, but more than that it needed the infallible wisdom and experience that came only with advanced years, a classical education and the bearing of a gentleman" (Lawrence, 1985, p.510).

With such a pedigree, the medical bodies, as well as the medical education debates and standards were distinctive from those in the USA. The Royal Colleges and the GMC, as remnants of guilds (Roberts, 2009), embodied and promoted many of the attributes of a craft, as described by Sennett (2009); they were distinctly hierarchical and immune to external scrutiny⁶¹, and emphasized heavily the cultivation of implicit knowledge (Gould, 1991; Irvine, 2006; Klein, 1995; Pollitt and Bouckeart, 1995).⁶²

These historical differences meant that the elements in the assemblage had a slightly different character from those same elements in the USA: 'The physician' in the UK during this period, for example, generally understood himself and his profession to embody craft as much as science; he respected hierarchy and tradition; and he saw limitations of technological advancements. As such, 'medical science' (like all the other elements) had slightly different connotations. Instead of suggesting that investigation and calculation was central to scientific medicine, for example, it was possible in the UK to argue to the contrary, that, "science is just as much disgraced by the overzealous application of elaborate technical investigation" as improved by it (Arnott, 1949, p.4626). These unique foundations surfaced repeatedly in discussions about quality during the period and provided distinct limits on the forms of calculations that could be undertaken. These limits can be seen in the forms of calculations that surfaced in the UK between 1945 and 1975 and the lively debates about the acceptability of American audit techniques in the UK.

⁶¹ Illustrative of this point, Lord Platt, former president of the Royal College of Physicians is quoted as stating; "It is important that the government of the profession should not be too democratic. It should be aware of all the views of its members, but should take its standards from the top and clearly favor that small and not usually vocal minority whose professional standards, be it in practice or research, stand far above the average" (Gould, 1991, p.107).

⁶² Starr (1982) makes explicit note of these uniquely British characteristics which did not travel to America because they reflected a hierarchical character of British society that was incompatible with the democratic and entrepreneurial ideals of America at its founding (p.42).

The forms of assessments of quality in the UK during this period lay closer to judgment than calculation, wherever they were applied. As in the USA, and consistent with the assemblage, the calculation of quality was the domain of the medical profession alone. It was repeatedly emphasized that, “only doctors have sufficient knowledge to make qualitative clinical judgements on their fellows—which must be in the name of good medicine and not of State policy or economics” (Towards Medical Audit, 1974, p.256). The “*implicit concordat*” (Klein, 2010, p.47) enshrined this fact about quality throughout the period and beyond. As Klein also aptly pointed out, having defined quality as a clinical matter, policy-makers had no choice but to “fall back on the professional view of what services were needed and how quality should be assessed” (Newdick, 2002, p.113, paraphrasing Klein).⁶³

The medical assessment of quality, when applied to the physicians or their environment, was a rarefied and limited one. Salter summarizes the period similarly as one in which “the quality of clinical practice [was] a matter for medical initiatives alone to judge, presided over by their high-priest and ordered according to their historical rituals” (Salter, 2004, p.121). These historic rituals were ones in which the individual physician was central:

The development of quality has been heavily influenced by the medical profession, with its strong roots in a craft-based approach to work, where quality is seen to be almost solely dependent on the skill of the craftspeople. This crafts-based approach to professional practice vests control of quality with the individual clinicians, largely at an implicit level, within the overall scope of their professional practice. (Boaden et al, 2008, p.27)

Within this arrangement, it was generally noted that, “doctors seldom looked at their clinical practice and its results” (Rivett, 2013, n.p.). Rivett recalls an indicative incident, around 1952, when, “a paper was put to the JCC that included lengths of stay, one physician loftily said ‘all that is needed is that a consultant should feel satisfied that he has done his best for the patient. This arithmetic is irrelevant.’” (ibid).

⁶³ Rose and Miller (1992) describe this medical enclosure in the 1950s as a product of constructing the sort of assemblage that has been described here. They explain: “Medics drew on a profound optimism concerning the ability of medical science to alleviate illness and promote health, in a variety of tactics that succeeded both in shaping the ‘policy agenda’ concerning health and in placing certain issues out of bounds for non-professionals. Further, medics came to dominate the administrative networks of health, forming a medico-administrative bloc that appeared resistant to all attempts to make it calculable in non-medical vocabulary” (p.194).

Although this sort of absolute dismissal of calculation was perhaps extreme, there is no doubt that measurement or calculation and quality were much less compatible in an assemblage in which craft occupied an important place. Indeed, it was often noted that any statistics of quality would overlook the intimate characteristics of what clinical practice and its quality entailed. In response to Collins' damning report of general practice quality—resting heavily on the fact that many practices lacked basic facilities such as wash basins and examination chairs—many GPs responded that “one cannot judge a doctor by the number of wash basins he installs. The practitioner who lacks an understanding of human nature can never give first-class primary care, no matter how good his premises and how many diagnostic aids he possesses” (Jeffs, 1972, p.817; Freeville, 1972; Steer, 1972).

This was similarly shown by Archie Cochrane’s experiences and reflections about quality. Although Cochrane was the leading advocate of an evidence-based medicine movement that sought to determine the effectiveness of clinical interventions on the basis of scientific evidence rather than judgment based on experience, he maintained strong reservations about the extension of measurement into the domain of quality. Reflecting on his experiences as a prisoner of war in World War Two, and his efforts to care in “ghastly” situations for injured prisoners, he found quality to belie the clinical rationality that he so adamantly championed:

I feel [...] rather diffident about rational discussion about quality. We all recognize quality when we see it and particularly when we receive it. In ‘cure’ outcome plays an important part in determining quality, but it is certainly not the whole story. (Cochrane, 1976, p.259)

Indeed, Cochrane’s statements illustrate that the medical establishment in the UK was not in any sense calculatively illiterate or fearful, but that the notion of craft which was so important to professional identity, medical education and training, and clinical practice, cast quality in very intimate, qualitative, and personal terms.

This frame delimited quite clearly the boundaries of home-grown assessment techniques. In contrast to American developments, there were almost no systematic and national efforts to calculate quality, either of physician practices or outcomes or of the care environment. The intensive reports about general practice quality, mentioned above, relied upon “relatively unstructured visits and the use of subjective criteria” to prove differences in quality where no objective standards existed (Baker, 1988, p.2). Although

the statistics generated by a national health system provided a bit of fodder for statistical experimentation, and certain hospitals undertook their own cautious calculations, these remained small-scale and tentative.⁶⁴ The only national system of assessment potentially related to quality was the Confidential Enquiry into Material Deaths process, established in 1932, and reformed in 1952.⁶⁵ This provided a clinically controlled system for investigating the causes of material death and highlighting desirable and undesirable medical practices. This process, consistent with the assemblage, was, however, extreme in its extent of being “both voluntary and entirely confidential” (Dawson, 1988, p.820). “No criticisms [were] ever made of any individual by name, nor [were] names of hospitals patients, clinicians, or pathologists mentioned at any stage”, its object or wish never to “reflect on individuals” and identifiable records were destroyed each year (*ibid*).⁶⁶

This assemblage also interacted with the reception that was given to the medical-audit techniques that were developing in the USA, and which from the mid-1960s were increasingly surfacing in the pages of the *BMJ* and *The Lancet*. Reflecting on the American audit experiences, most if not all authors noted the good intentions of the American project and its consistency with British professional aims (Quality in general practice, 1972, p. 412). Thould, for example, wrote;

Implicit in any practical medical audit is the need for an individual's performance to be measured against those of his fellows and against nationally accepted criteria of good practice. If we look at this honestly, can we seriously argue that this should not be so? (1974, p.279)

Others highlighted the consistency of the audit process with the wider movement, of which reformers such as Cochrane were a part, “from impressions towards

⁶⁴ Famously, Middlesex General Hospital undertook a “small investigation [...] into the use of x-ray facilities [...] 160 who used it little produced half the positives, while the 40 who used it a lot produced the other half” (Improvement of the NHS, 1957, n.p.).

⁶⁵ One might also include the Hospitals Advisory Service, Social Work Service, and Health Service Commissioner. However, their activities were decidedly non-calculative, concerning themselves with simply promoting good practices (Day and Klein, 1987a; Scrivens, 1995) and keeping “a watchful eye, mainly informally” (Klein and Hall, 1974, p.12) on activities. In 1969, the UK National Quality Control Scheme was also created to monitor the variance in laboratory results of clinical chemistry analysis of specimens.

⁶⁶ The view of many practitioners regarding statistics was that “we should not over-emphasize the importance of what one can measure” (Dudley, 1974, p.275).

measurements [and] from an empirical art to an exact science" (Dale, 1951, p.262) in support of the aims of the project (McWhinney, 1972b, p.277).⁶⁷

However, there was much more explicit professional resistance than that found in the USA at this time. Many argued that American-style peer review had little if any relevance to the UK context, in which the rituals of the medical profession dominated:

Since the inception of the NHS the chief guarantee of quality in hospitals has been the rigorous selection of hospital staff. The hierarchical organization of the medical staff in a British hospital allows greater supervision of work than the hierarchical organization of North America. (McWhinney, 1972b, p.279)

Other British physicians reviewing American efforts concluded, "locally this seems to be a matter of education via the postgraduate tutor, and nationally perhaps the concern of the Royal College of General Practitioners" (Thould, 1974, p.280; see also Quality and quantity, 1971, p.79). American measures were also seen to be irrelevant because they were inconsistent with the more subtle and interpersonal forms of learning and practice that the craft demanded. Indeed, the Professor and practitioner, Richard Doll, made this argument emphatically to his colleagues at a Nuffield Lecture:

[There] is a place for regular meetings between small groups of close colleagues and pathologists to review the events that lead to death; but formal reviews of the outcome of practice can create seriously wrong impressions unless they are conducted with statistical wisdom, and they can hardly be expected to encourage the development of mutual trust and recognition. (Doll, 1973, p.739)

Most importantly, however, British commentators were much more skeptical than their American counterparts that clinical standards upon which peer review calculations rely could ever be developed. Many reflected:

There would appear to be comparatively few conditions that would lend themselves to accurate audit and they would comprise only a small percentage of the practitioner's work. Even those conditions that lend themselves to audit—the so-called simple physical problems, such as an acute appendicitis—should have a related area where the attitudes and interpersonal relationships between doctor and patient are important and worthy of evaluation. When one considers applying standard criteria to the majority of consultations in general practice, one sees immediately the

⁶⁷ A handful of ardent reformers argued that audit was consistent with continued education, and should be adopted immediately: "A doctor learns chiefly from his own experience. The more information he has about his own working methods and the outcome of his actions, the greater his self-knowledge will be. The more he knows about how his own methods and results differ from those of his colleagues, the more opportunities he will have for identifying his own shortcomings. As an educational experience, a good system of medical audit is worth any number of postgraduate courses (Quality in general practice, 1972, p.412)."

difficulties of agreeing criteria, definitions, and classifications. (Thould, 1974, p.278)

For all of these reasons, a “cautious”, “voluntary” and slow approach to audit was urged, and only very “modest and fragmented” efforts resulted up to 1975 (Irvine, 2001, p.164).⁶⁸

Across the spectrum of arguments, both for and against the desirability of audit in the UK, the craft-based foundations and the personal nature of quality presented huge conceptual barriers to adoption. Indeed, this was something recognized by supporters of audit in the UK. Reflecting on the “dearth of means of assessing the quality” at his disposal, the Professor of Surgery at Kings, Ian McColl, reflected that the situation was “no accident” (1976, p.51). “It derives from a long tradition of clinicians avoiding acrimony and open criticism, morbid introspections of their work and defensive surgery” (*ibid*).⁶⁹ In other words, the calculative possibilities afforded to the profession were part and product of the specific assemblage in which quality was actively constructed.⁷⁰ However, although the American measurement movement was largely sidelined until 1975, the existence of these measurements highlighted the difficulty that the profession might face if it continued to rely on non-codifiable and craft foundations. Dollery, voicing an increasingly common concern, reminded his colleagues that, “the justification of ever-growing expenditure on health services must depend to a great extent upon evidence of quality and effectiveness [...]” (Dollery, 1971, p.8).

2.2 The assemblage breaks down, 1975-1985

⁶⁸ In Scotland, a pilot was undertaken, from 1969, to provide consultants annually with confidential data about the “number of cases treated; their age distribution; waiting time for admissions; duration of stay prior to operation; total duration of stay; number of surgical operations; and number of deaths” (Irvine, 2001, p.174). No central interpretation was undertaken (for this “would have required extensive local knowledge” (*ibid*)), and only very crude national averages were provided for potential comparison. While extremely limited in ambition, however, these reports were often met with extreme hostility. A review of the program noted comments such as “the computer has lied” and “lies, damned lies...” and other such dismissive remarks from its users (see Heasman, 1976, p.178).

⁶⁹ Dudley (1974) makes a similar remark, stating the slow adoption of audit was “the consequence of the individualism of the surgeon and his essentially optimistic outlook, which tends to deny the existence of trouble—at least in his own wards.” (p.275).

⁷⁰ Klein makes explicit note of the differences between the two jurisdictions; “There was no move [in the UK] towards controlling or even investigating the decisions of clinicians, in contrast to the United States where an open ended budgetary system led to a series of attempts to introduce a formalized system for reviewing clinical decisions” (Klein, 2010, p.62; see also Maxwell, 1984).

Between 1945 and 1975, and in both jurisdictions quality and its assemblage cohered into a stable and productive whole. Quality was, generally speaking, what the physician deemed it to be; and at the same time, the physician was defined by his ability to deliver high quality care. Although the relationships between physicians and quality varied between jurisdictions based on the geographically specific composition of elements enrolled in each assemblage, this mutually supportive arrangement produced stable and more-or-less reliable conceptions of what quality in healthcare was, and what it entailed. Whether designing blueprints for a national healthcare system in the USA, or building such a system in the UK, the arrangements of elements proved stable enough to identify what quality was, how it might be achieved, and even what was necessary to guarantee or assure it—even if, as the British GP controversies highlight, questions of quality found ways of surfacing through different routes and assemblages.

This coherence provided the foundation for increasingly grand activities and prodigious investments to be undertaken in quality's name. However, as we will see, the enrolment of ever more actors in each assemblage also brought with them connections and relationships that extended beyond the assemblage and presented opportunities for new possibilities to emerge. This section shows the way in which the assemblages in each jurisdiction became increasingly unable to contain and explain the problems of cost, the rediscovery of 'the patient' and other such preoccupations that in part emerged from within the assemblages themselves (c.f. Callon, 1998). This produced a situation where the notion of quality in healthcare was no longer clear or uncontested, and whose foundations were no longer known.

2.2.1 Cost and peer review overflows

By 1975, the relatively strong and stabilized assemblages in each jurisdiction had helped to construct a vast medical empire. In both the USA and the UK, the increasing specialization within the profession and the "technological imperative" (Bennett, 1977, p.127) which clinical aspirations facilitated had led to the construction of "gleaming palaces of modern science, replete with the most advanced specialist services" (Starr, 1982, p.363), capable of performing the gamut of newly-introduced treatments such as

dialysis and plastic hip replacements.⁷¹ These palaces and their products represented the accomplishments of the medical profession and their knowledge base to direct and define quality of care towards specific ends. The medical profession—backed by social acclaim for science, to which Starr explains, Americans now gave “unprecedented recognition as a national asset” (1982, p.335)—had avowed such gadgetry and medical probing necessary for the pursuit of quality.⁷² However, at the same time that these accomplishments reached their peak, they also produced effects that would couple with other national preoccupations to produce narratives of crisis that would disrupt existing calculative assemblages.

One effect of the productive capabilities of the assemblages, coupled with other changes such as the expansion of Medicare and Medicaid in the USA, was an unprecedented escalation in cost. In the USA between 1950 and 1970, the medical workforce had increased from 1.2 to 3.9 million people and expenditure had grown from \$12.7 billion to \$71.6 billion (4.5 to 7.3 % of GDP) (Starr, 1982, p.335; see also Strand, 2011), yet inequalities in coverage proliferated. The gleaming palaces of modern medicine that stood alongside “neighbourhoods that had been medically abandoned” (*ibid*, p.363) helped to redefine many elements in the assemblage’s (especially medical science’s) social association. As Starr (1982) describes it, “medicine has been a metaphor for progress, but to many it now became a symbol of the continuing inequalities and irrationalities of American life” (p.363).

Consequently, throughout the 1970s and 1980s, “the economic and moral problems of medicine displaced scientific progress at the center of public attention” (Starr, 1982, p.37). In other words, these overflows increasingly became unexplainable within the existing assemblage, and as such, presented challenges to its cohesive structure. The logic of cost containment, for the first time cast quality in marginal rather than absolute terms, “desirable but costly, worthy, but not at any price” (Scott et al, 2000, p.206). In

⁷¹ Although fewer and less extravagant gleaming palaces were built in the UK, the 1962 hospital construction plan (of which both parties were ‘rival salesmen’ (Klein 1995, 57))—its cost described in 1972/3 as ‘completely out of control’ (Owen 1976 in Allsop, 1995, p.46)—envisioned such goals, and the individual NHS organizations zealously pursued the same high-tech gadgetry and specialist skills as their American counterparts (Allsop, 1995).

⁷² Starr (1982) provides a good example, “The Commission on Hospital Care [1947] recommended a huge program of hospital construction [...] annual operating costs would add \$137 m a year to the nation’s health care bill, but the benefits, said the commission, would ‘fully justify’ the expenditure. *These benefits the commission evidently considered too obvious to establish [italics added]*” (p.349).

such a situation, quality could not unambiguously support the other elements of the assemblage, and they could not unambiguously define quality.

In the UK, medical expenditures increased at an equally unprecedented rate⁷³ but, constrained by national budgeting arrangements, generated different sorts of tensions than those seen in the USA. Throughout the 1970s, the general public satisfaction with the NHS compelled the politicians to largely isolate it from economic pressures. In trying to make the situation financially sustainable, however, the governments embarked on a number of reforms in which managerial rationalizers and medical professionals would seek to bring about cost savings through strong managerial action (Klein, 1995; Rose and Miller, 1992). While these efforts preserved the existing assemblage, their ultimate failure to satisfy either cost, political or professional aims, and the increasing rhetoric of financial constraints—reaching its peak in the second half of the 1970s—created incentives for politicians to rethink the concordat altogether. As Klein notes:

If Ministers were to prevent the economic triumph in containing spending from turning into a political disaster [...] they somehow had to demonstrate that outputs could be increased at a faster rate than inputs [...] In pursuing this strategy Ministers were caught in a dilemma however, to increase efficiency meant taking measures that were perceived as threatening by NHS providers—the medical profession in particular. (2010, p.106)

In other words, the overflow of cost created political pressures to challenge the existing assemblage, and to confront the system in which quality was defined, managed, and delivered.

These cost concerns did not automatically or immediately disrupt the assemblages that had prevailed in each jurisdiction since the 1940s. Indeed, history and international comparisons show that there is no natural or automatic point at which health costs lead to wholesale reorganizations of social understandings of care and quality (Appleby and Thorlby, 2008). However, they constituted an ever more volatile element that might be brought into the assemblage, and used to challenge, and redefine, any number of existing elements.

⁷³ Between 1958 and 1968 the input of real resources into the NHS more than doubled from its 1950-58 levels, and doubled again between 1968 and 1978, from 3.5 % of GDP to 5.6 % (Klein, 2010, p.55).

In the USA, these cost concerns increasingly interacted with another overflow of the assemblage: ever more information about quality produced by the Peer Review Organizations (PROs) that had replaced the Professional Standards Review Organizations (PSROs) in 1982 as the primary government effort to address over and under-use and, increasingly, quality. Indeed, in contrast to the UK's rarefied calculative systems, the highly structured PRO system of the USA produced new information that proved readily susceptible to re-enrolment toward new ends. In particular, the availability of medical guidelines and statistics allowed a variety of authorities to produce their own renderings of quality, and with this information to challenge assumptions within the assemblage. Using the tools and medical standards which the profession were developing, a variety of studies were produced in the USA between 1975 and 1985 to show the existence of potentially large numbers of preventable harms and deaths (Cooper et al, 1978; DuBois et al, 1987) and errors in anaesthetic management (Folli et al, 1987; Perlstein et al, 1979; Burnum, 1976). Such findings cast the relationship between physicians and quality in new light, suggesting the possibility that the two might not be as inherently consistent with each other as hitherto assumed.

At the same time, the PRO process and procedures were attacked on a number of fronts throughout the period. Studies of the PRO processes and outputs revealed medical oversight to be based often on incomplete information and undertaken on the basis not of science but simply intuition and experience (McWhinney. 1972a; Goran et al, 1975; Sanazaro, 1976; Williamson, 1971).⁷⁴ In light of these inconsistencies, a report of national efforts to measure and manage quality undertaken by the Institute of Medicine (IOM) in 1974 concluded frankly that, "this national goal of quality assurance is worthy, but its full achievement lies beyond the present capabilities of either the health professions or society at large" (IOM, 1974, p.1), and warned that the expectations of peer review should not be overstated.

Such inconsistencies increasingly challenged the existing calculative assemblage and the notion of quality that it sustained. Indeed, in response to these reports, physicians

⁷⁴ Investigations found, for example, that, "the staff members inferred that whether or not their estimates were valid, they at least seemed to be consistent" (Williamson, 1971, p.569); and that no relation existed between the processes and outcomes that were commonly believed to be closely aligned (see Brook, 1977).

pressed their colleagues to regain control of quality and maintain their privileged position in its definition. As Sanazaro says in 1976, for example

We should critically examine the effectiveness of audit and [continued medical education] in improving patient care by improving physician performance. At stake is the medical profession's continuing autonomy in assuring the quality of care. (p.241)

Indeed, the PROs, the profession soon realized, were highly susceptible to outside interests and objectives. Indicating the potential for PROs to be removed from the physicians' hands entirely, national rankings of PROs were produced in 1981. These were based on evaluation criteria that were not of the profession's making, including "organization and program management, the process of review, and impact or potential impact of review" (Lohr, 1985, p.12). Such rankings highlighted the potential for re-enrolment: built initially on the physician's monopoly access to quality, these PRO's increasingly became measures of the physician's ability to understand and improve quality itself!

2.2.2 The (re)discovery of the patient

Concerns about cost and the challenges surrounding the PROs, moreover, were increasingly overshadowed by a more widespread social and political challenge during the period; the realization on both sides of the Atlantic that physicians and society might understand quality and care differently. This argument emerged from medical sociology's rediscovery of the patient between the early 1960s and 1985. Following Parson's (1951) model of illness behaviour, which for the first time explicitly defined illness as a socially constructed identity, a flood of academic attention had been focused on the question of how patients understood and experienced illness.⁷⁵ By the late 1970s and early 1980s a substantial body of literature had amassed which described lay perceptions of illness and health in a way that seemed tangential, if not diametrically opposed, to the dominant bio-medical model.

This research showed that illness and health were not defined in objective physical terms, confined to the lesions within the body as the bio-medical model and dominant clinical conceptions had assumed. Rather, patients were shown to understand their own health and illness in a variety of environmentally and socially-situated ways: Their

⁷⁵ See Morgan, et al (1985) for a review of the early sociology techniques, also Chapter Three.

perceptions were based on functionality (Blaxter and Patterson, 1982; Pill and Scott, 1982), individual actions (Herzlich, 1973), social class (Locker, 1979), cultural patterns (Zola, 1973), and much else independent of physiological lesions (Stizia and Wood, 1997; Calnan, 1988; Cartwright, 1964; see also Chapter Three).

Perhaps the most disruptive output of this research was the increasing attention given on both sides of the Atlantic to the “paradox of health” (Barsky, 1988), which showed that more clinical intervention could produce patients that felt and understood their health *less* positively. This paradox cast elements of the assemblage in a more complicated and ambiguous light. McKeown’s 1979 book, *The Role of Medicine: Dream, Mirage or Nemesis?* illustrated this confusion:⁷⁶

So we are told on the one hand that medical science has already achieved miracles and that if we will only provide the resources and have a little patience it will shortly solve all of our problems, and on the other that an exact evaluation of twentieth-century medicine would do more to restore nineteenth-century faith in prayer. It is said that many countries already enjoy a high standard of health which will soon be raised further, and, on the contrary, that with changing conditions of life disease problems must always be expected to change and the goal of improved health is largely illusory. The doctor is described as a man of principle devoted to the advancement of science and the welfare of his patients, and as a charlatan who can be counted on to look after nothing but his own interests. (p.176)

To an unprecedented degree since the assemblage had started to gather momentum over the past thirty years, parts of the assemblage became more questionable and difficult to maintain. Using these lay perspectives as a foundation, many social scientists, and later reformers, argued that medical dominance of health might be socially and morally detrimental (e.g. Friedson, 1970; McKinlay and McKinlay, 1977; Zola, 1972; Kennedy, 1981). These critiques were also used to attack the medical model and its physiological focus.

Moreover, despite the increasing but begrudging accommodation by the profession of these ideas, they were often enrolled in a broader critique and in alternative visions of care.⁷⁷ In the USA, Starr (1982, p.388) notes a “generalization of rights” in the 1970s, in which specific activist groups sought to assert their own definition of health and illness.

⁷⁶ His title drew from two earlier books: Dubos’s (1959) *The Mirage of Health* and Illich’s (1975) *Medical Nemesis*.

⁷⁷ As Armstrong shows, the more public-facing and exposed medical fields also began to elevate the patients’ views “from an irrelevance to a theory” (1984, p.742).

In the UK, a similar rights movement emerged (Mold, 2010), in which statutory and voluntary organizations such as the Patients Association and Community Health Councils demanded more information, more participation, and more accountability for patients.

Although these claims on the jurisdiction of health did not necessarily address themselves to the concept and calculation of quality directly, in the USA the peer review groups (the PSROs and PROs) provided a platform for them to meet. The pages of JAMA began to be populated with the frustrated comments by physicians from some of the most prestigious institutions (Brook, 1977, p.171; Egdahl and Taft, 1976) as well as politicians (Kennedy, 1971), academics (McWhinney, 1972a, 1972b; Caper, 1974), and medical reformers (Menninger, 1975) of the inherent limitations of the existing biomedical conceptions of quality that dominated the peer review systems. Their arguments explicitly drew from the incomplete model of care that had recently been uncovered. One medical reformer, for example, explained:

Most discussions of health care quality give short shrift to the concept of caring itself [...rather they address only the...] objective, technical aspects of care i.e. how much the specific tasks carried out are consistent with the latest scientific knowledge and understanding of the disease process and the treatment thereof. (Menninger, 1975, p.836)

Another argued:

The patient looks for a great deal more than mere survival, or even relief of pain. He wants, in general, to function usefully in his family, in his job, and in his community; he wants to be free from anxiety; and, he wants to have a relationship with his physician which satisfies his particular needs. An evaluation of quality which stresses survival or relief from pain and neglects these other types of criteria for success is inadequate. (Sidel, 1966, p.764)

Between 1975 and 1985 it became increasingly clear that “about the only indisputable point [about quality] is that doctors and patients see it differently” (Williams, 1971 cited in Scott et al, 2000, p.259). Thus quality and its assemblage began to fail each other; whatever quality might be, it was not something that the existing assemblage could settle.

In the UK the lack of institutionalized quality organizations and standards, and the profession’s continued reliance on craft ensured that the same intense debate about what must and must not be included in the concept of quality was not nearly as visible. Indeed, it is important to understand the extent to which in the USA, the peer review

system, by simply stating quality assurance as a goal, even if it was not actively addressed, “necessitates articulating a usable definition of quality, establishing mechanisms to set professionally acceptable standards by which quality might be judged” (Lohr, 1985, p.2).

Even without such a platform, however, these wider social movements began to place pressure on the existing assemblage in the UK. In the medical journals and popular press, questions of the level of quality, although conceptually inaccessible, began to emerge. In 1984 for example, Maxwell of King Edward’s Hospital Fund counseled his colleagues:

In the harsh world in which we live the Treasury is not simply going to be impressed by anecdotal evidence about health care quality based on self-assessment. There has to be objective evidence [...] the next necessary step in this argument is to recognise that the quality of care cannot be measured in a single dimension. (p.1471)

McLachlan and his colleagues noted similarly:⁷⁸

[The] term quality of care is being increasingly used by both doctors and their potential patients. The meaning given is not always the same and when it is accompanied with proposals for assessment, something evokes emotional responses. (1976, p.3)

It was increasingly clear that quality could no longer be simply what the qualified physician declared it to be (see Light and Levine, 1988).

Increasingly powerful patient groups and the 1983 *Griffiths Report* of NHS management also exerted ideas about the foundation of quality that were inconsistent with the existing assemblage. With the availability of patient groups, medical professionals lost their uncontested centrality in health policy (Klein, 2010; Rose and Miller, 1992). As Rose and Miller explain of the NHS in the 1970s:

The patient was now to voice his or her experiences in the consulting room if diagnosis was to be accurate and remedies effective. The patient was also to be actively enrolled in the government of health, educated and persuaded to exercise a continual informed scrutiny of the health consequences of diet, lifestyle, and work. And patients, reciprocally, were to organize and represent themselves in the struggles over health. (p.195)

⁷⁸ Duncan (1980) similarly notes building pressures for “some form of quality assurance”. He quotes an article in *The Times* stating “[...] in some parts of the profession at least there is a feeling that something must be done [...] Whether doctors move fast enough to satisfy public and parliamentary pressures of whether the Parliament will decide it cannot wait long enough for doctors to put their house in order [...] are questions still to be answered” (p.301).

The *Griffiths Report*, building on changes in health economic thinking, proposed a new link between such patients and a changing notion of quality, arguing for the patient to become as a discerning consumer selecting care on the basis of the quality of the care that they perceived, an issue that is considered further in Chapter Five.

2.2.3 Professional decline

As more and more of the profession's allies in the calculative assemblage were redefined, the medical profession found itself increasingly less able to maintain its privileged position. In the USA, the medical profession was confronted with internal and external challenges. Internally, increased specialization had led to more diverse and irreconcilable professional perspectives on health and as a result AMA membership (and lobbying abilities) declined throughout the period (Scott et al, 2000). Externally, a series of court rulings between 1975 and 1985, were also slowly dismantling some of the social and political privileges that the professions had been historically granted (ibid).

These rulings were, commentators note, both symptoms and causes of the profession's declining power (Starr, 1987; Scott et al, 2000). They pried open the doors of the medical world to new interests by, for example, forcing the main self-regulatory body in the USA (the JCAHO) to grant privileges to non-physician members, and allowing the patients to control their medical files (Scott et al, 2000, p.225). They also reflected the fact that the medical world had already begun to lose some of its social appeal. The profession seemed at least partially responsible for the medical costs, disparities, and irrationalities that many in America perceived. As Porter notes, evidence was surfacing of millions of unnecessary operations and lab tests being performed every year (1999, p.687). In contrast to the heroic surgeon of the mid-1900s, physicians were seen, by the 1980s, according to Porter, to fetishize "running tests in an obtuse and inhumane manner" (ibid). This was reflected in a popular TV sketch at the time:

GROUCHO: If I were found unconscious on the sidewalk, what would you do?

INTERN: I would work up the patient

GROUCHO: How would you start?

INTERN: Well, I would do the laboratory work first. I would do a red count and hemoglobin and then a total white and differential count. (ibid)

In 1987, Starr notes emerging signs of danger to American professional autonomy. “A fundamental intellectual reassessment of medicine is taking place; a sense of impending change fills the air” (p.17).

In the UK the medical profession was facing a similarly daunting set of challenges. As Rose and Miller (1992) note, the 1970s saw increasing fragmentation of the medical monopoly of health administration with competition between GPs and consultants and the increasing organization of ancillary workers such as nurses, physios and occupational therapists (p.195). By the mid-1980s, the “implicit concordat” (Klein, 2010, p.141) was close to its breaking point: the country’s deteriorating economic situation was placing new strains on the NHS, doctors and nurses were for the first time taking industrial action in response, and medicine’s relationship with society and the political class was strained as never before.⁷⁹ Indicatively, in 1980 the BBC aired Ian Kennedy’s Reith Lecture in which he argued that “there should be a new relationship between doctor and patient, with people taking greater responsibility for their lives, challenging the power that doctors exercised” (Rivett, 2013, n.p.). As in the USA, both intellectual and social reassessment, and impending change filled the air.⁸⁰

2.3 Calculating Quality, 1985-2010

By 1985, and in both the USA and UK, it was increasingly clear that, as Williams had noted in 1971, “about the only indisputable point [about quality] was that physicians and patients understood it differently” (cited in Scott et al, 2000, p.259). Indeed, although some professionals (such as GPs) were more willing to accommodate new ideas about quality than others, the concept of quality was essentially debatable and contested. In contrast to the 1950s, where the “essentials” (APHA, 1949, p.899) needed to produce a high quality healthcare system were relatively clear and uncontested, there was increasing confusion in the 1980s about what quality meant and what attention to

⁷⁹ Reflecting the dire state of affairs, the Presidents of the Royal College of Surgeons, Physicians, and Obstetricians and Gynaecologists issued an ominous joint statement in 1987 cataloguing financial strain and deteriorating morale, and calling “on the government to do something now to save our health service, once the envy of the world” (Hoffenberg et al, p.1505).

⁸⁰ This decline in trust and authority of the medical profession in the late twentieth century reflects a broader historical trend in which the role and legitimacy of professional and scientific knowledge acquires an increasingly unstable place in society (Salter, 2004, p.35).

quality might entail. There was no strong assemblage, in other words, to hold one stable idea about quality together as one stable idea.

It was also unclear, even as early as 1975, that the widespread critiques of quality and its assemblage could be made into a workable alternative. In a series of letters in the NEJM commentators debated the question of whether the emerging understandings of quality could even be calculated at all. One naysayer argued:

I agree [...] that caring is important and that many consumers are concerned about the emotional support they receive from their physicians. I further agree that meaningful systems of assurance would have to capture this dimension [...] however [...] I see no way of discerning whether physicians care—much less how they perform this function. (Ginzberg 1975, p.1188; see debate in Jacobs et al, 1975)

Committees and colleges were quick to point out these practical limitations of taking the various new possible conceptions of quality foreword. The review of GMC evaluation procedures conducted by the Merrison Committee, for example, concluded “there is as yet no evidence to justify general re licensure because a system of licensing could not be based on measurement satisfactory enough to justify it” (Duncan, 1980, p.300). Indeed, despite the messy “overflows” (Callon, 1998) of existing conceptions of quality that had been visible for nearly the past ten years, it was still, in 1985, far from clear that these critiques might transpire into a new sort of assemblage.

In these jurisdictions between 1985 and 2010, however, these various critiques and disagreements were enrolled toward specific ends, and were part and product of a remaking of quality and its assemblage. This section illuminates the process by which a variety of new, existing, and reformed elements were enrolled in the construction of a new assemblage upon which quality could be stabilized and made calculable. To a greater extent than the previous period, this section shows the way in which assemblages in both jurisdictions become fundamentally intertwined, providing new possibilities and new tensions for the other. To capture this interaction, these next sections move back and forth between the two jurisdictions.

This section will show the emergence of an increasingly global calculative assemblage grounded upon specific new dimensions. From something based on clinical judgment, quality would become something that only “measurement science” (Epstein, 1995, p.57) could accurately capture and assess. From something that was controlled by the medical

profession and understood strictly within bio-medical terms, quality was reconstructed outside of these traditional domains to incorporate the patients' seemingly subjective understanding of care. From something once seen to be the nearly automatic product of sufficient medical education and accreditation, quality was reconstituted as something that demanded constant managerial attention and action, and therefore the hearts and minds of all. Part and product of this transformation, we will see, was a realignment of calculative tools. Although many of these calculative tools were once constructed in the USA by medical professionals in order to extend and protect the physician's privileged interpretation of quality and care, we will see them being re-enrolled and extended towards a critique and remaking of the assemblage, and eventually even of the medical profession itself.

2.3.1 Political urgency in the USA

In the USA in the late 1980s and 1990s the social and political worries about healthcare and its quality were politicized and popularized like never before. During this period, and against the background of increasing healthcare costs, a number of prominent research institutions, such as Harvard Medical School (1991), RAND (1997), the Institute for Healthcare Improvement (IHI), and the Institute of Medicine (IOM) (1992, 1994, 1998, 1999) published high-profile and emotive reports showing clearly that the existing systems of quality control were inadequate, even in existing bio-medical terms (Blumenthal, 1996). One IOM report, drawing on nearly a hundred studies between the 1950s and 2000, produced the headline; “more people die in a given year as a result of medical errors than from motor vehicle accidents, breast cancer, or AIDS” (Kohn et al, 1999, p.6). A similar Harvard Medical Practice study showed that “as many people are dying from preventable causes each year in the United States as would die if three jumbo jets crashed every two days” (in Blumenthal, 1996, p.1147).

Although the IOM reports did little more than synthesize existing literature, the political prestige of the organization (as a branch of the National Academies of Sciences) lent a new credibility and political urgency to the issue. These reports proved socially and politically disruptive and brought new urgency to the question of control of the quality agenda. As Blumenthal (1996) explains, “politically, it [created] the impression that much medical practice lacks scientific foundation, and it [emboldened] purchasers and

policy makers to challenge physicians' claims that they know authoritatively what constitutes optimal health care" (p.1147).

But if it was believed by some that the profession could not authoritatively know what constituted quality, neither could the purchasers, consumers, and policy-makers. This inadequacy was highlighted in the on-going debate about professional standards (PSROs), which had been renamed "Utilization and Quality Control Peer Review Organizations" (PROs) in 1982 and reauthorized in 1986 with strengthened quality review requirements (Kusserow, 1988, p.2-5). Investigations of the peer review processes continually found that there existed no stable ideas about quality or tools for assessing it, beyond those traditionally managed by the profession (Lohr, 1985). One 1988 report concluded;

The PROs' quality review efforts are limited by a lack of consensus regarding the definition of quality medical care, by the amount of resources available for such care, and by the current lack of sophisticated technology to assess quality. (Kusserow 1988, p.i)

These frustrations, "reflecting a growing debate across the country" (NY Times, 1987, n.p.) were also increasingly played out in the courts, where a number of external authorities were attempting to review clinical quality, but finding quality frustratingly inaccessible. No matter how desirable, outsiders simply could not render their own calculations or judgment of quality (see Haug, 1988). Thus at the same time that the peer review process was being extended to undertake quality assessment and even assurance, it was also becoming clear that beyond the profession (and even within), there was no framework of knowledge that could be put to work to articulate a definition of quality, let alone the tools to operationalize it.

2.3.2 Making measurement science in the USA

With quality problematic, frustratingly inaccessible, and with a variety of new aspirations around what it might be, the proposals advanced by Avedis Donabedian (1966, 1975, 1980, 1989) proved extremely valuable. Against the historically prevailing claims that only trained practitioners could offer a satisfactory, but implicit, measure of quality, Donabedian stated assuredly;

I believe, on the contrary, that the concept of quality can be rather precisely defined, and that it is amenable to measurement accurate enough to be used as a basis for the effort to monitor or 'assure' it. (Donabedian 1992, p.xxxii)

To guide this development, he offered the simple *structure, process, outcome model* of quality. In this model quality is understood, and evaluation is undertaken, based on statistically defined relationships between the structure, process, and outcome of care—whatever these may be (Donabedian, 1975).

Acutely aware of the distinct social and historical constitution of quality, he posited only a skeletal outline of desirable structures, processes, or outcomes and of the division of labor in understanding and developing these relationships. Rather than developing distinct ideas about quality, he stressed an exploratory approach in which statistical relationships are uncovered and opened to the eyes of all stakeholders. He stated;

Further progress in the ability to appraise quality beyond refinements in methodology is most likely to come from a program of basic research in the medical care process itself. This belief is based on the premise that before we can make judgments about quality, one needs to understand how patients and physicians interact and how physicians function in the process of providing care. Once the elements of process and their interrelationships are understood, one can attach value judgments to them according to intermediate and ultimate goals. (Donabedian, 1975, p.153)

Short-circuiting the debate about what quality actually is, he instead provided a powerful model for its re-discovery. This model implicitly suggested that measurement, or what would soon be called “measurement science” (Epstein, 1995, p.57)—the ability to demonstrate a statistical relationship between an activity and an outcome—could complement, compete with, or even perhaps replace medical science and its practitioners as a foundation for knowledge about quality.

Although his model was originally advanced in the 1960s, it only became widely read and accepted in the 1980s—a period in which quality had been made uniquely open to debate.⁸¹ His model could elicit quality in a way that was instantly relevant and facilitated the multiple aspirations of reformers, and as such, would be a central element in the assemblages of the future.⁸² His model of quality became increasingly intertwined

⁸¹ References to Donabedian in Google Book entries show that, despite publishing his model of quality since the mid-1960s, it was only constituted as important and only fit into the wider discursive milieu from the middle of the 1970s (see Appendix 2.1). This is something Donabedian noted in an interview he gave at the end of his career. He stated, “It took me about 10 years before my ideas became popular.” He continued, “Though they became popular, I always insist that it was being misrepresented, that I did not say what they say I said, and so on” (Berkowitz, 1998, no page).

⁸² Nearly all texts on the calculation of quality since the late 1980s explicitly or implicitly endorse Donabedian’s model as the foundation of the modern quality movement. For example, Legido-Quigley et al (2008) state; “Donabedian’s approach to describing and evaluating the quality of care has been

with both the clinical audit processes, and the increasing standardization and measurement movement within the profession to produce distinct effects. In medical hands, the model offered a seemingly rational means of understanding the clinical definitions of quality that had prevailed throughout the decade. It might be used to illustrate, for example, that many of their demands on hospitals, such as nurse-to-patient ratios, in fact improved clinical outcomes. However, in the hands of patient groups or political authorities, the model could be used to fundamentally redefine quality, and to establish the structures and processes that led to outcomes reaching well beyond the bio-medical model. Indeed, with the profession on the defensive, the model and the standardization process were quickly envisioned and propelled in such directions.

With Donabedian's model to hand, a number of public and private initiatives—embracing the range of health stakeholders and views on quality of care—were undertaken to rethink what exactly quality in healthcare should mean, and to establish structures and processes that contributed to these measurable ends. In 1990 the National Committee for Quality Assurance (NCQA) was founded, for example, to bring together a number of large employers, policymakers, doctors, patients, and health plans to build a new consensus on “what's important [in health care], how to measure it, and how to promote improvement” (NQF, 2012, n.p.). In 1999, similarly, the National Quality Forum (NQF) was founded with a similar purpose of bringing stakeholders together to “foster consensus around specific standards that can be used to measure and publicly report healthcare quality” (*ibid*).

These organizations and their efforts to render a stable notion of quality suggested new elements that might be enrolled and combined. Instead of asking the professions what quality was, the NCQA developed a formal Consensus Development Process (CDP) to find out. Moving beyond the confines of the profession and the bio-medical model, the CDP allowed anyone to submit performance measures that might constitute quality. These measures would then be vetted by the Steering Committee and Technical Advisory Panels, made up of the range of healthcare stakeholder groups including patients, with reference to a set of Measure Evaluation Criteria. Substituting “measurement science” (Epstein, 1995, p.57) for “scientific medicine” (Porter, 1997,

accepted widely and is possibly one of the very few points of consensus in the field of quality of care” (p.10).

p.679), the criteria required that successful measures demonstrate statistically a relationship between the measure and the “desired health outcomes”, be suitable for public reporting, and “important to making significant gains in health care quality” (NCQA, 2013, n.p.). Finally, in place of the approval of medical elders, the CDP required simply that “general agreement” be achieved among a variety of stakeholders in order for these new measures of quality to be deemed acceptable. This process illuminated the tentative emergence of a new assemblage of elements through which quality might be calculated and made up differently. A coherence among elements was emerging that had not been witnessed in the previous decade.

Yet, this did not necessarily mean that quality would or could be extended beyond the traditional clinical domain. Indeed, Donabedian’s model was built on an appeal to neutrality through numbers that was at odds with attention to “soft” or presumably immeasurable attributes of care advocated by the reformers, and the medical standardization process had appeared at odds with non-bio-medical conceptions of care (see Chapter Three; Donabedian, 1966, p.196; Acherson, 1974). In fact, the model and the measurements required seemed far more consistent with the bio-medical focus of the growing evidence-based medicine movement within the profession than the patient rights movement outside (Feinstein, 1994). In order to understand quality outside bio-medical terms, and using Donabedian’s model, the qualities of this outside world (the patient experience, interpersonal dimensions of care, quality of life, and the other outcomes which the bio-medical model had forgotten) had first to be made quantifiable.

From the early 1980s a variety of organizations in the United States embarked on programmes to reinvent quality through substantial investments in “modern industrial quality science” (Laffel and Bloomington, 1993, p.285). Think tanks, academic institutions, and non-profit groups established close links with and received substantial funding from mainstream policy groups and governmental bodies to establish new systems for measuring the quality outcomes that mattered most to a range of stakeholders. A handful produced a long-term (and eventually global) impact, which contributed to the transformation of the assemblage and a new notion of quality that extended far beyond the bio-medical model.

In 1987, for example, the Commonwealth Fund began one of a number of collaboration with the Picker Institute in order to develop measurement processes for “improving healthcare through the patients’ eyes”, leading to the development of the 61-question Picker-Commonwealth survey of patient-centered care, which quantified the way in which the patient experienced the hospitalization process (Beatrice et al, 1998). The 1989 Medical Outcomes Study expanded on this work to develop measures of a variety of “problems patients care most about, including their functional status, degree of disability, cognitive functioning, emotional health, and social interaction” (Moloney and Paul, 1991, p.272). As one commentator noted, these measures were likely to “expand the boundaries of the scientific approach”; in the future, “being a scientific practitioner will entail these broader aspects of the patient’s experience of illness” (Moloney and Paul, 1991, p.272). Similarly, in 1990 the NCQA awarded a RAND consortium a \$25 million federal contract to develop a quality and experience survey instrument. Also in 1999, the federal Agency for Healthcare Research and Quality (AHRQ) sponsored the development of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey program, to directly collect patient experiences of quality. Patient-reported outcome measures (PROMs) developed at an astounding rate, multiplying from a variety of generic questionnaires (such as the Sickness Impact Profile, Nottingham Health Profile, and Short Form 36) to an estimated 3,215 different instruments in 2007 (Fitzpatrick, 2009)—such instruments are the subject of Chapter Three, to follow.

Through these heavy metrological investments, a new assemblage began to emerge in which quality and its calculation expanded far beyond the bio-medical model. This was an assemblage held together not by trust in the professional’s privileged interpretation, but through the interpretation provided by statistical relationships of identifiable structures, processes, and outcomes of care. Quality was what the calculations ‘discovered’ or allowed. Equipped with the right calculative tools, almost anybody could take part in these discoveries.

These new elements in the assemblage took part in a mutual translation and transformation of themselves and others. One central adjustment undertaken from 1985 onward was to make ‘the patient’ and the patient perspective, through their incorporation into calculative processes, ever more indispensable and explicitly desirable elements of quality. As the NCQA accreditation program, for example,

adopted more and more measures of the patient's perspective, such as the CAHPS outputs, into its public reporting systems (e.g. HEDIS), such a perspective became increasingly institutionalized as a core component of quality.⁸³ Similarly, with the patient perspective measurements now available, the incoming president of the JCAHO in 1997 successfully pressed for a redefinition of the organization's mission and understanding of quality. Recognizing that "in the end, medical science has finite limits" (O'Leary, 1987, p.952), O'Leary explained, "we need to focus our attention on those who are receiving care or who will receive care in the future. That's the public in the broadest sense" (quoted in Viswanathan et al, 2000, p.1120).⁸⁴ Reflecting on these developments, it was recognized even in the UK context that "satisfaction has [...] come to be seen as a legitimate and desired outcome in itself. It has become an attribute of quality, a legitimate health care goal" (Williams, 1994, p.510).

This patient perspective also took on growing significance through its continual re-enrolment in new programmatic aspirations: the development of 'patient choice' aspirations, the idea of a medical 'marketplace' even in the English system, and a variety of other projects in which the newly discovered patient had a role. Beginning in the 1980s in the USA, efforts were undertaken to make 'the patient' an active part of the health system and a more discerning consumer, in order ultimately to deliver higher quality care at a lower cost. Regional and national initiatives sought to publicly report standardized data about mortality rates, infections, and patient satisfaction, in order to activate the patient customer in making choices about quality.⁸⁵ By the 1990s, consumer-focused websites such as healthgrades.com, healthcarechoices.org, and dartmothatlas.com had developed to the extent that patients in the USA could find, sort, rank, and compare the quality of their local physician, hospital, or clinic according to such standardized metrics (see Section 3.3). Reflecting the new importance of these

⁸³ The expanding domains of care paralleled their measurement. By 1991 there were 71 quality measures in eight domains of care including "satisfaction with the experience of care", "use of services", and "availability of care" (McIntyre et al, 2001, p.15).

⁸⁴ The launch in 1997 of the AMA's own physician accreditation programme, and its subsequent failure, shows the increasing necessity of the patient-perspective of quality. Although the programme embraced elements of the patient-perspective, it made heavy losses and was discontinued three years later (Szabo, 1997). Run by the medical profession for the medical profession, the programme was seen as "the fox guarding the hen house" (Starr, 1982 in McIntyre et al, 2001, p.16).

⁸⁵ These include the Health Care Financing Administration programme (1986-1993), which publicly reported standardized hospital mortality data and initiatives such as the California Cooperative Health Care Reporting Initiative, the Leapfrog Group, Cleveland Health Quality Choice Program, Minnesota Health Data Institute, Massachusetts Hospital Association, and Quality Alliances in dozens of regions.

metrics, by the late 1990s, payments in nearly half of provider organizations had been linked to quality outcomes derived at least in part from the patient (Rosenthal et al, 2007).

Alongside these efforts to measure the non-bio-medical aspects of care quality, some parts of the medical profession, such as the American College of Surgeons, had come to see the active measurement and comparison of clinical outcomes and the evidence-based medicine underpinning it as a fundamental part of professionalism (Timmermans and Berg, 2003, Ch. 1). On this basis, medical leaders such as Dr. Shukri Khuri undertook efforts to develop risk-adjusted mortality information that could be used to compare the clinical outcomes of care provided by individual surgeons and hospitals—much as Codman had suggested, to his cost, decades earlier (Jones et al, 1996; Hannan et al, 1994). The National Veterans Affairs Surgical Risk Study, initiated in 1994, was the largest and seemingly most palatable of its kind, being “endorsed by clinicians and managers in the [veteran hospitals] as one of the principal means of assessing the quality of surgical care for veterans” (Khuri et al, 1998, p.499). This indicated that, as efforts to measure things that extended far-beyond the bio-medical model were being developed, many medical professionals were also becoming more reliant on measures and measurement to understand the quality of their own work.⁸⁶

These investments in measurement, and the systems of coordination, compensation and regulation that grew up around them, helped to stabilize a new assemblage in the USA that extended beyond the bio-medical model, that was based on a measurement science accessible beyond the profession, and that, as we will see, allowed a diversity of improvement ideas and ideals to be attached. Indeed, by 1998, a variety of commentators declared new ideas about quality and its calculation a success. One author explained:

Over the course of the last 25 years, the field of health service research has bloomed, as have new techniques for measuring the quality of health care. Before 1970, quality existed simply in the eyes of the beholder. Since then, however, various tools have been devised to measure health status, satisfaction, and a series of outcomes. (Brennan, 1998, p.709)

⁸⁶ As Timmermans and Berg (2003) note of this movement: “From an emphasis on the schools that trained physicians, the instruments they employ, and the conditions under which they work, the evidence-based movement now solidly focuses on that which 100 years ago was forbidden terrain: the content of the physician’s work. Now physicians are no longer just urged to record clearly what they choose to do: [as a result of standardization] they are now *told* in detail what to do” (p.52-3).

Now that quality “could be measured rather than assumed” (Pronovost et al, 2007, p.1801) quality efforts in the USA focused less on debating measurability and more on standardization. Initiatives such as the Performance Measurement Coordination Council and the National Quality Forum were created to “ensure that procedures to measure health care performance are consistent, efficient, and useful for the many parties that need them to make important decisions about health care” (Skolnick, 1998, p.1769-70). In contrast to the disagreement seen in the 1970s and 80s, literature in the major health journals in the 1990s focused on standardization and even the degree to which quality measurement might follow the same standard-setting processes as accounting standards (Pronovost et al, 2007, 2009; Jayaraman and Rivenson, 2008).

By the turn of the century, quality and its calculation had been synthesized and stabilized into a newly workable whole. Following the two-year National Roundtable on Health Care Quality (1996-8), which brought together representatives from almost every national stakeholder group, the participants all endorsed the conclusion that:

The quality of health care can be precisely defined. In many instances, quality measures have the same degree of accuracy as the majority of measures used in clinical medicine to make vital decisions about patient care. These quality measures have been used in a wide array of scientifically valid studies to assess the nature and magnitude of specific quality problems. (Chassin, 1998, p.12)

On the necessity to include the patient’s perspective, the link to measurement capabilities was explicit:

There have been many advances as well as refinements in the field of quality measurement. As the acceptance of these measures has increased, so has the audience for them. With this wider attention has come the need to broaden the domain of measures to include outcomes as well as processes of care and to speak to the concerns of consumers by developing outcome measures that go beyond immediate morbidity and mortality to include various kinds of functional status. (ibid)

In contrast to the undeveloped nature of quality measurement and assurance, as described by the IOM in 1974, by 1989 an inclusive notion of quality had been made measurable and real. There were of course on-going debates about the best choice of measures, but these tended to reinforce the optimism around, rather than destabilize, the newly formed assemblage.

2.3.3 An American model for the UK

In the UK, a series of high profile and emotive medical scandals from the late 1990s onward produced the same social anxiety and political urgency that the IOM reports had created in the USA a few years earlier. In 1998 a public enquiry was launched to investigate excessive infant mortalities at the Bristol Royal Infirmary, and in 1999 another was undertaken to examine the unconsented retention of organs at a number of other hospitals in the NHS. Both illuminated widespread and long-running failings. The Bristol Royal Infirmary Investigation revealed that nearly one third of all children in the unit received “less than adequate care” and that “between 30 and 35 more children aged under one died [...] than would have been expected in a ‘typical’ unit” (BRII, 2001, 0.11).⁸⁷ The final report’s comments on clinical oversight of quality showed the core of the existing assemblage to be deeply problematic. It stated:

[The] most essential tool in achieving, sustaining, and improving quality of care for the patient was lacking [...] clinicians had to satisfy only *themselves* that the service was of sufficient quality. (Smith, 2001, p.81)

With three physicians found guilty of serious professional misconduct, it was argued that trust on the qualified physician was uncertain, and that as such, they could no longer remain the foundation of quality. As one BMJ commentator stated, “At the heart of the tragedy, which has been Shakespearean in its scale and structure, is, as the GMC said, ‘the trust that patients place in their doctors.’ That trust will never be the same again [...] all had changed, changed utterly” (Smith, 1998, p.1924; see also Klein, 1998).

This trust was further eroded by the investigation of Harold Shipman for serial murder of a large number of his patients in 2000. It took a variety of the victims’ families to bring attention to the case, which ultimately revealed, through an investigation of standardized mortality rates, that Shipman could have killed hundreds of his patients throughout the years (TSI, 2002). The inattentiveness on the part of regulators to these statistical variances in mortality data highlighted the limitations of the GMC’s regulatory approach and emboldened the government to challenge the foundation of the calculative assemblage. As Leatherman and Sutherland (2003) explain, “whilst encouraging reform, these infamous cases also undercut the ability of entrenched interests to fight the new quality-related initiatives [...] The Government was politically

⁸⁷ The report was explicitly described as “the British equivalent of the IOM reports” (Shaw, 2005, p.225).

driven and time pressured to act decisively and expediently, with the professions largely in a reactive state" (p.22).⁸⁸

This social, political, and professional atmosphere in the UK resembled that of the USA in the years following the IOM reports; the elements in the existing assemblage were unable to justify each other and there was widespread pressure for reform. The only thing left to do was to find a workable alternative to the systems and understandings that had prevailed for nearly a decade, and for this, the developments in the USA proved a convenient and ready-made model. Indeed, in the wake of medical scandals authors in the *BMJ* and *The Lancet* argued forcefully for the application of measurement techniques developed in the USA (Mohammed et al, 2001; Scally and Donaldson, 1998).

This American model had, since the 1990s, spread quickly into other jurisdictions and international definitions and frameworks (see Chapter One). Researchers and reformers in the UK could and would appeal to the American model as a 'scientific' alternative to the idiosyncratic and non-calculative one they had relied upon for so long. Commissioned by the Nuffield Trust (a health think tank) to undertake a widespread and thorough assessment of NHS quality, for example, Sutherland and her American co-author began their analysis with the proclamation that an "international consensus" (2003, p.22) exists regarding the definition and measurement of quality:

The technical quality-of-care field has an emerging shared perspective on which key domains of quality are important to measure, as well as an increasingly common view of essential data elements, definitions of measures and reporting conventions. Similar frameworks for assessing and reporting quality of care are being used [internationally]. (Sutherland and Leatherman, 2003, p.85-6)

Similar appeals to this consensus surrounding the American model were seen throughout the 2000s in the medical press and policy debates. One *BMJ* article, for example, stated that:

Over the course of several decades, clinical, health services and social science researchers have produced literally thousands of validated instruments that facilitate the consistent, reliable measurement of patient-

⁸⁸ Over the following years these concerns were further reinforced by studies from Dr. Foster, along with the Department of Health (2000), Audit Commission (2001), National Patient Safety Agency (2002), and Nuffield Trust (Leatherman and Sutherland, 2003), which created similar attention-grabbing headlines as were seen a decade earlier in the USA (Hawkes, 2009b).

reported health. Patients' perspectives on their health outcomes can now be measured in most clinical areas. (Devlin and Appleby, 2010, p.3)

To the argument which had sustained existing conceptions of quality and its calculation for so long—that the learned physician alone could understand and make such judgments—the American model proved a powerful alternative. The reaction to the Nuffield Trust report clearly showed this. One commentator stated, “We may know high quality health care when we see it, but can we measure it, benchmark it, and put it into graphs? Leatherman and Sutherland do just that [...]” (Appleby, 2005, n.p.). The American-made calculative tools that these authors and many others exhibited in the UK proved a central element in the reformed calculative assemblages of this period.

The American model was in many ways consistent with the rhetoric and principles that had been developing in the British public sector since the 1980s. Since that time, a series of market-inspired reforms, aiming primarily to cut costs, had developed management ideas consistent with private sector notions of the customer, providers, and contracts and had focused attention on the definition of the outputs and (to a lesser extent) outcomes of public services (Pollitt and Bouckaert, 1995, p.9; Vidler and Clarke, 2005; Bevir and O'Brien, 2002). During that time, the patient as a customer had been articulated and advanced as an important part of operationalizing an efficient public market for services (Shaw, 2005, p.224; Carter et al, 1992). The 1984 restructuring of the NHS was undertaken on the ideal that devolution of power would make it more responsive to patient demands and needs. The introduction of an internal market and GP fund-holding, and the *Patients Charter* in 1991 were similarly attempts to make services more responsive to customers than the traditional professionals (see Chapter Five). The reforms bolstered the use of performance measures, ensured the involvement of patients in regional health authorities, and called for the introduction of medical audit. All of these ideas were consistent with the American model, seeking to open up the medical domain of quality, and operationalize the consumer in a more-or-less direct way.⁸⁹

⁸⁹ As Klein (1995) notes, these ideas were fundamentally at odds with the prevailing system: “the NHS, throughout its history, had been characterised by the fact that that its outputs were decided by the medical profession. Since the NHS existed to meet need, and since only professionals could define what need was, it followed that what doctors produced was *ipso facto* the right product. Moreover, and even more self-evidently, only doctors could judge the standards of their peers. To ask whether the right goods were being produced and to question the adequacy of standards was therefore to threaten the secret garden of professional autonomy” (p.151).

Until the late 1990s, these consumerist ideas about quality and its calculation were largely rhetorical (Needham, 2006) and did not significantly alter the “secret garden of professional autonomy” which guarded prevailing notions of quality (Klein, 1995, p.151). Although performance indicators were intended to focus a debate about outcomes in all government departments, fundamental uncertainty about what these might be in the NHS ensured that the hundreds of measures that were developed focused simply on productivity and volume “to the neglect of measures of quality outcome and consumer satisfaction” (Carter et al, 1992, p.116). Measures to activate the consumer were also often tokenistic (Mold, 2010, p.506). The 1989 white paper, for example, purported to embrace the patient perspective while continuing to maintain that “the Government’s approach is based firmly on the principle that the quality of medical work can only be reviewed by a doctor’s peers” (DH, 1989, p.40, section 5.8.). Lord Griffiths, reflecting on the progress since his review, was appalled that “there was no attempt to establish objectives at the centre and no concentration on outcomes” (in Allsop, 1995, p.189).

The direct appeal to the American model that occurred alongside the scandals of the late 1990s, however, reinvigorated these ideals. Beginning in 1997 and 1998, an array of national programs to define, measure, and manage patient-centered notions of quality—described as the “most ambitious, comprehensive, systemic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation’s health care system” (Leatherman and Sutherland 2003, p.1)—were pursued.⁹⁰ These reforms began with Labour’s 1997 white paper, *The New NHS; Modern, Dependable*, which declared that “the needs of patients will be central to the new system” and “quality will be the driving force of reforms” (DH, 1997, n.p.). The government’s following consultation paper, *A First Class Service: Quality in the NHS* (1998) proclaimed that a debate about quality that had been avoided during the 1980s would finally be undertaken:

The Government is determined to place quality at the heart of healthcare. For too long the emphasis has merely been on counting numbers, of measuring activity, of logging what could be logged, but this ignored the real needs of the patients. (Summary, Paragraph 3)

⁹⁰ Following the Thatcher reforms, quality and its relationship to efficiency could be portrayed as “an essentially unpolitical question of ‘good management’” (Pollitt and Boukaert, 1995, p.9).

With all of the tools to measure the patient experience and perspective now available, it was declared that what would be counted, and what would matter most in the NHS, would be their perceptions or *experience* of quality in care. Every government document since 1998 has not just elaborated on this central point but has sought to spell out, in more and more specific terms, the details of its instantiation (Salter, 2004, p.59).

Drawing on the American model, measurement was seen as central to quality and the cost concerns to which it was associated. The 1998 reforms envisioned a “comprehensive, management-led system of clinical governance” to remake quality and its calculation (DH, 1998). A new national standard-setting body, the National Institute for Clinical Excellence (NICE), would produce clinical standards and best practice, and a new quality regulation body, the Commission for Healthcare Improvement (CHI), would ensure that effective systems of measuring and improving quality were in place. Each of these organizations had explicit mandates to develop the tools and skills necessary to understand and measure quality from beyond the strictly bio-medical model. In addition, a NHS Performance Assessment Framework “based on the balanced scorecard approach” was developed to address, among other things, the “patient/carer experience” that would be measured through a new National Survey programme (DH, 1999, no page). These explicit responsibilities around quality and its measurement encouraged the calculative tools developed in the USA to move across the Atlantic. Indicatively, the Department of Health contracted with the European branch of the American Picker Institute to develop and run its annual patient experience surveys (Baker, 2000, p.166-7).

Like in the USA, the prominence and responsibilities of patient and consumer advocacy and protection groups also proliferated during this period. Following a series of consultations on “involving patients and the public in healthcare” (DH, 2001a, 2001b), the government called for the creation at the regional and national levels of Patient Forums, “to strengthen the patients’ voice” (Coulter and Elwyn, 2002, p.S23) and the Commission for Patient and Public Involvement in Health. These would be supported by Patient Advisory and Liaison Services (PALS) in each healthcare provider with the power to “monitor, review and inspect all aspects of local health services from the patient’s perspective” (Guardian 2001, n.p.; see also DH, 2000a, 10.17-10.19). Patient involvement in health research priorities was also extended in 2001 and 2003 with the

expansion of Consumers in NHS Research to cover social care and public health research under the title INVOLVE (see Boote et al, 2002).

Thus between 1985 and 2010, American calculative tools, specific new stakeholders, political urgency, and a professional distrust were enrolled in the development of a new assemblage. In steps, the conceptual and material framework in which quality could be calculated and understood was rearranged; the physician's privileged interpretation became increasing invalid not because it was any less accurate or robust, but because the terms of accuracy and robustness had changed. By 2005 it was taken for granted that quality would not be simply what the qualified physician declared. Rather it would be what the measures that had some kind of patient-focus declared it to be. Indicative of this new calculative foundation, a high-profile physician reformer, Lord Darzi, outlined another wave of administrative reforms in 2008. Indicatively, his proposals started with the premise that "If quality is to be at the heart of everything we do [...] it must be understood from the perspective of patients" (Darzi, 2008a, p.47). To operationalize the concept he outlined a vast calculative apparatus to "bring clarity to quality, measure quality, publish quality performance, and raise standards by rewarding quality". "After all", Darzi stated, "you can only manage what you measure" (*ibid*). Like the CDP in the USA, this national program would supplant the medical conception and control of quality with a measurement and consensus-based project. The NHS Information Centre would develop hundreds of "validated" indicators of quality, "in partnership" with patients and doctors, and let local providers choose those that are most meaningful and relevant to their services (NHS Information Centre, 2009).

Darzi's agenda represented well the way in which new ideas about quality and its calculation came to hold each other together. A notion of quality in which the patient's perspective was crucial meant that good calculation needed to take specific US-inspired forms. On the basis of these forms of calculation, moreover, quality's boundaries became increasingly solidified—as something that can only be understood, for example, through patient surveys. Quality and calculation thus came to stabilize each other; through the multiple translation and elements that made quality and its calculation fit each other, the two sides of the same movement cohered into a temporarily stable whole.

2.3.4 Putting the patient at the heart of healthcare

Conceptually, the idea of the patient or customer as a central concern in healthcare provided a lynchpin for a range of management ideas developed in industrial, aviation, and other private sectors to fit comfortably into this new assemblage.⁹¹ Concomitant with the re-alignment between the re-envisioned patient and the operationalization of the healthcare consumer, a flood of new improvement ideas entered healthcare, beginning in the USA. Many stemmed from a much-cited 1989 paper in which Donald Berwick argued for “continuous improvement as an ideal in healthcare”⁹² He argued:

In other industries, quality improvement has yielded high dividends in cost reduction that may occur in health care as well [...] therefore [...] modern technical, theoretically grounded tools for improving processes must be put to use in the healthcare setting. The pioneers of quality improvement—Shewhart, Dodge, Juran, Deming, Taguchi, and others—have left a rich heritage of theory and technique by which to analyze and improve complex production processes, yet until recently these techniques have had little use in our health care systems. (1989, p.55)

Berwick attracted considerable political and financial support for this movement and founded the Institute of Healthcare Improvement (IHI) in 1992 to develop these techniques for a healthcare setting and deliver this message across the globe.⁹³ His efforts to “apply business best practice” to healthcare quickly earned him the reputation as “the single most influential worldwide leader and driver of healthcare processes, practice, and clinical outcome improvement” (Scanlon, 2008, p.1).

In the USA, the IHI principles were explicitly adopted by the JCAHO, the primary US healthcare accreditation agency, in its 1997 reorganization (Brennan, 1998, p.715; Luce et al, 1994, p.266). To replace its purely bio-medically-motivated minimum standards of quality, it developed hundreds of patient-focused indicators which teams at hospitals

⁹¹ This conceptual connection is explicit in the NHS handbook *Quality Improvement: Theory and Practice in Healthcare* (Boaden et al, 2008), which explains; “All industrial approaches to quality improvement involve the identification of the customer, who may be internal or external to the organization, and subsequently, their needs [...]” (p.107).

⁹² The continuity between Donabedian’s definition of quality and measurement agenda with the demand to manage it in a particular manner can also be seen in Donabedian’s later writings, which contain the same industrial-sector terminology. In 2003, for example, he explains that his understanding of quality is incompatible with the term quality assurance and instead is consistent with “improvement or better still continuous improvement” (p.xxiv).

⁹³ The IHI readily advanced American quality conceptions in international forums. Their timeline notes the International Summit on Redesigning Healthcare (2000), the Asia Pacific Forum on Quality Improvement in Healthcare (2001) the founding of the Quality and Safety in Health Care Journal (2002), and The National Forum (2005).

could choose from, and stressed the use of manufacturing-sector tools to drive and demonstrate quality change. Although the core measures were published publicly on the *HospitalCompare.org* website, the measures were intended largely for internal continuous improvement efforts. “By introducing a data-driven and more continuous accreditation process”, it was stated, “the [JCAHO] expects to increase the relevance and value of accreditation for all users while supporting accredited organizations’ internal quality improvement efforts” (Lee et al, 2000, p.54). Along these same industrial-sector lines, a variety of organizations, such as the Pittsburg Regional Health Initiative (PRHI) developed a range of “the necessary tools, expertise, education, models and networks to perfect patient care and safety in their organizations” (PRHI, 2012, n.p.). They embraced models such as Toyota’s Production System and Alcoa Business Solution to make the patient perspective on quality a real and manageable endeavor throughout healthcare organizations (*ibid*).

In the UK, Berwick attracted similar attention, publishing an astonishing number of articles⁹⁴ in leading UK journals titled, for example, “What can the UK learn from the USA about improving the quality and safety of healthcare?” (Tomson and Berwick, 2006), became closely involved in NHS quality and safety initiatives, and was later knighted for his work.⁹⁵ His efforts were central to the movement from the input and output focus of the Thatcher era to the patient-outcome focus that followed. Berwick and his colleagues argued in the *BMJ* in 1992:

The introduction of market conditions into the NHS, designed to achieve greater accountability and create incentives for efficiency and improved quality of care, will not alone be sufficient to achieve improvement. Also needed is a sound and effective method by which medical leaders, managers, and practitioners can implement strategies for improvement. (Berwick et al, 1992, p.304)

Quality, constructed as it was, lent itself to these same improvement ideas. The 1999 Health Act and subsequent legislation embraced them explicitly, stating in the subsequent consultation document that, “NHS organizations are accountable for *continuously improving* [italics added] the quality of their services and safeguarding high standards of care by providing an environment in which excellence in clinical care

⁹⁴ Also see Berwick (1996, 2002, 2003, 2008).

⁹⁵ Berwick became a Fellow of the Royal College of Physicians in 2004, was made an Honorary Knight Commander of the Most Excellent Order of the British Empire, and was asked to lead and write a full review of NHS safety and quality in 2013 (see Section 4.6).

will flourish" (Salter, 2005, p.128). The rapidly expanding NHS Modernisation Agency, established in 2001 to deliver these quality improvements, worked directly with Berwick's IHI to bring these tools and principles into the everyday activities of hospitals in the UK. Lord Darzi was a Modernisation Agency Board member and supporter.

On the basis of Berwick's and others' (Blumenthal and Kilo, 2001; Tuckman, 1994) pronouncements, a changing notion of quality came to be attached to an equally shifting but specific notion of quality improvement. In place of the medical management of quality based on medical and craft-based knowledge, a variety of principles and tools originally developed in the manufacturing and high-reliability sectors were adapted for and articulated and operationalized within the healthcare sector.

As will be shown in Chapters Three and Four to follow, these principles and tools were both transformed and transformative of their new setting and situation. As we will see in Chapter Three, these new ideas about quality improvement took part in re-describing and re-presenting the patients and healthcare organizations in ways that were more like the manufacturing products and settings that they were originally developed to operate within. As we will see in Chapter Four, these new ideas and tools were themselves reimagined and re-deployed toward the more variable realities of a healthcare setting. Whether transforming or being transformed, these new quality management and improvement ideas and processes came to present a very specific and bounded notion of what counts as improvement, evidence of improvement, and improvement behavior. Such new evidentiary terms are based on the principles of bottom-up change and constant experimentation that came to be central to these improvement ideas and ideals.

2.4 The making and remaking of the notion and calculation of quality

These heterogeneous and complex movements, overlapping in and around the notion of quality and its calculation, cohere so as to constitute the distinct way in which quality and indeed healthcare and caring itself can be thought about and acted upon in 2010 and beyond. Despite the likely age-old importance of some notion of quality in providing care, this is a discursive and conceptual world of quality that few doctors practicing a few decades ago would recognize (Blumenthal, 1996). It is also a world of quality,

illuminated in more detail in the chapters that follow, that is intimately connected with changing expertise and interventions in healthcare, a reconfiguration of healthcare organizations, and a remaking on the image of the healthcare professional. While quickly changing realities of health and healthcare are themselves unsurprising, this chapter has sought to illuminate the conditions of transformation and the process by which something as central to the physician's role and identity as quality became, in a matter of years, unimaginable.

The historical morphology of the assemblages of quality and its calculation illuminated throughout this chapter and represented schematically in the three figures below, highlight the unique arrangements of this transformation. Between 1945 and 1975, this research identified the elements (to summarize them crudely) of the learned medical professional, medical technologies such as the x-ray, trust in the profession, and science interacting with peer review, the technological hospital, the bio-medical model, and distinct forms of medical education and accreditation to hold each other together in such a way to as render and gain stability from a specific notion of quality and means of its calculation. As a whole, this assemblage of elements rendered a notion of quality and possibilities for its calculation that were represented aptly by Dorman in 1969 when he stated “the only people really qualified to judge the competency of a physician [or quality at all for that matter] are other physicians” (p.921-2).

Quality's Calculative Assemblage: 1945-1975

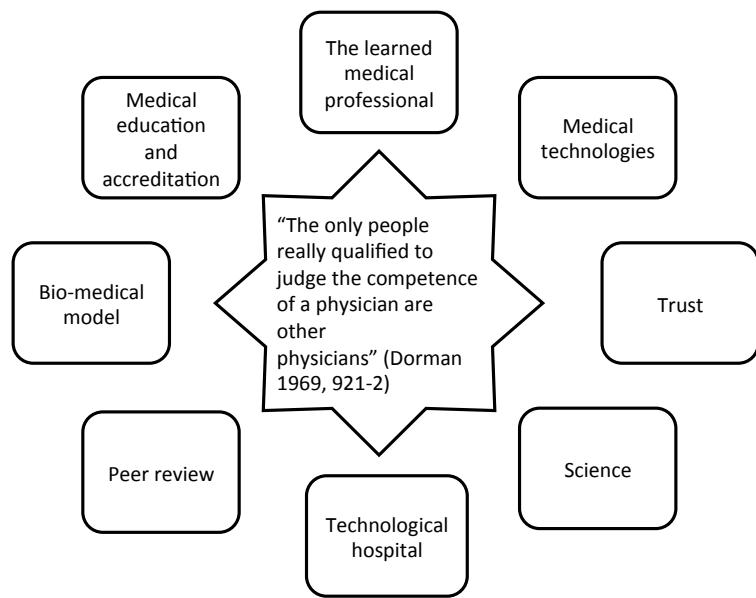


Figure 2.1: Quality and its calculation, 1945-1975

This research then identified the introduction between 1975 and 1985 of new elements into the assemblage that came to attach to, destabilize, and in part transform existing elements and the relationships between them. It showed, in particular, the emergence of new notions of the patient based in medical sociology and psychology becoming intertwined, in a disruptive way, with the trust that had historically been granted to the profession, the traditionally-defined bio-medical model, the appeal of science, and the existing systems of medical education and accreditation. It also showed the substitution during this period of measurement science for the more generalized appeal of science as a symbol of rationality and progress. Its claim to numbers presented a means of interrogating and finding fault in many of the elements such as clinical peer review that had hitherto been sustained in science's name. It also offered the possibility for any number of other authorities (other than medical professionals) to have a claim on scientific medicine—as they did by, for example, calculating a rating of the effectiveness of the different peer review groups. These sets of elements, this chapter showed, could not maintain any sort of distinctive form and stability. As a result, just one definition and calculation of quality could not be rendered. Rather, quality and its calculation, within this assemblage, were best expressed by Williams as “[...] the only

indisputable point [about quality] is that doctors and patients see it differently” (Williams, 1971 cited in Scott et al, 2000, p.259).

Quality's Calculative Assemblage: 1975-1985

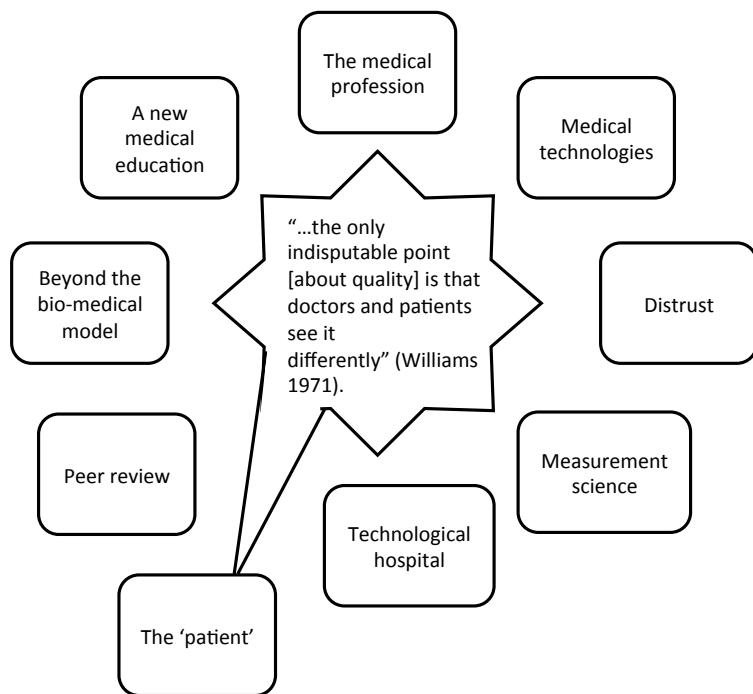


Figure 2.2: Quality and its calculation, 1975-1985

Between 1985 and 2010, finally, this research illuminated the re-stabilization of a particular set of elements to render the notion of quality and principles of its calculation that would become central to the *contemporary promise of quality*. These re-formed and substituted elements included the evidence driven medical professional epitomized by Lord Darzi, the ideas and model of quality developed by Avedis Donabedian, the industrial quality improvement movement, the ideals and principles of transparency and choice that became ever more central to healthcare policy-making, the reformed patient's view, 'measurement science', the processes and ideals of evidence-based medicine, and less explicitly, attention to cost. These elements, and the constitutive relations forged between them, were shown to provide a relatively stable and increasingly international notion of quality and means of its calculation. They provided a specific and at least temporary frame or framework through which quality could be conceptualized, discussed, and acted upon. This was one, articulated by Donabedian (1992), in which “the concept of quality can be rather precisely defined, and that is

amenable to measurement accurate enough to be used as a basis for the effort to monitor or ‘assure’ it” (p.xxxii).

Quality's Calculative Assemblage: 1985-2010

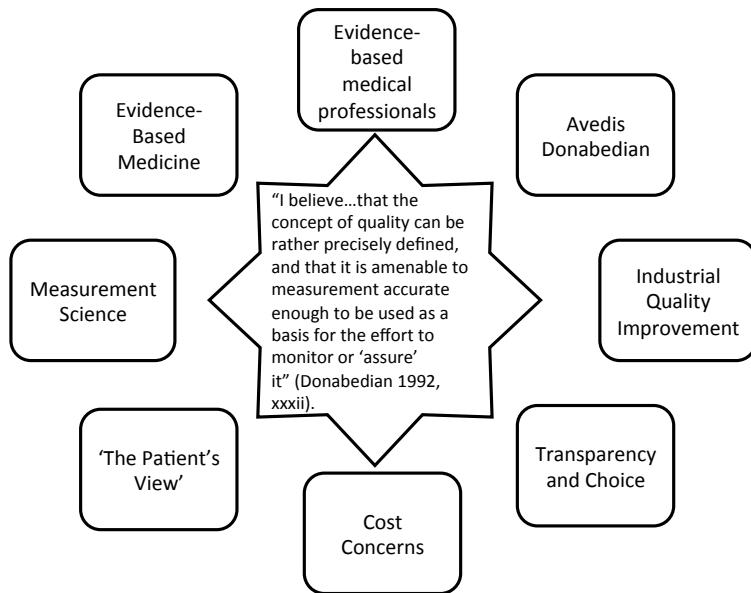


Figure 2.3: Quality and its calculation, 1985-2010

This historical investigation of quality and its calculation has thus showed quality to be *made up* from the assembling of distinct people, ideas, expressions, and things. Neither simply, “descending out of the a priori blue” (Dewey, 1984, p.31), nor “waiting for a scientist, like Prince Charming, to awaken and reveal [it]” (Callon, 1999, p.46), quality (like value) is shown to be constituted and reconstituted on the basis of the specific relation and relays formed among elements within geographically and historically distinct *calculative assemblages* (Deleuze and Parnet, 1977/2007; Callon and Law, 2005). By investigating these changing elements that have given stability to notions of quality throughout time, this chapter has also uncovered some of the dynamics by which quality and its calculation move between place and time. It demonstrated that quality does not move in some pre-determined or linear direction, but instead is part and product of unexpected movements, transformations, and reversals among elements, that included the redirection of technologies (such as peer review) in new directions (from hotel aspects of care to the actions of physicians themselves) and the remaking of ideals (for example, about the patient) into entirely new things (into consumers of care). The

movement of quality was thus shown to be a complex, unpredictable, and indeed chaotic one consisting of “translation”, to use Latour’s (1991, p.114) words, “not trajectory”.

This chapter showed this messy constitution and reconstitution of quality to be a distributed movement among and between many different forms of elements, be they ideas, technologies, people, or things (c.f. Callon, 1987). It showed, for example, an ideational element such as trust in the medical profession to be inseparable from the production and construction of tangible technologies and systems such as medical education and curriculum and practices of hospital standardization, and for these to be inseparable from the constitution of the individual physician as the central element in rendering judgments of quality from 1945-1965. It also showed the work of many individuals, such as Avedis Donabedian and Donald Berwick to be important to quality’s movement, much as many accounts of quality suggest (see Section 2.0). However, in contrast to these heroic accounts of change, this chapter showed the work of these individuals always to be made central through its connection with, enrollment in, and translation into a variety of other elements such as existing technologies, and hopes and dreams. These individuals, as such, were shown to be sustained, much like the physician’s privileged judgment or skill, by the mutual and recursive interactions between and among the network of elements involved (c.f. Callon 1992, p.137-8). For Donabedian and his ideas about quality, this meant, as he stated in 1998, that “though they became popular, I always insist it was misrepresented” (Berkowitz, 1998, no page).

This chapter also showed the historically-specific forms of quality to be intimately interconnected with changing forms of its calculation. As part and product of the same changing assemblage of elements, quality and its calculation were shown to recursively act upon and help to constitute the other. It showed, for example, the way in which, between 1945 and 1975, judgment-based forms of calculation were made inseparable from the physician-based notion of quality not just in that one was a product of the other, but that the two were a product of, and helped to support, the whole set of elements and movements that made each other cohere. Quality and its calculation were thus shown to be part and product of the same process of qualitization, or what Callon and his colleagues call “qualculation” in which numbers and properties are made to fit

each other so as to produce the things, objects, or economic goods themselves (Callon and Law, 2005; Callon et al, 2002).⁹⁶

As such, this chapter has shown that movements in quality and its calculation were due less to the progress of scientific sophistication and measurement accuracy than to the displacement and substitution of one set of self-referential and self-supporting elements (which together constituted an assemblage) for another. Indeed, quality was shown to move between time and place on the basis of the movement of a whole variety of changing elements that merely re-presented quality and themselves within a new and distinct formation. This highlights the essential fallibility and fragility of changing concepts of quality. As based not in some ever more precise uncovering of quality's true essence, but in the chaotic and even sometimes happenstance interaction of diverse elements, the concept of quality is shown to be something that might do many things other than the sorts of positive and optimistic aspirations of which it is associated. In order to better understand and appreciate the significance (and the limitations) of this notion of quality, this chapter suggests, we must attend to all of the things that are done on the basis of this particular rendering of quality and its calculation.

Such an investigation of what is done in this particular concept of quality's name is the subject of the chapters to follow. Chapter Three will investigate the particular form and function attributed to the patient's view of quality within this calculative assemblage. It will show the way that the 'patient' view', which is seemingly indispensable to calculations of quality, came to be embodied in the patient experience survey and it will show the way that this particular embodiment of the patient came to take part in potentially far reaching changes in the forms of knowledge and expertise and even interventions needed in order to deliver high quality healthcare. Chapter Four will follow the processes by which the notions of quality and quality improvement imaginable within this specific assemblage came to be expressed in distinct

⁹⁶ This chapter also reinforced the view articulated by Callon and Muniesa (2005) in the case of market calculation, that the terms of calculation or judgment (or any variant in between) are constituted by the distinct and uneven historical distributions of "calculative agencies" (p.1236-1244) among people and technologies. The movement from professional judgment to formal calculation illuminated here, as such, was shown to not be one from the physician's mind to the tools of medical science, but between whole infrastructures of elements to give these things such distinctive responsibilities. In contrast to the processes of economic "qualification" (Callon et al, 2002) which Callon and his colleagues study, however, the process of *qualitization* illuminated here, had less to do with rendering into existence stable qualities and goods in particular, and more to do with the rendering into existence of quality and goodness more generally (a set of aspirations as much as characteristics per se).

programmatic form, operationalized in specific public policy interventions, and then experienced and responded to within hospitals and wards.

Chapter 3

Knowing Patients, Doing Quality Improvement: A history of the patient survey in hospitals

That which is invented is not an illusion; it constitutes our truth. (p.3)

- N. Rose (1996) *Inventing Our Selves: Psychology, power and personhood*

3.0 Introduction

This chapter is concerned with the emergence of the patient survey in the USA and elsewhere in its distinct contemporary form and function. It is a form in which patients are asked a set of nationally standardized questions about their specific experiences with providers of care (see Appendix 3.1). It serves the function of providing comparable information about the quality of care delivered by individual healthcare organizations. As we will see, this chapter is also and simultaneously about much else. It is about, on the one hand, a set of heterogeneous movements that came to constitute the survey as a solution to the problem presented by the measurement of quality in the USA and elsewhere from the early 1970s onwards. It is about, on the other hand, the reconfiguration of the patient along new dimensions and concerns and the movement of medical knowledge into new domains. It is a metrological invention, which, as Rose (1996) notes of psychological complexes, helps to constitute people and the ways they can be known.

Indeed, the contemporary patient survey had its roots in a distinct problem emerging in the early 1970s. At that time, it was shown in Chapter Two, healthcare commentators in the USA and elsewhere argued that quality was a matter of urgent concern. It was also increasingly clear that multiple perspectives on quality existed, and that in many instances “patients and physicians see it differently” (Williams, 1971 cited in Scott et al, 2000, p.259). Medical reformers increasingly stated that medical conceptions of quality were paternalistic and ignored the real needs and desires of the patients themselves (Brook, 1977; Egdahl and Taft, 1976; Kennedy, 1971; Caper, 1974). They stated, for example:

Most discussions of health care quality give short shrift to the concept of caring itself [...]. Rather they address only the... objective, technical aspects of care, ie, how much the specific tasks carried out are consistent with the latest scientific knowledge and understanding of the disease process and the treatment thereof. (Menninger, 1975, p.836-7)

Yet, at the time, the solution to these concerns was hardly imaginable. Reformers demanded objective measures of performance so that consumers, purchasers, and the government could make informed decisions about care. But the “concept of caring itself” (*ibid*) and in particular the complex ways in which patients themselves understood and experienced care and its quality, appeared to be frustratingly intangible and elusive (Office of Technology Assessment, 1978). As we saw in Section 2.3, even those keen to make these perspectives on quality count noted that they were, and perhaps would always be, immeasurable (i.e. Arrow, 1963). One such commentator stated:

I agree [...] that caring is important and that many consumers are concerned about the emotional support they receive from their physicians. I further agree that meaningful systems of assurance would have to capture this dimension [...]. However [...] I see no way of discerning whether physicians care—much less how they perform this function. (Ginzberg, 1975, p.1188; see debate in Jacobs et al, 1975)

She concluded, “In my discipline as an economist we learned early that many things may be desirable but only some are worth the effort” (*ibid*).

However, these potentially insurmountable problems were, over the next thirty-five years, seemingly solved (Chassin et al, 1998).⁹⁷ In parallel to and intertwining with the discursive and conceptual movement discussed in the previous chapter, a variety of organizations developed thousands of diverse instruments to capture and report on these hitherto inaccessible aspects of quality. As Devlin and Appleby write in 2010:

Over the course of several decades, clinical, health services and social science researchers have produced literally thousands of validated instruments that facilitate the consistent, reliable measurement of patient-reported health. Patients’ perspectives on their health outcomes can now be measured in most clinical areas. (p.3)

⁹⁷ Although these measures have been declared a success, and incorporated into ever more regulatory and information mechanisms on the basis of their seeming accuracy or suitability to the task, there continues to be resistance against the measures, and their limitations are made visible almost weekly as cases of neglect and arguably inhumane care emerge (see Chapter One, footnote nine). Their limitations are also made visible in ongoing discussions about the use of the measures for performance pay (see Gillam and Siriwardena, 2010; Press and Fullam, 2011).

By 2010, instruments like quality-adjusted life year measurements were seen to allow the patient's perspective to be included in effectiveness research and technology assessments (Benzer, 2013), new patient interrogation techniques at the bedside were seen to place the patient and the doctor on a more equal footing (Armstrong, 1984), responsiveness indexes were seen to help make the patient's view an important dimension of performance (WHO/Darby et al, 2000), and standardized survey instruments were seen to allow regulators, practitioners, and other healthcare purchasers to see and understand the quality of care "through the patient's eyes" (Gerteis et al, 1993).

The development of these diverse calculative tools had drawn inspiration from and also helped to construct the contemporary assemblage of quality illuminated in the previous chapter. Without a calculation of the patient's view, it was suggested that quality would remain in the dark depths of professional judgment alone (Donabedian, 1988). But with these new measures, the things that mattered most about quality could be understood.⁹⁸ Through measurement, they made a specific operationalization of quality possible—one ostensibly that put an end to professional paternalism, redefined the place of the patient in healthcare, and that offered new possibilities to policy-makers (Lohr et al, 2009). And indeed, on this basis, these calculative practices have been elaborated and operationalized in healthcare reforms across the world.⁹⁹ In the UK, for example, patient-reported outcomes measures (PROMs) are increasingly used for effectiveness evaluation and national patient surveys are tied to commissioning arrangements, regulatory risk profiles, and reported publicly. In the USA, similarly, the national patient survey known as the Consumer Assessment of Health Providers and Services (CAHPS)—which is the primary tool investigated in this chapter—has been linked to Medicare and Medicaid reimbursement rates and reported publicly on the Hospital Compare website since 2009 in the hope of driving patient choice.

⁹⁸ Indicatively, these measurement successes proved central to an IOM consensus statement produced in 1998. It stated that, "The quality of health care can be precisely defined" and that "In many instances, quality measures have the same degree of accuracy as the majority of measures used in clinical medicine to make vital decisions about patient care", the report identified "problems in healthcare quality" that "are serious and extensive", and "called for urgent action". "Taken together", the report argued, "these circumstances require a major effort to rethink and reengineer how we deliver health care services and how we assess and try to improve the quality of care" (Chassin et al, 1998, p.11).

⁹⁹ It was for this reason that commentators cited these calculative efforts as "grant making with an impact", and clear examples of how "grant making can advance a field" (Beatrice et al, 1998, p.236).

This historical movement—from a patient’s perspective on quality that was inaccessible and hardly “worth the effort” (Ginzberg 1975, p.1188), to a patient’s perspective that could be “measured in most clinical areas” (Devlin and Appleby, 2010, p.3)—is the topic of this chapter. More specifically, this chapter investigates the historical emergence of the patient survey as a central means of measuring quality from the patient’s perspective, its programmatic operationalization, and some of its effects. Such an investigation, as we will see, begins to provide a crucial understanding of the way that the discursive transformations discussed in the previous chapter simultaneously develop and draw upon the material and programmatic transformations that we see unfolding in this chapter and the next.

This history has, in one sense, already been written. Indeed, the CAHPS development programme has been a meticulously well-documented project (see official timeline in Appendix 3.1). Many reviews (Jordan et al, 2005; Kimmerling et al, 2001; National Quality Forum, 2005), journal articles (Giordano et al, 2010; Darby et al, 2005; Keller et al, 2005; Goldstein et al, 2005; Sofaer et al, 2005; Levine et al, 2005), reflection pieces (Lake et al, 2005; Giordano et al, 2010), and external commentaries (Casey et al, 2007; Quigley et al, 2008; Gerteis et al, 2002) document the fifteen-year development process in great detail. They describe this process as merely another humble scientific endeavor: a process, similar to popular descriptions of laboratory science itself, of technical developments on the one hand, and careful listening, testing, and due processes on the other. They describe the process as one simply of establishing measures that allowed the patient’s long lost voice to be heard. As the developers of the influential Picker-Commonwealth survey explained;

Our conscious effort throughout this project [...] has been to set aside those *professional* frames of reference in order to cast a clearer light on the *patient’s* perspective. Our aim is to find out what patients want, need and experience in healthcare, not what professionals (however well-motivated) believe they need or get. We invite the reader, at least for their time being, to do the same. (Gerteis et al 2002, p.xviii)

This development process, undertaken on seemingly a-professional terms was, one of merely elaborating the stage for such listening:¹⁰⁰

Our first task was to develop a survey instrument that would elicit specific reports from the patient about the aspects of care they perceived as

¹⁰⁰ They state, “we stake no exclusive claim to the territory explored in these pages, nor do we pretend to be pioneers” (Gerteis et al, 2002, p.xxi).

important, in lieu of the satisfaction ratings generally used on patient surveys (Cleary and others 1991). Based on focus-group findings, we developed a list of statements reflecting specific experiences of aspects of care patients had mentioned—for example, ‘after surgery, the anaesthesiologist came to see how the patient was doing’, or ‘the nurse asked the patient about his worries.’ We then asked groups of physicians, nurses, and the health experts familiar with the patient’s perspective to review the statements and assess their importance [...]. The remaining statements were then turned into sixty-two interview questions. (Gerteis et al, 2002, p.11)

Other documentation cites careful sampling processes, rigorous factor analysis, multiple trials and detailed cognitive interviewing, the staging of lengthy listening activities, the meticulous consultation of all the healthcare stakeholders, and other seemingly technical activities to account for the stabilization of a specific patient survey, yet suggest that successful representations were those that emerged, as if unaided, from the patients themselves.

Similarly, the contemporary significance and effects of such achievements have already been elaborated. While it is noted that these new calculative tools are imperfect (Press, 2004; Lagu and Linderauer, 2010), subject to gaming (Shaller et al, 1998), and likely to face professional resistance (Ketelaar et al, 2009), they are nonetheless commonly described as merely tools, like a stethoscope, for bringing to light the reality of the patient and her care. Validated on the basis of the ‘measurement successes’ of which they are part and product, they are understood, like many accounting devices, as merely functional tools which allow the things they describe to be acted upon better and more fully (see Miller and O’Leary, 1994a). CAHPS and other such surveys merely reveal, uncover, and “empower” (McAllister et al, 2012, p.157) their patients (Gerteis et al, 2002, Ch.1). There is no suggestion that the measures could in fact be capable of transforming the patient and indeed the requirements of caring which they aim to measure and report upon.

The research approach pursued here, however, is distinctive from the above in two respects. This study is approached, firstly, on the basis of a body of research which acknowledges the historical specificity and contingency of the form and function(ality) of accounting and measurement (Hacking, 1992; Hopwood, 1992; Hopwood and Miller, 1994; Kula, 1986). This line of work suggests that while accounting and measurement have a seemingly timeless “procedural specificity” (Hopwood, 1992, p.126) and a

“rational” appeal (*ibid*, p.129), their contemporary significance can only be explained by attending to the “complex nexus of practices, procedures, institutional arrangements, and bodies of knowledge” (*ibid*) that has allocated distinct forms of measurement such authority in the first instance. This work highlights the need, in other words, to attend to the “emergence of a style of thinking about truth and falsity that established the conditions for entertaining a proposition as being capable of being taken as true or false in the first place” (Rabinow, 1996, p.31). This research aims to undertake such analysis. It aims to uncover and explore the relations and interlinkages that come to constitute the patient survey, in its contemporary form, as a valid and robust measure: a provider of truth about the patient’s view (see Samiolo, 2012).

This approach requires that analysis extends beyond the official reports and practices of the survey development process. It requires that we treat these reports not as historical explanation as such, but as products of the multiple movements in diverse and heterogeneous fields that provide the conditions for these reports to weave together some sort of historical continuity and rationality. To do this, this research traces the contemporary patient survey (in particular the CAHPS survey) from its current official bibliography down through its genealogical roots that lie in the activities of World War Two.¹⁰¹ Undertaking a roughly bibliometric analysis—that is, by following citations in the development literature mentioned above for multiple generations—and attending closely to the changing methodological concerns and advancements supplied in this official literature, this chapter outlines a shifting set of relationships which interact with what it takes to establish survey truth with distinct knowledge bases, preoccupations, ideals, and concerns over time.

This research is approached, secondly, on the basis of a body of literature that highlights the “constitutive” and “productive” potential of measures and measurement activities (Callon, 1998; Miller and Rose, 1997; Miller and O’Leary, 1993; Hopwood, 1983; Power, 1996). This literature highlights the “dualistic aspect” of measures as both derived from the changing relations and elements which make it what it is, and also constituting and acting upon these relations and presenting new possibilities for the subjects which it seeks to measure and act upon (Burchell et al, 1985, p.385). In doing so, it draws our attention to the power of measures to take part in constituting the world

¹⁰¹ This 260 item bibliography was supplied on the CAHPS website until the program expired in 2013.

that they envision (Callon, 1998), to create and make real new distinctions and equivalences (Espeland and Sauder, 2007), and to reconfigure the objects whose properties they seek to capture (Power, 1997). Such possibilities in the healthcare domain have been elaborated by Berg and Harterink (2004), Armstrong (1984) and others (Benzer, 2013; Rose, 1996). These authors illuminate a diversity of processes through which changing medical measures and probes are “fundamentally intertwined with the new shape that both the patient’s body and the medical institutions acquire” (Berg and Harterink, 2004, p.15). They show medical note taking, patient interrogation techniques at the bedside, and quality of life questionnaires *re-embodying* and *re-presenting* the patients to various authorities in terms of distinct new dimensions and requiring distinct new interventions and things.¹⁰²

This research approach aims to investigate and better understand the way in which the patient surveys and the changing terms of their construction come to potentially represent the patients of its enquiry, and to investigate its effects. This means casting aside the notion that the patient and her views merely lay waiting for the survey methodologist to come, “like Prince Charming,” to uncover and reveal them (see Callon, 1998, p.46 on similar methodological aims in a different domain). Instead, this research looks to triangulate the ways in which terms of methodological success co-construct the characteristics of the patients that they seek to reveal. To do this, it seeks to highlight the multiple mechanisms that give these characteristics value and make them real. To highlight the consequences, trade publications were analyzed, and interviews were undertaken with those professionals (known as Chief Experience Officers) whose formal responsibilities include the measurement and management of the patient bodies presented by the contemporary patient surveys.¹⁰³

¹⁰² As Berg and Harterink (2004) state, the *embodying* of the patient involves “the production of a patient with a body whose characteristics are the effect of the interrelation of the patient with a growing number of professionals and investigative instruments [... it] denotes a process rather than an *a priori* condition; it points at the achieved characteristic of ‘having a body’. ‘To embody’ is a verb that denotes the active incarnation of an entity with a specific body; it is intended to draw attention to the activities of the ensemble of entities—the investigative technologies, the record, the patient, the nurses—which together perform this specific embodiment” (p.14).

¹⁰³ Five interviews were undertaken with former and current Chief Experience Officers in major US hospitals and consultants in the area between August 2011 and January 2012. Four virtual focus groups, convened in 2012 by a non-profit research group to define the core “domains” of patient experience, were observed and transcribed. Two separate interviews were undertaken with the researcher leading the virtual focus groups and domain development process (see Annex 1.2).

These approaches, it will be shown, articulate a specific history and significance of the contemporary patient survey. This chapter will show the contemporary patient survey, and the distinct characteristics of the patient which it embodies, not to be the natural or indisputable product of scientific and social enquiry, but to be part and product of movements in heterogeneous and overlapping fields stabilized, always temporarily, along distinct dimensions or points of concern. It will show, moreover, that the patient is not 'empowered', nor is she ever made to speak more 'clearly'. Rather, she is provoked into existence in new and different ways. The terms of the provocation—the questions and the way they are asked—moreover, are shown to be consequential for the nature and delivery of care. By asking questions about objective experiences of the care process, such as "During your hospital stay, how often did nurses explain things in a way that you could understand?" and "During your hospital stay, how often did doctors explain things in a way that you could understand?" (see Appendix 3.2)—rather than asking open-ended questions or asking about levels of 'satisfaction' more generally, the survey produces a distinct new set of dimensions of the patient (experiences) that new knowledge bases and new interventions are called upon to address as a medical concern.

This history of the patient survey is presented in three sections, which highlight the temporary, if fragile, stabilization of distinct forms and functions of the patient survey, and their attendant characteristics of the patient throughout time. Section 3.1, *the post-war morbidity surveys and the reconstitution of the patient (1945-1980)* follows the way in which heavy investments in survey capabilities during World War Two combined with sociological interest in the patient's subjective world and the rise of public health and psychological expertise. It shows how these networks and interactions helped to establish an importance, and to stabilize a fairly specific form and function, of the patient survey. Although, as will be shown, the survey returns illuminated a messy and confusing set of new sociological and psychological attributes about patients, they nonetheless elevated the importance of the patients' view as an object in itself. This was a view, moreover, that was subjective and sociological in nature and populated by notions such as satisfactions, feelings, perceptions, ideas, and relations, that were all increasingly of medical and governmental concern (Rose, 1996).

Section 3.2, *patient satisfaction and the quality of care (1980-1995)*, illustrates the way in which this new concern for 'the patient's view' combined with concerns about the

quality of medical care and ideas about its improvement to provide a new function for the patient survey. Rather than illuminating social-psychological aspects of the average patient, it was suggested that it should be used to learn about and differentiate between the quality of care provided by healthcare providers. It shows the way, moreover, that consumerist ideals regarding the medical marketplace (Mold, 2010) and a “cognitive revolution” in survey research (Jobe and Mingay, 1991, p.176) interacted to conceptualize a form that appropriately fit the survey’s new function. This was a form, uniquely, that asked patients about specific experiences of the care provided to them, and that, as such, could differentiate between the activities of providers and provide ideas for its improvement.

Section 3.3, *quality measurement and the rise of the Chief Experience Officer (1995-2012)*, illuminates the way in which this particular form of the patient survey and the specific characteristics of the patient that it embodies came to be made significant within healthcare organizations themselves. It documents the development of the national standardized patient survey program, the Hospital Consumer Assessment of Health Providers and Services (HCAHPS) survey in the USA and its instantiation into regulatory and commercial requirements. It shows the way in which this new significance of the survey establishes experiences as central objects of management and expertise in hospitals—the objects that Chief Experience Officers are employed to address and improve. In doing so, it highlights a distinct relationship between changing fields of knowledge about a domain and the changing fields of knowledge about its measurement. Far from functionally derived, the measurement of the patient and her views are shown to reshape the patient and the practices and processes of caring around the properties of *experiences* of care.

3.1 Post-war morbidity surveys and the reconstitution of the patient, 1945-1980

Prior to 1945, the use of surveys to undertake systematic and widespread investigations of health and illness in the USA and UK had a long and significant history. As authors such as Marsh (1982) have shown, various worries about population in the 17th and 18th centuries, along with middle-class fears of cholera and the moral, social and political factors that they associated with it in the early 19th century precipitated widespread and complex survey undertakings in the UK and abroad (Halfon, 2007).

Surveys from the 1880s through the early 1900s, moreover, were concerned with far more than counting the dead, and exhibited technical capabilities that are often overlooked (Marsh, 1982). In the early 1900s, for example, philanthropists undertook ambitious projects to illuminate not just the rates and variations of health and illness but the complex causes and even solutions to them. Rowntree's surveys of wage-earning families in York (in 1899, 1935 and 1951), for example, used direct interviews and structured schedules to ask about a breadth of factors that were seen in the early Victorian years to be associated with poverty, and combined this data with detailed family budgets to illuminate specific new life-cycle dynamics of poverty.

This work and developments that followed established many of the contemporary principles of survey design and function. In particular, these surveys “demonstrated knowledge of the use of [precoded questions] and percentages, and used carefully trained interviewers, following a schedule”—as can be seen in the extract from a 1919 survey provided in Figure 3.1 below (Marsh, 19855, p.15). They also began to establish the survey as a tool for broader social scientific exploration, rather than mere fact-finding. It is for these reasons that many historians identify these activities as the “origin of survey research” (Marsh, 1982, p.16). However, this chapter suggests that it was World War Two and the developments that followed in its aftermath that precipitated the significant changes in the nature and significance of the patient survey, and ultimately gave rise specifically to its contemporary form. While technological changes were part of this story, its movement was part and product of wider and more significant changes related to the nature of knowing patients more generally.

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organisation.*

Figure 3.1: Extract from *Inquiry into the City of Sheffield, St Phillips Settlement, 1919* (from Marsh, 1982, p.23)

While the use of the survey to undertake investigations of health and illness increased at a steady pace throughout the early 1900s, the information exigencies of World War Two rapidly expanded the scale and significance of the surveys. Budding psychological and psychiatric epidemiology expertise, which were brought to bear in order to screen, select, and rehabilitate soldiers, and in Britain to investigate the strains and stresses caused among the civilian populations by aerial bombardments and rationing, led to survey efforts of a new scope and scale (c.f. Miller and Rose 1994; Rose 1996, 1985). In the UK, for example, the civilian involvement in the war raised questions about nearly every aspect of daily life; the nutritional intake of schoolchildren, public attitudes toward food rationing, farmers' reception to the Dig for Victory campaign, indices of sickness, women's attitudes to certain types of underwear and wearing certain trousers all became questions of seemingly pressing war interest.¹⁰⁴ This led to large investments in survey techniques and capabilities and the development of national survey programs

¹⁰⁴ One report noted: "Government activity in many spheres requires detailed information on aspects of social life. Only with this information can the greatest efficiency in planning be secured and everything done to secure personal welfare of the populations. This is specifically so where government activity comes into close touch with the personal life of individuals. It was therefore felt that detailed information should be secured on a subject which is of interest to most women - foundation garments" (in ONS, 2011, p.2).

that extended well beyond the wartime years. In the UK, the Wartime Social Survey Unit was developed under the Ministry of Defence to undertake a variety of national surveys (ONS, 2011; Box and Thomas, 1944; Thunhurst and Macfarlane, 1992, p.317). In the USA, similarly, the Research branch of the US Army developed extensive morale and attitude surveys which extended to broader post-war efforts such as the National Health Interview Survey (1957) and the General Social Survey (1971).

This activity helped to raise the capabilities and profile of the survey technique.¹⁰⁵ But it was also part and product of much broader changes in heterogeneous and diverse fields, that came to redefine the nature and significance of the survey, and establish the substantive foundation for its contemporary form and function. These changes, elaborated in the following sections, were threefold.

Firstly, the rising prominence of psychological and psychiatric epidemiology expertise during the war was part and product of establishing a new significance of the survey for medical investigation. While previous surveys were interested in aspects of health and illness, due to their seeming relationships to poverty, criminality and other such concerns, we will see that it was only from 1945 that major parts of medicine came to be concerned with what the surveys showed the patients to do, think, and even feel.

Secondly, the war efforts were also interwoven with a new sociological concern for the patient and his or her social world that surveys were helping to illuminate and construct. While surveys undertaken prior to this date were marginally interested in the subjective world of the respondents (what they thought and how they thought about the education of their children, for example), we will see that it was only from 1945 that this subjective world came to be the central focus, indeed the unique subject, of the survey technique.¹⁰⁶

¹⁰⁵ Fowler (2009, p.5) noted: “During World War Two, a group of social scientists was housed in the Department of Agriculture to do social surveys related to the war effort. It was then that area probability sampling became firmly entrenched for sampling general populations in social surveys”.

¹⁰⁶ The survey activities undertaken by Booth and Rowntree were not considered to be sociology at the time. Nor, Marsh explains, would they “have been happy describing themselves as ‘sociologists’, for this world connoted the attempt to erect grand social theories and explanatory schemes at variance with the dominant philosophy of social engineering which motivates the early poverty research” (March, 1982, p.27).

Thirdly, we will see that these movements, together, provided a historically unique form and function to the survey and its returns. On the basis of methodological concerns constructed with distinctive ambitions in mind, we will see the way that the survey and its findings came to construct an alternative or even substitute for the bio-medical patient and her body of the past. It was this new notion of the patient that provided the foundation for a new set of preoccupations, concerns, and survey efforts, elaborated in Section 3.2, which constituted the contemporary patient survey.

3.1.1 A “paradigm shift” (Klerman, 1990, p.27) in psychiatry

As a number of authors have noted, the screening, selection, and rehabilitation activities during the war in the USA and UK precipitated a number of far-reaching effects on the nature and significance of the survey and the psychological expertise of which it became part and product (Carlson and Klerman, 1990; Pols and Oak, 2007). The diverse but intermingled routes through which the survey and wartime activities impacted upon each other were three-fold.

Firstly, the screening and selection activities undertaken by the burgeoning psychiatric units in the military illuminated a potentially vast sea of mental ill health. In the USA, the initial psychiatric screening methods (which aimed not just to exclude the “mentally ill” but also those that psychiatry was beginning to define as suffering from “neuroses” or “maladjustment”) showed nearly twelve percent of those screened to be mentally unfit (Pols and Oak, 2007, p.2133; see also Armstrong, 2002, p.128). And even with these rigorous screens, there were nearly double the rate of discharges during the World War Two on psychological grounds than in previous wars. This seeming preponderance of ill health in America’s servicemen established, in the post-war period, a new and concerted attention to address mental illness in the community. As Carlson and Klerman (1990) and others note, “the publicity given to the high rates of mental retardation, psychoneuroses, personality disorders, and psychosomatic illness focused public attention on mental health problems and supported post war efforts to obtain more information on rates of psychiatry and disability” (p.28).¹⁰⁷

¹⁰⁷ Klerman (1982) also notes the importance of the newly established veterans hospitals, which were now tasked with addressing the post-war psychological challenges of soldiers, in the emergence of this new attention to mental ill-health.

Secondly, wartime investigations into the psychological neuroses experienced by military and the civilian populations began to highlight non-somatic and social factors such as traumatic experiences, perceptions of social support, team dynamics, and pre-existing anxiety or depression that might contribute to ill health and post-war adjustment. Investigations undertaken during the war showed that “whereas the rates of psychoses in the military remained relatively stable, the rates of psychoneuroses and personality reactions fluctuated and were related to combat and/or other *situational stresses* [italics added], such as extreme deprivation” (Carlson and Klerman, 1990, p.28; Pols and Oak, 2007).¹⁰⁸ On the basis of such findings (and in contrast to the mainstream model of psychology and illness at the time) it was recognized by the end of the war “that every soldier, however well led and well trained, would ultimately cease to function if continuously exposed to the intense stress of combat” (Jones et al, 2006, p.61). UK investigations of civilian responses to bombing illuminated a similar environmentally contingent picture of health and illness: “civilians, if subject to similar pathological pressures were no different” (ibid).

This early psychological attention to environmental and contextual factors precipitated a far reaching “paradigm shift” (Carlson and Klerman, 1990, p.27) in psychology and epidemiology in the years to come (Pols and Oak, 2007).¹⁰⁹ While previous psychiatric etiology had been concerned with the individual factors that predisposed people to mental ill-health, and clinical epidemiology for the most part concerned itself with the somatic “degeneration” of individuals, post-World War Two etiology was increasingly focused on the “social institutions and historical forces” that might affect “the variations and prevalence of distress and disability” (Susser, 1985, p.150; see also Carlson and Klerman, 1990).¹¹⁰ It was this new epidemiological psychiatric paradigm, a changing

¹⁰⁸ As Glass (1972, p.995) explains, “Perhaps the most significant contribution of World War Two military psychiatry was the recognition of the sustaining influence of the small combat group or of particular members thereof, variously termed ‘group identification’, ‘group cohesiveness’, ‘the buddy system’ and ‘leadership’” (in Pols and Oak, 2007, p.2136).

¹⁰⁹ This change was also part and product of the morale studies that were undertaken during the war. Rather than suggesting some people were predisposed to low morale, “the emerging consensus was that nearly everyone would suffer low morale if they were subject to certain conditions for a certain period of time [...] (Jones et al' 2006, p.60). “By the end of the second world war it was recognised that every soldier, however well-equipped and well-led, would ultimately cease to function if continuously exposed to the intense stress of combat” (ibid, p.61)

¹¹⁰ As Carlson and Klerman, (1990) explain: “Planners of epidemiological research in the post-World War Two period were impressed [...]with the wartime psychiatric studies] and concluded that

causation of psychiatric ill-health, that ushered in the “golden era of social epidemiology” that came to fruition in the decades after World War Two (Klerman, 1986, p.162; Carlson and Klerman, 1990).¹¹¹ Indeed, by 1955, the National Advisory Mental Health Council explained the change in this way:

The concept of etiology as embraced by modern psychiatry differs from the simple cause and effect system of traditional medicine. It subscribes to a ‘field theory’ hypothesis in which the interactions and transactions of multiple factors eventuate in degrees of health and sickness. (in Carlson and Klerman 1990, p.29)

Thirdly, and relatedly, this budding concern for the environmental and historical factors that precipitated ill health and the screening activities in the US, which asked specific questions of the respondents rather than relying on medical diagnosis, highlighted the potential to produce disease classification on the basis directly of what people said and did (Bebbington et al, 1980).¹¹² This led, as Susser (1985) explains, to the “single innovation in the epidemiology of mental disorders after World War Two: [...] the attempt to escape the confines of medical diagnosis” (p.315). While previously medical ill-health could not exist without a medical diagnosis, the changing terms of psychiatry and epidemiology held out the possibility for what people said to become a medical diagnosis in itself (Armstrong, 1984).

These changes in the nature and object of certain strands of medicine all intermingled with a changing place and prominence of the survey in the post-war period to establish a new significance of the survey returns. Indeed, following World War Two, and closely linked with these new psychological concerns, the “morbidity survey” (Susser, 1985, p.153) was given a specific and central medical significance. On the basis of potentially huge amounts of undiagnosed mental ill health in the community and a myriad of contextual factors which might precipitate its emergence, large scale surveys were undertaken in both countries to establish the (self-reported) rates of ill health that existed outside of the existing clinical gaze (e.g. Srole et al, 1962; Hollingshead and Redlich, 1958; Myers and Bean, 1968; Gurin et al, 1960) and the sorts of environmental

precipitating stress, rather than predisposition or vulnerability was the major factor in the causation of psychiatric illness” (p.28).

¹¹¹ This movement is also, notes Susser (1985, p.149), related to transition in medical thinking from an emphasis on infectious to chronic disease.

¹¹² Bebbington et al (1980, p.315) note: the “psychiatric screening of services populations during World War II [...] led to a generation of questionnaire measures of psychiatric disorder”.

and social factors that accounted for variations in health, and that were increasingly medical concerns themselves (e.g. Duncan-Jones and Henderson, 1978; Brown and Harris, 1978; Henderson et al, 1979).¹¹³

These surveys reinforced the new subject of their medical enquiry. They illuminated frequencies of “mental impairment of psychiatric dysfunction”, Susser notes, that “were met with open disbelief because of their magnitude” (1985, p.154). The possibility of such unimaginable ill health highlighted the need for medical enquiry to embrace and better understand these self-reports more. As Klerman explains, the findings accentuated the ongoing transformation of psychiatry to embrace surveys, and the new subject of medicine that was illuminated by them:

The new methodology emanating from this paradigm was the development of structured interviews to obtain standardized information about the patient’s past history and current social functioning symptomatic status. In parallel, sets of operational criteria and diagnostic algorithms were codified and used in assigning an individual patient to one or another diagnostic category. (Carlson and Klerman, 1990, p.30)

Thus, in the post-war years, the morbidity surveys increasingly asked about contextual factors and eschewed observations and diagnoses from anyone but the respondents themselves.

These morbidity surveys were not necessarily new in form. Like some previous surveys, they were addressed to a representative sample of a chosen population. Trained interviewers asked a series of more or less open-ended questions (from interview schedules) directly to respondents about their histories, circumstances, and symptoms. They also recoded observations about more objective criteria. Figure 3.2 below, illustratively, shows a section of the interview schedule from the Midtown Manhattan study, which was “representative” of surveys of this type throughout the 1950s and 1960s (Carlson and Klerman, 1990, p.29).

¹¹³ Armstrong notes analysis of 10,000 questionnaires undertaken in 1939. The report found that “in general, these figures indicate a shift in emphasis from consideration of disease as entities to those involving hygiene, sanitation, facilities for medical care, climate, diet and the like” (2002, p.104).

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Figure 3.2: Extract from Midtown Manhattan study interview schedule (from Srole et al, 1962, p.389)

However, the survey questions and their returns increasingly represented a new significance for medical knowledge. The authors of the Midtown Manhattan survey, for example, suggested that the self-reports of symptoms elicited in the survey could

represent disease itself. They argued, on the basis of the Army's Neuropsychiatric Screening Adjunct and the Minnesota Multiphasic Personality Inventory, that the diseases of interest could be captured merely by the self-reports and the scales used to translate them (Srole et al, 1962, p.40-45). They also argued that, though disease may manifest itself through a number of somatic pathways, for the purpose of learning about the large-scale causation of illness, they could concern themselves simply with the environmental factors that were statistically related to the changes in ill health that were reported. While "mentally disturbed are etiologically heterogeneous to a high degree" (Srole et al, 1962, p.16), the authors suggested, it was these environmental factors which they might take as their subject of medical knowledge.

This was a significant change in medical perception. The survey thus conceived began to stand in for the patient's body. The survey returns did not just illuminate symptoms, but rather the symptoms were reconceptualized as the disease itself. As Armstrong points out, "patients who reported themselves as being highly anxious could be described as having anxiety disorder and those reporting depression could be labelled as having (clinical) depression" (Armstrong et al, 2007, p.536-7). The surveys and their findings began to de-differentiate the existing separation between symptom and disease, social and pathological, cause and effect, and to provide a new status for what the patient said. As Carlson and Klerman (1990) note;

[The] categorical approach to mental illness emphasised the theory and measurement of these disorders. The criteria for assigning individuals to diagnostic categories would be based on algorithms, which, wherever possible, were based on operationally defined, observable manifestations of psychopathology with minimal inferences as to presumed causation. (p.29)

Such a movement was a distinct change in the relationship between the survey and certain strands of medical knowledge; survey returns came to recreate the dimensions and boundaries of the medical patient and her body.

Moreover, as David Armstrong (1984, 2002) shows, this movement—the substitution of the physical patient's body for the self-reports of the patients themselves—grew in medical significance throughout the 1960s and 1970s. The mass of psychological ill health identified in the psychiatric morbidity surveys was extended to identify and reaffirm the more general medical problem of the "medical iceberg" in the community (Armstrong, 1984, p.740). On the basis of this potential iceberg, clinicians like

Wadsworth (1971), from Guy's Hospital London, undertook morbidity surveys in the surrounding boroughs in order to “ascertain the extent of disease (i.e. deviation, as defined by the respondent, from his normal state of health),” and determine “the measures taken to alleviate or cure these complaints” in the surrounding boroughs (Wadsworth et al, 1971, p.7; see Donabedian and Rosenfield, 1961). Finding that only 32% of the population with complaints took them to their doctors (*ibid*, p.30), such studies re-confirmed the medical importance of this new medical space for enquiry.¹¹⁴

Similarly, the environmental factors highlighted in psycho-epidemiological surveys developed into the wider notion of “multiple causation theory” (Wadsworth et al, 1973, p.6) as authors such as Mechanic and Volkart (1960) undertook more survey activities to illuminate ever more social-psychological elements in the complex causation of reported ill health. These findings, moreover, highlighted the need for yet more survey investigation of the new constructs such as “lifestyles”, “social class”, and “stress” that were thus becoming a point of medical concern (see Armstrong, 1984, p.741). In a reciprocal fashion, the surveys thus expanded to access this new patient-reported world that medicine deemed important, and on the basis of these findings, medicine began to redefine the world of health and illness that it took as its subject.¹¹⁵

As Wadsworth et al's (1971) findings, presented in Figures 3.3 and 3.4 below illustrate, the survey increasingly presented a new object of medical enquiry to medicine. Diagnosis and disease could be either clinical or non-clinical, complaints could be medically affirmed or self-reported, somatic or environmental, yet they were all increasingly medically relevant and real.¹¹⁶ It was the survey technology, bound up with movements in medicine, which made this de-differentiation and the new way of knowing patients possible. Armstrong explains:

¹¹⁴ Indicatively, his survey was explicitly concerned with what the person said, *vis-à-vis* the traditional diagnosis: “A clinical examination and assessment of each respondent was felt not to be necessary, since interest was focused not on diagnosis, but on the person's own management and interpretation of complaints (Wadsworth et al, 1971, p.11-12).

¹¹⁵ Reflective of this broadening scope, for example, questions in the 1977 General Household Survey, such as “During the two weeks which ended last Sunday, did you have to cut down at all on the things you usually do because of illness or injury?” changed to “I'd now like to ask about anything else you've had the matter with you in the last 14 days ending Sunday” (in Cartwright, 1983, p.11).

¹¹⁶ Such an object, for example, became increasingly integrated and affirmed in medical teaching and textbooks (Armstrong, 1984, p.742). Reflecting this change, even in the leading bedside medical question, “What is your complaint?” became “Now please tell me your trouble” in this post war period (*ibid*).

Surveys had a long history [...] In these surveys, respondents were simply treated as reporters of the world external to them. The idea that survey techniques could also be used to explore the vast unknown geography of the inner world only began to emerge in the mid-twentieth century alongside the clinical experiments that elicited the early signs of the patient's mind (2002, p.149).

The survey and the changes in medicine thus advanced and made possible the other.

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Figure 3.3: Changing diagnosis and disease (from Wadsworth et al, 1971, p.55)

TABLE V.—Result of Treatment (174 Patients Able to Answer Part 3 Questions)

Doctor's Opinion	Patient's Opinion		
	Cured or Improved	Unchanged	Worse
Cured or improved	129	12	2
Unchanged .. :: ::	22	4	4
Worse ::	1	0	0

Figure 3.4: Changing diagnosis and disease (from Hugh-Jones et al, 1964, p.662)

As Armstrong and others point out, such excursions into the social and psychological did not automatically or fully implode long-standing medical constructs; investigations of why patients chose to take symptoms to their doctor was argued by some at that point “to have no necessary relationship with a person's actual health status as only medicine was [as yet deemed] competent to judge whether those symptoms indicated real disease” (Armstrong et al, 2007, p.572). But they did begin to stabilize, alongside the old patient body, a new one that could be interrogated on the basis of the morbidity

survey. As we will see, this new form of medical investigation took part in a redefinition of the medically relevant aspects of patients. On the basis of survey findings, patients were shown increasingly to have distinct views about illness, to have behaviors, social classes, jobs, and age-related issues that interacted with the disease (Collins and Klein, 1980; Cartwright, 1983, p.12). Indicatively, Wadsworth's study concluded:

Diagnosis has been likened to peeling off successive layers of an onion. I insist that the opposite process is equally important: the layers have to be put back if we are to see what an onion really is. After a long preoccupation with tissues, organs and 'disease', the patient is being rediscovered and we are rediscovering too, his family, and rediscovering the community and environment of which they are part. (Wadsworth et al, 1971, p.91)

It was, however, the parallel movements in medical sociology that helped to give these new dimensions of the patient a wider reality and significance. It is to these movements in sociology that we now turn.

3.1.2 Sociological significance of the social survey

Beyond the movement of medicine outlined above, the wartime activities also precipitated a new and significant set of relationships between the survey and the activities and disciplines of American and British medical sociology. These unfolded throughout the 1950s, 1960s and 1970s. These changing relations, we will see, combined to elevate the status and significance of the survey and its findings in a number of fields, just as had been described in the area of medicine. A number of movements broadly centered in the domain of sociology—although quickly expanding into the areas of opinion polling, consumer research, and subjective measures—came equally to construct the patient survey as a significant stand-in for the sociological bodies of the past.

The wartime efforts to attend to the morale of soldiers in the USA laid the groundwork for new streams of sociology concerned with the social-psychological dynamics of action, that were inextricably interwoven with the social survey. During the war, academic sociologists such as Stouffer, Merton, Lazarsfeld, Likert and Guttman, based in the Department of Defense, had undertaken hundreds of "attitude surveys" (Lazarsfeld, 1949, p.370) and conducted over half a million interviews with soldiers in order to access the social and subjective world of which attitudes and morale were

tentatively thought to be dependent. Bringing a new statistical rigor and new multivariate analysis techniques to the survey, this research began to elaborate the foundations of a new stream in sociology, whose primary source was the survey and whose primary subjects were hitherto inaccessible aspects of the social world.

These authors used the data gathered from the wartime surveys and activities to produce a series of volumes called *The American Soldier* (Stouffer, 1949; Merton and Lazarsfeld, 1950) and “expository reviews” (Lazarsfeld, 1949) in the immediate post-war years, which elaborated the foundation and demonstrated the benefits of this new sociology. In these publications, they argued that attitude surveys could provide for the social world the sort of objective and standardized properties of subjects (such as mass, temperature, etc.) that the natural sciences (which they took as their exemplar) were able to rely upon. They stated:

The mere description of human behavior, of its variation from group to group and of its changes in different situations, is a vast and difficult undertaking. It is this task of describing, sifting and ferreting out interrelationships which surveys perform for us. (Lazarsfeld, 1949, p.379)

They argued that this systematization of the social could also provide a means of advancing social theory. Lazarsfeld argued that the survey activities could not only overturn conventional assumptions about social facts—that “men from rural backgrounds were usually in better spirits during their Army life than soldiers from city backgrounds” (1949, p.380), for example—but that they could also illuminate sociological underpinnings of “human behaviour” (ibid). One such finding Lazarsfeld pointed to was the way that his colleagues were able to “convincingly document by statistical data” the “psychological process” by which “primary groups shape the thinking of the individual” by being repeatedly administered to a series of troops that had been removed from their group and inserted into new ones (p.383). On the basis of the survey returns they showed that, for example, the men identified with some aspects of the new group while changing their thinking about themselves: they “acquired excessive pride [...] with regard to their outfits, but they also developed feelings of inferiority about their own abilities” (Lazarsfeld, 1949, p.383-4).

This work helped to bring about a similar movement to that seen in psychiatry and epidemiology in these same years. This new sociological framework held out the possibility that the social-psychological world made visible by the attitude survey could

stand in for the world that case research and other such sociological traditions had relied upon for so long. It provided a “new social science”, whose modern method would be “the rigorous testing of explicit hypotheses on largely quantified data accumulated by structured observation in empirical situations approximating (with specified deviations) the model of controlled experiments” (Lerner, 1950, p.222 in Platt, 1966, p.60).

While there was some notable backlash to this movement within American and (especially) British sociology (see Converse, 2009, p.222), contemporary historians suggest that the volumes provided “profound and numerous” contributions to “social science in general and social psychology in particular” in the post-war years (Converse, 2009, p.222; see also Platt 1966; Marsh 1982).¹¹⁷ In the USA, the book was greeted, as “an exemplar of the ‘new social science’, ‘the modern method’—not only by the publicists [...] but also by social scientists, humanists, members of the military, and journalists” (Converse, 2009, p.222). Moreover, its enterprising authors established large and high-profile academic research centers, with close ties to government and industry, building on their war-time work. “All this combined”, Platt notes, “to establish and give hegemony to the new model survey, and to the departments where its leaders were now located” (1996, p.50).

These post-war American sociology movements also became deeply connected with the rise of social indicator research (Duncal, 1984, Ch. 3), opinion polling (Lazarsfeld, 1957) and consumer research (Wells, 1993; Arndt, 1986), and other developments that had significance far beyond the sociology departments in American universities (c.f. Rose, 1996).¹¹⁸ These academics (as well as others such as Blumer and Burgess of the University of Chicago) expanded this wartime work in order to advance the survey as a means of providing government, corporations, political strategists, and anyone else access to the inner minds, happiness, feeling, satisfactions, and other such constructs of its population and voters. Survey units, such as Princeton’s Office of Public Opinion Research, and Lazarsfeld’s Bureau of Applied Social Research at Columbia were

¹¹⁷ Marsh noted: “By far the biggest contribution to thinking about the use of survey data to answer sociological questions, which are of their essence causal, was given by the quite extraordinarily original and prolific writings of one man, Paul Lazarsfeld” (1982, p. 44).

¹¹⁸ Large UK institutions, such as Tavistock, for example, established psychological investigations of “the subjective meaning of consumption of the ordinary individual” in everyday life as central to advertising, choice and consumption between in the 1950s and 1960s (Miller and Rose, 2008, p.130).

established at many of the leading schools. And consumer research, stemming from analysis of activities such as the wartime bond drives, proliferated in the post-war years.¹¹⁹

In the UK, the wartime information activities were distinct from those in the USA, but nonetheless contributed to a similar reconfiguration of the status of the patient's view. Although there were early efforts to involve academics in a thoroughgoing analysis of population morale as in the US, there was a strong public opposition to such governmental "snooping" (Marsh, 1982, p.33-5). As a result, the survey activities, such as the Wartime Social Survey, "restricted itself to a variety of surveys on diet, the efficacy of rationing, knowledge of venereal disease [...] and other more directly factual topics" (ibid, p.33). In place of the subjective-focused surveys in the USA, the wartime efforts involved much more use of qualitative and descriptive investigation of this social and subjective space. Of particular note were the activities of Mass Observation, which recruited a number of civilian reporters to undertake detailed journals of social life that they observed. While the reports were of variable quality, at their best, Marsh suggests, they provided some of the "finest pieces of social research of the period" (1982, p.33). This style of investigation was carried forward into the post-war years with a sociology that tended to embrace a more narrative and descriptive tradition (see Tonkiss, 2004; Mastrofsky et al, 2010, p.225).

All of this work, whether overtly sociological, or undertaken for polling, government or private sector purposes, helped to supplant the person that had been presented previously with the person provided by the survey—just as in medical psychology. And indeed, in the post-war years, medical sociology extended and reified the survey and the patients that it discovered in the same iterative way that was taking place in medicine. Koos' (1954) exploration of "what people think and why they behave as they do in regards to health" (p.38), undertaken on the basis of an interview schedule asking patients about how they would respond to hypothetical symptoms, marked, Armstrong

¹¹⁹ Wartime activities, such as the enormous advertising campaigns for war bonds and stamps, also resulted in post-war analysis that advanced these fields. Of particular note, for example, was Merton, Fiske and Curtis' *Mass Persuasion: The Social Psychology of a War Bond Drive* (1946), which sought to specify the cognitive structure that had to be created to result in a successful sales drive. The SSRC "Committee on Measurement of Opinion, Attitudes and Consumer Wants" also began its work in 1945 by commissioning pieces by Lazarsfeld, Blumer, and others, and the American Association for Public Opinion Research was launched to further advance these survey activities. The Social and Community Planning Unit, was similarly established in the late 1970s in the UK.

(1984) notes, the beginning of a proliferation of socio-medical surveys in the coming years.

Indeed, in the years to come, Freidson (1960, 1961a, b), Duff and Hollingshead¹²⁰ (1968), Zola (1966), Hannay (1979) and others in the USA, argued that “medical practice [...] requires for its very existence satisfaction of conditions that lie outside its domain of technical expertise [... and that] they are sociological in character” (Freidson, 1961a, p.9). And they set out to find and illuminate this sociological space using structured survey questions and quantitative analysis of their results.¹²¹ As some of the tables from Freidson’s studies, presented in Figure 3.5 indicatively show, the sociological space that was illuminated was one populated by the things people said, thought, and felt, rather than the traditional medical and sociological bodies. It was a social space between bodies and the deeply personal and psychological space of perceptions, fears, hopes, and concerns (c.f. Armstrong, 2002; Miller and Rose, 1997).

¹²⁰ This research brought together a physician and sociologist to explore and help constitute the new patient of the survey.

¹²¹ The relationship between the method and the world it illuminated was explicitly noted by Zola (1966), who stated: “[...] illness is generally assumed to be a relatively infrequent, unusual, or abnormal phenomenon. Moreover the general kinds of statistics used to describe illness support such claims [...] though such statistics represent only treated illness, we rarely question whether such give a true picture” (p.615). On this basis, Zola set out to use the survey method to investigate these claims, in the process illuminating a huge amount of undiagnosed and untreated disorders that social pressures and preoccupations kept from medical view.



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Figure 3.5: Survey and sociological space (from Freidson, 1961a, p.47)

In the UK, Ann Cartwright undertook similar investigations of the sociological world surrounding health and illness. Using structured interviews but supplementing these

with more qualitative exploration, sociologists like Cartwright presented detailed accounts of the patient's thoughts and feelings about care. Cartwright's (1964) investigation of "what it is like to leave your home and family and go into hospital, where you are dependent on strangers for physical care and companionship" (p.33), for example, was undertaken by interviewing over 700 people discharged from hospitals as well as a number of hospital staff, using a structured questionnaire that asked specific scale-based questions for statistical purposes as well as open-ended questions for illustrative and qualitative detail. The findings, reported in the manuscript *Human Relations and Hospital Care*, combined rich personal accounts of experiences of care and its failure with statistical evidence that many problems, particularly around communication, were not anecdotal complaints but systemic and widespread 'facts' of hospital care.¹²² With these documented information dysfunctions Cartwright argued that, in fact, "the successful application of medical knowledge depends on what patients think and feel about doctors, nurses and hospitals" (1964, p.3).¹²³

TABLE 23
SATISFACTION WITH INFORMATION
AND THE NURSES AND SISTER AS INFORMANTS

	<i>Proportion not able to find out all they wanted to know</i>	<i>Number of patients in each group (= 100 %)</i>
Obtained information from both the sister and nurses	14	130
Obtained information from the sister but not the nurses ..	13	263
Obtained information from the nurses but not the sister ..	26	80
Obtained information from neither the sister nor nurses ..	33	224

Figure 3.6: Satisfaction questions (from Cartwright 1964, p.112)

¹²² Cartwright concluded, "If it [the NHS] is to be effective, it must be based on knowledge about the facts, and the public needs to recognise that the interests of both patients and the staff can be served by informed criticism and demand for improvements" (1964, p.205).

¹²³ Similarly, seeking to determine "some facts of admission on patients, from their point of view", practitioners from King's College Hospital undertook a survey of the patients admitted to one unit of the hospital (Hugh-Jones et al 1964). Asking questions such as "How did you feel about coming into Kings College Hospital? Mainly anxious/mainly relieved/Both/Too ill" and "Were you, on the whole, during your stay in hospital contented/discontented/concerned?", they presented their findings as potentially useful in determining means of improving the "efficacy of services" currently provided.

These studies did not automatically replace the existing patient with a newly-socialized one. One medical review of Cartwright's study, for example, curtly dismissed her findings.¹²⁴ The reviewer stated:

[The] successful application of medical knowledge depends less on what people think and feel about doctors, nurses, and hospitals as is claimed [...] than on the evidence that medical knowledge has been so successfully applied in the past. (Higgins, 1965, p.128)

Such reactions, however, were increasingly difficult to sustain. Cartwright, reflecting a broad change in the nature and the significance of the survey for sociological and medical knowledge, responded to her critics by stating:

[You] seem to regard non-random data from doctors as 'hard' while stating that data from a random sample of people or patients are 'soft'. But, as [others] point out, 'rather than measuring something less than 'objective' clinical assessments, *self-reports may be measuring something more* [italics added]. (1981, p.308)

Indeed, the reality of this "something more" (ibid) was apparent even in Higgin's dismissive critique. In an attempt to justify his dismissal, he pointed to various findings from American social surveys that were different from Cartwright's. It seemed that, even if one wanted to dismiss the surveys, doing so required some sort of alternative survey returns. The terrain of the patient was already being re-mapped in terms of thoughts, feelings, aspirations, social and environmental relations, and all the other new terms that the surveys could construct at the objects of medicine and sociology.

3.1.3 Methodological movements and the re-presentation of the patient in healthcare

The cumulative effect of these medical and sociological movements was, by 1980, to establish a historically new and stable code of knowledge about the patient alongside, if not substituting for, the traditional medical one. As Armstrong explains, the gaze of the morbidity survey and the field of the patient's social world came to mutually support and rely on each other to disrupt the existing notion and boundaries of the patient. He states:

A concomitant of the spread of morbidity surveys in the post-war years was the redefinition of the patient. Under the old regime the patient was no more and no less than the body which enclosed the lesion. The surveys on the other hand embraced everyone, and found that almost all experienced

¹²⁴ Beeson (1968) issued a similarly scathing review of Duff and Holingshead's study, calling it a "misadventure", demonstrating, "in a negative way [...] importance of adhering to the normal procedures for scholarly study" (p.240).

‘physical’ symptoms or that most were mentally ill. [...] The conceptual and methodological correlation between the patient’s views and the lesion began to fragment as a new referent [sic], the social, made its appearance. (1984, p.740)

Indeed, ‘the patient’ that the surveys were illuminating and medicine was increasingly addressing was no longer one that had merely a somatic body, that existed within the walls of healthcare establishments, and that the traditional bio-medical model was designed to address.

Instead, the patient that was of medical and sociological interest was one that had a distinct perspective and point of view that needed to be provoked, attended to, and addressed. Indeed, the survey activities of this period illuminated a whole new set of dimensions or characteristics of the patient that were rapidly acquiring medical relevance and concern. Such characteristics included things like “social class”, “stress”, “patients’ perceptions” (Houston and Pasanen, 1972), “attitudes” (Hulka et al, 1970), “recipient’s reaction” (Jolly et al, 1971). Indicative of the emergence of new aspirations around the consumer and his or her choices, as for example, central for a efficient healthcare marketplace (see Mold, 2010), characteristics such as “client evaluations” (Kisch and Reeder 1969), “consumer assessments” (Leblow, 1974), and “the consumer’s view” (Cohen, 1971) were also making their appearance. Summarizing these changes, Armstrong explains:

Under the old regime treatment success was evaluated by the disappearance of signs. In the new, the patient’s attitudes were important [...] In effect the patient’s view, from being a measure of effectiveness, was moving to be a problem in its own right. (1984, p.741)

Although the new map that characterized the patient was populated by a messy and overlapping set of characteristics, by 1980 it was clear that the characteristics that mattered were those derived from the survey and that illuminated “*the patient’s view*” (Armstrong, 1984).¹²⁵

None of the socio-medical constructs were as readily, but problematically, advanced as that of “patient” or “customer satisfaction” (Leblow, 1974; Locker and Dunt, 1978). From both a medical perspective and a sociological one, the patient’s satisfaction was

¹²⁵ Armstrong (1984) writes: “The reconstruction of patient’s views, from being a measure of medical effectiveness, to become the location of a major problem in its own right—through the notions of ‘coping’ and ‘adjustment’—began to take effect from the late 1960s, though its beginnings can be identified in the extension of psychological medicine in the immediate post-war years” (p.741).

increasingly seen to be central to the way in which the patient interacted with health and illness, medical professionals, and the medical system more generally. From a medical perspective, patient satisfaction increasingly mattered because it was shown repeatedly to be “a potentially important factor in health care in that it may influence whether or not a patient seeks medical help, whether the patient complies with a therapeutic regimen and whether the patient maintains a continuing relationship with a physician” (Larsen and Rootman, 1976, p.29; see also Apple, 1960; Kincey et al, 1975; Cartwright, 1983, p.87-92).

From a sociological perspective, it was stated that satisfaction was important in its own right. For sociologists patient satisfaction was an indicator of aspects of medical care that were traditionally overlooked by bio-medical measures (Locker and Dunt, 1978). Moreover, for authors like Cartwright, it was an attribute of care that required illumination to change the balance of power and make political distinctions about medical performance more generally. As she explained in a later reflection:

The most fundamental contribution made by surveys in the health field is that most of them are concerned with the needs, experiences, and attitudes of patients in a service which might otherwise be dominated by professional paternalism. In a very real sense, *surveys are part of a democratic process: they are essentially sample referendums* [italics added]. (Cartwright, 1983, p.198)

On the basis of these overlapping medical and sociological concerns, there was a huge amount of survey activity directed at provoking *satisfaction* with care throughout the 1960s and 1970s. This activity illuminated all sorts of relationships around satisfaction, even while defining and asking about it in a variety of ways (Leblow, 1974; Locker and Dunt, 1978). Asking a number of different direct (e.g. Tessler and Mechanic, 1975) and indirect (e.g. McGhee, 1961; Fisher, 1971) questions about satisfaction and measuring the responses on different scales (see Ware and Snyder, 1975, p.669), this research, not surprisingly, produced a confusing mix of different results (see Locker and Dunt, 1978, p.236).

The survey and the movements of which it was part and product served, in summary, to reconstitute both the dimensions and significance of the person that would matter from the 1980s onwards. Whether conceptualized as ‘patients’ or ‘customers’—a distinction yet to be established—the person with ill health was a person that had *needs, desires*,

attitudes, perceptions and even *satisfactions* that were related to any number of social and environmental factors, and that had to be attended to and improved.

The constitution and stabilization of this new notion of the patient was one, moreover, made possible by fitting the objectives of the survey with specific methodological developments and norms. As Leblow (1974), for example, explained, consumer opinion of care was becoming a pressing concern because of “the increasing concern with patient care among members of the medical profession [*and*] the introduction of social scientists with their sophisticated sampling techniques into medical care settings” (p.328). The form of the survey and the methodological concerns converged in this period in a number of specific ways to stabilize the new patient and her view.

Firstly, right up to the 1980s, the survey was conceived as a tool for uncovering truths about people, situations and caring generally. In contrast to later years, the surveys aimed not to distinguish between particular providers and particular people, but instead to illuminate new characteristics of people and patients that mattered. These ambitions meant, as Leblow explains in a review of the literature in 1974, that the biggest methodological challenges revolved around that “of determining the type of care the *average* [my italics] American receives” (p.335). Establishing generalizability of the findings was the primary methodological hurdle in establishing survey truth. As such, the research went to lengths to demonstrate that their surveys illuminated aspects not of some particular set of people or providers, but the care context generally. Extensive demographic data was used to validate the random selection of patients, interviewers were trained extensively to avoid bias, particularly in selection, and attention was given to bias-related sample sources, like election registers (Cartwright, 1983, p.4-24).

Although some of these sampling principles failed famously, for instance, in the opinion polling around the 1948 US election and those in the UK in 1970 and 1974, it was still by addressing sample selection or “generalizability” (Locker and Dunt, 1978, p.286) that the surveys could claim credibility (e.g. Kincey et al, 1975, p.559; Larson and Rootman, 1976, p.30). The centrality of this issue was illustrated in the negative reactions to Cartwright’s findings, where Higgins (the critic cited above) argued that Cartwright could not be right because the findings were inconsistent with surveys done elsewhere. He quipped:

Eight per cent of those questioned stated that *they* had suggested referral to hospital, not the doctor. This figure is very much less than that obtained (51%) in a survey in North Carolina. Are conditions in the two countries so different [...] to resolve all doubts that the patient might perhaps have been mistaken [...]?" (1965, p.128)

Faced with such differences (which were prevalent in all survey research), Cartwright pressed her claims by appealing to sample robustness. On the basis of her claimed methodological rigor, she argued that eight percent of patients, "in fact", suggested referral in England (Cartwright, 1964, p.205).¹²⁶

A second methodological concern stemming from the framing of the survey ambitions throughout this period was the "reliability" of the survey returns (Leblow, 1974). For many medical researchers this challenge was one of the trustworthiness of the patients. Wadsworth, for example, identified three specific challenges of patient information that he had to overcome:

First, it is a well-known and documented fact that certain conditions are in themselves liable to be considered not sufficiently socially acceptable to be mentioned at interview—e.g. venereal disease, illegitimate pregnancy, and even haemorrhoids. Second, there seems sometimes to be an underlying fear or superstition among respondents that to talk of an illness increases the likelihood of its occurrence. Third, the dangers inherent in interviewing persons by proxy are well known. Memory errors form the other major area of difficulty. These may take the form of involuntary or voluntary suppressed reporting of an illness which masks the real situation. (Wadsworth et al, 1971, p.93)

It was suggested that the survey could be designed to eliminate these biases and produce a generalizable notion of the patient by providing a frame of reference to the patients, by using structured probes (e.g. by asking an equal number of negatively and positively framed questions) (Ware et al, 1977b), by training the interviewers to produce comfort and familiarity with interviewees, by asking more specific questions, and in some cases by attempting to validate the data with reference to observations and other sources of information (see Locker and Dunt, 1978, p.286; Leblow, 1974). Despite these efforts, evidence of the extent to which "subjective" answers to surveys aligned with "objective" facts showed that the patient's view to some extent (often a great extent) diverged, leading authors to conclude that "such results should make one cautious of

¹²⁶ Indeed, even in 1981, when negative views were expressed about the methodology of a follow-up to Cartwright's 1964 study it could be confidently retorted that: "It is a brave man who tangles with Dr Cartwright on issues of statistical treatment of her data or social class classification; and in this instance the courageous proved foolhardy" (Jefferys, 1981, p.2059).

patient evaluation, although these findings do not imply that patient opinions should be abandoned altogether" (Leblow, 1974, p.334).¹²⁷

This seemingly methodological problem was, however, largely neutralized by the argument that the patient's view was distinct and important in its own right. Authors of all backgrounds increasingly pointed out that the assumption that patient opinion had to be validated with medical 'fact' was itself unfounded, given the concern for the patients as such. Locker and Dunt, in their literature review, for example argued that:

[There] is no necessary correspondence between the views of providers and consumers since their evaluations may be based on radically different criteria [... The] question is not necessarily one of deciding whether professional or consumer opinion should be regarded as more central, but how they can be reconciled in the formulation and implementation of policy. (1987, p.290)

A few years later Ware et al (1983) similarly highlighted this inconsistency, arguing:

Although satisfaction ratings are sometimes criticized for not corresponding perfectly with objective reality or with perceptions of providers or administrators of care, this is their unique strength. They bring new information to the satisfaction equation, (Ware et al, 1983, p.247)

Validity, thus conceptualized, required only good sampling, and perhaps could be backed up by conducting the survey on the same respondents at different points in time ("test-retest validity") or by asking multiple questions on the same point ("internal validity"), although such practices were rare (Ware et al, 1977a, p.10-13; see also Locker and Dunt, 1978; Leblow, 1974).¹²⁸

The final methodological point that began to emerge as a serious issue in the late 1970s related to the question of what exactly "satisfaction" was.¹²⁹ Although it was increasingly clear that satisfaction mattered, authors began to question the theoretical

¹²⁷ In a literature review, Leblow (1974) states that "parents of pediatric patients claimed they followed physician's instructions more than they actually did", that "a large difference was found between parent verbal statements about drugs taken and that revealed through urine samples" (p.334).

¹²⁸ This is implicit in Leblow's (1974, p.334) consideration of the issue; "patient questionnaires remain the best method of reaching important aspects of patient care such as how the patient perceived and felt about care. Ratings by others would not be able to assess certain aspects of the interactions of the medical personnel and the patient". Patients, he maintained are not ever "wrong" in their perceptions (*ibid*).

¹²⁹ Beyond the three methodological challenges mentioned here, there were also very substantial practical concerns about funding, coding, data analysis, and sample access. Moreover, it must be highlighted that the notion of a good survey was not well defined during the period. Methodology sections of surveys were often quite difficult to interpret, idiosyncratic or altogether missing (see Ware et al, 1977a, b).

underpinning of the notion itself (Ware et al, 1977a). Locker and Dunt, for example, argued:

Studies of satisfaction with care must be methodologically sound and have an adequate conceptual and theoretical basis. Though conceptual and theoretical matters are logically prior to discussions of methods and measurement, they have been somewhat neglected in the literature. For example, it is rare to find the concept of satisfaction defined and there has been little clarification of what the terms means [sic] either to researchers who employ it or respondents who report it. (1978, p.288)¹³⁰

This lack of a theoretical construct led to a variety of efforts to empirically illuminate what satisfaction was or entailed.

Authors that had previously been concerned simply to show that the patient had discernible levels of satisfaction began to consider the things that mattered *to* the patient's satisfaction as time went on. Larson and Rootman (1967) and others began to not just ask patients about how satisfied they were with medical professionals, but what it was that precisely made them feel this way. By 1977, Ware was able to summarize a wide range of associations:

Ratings have been significantly linked to characteristics of providers and services. Patients tended to be more stratified when providers gave more information (Houston and Pasanen 1972); when they were consulted by a physician (Linn 1975); when patient plans were explained (Bashur, Metzern and Worden, 1967); when providers were happier and held more favorable attitudes toward patients (Greenly and Schoenherr, 1975); and when providers showed a personal interest (King and Goladman, 1975). (Ware et al, 1977a, p.13)

The psychologist and health outcomes researcher, John Ware, and his colleagues at the think-tank RAND (1977) took this line of questioning even further, developing a taxonomy of patient satisfaction for the construction of their Health Satisfaction Questionnaire. It identified eight “distinguishable dimensions” that existing surveys indicated made up the “major sources of satisfaction and dissatisfaction with care” (art of care, technical quality of care, accessibility/convenience, finances, physical environment, availability, continuity, and efficacy/outcomes of care) (Ware et al, 1977a, p.3-4). They suggested that these domains could be measured, rather than satisfaction itself. Writing in 1977, Ware was ahead of his time. Although he was drawing upon the

¹³⁰ They continued, “Another important issue that needs consideration is the process by means of which respondents decide whether they are satisfied or dissatisfied. On what are expressions of satisfaction and dissatisfaction based? Given the preoccupation of most researchers with the identification of socio-demographic variables associated with satisfaction, little attention has been directed towards developing a well-defined sociopathological theory of satisfaction” (Locker and Dunt, 1978, p.288).

myriad of studies published in the post-war years, he was envisioning them used in a new way: as a dependent rather than independent variable, and as a means of assessing the care provided by healthcare providers themselves. This inversion of variables indicated the extent to which the patient's view had come to represent an object of attention in its own right. As the next section will show, presenting the patient's view as a dependent variable presented all sorts of new possibilities for the survey and for healthcare.

Although it is tempting to suggest that the new dimensions of the patient were the product of substantive measurement advancements and the taming of the social and subjective world by measurement and its sciences, authors noted that questions about survey design were still far from resolved. Recounting the development right up to 1980, Marsh noted a plethora of unresolved questions for survey research, stating, “the list of current methodological concerns of survey research involved in measuring attitudes, opinions, and ideologies could be extended indefinitely” (1989, p.147).¹³¹ She concluded, somewhat pessimistically that “social science is intimately bound up with the subjective reality of social actors; social measurement, if it is to be valid, must have some better answers than it currently has to questions like the above” (*ibid*). Yet, the construction and attention to these methodological concerns had helped to stabilize the validity and the medical and sociological integrity of a newly-constituted patient's view. Although the specific constructs that constituted the view were far from uncontested, overlapping, and constructed upon multiple theoretical terms, they were part and product of the more significant stabilization of a distinctive “style” of knowing (see Hacking, 1992; Samiolo, 2012) about patients and care.

To summarize, the survey activities between 1945 and 1980 became intertwined with distinct and heterogeneous but overlapping movements in medicine, sociology, and related fields. This particular set of interactions, spurred into existence on the basis of

¹³¹ More specifically, Marsh lists the following unresolved questions: “Should one ask open or closed questions (Schumal and Presser 1979a)? Should respondents be asked to record general affect towards people or policies (the Gallup approach) or should they be asked to endorse higher-level arguments (the Harris approach)? What models should be used to measure attitude consistency (Judd and Milburn 1980)? Should a ‘no option’ category be explicitly offered to respondents (Schuman and Presser 1979b)? Which response categories should be used: yes/no; agree/disagree (Bishop et al 1979)? What causes two identical questions, asked by different research houses to produce different results and track differently across time (Turner and Krauss 1978)? Can one avoid socially desirable responses (DeMaio 1980; Bradburn et al 1979)?” (1982, p.147).

information activities of World War Two, helped to establish a distinct new code of knowledge and new characteristics and attributes of the patient that existed and were matters of medical concern. These characteristics, which included “satisfaction”, “experiences”, “perception”, “family” and “feelings” to name just a few, were multiple, overlapping, and far from fully specified, yet different from those of traditional western medicine. Residing in the social-psychological world of patients, and determined on the basis of what those patients thought and said, they established the medical relevance, if not pre-eminence, of the patient’s view. The patient’s view was, as such, elaborated at the intersection between the broad movements of medicine and sociology and the methodological preoccupations, concerns, and developments, that stabilized the code of knowledge.

As we will see in this next section, this new code of knowledge, rather than developing toward an ever more refined and ‘accurate’ notion of the patient (as teleological accounts might suggest), in fact provided the foundation for a whole new function for the survey and notion of the patient to be articulated and pursued. From something that illuminated the social-psychological world of the average patient and established its medical and sociological relevance, we will see the way that the survey was directed toward the illumination of the level and quality of care that distinct healthcare providers delivered to patients. This new orientation, built at the intersection of new preoccupations and new methodological challenges, rendered a new notion of the patient and characteristics of the patient real. This new patient, characterized and embodied in healthcare as a series of discreet *experiences*, will be shown in the final section to have a series of potentially far reaching consequences for the nature of medical knowledge and delivery of medical care.

3.2 Patient satisfaction and the quality of care, 1980-1995

The changing notion of the patient in healthcare, of which the movements described in the previous section were part and product, took on a distinct significance from the 1980s, which as we will see, once again transformed the form and function of the survey and embodied a new notion of the patient in healthcare. These changes were the product of three overlapping movements that converged between 1980 and 1995.

Firstly, the new notion of the patient came, from the 1980s onwards, to be assembled into and transformed on the basis of a “consumerist movement” in healthcare (Mold, 2010). Although the consumer movement had roots in the sociological findings of the 1960s and 70s, it became reconstituted and operationalized as central to healthcare delivery from the 1980s. This movement provided a new significance to the attributes of the patient that were provoked in the post-war period. No longer of merely medical and sociological concern, the satisfaction, feelings, and expressions of the patient-consumer came to be seen, from the 1980s, as central to efficient markets and the delivery of public services and even an articulation of a democratic vote or process.

Secondly, these new conceptions of the role of the patient-consumer and his or her views came to interact with distinct worries about the quality of care, and specific models for its improvement. The role of the patient-consumer interacted with new concerns for quality and ideals of its improvement to highlight the need to capture patient-consumer assessments of the quality of care delivered by individual providers. This distinct new set of concerns provoked the patient survey in altogether new directions. Rather than illuminating new psycho-social aspects of the average patient, they were now called upon to measure the views of patients about their healthcare providers in order to specify and improve the quality of care.

Thirdly, a “cognitive turn” in psychology (Platt, 1996, p.199) provided the foundation for a new form of the survey to emerge and stabilize. This cognitive turn, concerned to illuminate the cognitive processes that take place between environmental stimuli and patient reports, provided a new set of principles for survey design (Gardner, 1985). These design principles—which included cognitive interviews, the construction of dimensions of experience, elaborate lab-based testing, and questions about specific patient *experiences*—provided not just a new template for patient surveys, but established a new notion of the patient and object of medical-administrative concern.

3.2.1 The patient as consumer in healthcare

As a number of authors note, the survey findings provided by Cartwright and her colleagues came to interact with new ideas about the patient as a *consumer* of care (Mold, 2010; Tomes, 2006). Throughout the 1960s and 70s, the survey findings of

patient discontent, professional paternalism, lack of communication, and failures to address patient concerns translated into the emergence of a variety of patient-led and occasionally government-established groups, which sought to protect and advocate on behalf of these newly conceptualized patients.¹³² Throughout this same period, a more general reconceptualization of the role and significance of the consumer and consumption was also taking place. As authors such as Schwarzkopf (2009, 2011) and Miller and Rose (1994, 1997) note, the consumer and his or her views, while always problematic, came increasingly to be linked up with and connected to the realization of a number of both optimistic and mundane dreams and schemes. Satisfaction became more than a personal preference, but an expression of a “democratic vote” and much else (Schwarzkopf, 2009, p.242).¹³³

In the case of health, these two movements began to transform the patient-customer from the 1970 onward. Summarizing a series of such changes in the NHS during the 1970s, Miller and Rose (1990) state:

The health consumer was transformed, partly by developments in medical thought itself, from a passive patient, gratefully receiving the ministrations of the medics, to a person who was actively engaged in the administration of health if the treatment was to be effective and prevention assured. The patient was now to voice his or her experiences in the consulting room if diagnosis was to be accurate and remedies were to be effective. The patient was also to be actively enrolled in the government of health, educated and persuaded to exercise a continual informed scrutiny of the health consequences of diet, lifestyle and work. And patients, reciprocally, were to organize and represent themselves in the struggles over health. By 1979, 230 organizations for patients and disabled people could be listed in a directory [...]. (p.76)

¹³² Documenting this link, Mold (2010, p.509-10) notes, for example: “Ann Cartwright's 1964 survey for the Institute of Community Studies found that 23% of hospital patients were unable to find out all they wanted to know about their condition (Cartwright, 1964). One way in which discontent with services manifested itself was in the establishment of organisations to campaign for, and provide, improvements (Deakin, 1995). The public were demanding better services but, by creating their own groups, also demonstrated a desire for a role in deciding how these were shaped.”

¹³³ Indicative of this new significance of the consumer, there was a flurry of activity directed at helping the consumer-citizen realize his or her (often her) expression in terms of preferences and satisfaction. Consumer Rights groups such as the Consumers' Association (1956) and the National Consumer Council (1977) in the UK, and Consumers' Research and more political outfits such as Public Citizen in the USA (see Tomes, 2006), were all established to campaign for and provide the citizen-consumers with the sort of objective information and protection from fraud that were seen at that time to be required.

This “vogue of participation” (Mold, 2010, p.512) was seen in both the USA and UK throughout this period.¹³⁴ However, it was only in the 1980s that “new models of consumerism in health care began to take hold”, which related specifically to quality (ibid).

Building on movements in health economics (which paralleled wider changes in post-war economic thought), the patient-consumer was articulated in the 1980s not just as a matter of ‘patient rights’, but as central to the effective and efficient design and delivery of healthcare. Indeed, economists like Alan Enthoven, in contrast to earlier economic thinking (i.e. Arrow, 1963), argued that the optimal allocation of health interventions could only be achieved by activating the patient-consumer and allowing him or her to purchase the services that fit his or her individual perceptions and needs (see Chapter Five; Enthoven, 1985). Academics and reformers in both the UK and USA also increasingly called for the import of private-sector managerial principles that focused on managing and improving customer views into the public sector (see Chapter Five; Osborne and Gaebler, 1992; Pollitt, 1995).

“New Public Management” (NPM) reform inspired by these twin managerial and economic movements (Hood, 1991) positioned the patient-consumer (and her views, expectations, satisfactions, etc.) as the dominant character in US and UK healthcare from the early-1990s onwards, largely through the import of accounting-based technologies (Kirkpatrick and Martinez-Lucio, 1995; Kurunmäki, 2008; Tomes, 2006).¹³⁵ As Humphrey et al (1993) note, the import of budgets, contracts, and other such accounting tools linked up the patient-consumer came with the hospital and other public organization management practices and the role and success of the state. One such, often overlooked, technology was the survey. As Mold, similarly explained of the use of surveys after early NHS reforms:

Finding out what patients thought of services became more common during the 1980s, particularly following the 1983 Griffiths enquiry into management in the NHS and the introduction of general management to the health service. One of the chief responsibilities of newly-installed managers was to assess consumers’ views of services and to adjust services

¹³⁴ The Community Health Councils in the UK and Community Mental Health Centers (in 1963 and 1965) in the USA were examples of such government-sponsored consumer participation groups.

¹³⁵ See Chapter Five for a summary of such reforms in the NHS.

accordingly. The most common way of achieving these aims was through patient satisfaction surveys. (2010, p.514)

Surveys also, as explained in Chapter Five, became increasingly important for contracting and performance evaluation throughout the 1990s.

The degree to which these reforms empowered or gave voice to the complex patients that had been illuminated previously was widely contested (Mold, 2010). Yet, at least rhetorically, these NPM reforms elevated the patient's view from a matter of medical efficiency and sociological enquiry to an idea and ideal whose realization was synonymous with democratic expression, rational organization, effective public services, and even human rights (Starr, 1982, p.388-93). From the early 1990s onward, the patient-consumer, with the needs, desires, expectations, even whims, was the person around which care was, in theory, now designed to address (McLaughlin et al, 2002). As Vuori stated boldly in his 1991 exposition of the need for systematic measurement of patient satisfaction in healthcare:

In the old days, the children would say that they want to become a firefighter or a nurse when asked what they will do when they grow up. Today, they might well say that they want to become a customer. They have noticed that in the marketplace, the consumer is the king. Producers who do not heed the needs and wishes of the consumers do so at their risk. Dissatisfied customers keep the producers on their toes and push for the improvement of quality. Improved education helps the consumers to set criteria for good quality. They are increasingly vocal and well organized to make their voice heard (Vuori, 1991, p.187).

This operationalization of the patient-consumer, perhaps unsurprisingly, went hand in hand with increasing calls to undertake more survey activities, and to refine the characteristics of the patient in a more detailed way. As Ware explained just as survey activities came to proliferate:

Emphasis on patient satisfaction with health and medical care services is on the increase. [...] This emphasis is consistent with a broader trend toward holding those who control and provide essential services more accountable to their consumers in ways other than the ones that commonly operate in the marketplace. (Ware et al, 1977a, p.1)

A similar explanation was proffered in the UK, where Fitzpatrick (1991) writes:

A single explanation of why surveys of patients' views have suddenly become such a visible and regular aspect of the NHS would probably not cite the impact of scientific arguments about the evaluation of health services but the far more influential NHS Management Inquiry [Griffiths Report, 1983] [...] crisply and emphatically condemned the failure

of the NHS to use the well-established techniques of market research to elicit the views and experiences of its users. (p.887)

While these calls for more surveys served to bolster the on-going activities, they also, as we will see, came to articulate new ideas about what a patient survey should do and how the survey itself should be undertaken.

3.2.2 Quality measurement and quality improvement

This operationalization of the patient-consumer intertwined with the efforts to define, measure, and improve the quality of healthcare, as such ideals came to be ever more insistently expressed in the 1980s and 1990s. These efforts emerged, as is illustrated thoroughly in Chapter Five, hand in hand with the efforts to operationalize the managerial and market-inspired NPM reforms in the UK and USA. The rise of Health Maintenance Organizations (HMOs) and the Prospective Payment System (PPS) for government insurance schemes the USA, and the creation of an internal market and the use of Diagnosis Related Groups (DRGs) costing systems in the UK in efforts to control costs and create more customer-centered health systems simultaneously produced a new need to explicitly define, specify, and assure quality.

In this situation, the argument and model for measuring quality advanced by Donabedian as early as 1966, but largely overlooked since then, became uniquely attractive (see Appendix 2.1). As documented in Section 2.3.2 his structure-process-outcome model held out the possibility that quality could not only be measured, but that it could be measured in part from the patient's point of view (Donabedian, 1966/2005).¹³⁶ This suggested that the reconstituted patient could be given a 'voice' in healthcare, and simultaneously new judgements about quality could be rendered. As Donabedian explained in 1980:

[Client] satisfaction is of fundamental importance as a measure of the quality of care because it gives information on the provider's success at meeting those client values and expectations which are matters on which the client is the ultimate authority. The measurement of satisfaction is, therefore, an important tool for research, administration, and planning. (p.25)

¹³⁶ Donabedian (1966, p.166) explained, "the ultimate validator of quality of care is its effectiveness in achieving or producing health and satisfaction".

With Donabedian's models and ambitions in hand, surveys of patient satisfaction came to be re-envisioned as something new. Rather than using the survey to understand attributes of the patients or characteristics of care generally, a number of researchers and reformers argued for surveys of patient satisfaction to be used as measures of the quality of care provided by specific providers of care. Used in this way, the patient could choose between providers, and providers would in turn be forced, at least in principle, to direct their activities at satisfying the things that mattered most to patients. They argued for patient satisfaction, in other words, to be a dependent rather than independent variable in survey investigation.

Evidence of a relationship between patient satisfaction on the one hand and the things providers of care did on the other, had been accumulating since the 1970s. The amount of information provided (Houston and Pasanen, 1972), the amount of time spent with the patient (Linn, 1975), continuity of care, the size and environment of the hospital, and a huge number of other variables, were shown to be related to patient satisfaction (Ware et al, 1977a, p.13; see also Pascoe, 1983, p.199-203). But only by 1980 was satisfaction fully and confidently argued to be an indicator of the quality of care in its own right. Drawing on the growing popularity of Donabedian's model, survey researchers such as Ware et al (1977a) began to write explicitly of the link between the work they did and the need to measure the quality of care:¹³⁷

Regarding satisfaction as a dependent variable, Donabedian (1966) argued that patient satisfaction (along with health status) is an ultimate outcome in evaluating quality of medical care. (p.24)

“His argument” Ware et al continued, “[...] clearly implies that the patient satisfaction concept is an important dependent variable in health and medical care research” (*ibid*).

The use of the patient survey as a means of interrogating the quality of care provided by individual healthcare organizations and systems was bolstered with the influence of the more optimistic and programmatic objectives of quality improvement, total quality management, and continuous quality improvement (CQI), as advocated by Donald

¹³⁷ Similarly, looking forward Locker and Dunt (1978) write, “the consumer’s opinion of services is being taken into account in assessments of quality. Thus, evaluating the quality of medical care involves the measurement of its benefits to patients and the community at large” (p.283). Linder-Pelz also writes in 1982, that “the satisfaction of the consumer is seen as a necessary outcome of any transaction irrespective of the efficacy of that transaction” (p.577) in order to explain the renewed interest in surveys of patient satisfaction. Merkouris et al (2004) reiterate, “Patient satisfaction has become an established outcome indicator of the quality and efficiency of healthcare systems” (p.355).

Berwick and others in the USA from 1989 (Berwick, 1989; Laffel and Blumenthal, 1989).¹³⁸ They introduced industrial quality control principles to healthcare that put the measurement and management of patient satisfaction at the center of organizational activities and control (see Berwick, James and Coye, 2013; Section 2.3.4). This relationship became explicit with Berwick and others jointly leading large grants that sought to measure, report, and improve upon patient-centered quality of care. Their work, like that of others, solidified an almost indisputable link between the survey measurement of patient satisfaction and the requirements and necessities of quality improvement (see OTA, 1988, p.245). As Old and Woodridge write:

Consumer surveys are receiving increased attention as a component of Total Quality Management and Continuous Quality Improvement to enhance quality of care services [...] though controversy still exists about the role of consumer information in monitoring quality [...] most researchers, policymakers, and managers agree that consumer satisfaction is an important measure of quality and, hence, of system and health plan performance. (1985, p.155)

Similarly, Rubin explains:

American organizations are finally adopting the quality improvement theories of Deming and Juran responsible for post-war Japanese industrial success. A key component of these theories is that suppliers of a good or service must receive feedback from consumers in order to identify deficiencies and guide improvements. Consumer satisfaction surveys are thus evolving from marketing tools to product and service quality measures. (Meterko, 1990, p.S3)

The survey thus increasingly became a core mechanism for understanding quality general and quality as the patient understood or experienced it more specifically.

The patient satisfaction survey was therefore at the center of a confluence of multiple movements in which it was both an input and an output. The work of surveys and their attending ambitions up to the 1980s produced a new patient, and provided a new significance for the patient's perspective and satisfaction regarding care. It was on this basis, at least in part, that the variously constructed consumer movements drew, and the quality measurement and improvement movement relied upon, to construct the patient's perspective on quality as an indicator of performance. Reflecting on this change, Stamps and Finkelstein (1981) write:

¹³⁸ On this point Pascoe writes, in 1983 that; "All available evidence clearly indicates that improved organization and delivery of health care is met with favorable patient response. Such consistency would seem to enhance the validity of patient satisfaction as an indicator of quality of care" (p.200).

Patient satisfaction has long been of interest to health professionals, although the emphasis has changed somewhat. For example, 10 years ago the issue centred around whether to consider patient perceptions; today the discussion centres on how much weight to give the patients' perceptions and how to measure those perceptions. (p.1108)

As this quote suggests, between 1971 and 1981, the orientation and ambitions attached to surveys changed substantially.¹³⁹ It also placed a new set of methodological demands on the survey technique and gave rise to the patient in an altogether new form.

Indeed, the new ambitions towards which the surveys were attached produced a variety of historically distinct methodological preoccupations and concerns. Small scale surveys that were previously problematic because they said little about the average patient, became valuable because they said potentially a lot about the *individual provider* of care. Similarly, reports of consistently high levels of satisfaction quickly lost their information value; rather than indicating something consistent and important (even laudable) about the way in which patients generally understood and evaluated their healthcare system, they indicated the need to find indicators of satisfaction that could differentiate between providers, could root out the so-called bad apples, and (better yet) could supply providers with ever more information about what they could improve from the patient's point of view. In order to improve patient satisfaction, and quality more generally, the surveys needed to highlight the *specific* things that providers might do in order to improve patient satisfaction.

These ambitions also created an important new differentiation in acceptable survey design. Previously, satisfaction was something that could be brought about and celebrated in its own right, and due to any set of influences. From roughly 1980 onward, it became important to distinguish between the satisfaction attributable to the patient (his or her socio-demographic characteristics, her mood, her form of payment, her expectations, psychological state and much else) from the satisfaction attributable to the provider of care (what the provider did or did not do, and how they did it). Indeed, as reviews of the literature increasingly pointed out, satisfaction was more or less related to *both* the attributes of the patients and the providers. Ware and others pointed out that "a patient satisfaction rating is both a measure of care and a measure of the patient who

¹³⁹ Ware and Snyder (1975) write, "consumer emphasis in medical care evaluation is the result of several factors including: government support for such research, the influence of social scientists, concern about the general population, and the increasing focus on health as a quality of life" (p.669).

provides the rating" (Ware et al, 1983, p.248) and that in fact, "the little information that exists regarding effect size actually suggests that satisfaction may be more affected by patient factors than by organizational characteristics" (Pascoe, 1983, p.200).

Hitherto this was not a problem; satisfaction mattered simply because it was related to patient behaviors that had a major clinical impact. But, when used to evaluate the performance of care providers, it seemed inadequate and unproductive to hold providers accountable for satisfaction generally. In this context, such ambiguity became a new and major problem for survey design.¹⁴⁰ As Ware et al (1977a) explained:

Without a better understanding of what causes patients to be more or less satisfied with the care they receive, however, it is not clear whether the medical care system should be held accountable for all the variability in satisfaction scores. For example, to the extent that more general life sentiments (e.g., community and life satisfaction) determine how patients evaluate their care, satisfaction should not be viewed as an ultimate outcome of care. Rather, to the extent that satisfaction scores reflect general concepts like life satisfaction, they would be better used to evaluate society at large than specific programs within the medical care system. (p.24-5)¹⁴¹

To accurately measure patient satisfaction, in this new context, it was important that the patient herself (her moods, her background, etc.) was at least mostly removed.

Beyond the accuracy of measurement, moreover, it became increasingly clear that even the best measure of satisfaction might not lead, in itself, to the sorts of improvements that were expected to be achieved. Indeed, as Donald Berwick's influential 1989 article argued, information for quality improvement was required that aimed to do more than root out "the bad apples" (p.53). Instead, he explained, "Real improvement in quality depends, according to the Theory of Continuous Improvement, on understanding and revising the production processes on the basis of data about the processes themselves" (ibid, p.54). With the aim of quality improvement in mind, the broad indications of satisfaction, even if they could differentiate between providers, seemed potentially

¹⁴⁰ Locker and Dunt note similar challenges and suggest alternative approaches until the survey is better designed: "Until the problem of validity is clarified, it seems that research must resort to a method suggested earlier. That is, where respondents are asked to assess a service, they should do so on the basis of descriptions of their experience with that service. Questions which distinguish between providers of care and the service provided would reduce the contamination of one by the other" (1978, p.288).

¹⁴¹ Ware et al continue, "Demonstrating that patients tend to be less satisfied when their services and care are poor is useful if satisfaction data are used only to determine how consumers feel about their care in general. If satisfaction data are used in planning programmatic interventions, evidence that the specific nature of problems with care and services can be detected with patient satisfaction scores is necessary" (1977a, p.15).

unable to provide the sort of actionable insight about the processes of care that needed to be improved. Indicatively, by 1990 commentators highlighted the limitation of such measures and the ideals of quality improvement that were being developed in industry:

The actual value of patient satisfaction studies as part of total quality measurement process is disputed in both academic literature and the practice of medicine. Where they are used, little is known about their actual effect on the organization and delivery of health services. (Nelson, 1990 in Vuori, 1991, p.183)

As Berwick's ideas and ideal for quality improvement became ever more central to the health care discourse in the years to come, such reflections highlighted new challenges for the patient survey (see Williams et al, 1998).

3.2.3 The “cognitive turn” in survey design

These new challenges for the patient survey also intertwined with new expertise around survey design that emerged from a budding cognitive psychology movement. This movement uniquely concerned itself with the “mentalistic processes” (Ross et al, 2010, p.6) and “construal” activities (Ross et al, 2010, p.8) that took place in-between the things that happened in the physical world and the subjective responses and interpretations of individuals. Moving beyond the issues of “affect, context, culture, and history” (Gardner, 1985, p.39) that had preoccupied its predecessors, this “new science of the mind” aimed to map, often using lab-based experiments, the “symbols, schemas, images, ideas, and other forms of mental representation” which accounted for the individual responses to the changing environmental inputs and stimuli (*ibid*).¹⁴²

This cognitive perspective was brought to bear on some aspects of the early satisfaction work. As early as the 1960s and 1970s, authors such as Larsen and Rootman (1967) and Hulka et. al. (1970, 1971, 1975) had worked to uncover the cognitive factors and processes that translated the satisfaction concept from a set of external events into a judgment made by respondents. On the basis that such work might provide a means of separating the patient factors from those of the providers of care, a number of authors again took up this work in the 1980s. Linder-Pelz (1982) was one of such researchers to seek to develop and test a theoretical and “explicit model of satisfaction with health

¹⁴² Gardner (1985) notes, “the stuff of representation,” which cognitive science is directly concerned, “is found between input and output” (p.38).

care" capable of "defining the concept and specifying its various determinants and consequences" (p.577) on the basis of the cognitive categories of patients themselves.¹⁴³

As Figure 3.7 below shows, there were a number of such cognitive models of satisfaction that were seen to require testing and development in order to provide insights into effective survey design.

Table 2. Six hypotheses regarding the social psychological determinants of patient satisfaction*

Hypotheses	Source
1. Satisfaction scores will be directly related to the sum of the products of <i>beliefs</i> (expectations) and <i>valuations</i> (values) scores regarding various aspects of the care	[9, 14]
2. Satisfaction scores will vary positively with the extent to which <i>perceived occurrence</i> concurs with prior <i>expectation</i>	Fulfilment theory [6]
3. Satisfaction scores will be directly related to the <i>perceived occurrence</i> score less the <i>expectation</i> score, all divided by the <i>expectation</i> score	Discrepancy theory [6]
4. Satisfaction will vary positively with the concurrence of <i>perceived occurrence</i> and prior <i>expectation</i> only when the object is <i>valued</i>	A variant of Hypothesis 2 developed in discussion with Ware
5. A combination of <i>positive expectation</i> and <i>positive perceived occurrence</i> will yield the highest satisfaction scores, while <i>positive expectation</i> and <i>negative occurrence</i> will result in the lowest satisfaction scores	Developed in discussion with Ware. Hypotheses 4 and 5 posit that satisfaction is a function of the <i>interaction</i> of expectations, values and occurrences, rather than a simple discrepancy function
6. Satisfaction will be greatest when occurrence is perceived to be as good as, or better than, that received by others	Social comparison theory [33]

* These are not *alternative* hypotheses; more than one of them may be supported without this necessarily being contradictory.

Figure 3.7: Cognitive models of satisfaction (from Linder-Pelz, 1982, p.581)

Although the explicit cognitive theory building and testing never resulted in anything close to a fully specified satisfaction construct (Williams, 1994; Carr-Hill, 1992), it was part and product of an increasing role for cognitive psychology in survey design. Indeed, authors note specific conferences in the USA in 1980 and the UK in 1978 which heralded a "cognitive revolution" in survey design and brought these ambitions to the fore.¹⁴⁴ These conferences were convened by major research funders specifically to develop the survey technology on the basis of cognitive psychology (Tanur, 1992):

¹⁴³ Other research sought to address the issue by specifying to a greater degree the socio-demographic factors that might be systematically influencing or biasing patient reports of satisfaction with the providers of care. The assumption was that, as with the use of diagnosis-related-groups, outcomes could be adjusted for the case mix upon which they drew. Such work demonstrated many variables of significance to satisfaction studies, but with little consistent agreement on the impact of most factors, with the exception perhaps of age, which leads to consistently more favourable reports of satisfaction. Fox and Storms, summarizing the situation in 1992 explained, "the literature on satisfaction with health care presents contradictory findings about sociodemographic variables [...] This situation can grow so chaotic that some writers dismiss [sociodemographic] variables as reliable predictions of satisfaction" (in Carr-Hill, 1992, p.237).

¹⁴⁴ Jobe and Mingay (1991) state: "The first organized effort to assess the potential for the application of advances in cognitive science to survey-taking occurred in 1978 in the United Kingdom, when the Royal Statistical Society and the Social Science Research Council co-sponsored a seminar on retrospective and recall data in social surveys [...] Two years later in the United States, the non-profit Bureau of Social

[To] delineate the applicability of previous research on cognition to the survey process, to outline how survey methods might be used for a vehicle for cognitive research, and to develop an agenda for follow-up collaborative research, that would benefit both cognitive science and survey methods. (Jobe and Mingay, 1991, p.176)

Indeed from these initial collaborations (focusing heavily initially on crime surveys), authors note the emergence of a “radical departure from the status quo” in survey research and design in the years to come (Platt, 1992, p.272).

Cognitive psychology, or “applied cognitive psychology” as it was called to indicate its extension into the non-experimental world (Landauer, 1987 in Barnard, 1991, p.153), remained unable to provide a fully-specified satisfaction construct, but it did contribute new principles and processes to survey design.¹⁴⁵ In particular, cognitive research offered a means of explaining and addressing the sorts of biases and interactions between the survey questions and the respondent that had been observed previously but never understood to the extent that they could be separated from the survey findings. Question wording, form and order, and the tendencies, for example, to answer positively to socially desirable questions, and their effects all came to be documented as cognitive phenomena. In 1991, Jobe and Mingay stated:

Cognitive psychology [...] can provide a theoretical basis for designing questionnaires to minimize these effects [of questionnaire questions], or for determining the sizes of these effects, and allowing for them when interpreting the data, as desired by the question designers. (p.179)

This work provided a new foundation for seemingly good survey design; the questionnaire biases could now be separated from those introduced by the respondents themselves.

The cognitive turn also provided a new scientific foundation for the validity of survey questions to be established. While in the past survey questions and concepts were seemingly valid in their own right—expressive as they were of the patients’ view—they

Science Research, with funds supplied by the US Bureau of the Census and the Bureau of Justice Statistics, convened a 2-day workshop to see what recent psychological research on cognitive processes might have to offer the improvement of respondent reporting of incidents of victimization in the National Crime Survey” (176-7; see also Tanur 1992, 1-10). They explain that these efforts were renewed in the US with the National Academy of Sciences’ Committee on National Statistics’ two-year investigation into such matters in 1984, and a handful of research projects on specific issues relation to cognitive psychology and survey design funded by the National Science Foundation beginning in 1985” (p.177).

¹⁴⁵ Indicative of the uneven and tentative pace of the movements, Platt notes in 1992 that, even after substantial activity in cognitive survey design, the movement has “so far raised more questions than answers” (p.9).

could, with the help of applied cognitive psychology, be validated through their correspondence with the patients' subjective realities and the theories of their specification.¹⁴⁶ Using techniques such as cognitive interviewing and different testing activities from cognitive psychology, survey designers could construct their questions to fit as closely as possible into the distinct cognitive categories and schema of the respondents.¹⁴⁷ By 1992 it was stated that:

the cognitive laboratories in the government [survey] agencies now use such tools as think-aloud protocols and cognitive interviewing with small numbers of subjects to do early pretesting and to secure insight into redesign options, sometimes even options favoured by previous field testing. (Tanur, 1992, p.9)

Moreover, by constructing theoretical specifications of the survey categories and schema and their relationship to cognitive processes, "internal reliability" or "construct validity" of the tool could be tested empirically using the factor-analysis developed previously for socio-demographic variables of interest (e.g. Fitzpatrick, 1991, p.888; Baker, 1990).

Attention to these new cognitive dimensions established a distinct and enduring change in the methodological terms of successful survey design. As Banaji and Heiphetz have stated recently of this lasting influence:

Agreement exists that a paradigm shift has occurred in survey measurement, with the emphasis having shifted from the statistical models of sampling errors (with a focus on the effects of survey errors on estimates) to a psychological concern with the interpretation of questions, the reasons for non-response, and the effects of context on responses [...] The influence of models of cognition, including social cognition, is evident in the questions that have been posed about the self-report data. These models shifted the focus to understanding the mind of the respondent and the natural correlates of self-reported data, including age, culture, and context effects of every form [...]. (2010, p.360)

¹⁴⁶ Validity still "loomed the greatest challenge for satisfaction measurement" (Ware et al, 1983, p.259), but, pointing to the American Psychological Association (APA) guidelines, authors like Ware highlighted that "a solution that is becoming standard is the strategy of construct validation", using factor analysis among other things to "examine a wide range of variables to determine the extent to which an instrument produces results that are consistent with what would be expected for the construct to be measures (APA, 1974)" (*ibid*).

¹⁴⁷ Levine et al (2005) explain: "Prior to 1984, survey questions were evaluated using loosely structured respondent debriefings, interviewer debriefings, or through psychometric approaches, if they were evaluated at all. However, a 1984 conference, bringing survey methodologists and cognitive psychologists together, marked a point when survey methodologies began to accept in principle that questions should be assessed in new ways, which came to be known as cognitive testing" (p.2038).

This “paradigm shift” (ibid), moreover, came to interact with the consumerist movement, quality and quality improvement ambitions and ideals, and patient survey research in a specific way.

These emerging cognitive standards were tentatively expressed in the patient survey literature as early as the mid-1980s by a number of authors closely aligned with the cognitive psychologist, John Ware.¹⁴⁸ In a 1988 review for the US Congress’ Office of Technology Assessment (OTA) titled *The Quality of Medical Care: Information for consumers*,¹⁴⁹ Ware declared these cognitive terms as “generally accepted guidelines” for determining validity and reliability of survey instruments (OTA, 1988, p.236). In doing so, he deemed much of the previous research on patient evaluations of quality insufficiently robust for current use. Motivated by the new practical considerations presented by the use of surveys to measure quality and quality improvement, Ware also, and more significantly, outlined tentative new directions in survey design that might meet its new conceptualization as a tool for consumer assessment of the quality of providers. This involved, he stated, developing the “promising but rarely employed strategy” of basing assessments “on the patients’ reports of what does and does not occur” (ibid, p.246). While noting that “overall global measures (e.g., overall satisfaction ratings, whether patients are willing to recommend a hospital to others, health care plan disenrollment rates) [...] are not unrelated to quality of care” (ibid), the most valid assessments of the *providers* of care could only be acquired by asking specific questions about “distinct quality-related attributes that can be measured and interpreted separately” (ibid).¹⁵⁰ He suggested, in other words, abandoning the notion of

¹⁴⁸ Ware’s doctoral research on the “Dr. Fox Effect” in medical education was uniquely concerned with the relationship between the seductiveness of the teachers, the technical content that they provided, pupil satisfaction, and the tested learning outcomes. He illuminated the ways in which the style and content of teaching related to the student evaluations and performance. Separating such variables and influences was very similar to the ambitions now facing patient survey developers (see Ware and Williams, 1975).

¹⁴⁹ This review notes all three influences highlighted during this period. It states “Quality assessments have customarily taken the perspective of the medical provider. Recent events, however, have promoted consumers’ role in evaluating providers and making decisions about medical care. Efforts to advance consumers’ interests are occurring throughout society, and the changing role of consumers within medical care reflects this societal trend. The increased emphasis on consumers also reflects the influence of strategies to increase price competition in medical care. People have always had a legitimate interest in the quality of their medical care. But recent policy changes have created a milieu in which the consumers and providers of medical care have become more sensitive to price. In that milieu, information about the quality and cost of care is needed by consumers to aid them in selecting physicians and hospitals” (OTA, 1988, p.51).

¹⁵⁰ Indicative of the widespread standardizations to come in the 2000s, he also stated: “To be valid, comparisons among physicians or hospitals must be based on standardized survey instruments, data

satisfaction, and putting in its place, the actual activities that patients suggest make up the notion itself.

Ware and his colleagues pursued this agenda throughout the 1980s, 1990s and 2000s as the survey was increasingly advocated as a tool for improving the quality of care. They noted that general satisfaction measures failed to adequately differentiate between organizations, provided little actionable insights to these organizations about aspects of quality that might be improved, and were impossible to validate externally. To arrive at a usable notion of satisfaction, they reiterated that one could simply collate the various things that were shown—through surveys, cognitive interviewing, or other means—to matter to patients. These, they suggested, could then be grouped theoretically into dimensions or attributes of satisfaction, and then incorporated into surveys by asking patients about specific experiences of care related to these dimensions. These dimensions could be tested empirically against patient responses using factor analysis to validate the existence of such dimensions. By doing this, and by paying careful attention to survey design, they argued that the survey could fulfill all the demands of the time. By asking questions about *experiences* rather than general feelings about care, in other words, just enough of the patient could be removed.

Ware, Snyder, Wright and Davies' 1983 Patient Satisfaction Questionnaire (PSQ) represented a major milestone in the movement, and its design became the template of many to come in the following years. There, Ware and his colleagues began by developing a construct of satisfaction by undertaking a literature review and content analysis of the things demonstrated to matter to patients. Of the 1,800 possible satisfaction issues identified, they grouped them into 68 specific (and mostly verifiable) questions about their experiences with care (see Figure 3.8), which, they hypothesized, represented seven distinct dimensions of care, and could be presented as a similar number of multi-item scales (see Figure 3.9). Consistent with APA guidelines, these groupings could then be tested with factor analysis on pilot study returns to determine the extent to which they indeed represented logically and statistically valid constructs. As such they were able to produce distinct things that providers might improve upon

collection procedures (e.g., personal or telephone interview, self-administered questionnaire), and survey methods (e.g., timing of administration), as well as on representative samples. Reproducible scores can be achieved only if methods are carefully standardized" (Ware in OTA, 1988, p.247).

(access, finance, resources, continuity of care, etc.) that could be ‘accurately’ measured by asking patients about distinct experiences related to each concept (e.g. “I hardly ever see the same doctor when I go for medical care”) (Ware et al, 1983). Establishing these relationships empirically allowed them to conclude, “the weight of empirical evidence regarding the generalizability of the item and the higher-order factor analysis clearly indicated that PSQ items and subscales measure distinct dimensions” (ibid, p.260).

TABLE 1
ITEMS IN FORM II OF THE PSQ

Item Number	Item Content
1*	I'm very satisfied with the medical care I receive.
2	Doctors let their patients tell them everything that the patient thinks is important.
3*	Doctors ask what foods patients eat and explain why certain foods are best.
4*	I think you can get medical care easily even if you don't have money with you.
5*	I hardly ever see the same doctor when I go for medical care.
6*	Doctors are very careful to check everything when examining their patients.
7	We need more doctors in this area who specialize.
8*	If more than one family member needs medical care, we have to go to different doctors.
9*	Medical insurance coverage should pay for more expenses than it does.
10*	I think my doctor's office has everything needed to provide complete medical care.
11	Doctors never keep their patients waiting, even for a minute.
12*	Places where you can get medical care are very conveniently located.
13	Doctors act like they are doing their patients a favor by treating them.
14*	The amount charged for medical care services is reasonable.
15	Doctors always tell their patients what to expect during treatment.
16*	Most people receive medical care that could be better.
17	Most people are not encouraged to get a yearly exam when they go for medical care.
18*	If I have a medical question, I can reach someone for help without any problem.
19*	In an emergency, it's very hard to get medical care quickly.
20	I can arrange for payment of medical bills later if I'm short of money now.
21*	I am happy with the coverage provided by medical insurance plans.
22*	Doctors always treat their patients with respect.
23*	I see the same doctor just about every time I go for medical care.
24	The amount charged for lab tests and x-rays is extremely high.
25*	Doctors don't advise patients about ways to avoid illness or injury.
26*	Doctors never recommend surgery (an operation) unless there is no other way to solve the problem.
27	Doctors hurt many more people than they help.
28*	Doctors hardly ever explain the patient's medical problems to him.
29*	Doctors always do their best to keep the patient from worrying.
30*	Doctors aren't as thorough as they should be.
31*	It's hard to get an appointment for medical care right away.
32*	There are enough doctors in this area who specialize.
33*	Doctors always avoid unnecessary patient expenses.
34*	Most people are encouraged to get a yearly exam when they go for medical care.
35*	Office hours when you can get medical care are good for most people.
36*	Without proof that you can pay, it's almost impossible to get admitted to the hospital.
37	People have to wait too long for emergency care.

Figure 3.8: Satisfaction items (from Ware et al, 1983, p.252)

VALIDATED ITEM GROUPINGS FOR PSQ SUBSCALES

Dimension/Item Grouping	Item Number
Access to care (nonfinancial)	
1. Emergency care	19, 37, 48
2. Convenience of services	12, 43
3. Access	18, 31
Financial aspects	
4. Cost of care	14, 24, 49, 63
5. Payment mechanisms	4, 20, 36, 56
6. Insurance coverage	9, 21, 38
Availability of resources	
7. Family doctors	53, 67
8. Specialists	7, 32
9. Hospitals	42, 61
Continuity of care	
10. Family	8, 65
11. Self	5, 23
Technical Quality	
12. Quality/competence	3, 6, 17, 25, 30, 34, 50, 51, 60
13. Prudence-Risks	47, 54
14. Doctor's facilities	10, 40
Interpersonal manner	
15. Explanations	28, 62, 66
16. Consideration	22, 26, 29, 39, 55
17. Prudence-Expenses	33, 68
Overall satisfaction	
18. General satisfaction	1, 16, 45, 58

Note. Source: Adapted from Figure 21 in Ware, Snyder, and Wright (1976a), p. 196.

Figure 3.9: Dimensions of satisfaction (from Ware et al, 1983, p.256)

While there was little certainty over the exact content and number of dimensions that should or should not be included in satisfaction, Ware's initial activities to taxonomize the dimensions of the patients' view on the basis of cognitive categories represented a major change in the representation of the patient. It offered a way to seemingly capture the patient's view by deriving it from the patient's own cognitive categories while at the same time ensuring that the patient's view was confined to the things that providers could address and improve. No longer a person with a hodgepodge of socio-psychological characteristics of medical concern (such as satisfactions, perceptions, expectations, worries and fears, family relationships etc.), although built upon the existence of such attributes, the new patient was expressed and operationalized as a consumer that would provide actionable insight about the quality of the activities undertaken by health care providers.

This dimensionalization, and the processes and psychometric tests to support it, became common practice as quality improvement and consumerist ideals came to the fore in the

1990s. The highest profile survey development projects throughout the 1990s adopted such an approach. The Commonwealth-Picker survey of patient experiences of hospital care, for example, explained its development process in this way:

Our first task was to develop a survey instrument that would elicit specific reports from the patient about the aspects of care they perceived as important, in lieu of the satisfaction ratings generally used on patient surveys (Cleary and others 1991). Based on focus-group findings, we developed a list of statements reflecting specific experiences of aspects of care patients had mentioned—for example, ‘after surgery, the anesthesiologist came to see how the patient was doing’, or ‘the nurse asked the patient about his worries.’ We then asked groups of physicians, nurses, and the health experts familiar with the patient’s perspective to review the statements and assess their importance [...] The remaining statements were then turned into sixty-two interview questions. (Gerteis et al, 2002, p.13)

Indeed, Gold and Wooldridge (1995) trace the lineage of US health plan surveys directly back to the precedent set by Ware and his colleagues. As they explain:

Many current surveys are based on the GHAA Consumer Satisfaction Survey instrument [which] was based on others, beginning with satisfaction measures developed in the 1970s [by] Ware and Snyder (1975) and Ware et al (1983) [...] that were adapted first for the Health Insurance Experiments and later for the Medical Outcomes Study [shown in Figure 3.10 below]. (p.163)

Similar designs were also replicated in Kuwait, Sweden, the UK, Australia and France (Castle et al, 2005).

Ware’s approach became a standard for addressing the newly established aim of comparing providers and illuminating aspects of care that needed to be improved. Survey programs in the 1990s and 2000s would start on the premise that, for example, “global satisfaction measures tend to mask areas of dissatisfaction with care and do not indicate the changes required to increase patient satisfaction” (Bamford and Jacoby, 1992, p.153). On this basis, they would state that questions must be designed to “address specific aspects of care and to elicit patients’ views and preferences for the delivery of care” (*ibid*). They would dismiss a variety of other survey approaches because “far too many [patients] claim they are satisfied and [...] because the extent of dissatisfaction does not tell us what needs to be changed” (Carr-Hill, 1992, p.241). They would note that as a matter of fact “the technique of factor analyses has demonstrated that patient satisfaction is chiefly determined by six dimensions [...]” (Health Policy Advisory Unit, 1989, p.23 in Carr-Hill, 1992, p.238). They would also echo the APA statement that “the most appropriate method for evaluating questionnaires of this type is

assessing the internal consistency where items would be expected to be related on theoretical grounds" (Bamford and Jacoby, 1992, p.156). As such, surveys no longer illuminated the social relationships surrounding the patients but the activities and performance of healthcare providers themselves.

In 1990, the first multi-site survey of "Patient Judgments of Hospital Quality" was developed by John Ware, Donald Berwick (the leader of the continuous quality improvement movement) and others from the previous survey projects on these same and seemingly irrefutable terms (Meterko, et al, 1990). From the outset, they noted that "minimal psychometric standards" required that the survey include distinct dimensions of quality, that they demonstrate internal reliability, and that they "detect significant differences among any two groups of respondents receiving care at different places, or times, or under known different conditions" (ibid, p.S9). At this point, the process for producing such an instrument was well established. As they explained:

We took several steps to construct valid and reliable quality-of-care scales based on items in [the] questionnaire. We began with a priori item groupings based on our literature review and the resulting conceptual framework. Second, we used exploratory factor analysis to test these hypothesized item groupings and to check for un-hypothesized factors. Third, using the item groups (factor scales) that emerged from the factor analysis and taking into account theoretical relationships and item content, we constructed multi-item scales measuring how patients rate specific components of hospital care and the outcome of their stay, Fourth, we evaluated the psychometric properties of these scales by calculating descriptive statistics for each scale, estimating their reliability, and by assessing their validity. (Meterko, et al, 1990, p.S23)

By addressing such methodological concerns they were able to conclude that, "we have confirmed in a large multihospital study that patients evaluate several components of hospital care distinctly [...]. We can measure patient evaluations of these components using simple summated rating scales" (ibid, p.S29). Moreover, they concluded, "the scales are precise enough to detect differences [between providers] when they exist" (ibid, p.S41). As such, while the authors still expected and hoped "to see substantial advances in the state-of-the-art of measuring patient hospital experiences over the next few years" (ibid), they were also confident that the method developed was "practical and would work", and "encourage[d] others to use this first generation survey form" (ibid, p.S42) in order to develop it further.

This sort of survey proliferated from the early 1990s onwards. By 1995, in the USA “more than 95 percent of HMOs and about 55 percent of PPOs surveyed [reported] that they use consumer surveys to monitor care” (Gold and Wooldridge, 1995, p.156). As explained in the previous chapter, major national and state regulators (such as the NCQA), regional purchasers (such as Leapfrog Initiative), individual health plans, and other stakeholders (such as the Hospital Compare website) also began to incorporate this form of patient survey into quality regulation and improvement. Patient surveys, as a result, became synonymous with quality and quality performance, and the patient satisfaction surveys based on Ware’s framework became central components of quality measurement, initially in the USA, but spreading elsewhere in the years to follow (see Section 2.3.3).

The proliferation and increasing importance of the surveys, moreover, went hand in hand with the re-embodiment of the patient in yet another distinct form. Although the patient surveys continued to vary in the dimensions and specific questions asked, they all presented the patient as a series of more-or-less-verifiable *experiences* that could be recorded, related to the providers of care, and (ideally) addressed and improved upon. Indeed, while the dimensions provided handy categories for the concept of satisfaction, it was specific questions about experiences with care that were asked to the patients themselves. Only by asking about such experiences, it was stated, could the idiosyncratic and whimsical elements of the patient be removed from their perceptions of the care process itself. Although there might be one or two general satisfaction questions (typically, “would you recommend this hospital to a friend or family if they needed hospital care?”), the survey was now primarily interested in the specific experiences of patients that related to the quality of care. The questions would ask, for example, “During your hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?”. The “consumer satisfaction survey” of the 1990s was one, as represented in Figure 3.10 below, that dimensionalized, and then made into a series of specific and separate experiences, the patient and her view.



*This image has been removed as the
copyright is owned by another
organisation.*

Figure 3.10: Group Health Association of America survey (from Meng et al, 1997, p.243)

By the mid-1990s, these survey activities, caught up in these heterogeneous and changing fields, had helped to realize the contemporary promise of quality. Following a two-year national roundtable in the USA on the quality of care and the “urgent need” to improve it (Chassin et al, 1988, p.12), it was declared that there now existed measures “that go beyond immediate measures of morbidity and mortality” (*ibid*) that “have the same degree of accuracy as the majority of medical measures used to make vital decisions about patient care” and that “have been used in a wide variety of scientifically

valid studies” to assess quality problems (*ibid*). Anyone concerned about the patient, and indeed quality, had a means, albeit an imperfect one, of seeing “through the patient’s eyes” (Gerteis et al, 2002, p.1).¹⁵¹ Along the way, however, the patient’s view and the things about the patient that mattered were radically transformed. The patient-consumer was embodied as a series of *experiences* that had to be measured, managed, and improved.

As we will see in the next section, the re-embodiment of the patient as a series of experiences represented more than a semantic change. Debates about the true voice of the patient aside, the survey’s instantiation into ever more regulatory and commercial mechanisms established one very specific means through which healthcare providers could elaborate a knowledge of the patient. The re-embodiment of the patient as a series of experiences that needed to be managed and improved, moreover, went hand in hand with the emergence of specific new expertise in healthcare, aiming and claiming a unique ability to address this new patient, which was of medical and commercial concern.

3.3 Quality measurement and the rise of the Chief Experience Officer, 1995-2010

On the basis that there was an “urgent need to improve the quality of care” (Chassin et al, 1998, p.12), that there was widespread consensus that the quality of care must be understood at least in part from the perspective of the patient, and that “reliable and reproducible” measures of the patient’s experiences existed (Fitzpatrick, 1991, p.888; Sisk, 1998), the late 1990s saw increasing calls for a national standardized patient experience survey in the USA. Indeed, following the Health Care Financing Agency’s experiments in the late 1980s to report cardiac surgery mortality data, as well as a number of similar public reporting initiatives, advocates began pressing for a nationally standardized measure of patient experiences at the level of health plans and providers (e.g. Urden, 2002). Such measures, it was argued, would allow “apples for apples” comparisons between providers (Darby et al, 2005, p.1973) on the dimensions of quality

¹⁵¹ The President’s Advisory Commission on Consumer Protection and Quality in the Health Care Industry made a very similar set of statements in 1998 (see Shiels et al, 1999, p.I; see Ferlie and Shortell, 2001 regarding the UK context).

that “mattered most to the patients” (Gerteis et al, 2002).¹⁵² As a National Quality Forum (NQF) consensus report explained:

Because patients’ perceptions of the quality of healthcare often differs from those of their professional caregivers, purchasers, or quality ‘experts’, it is necessary that patients themselves tell us how they view their care. Simply put, in order to understand what patients think of their hospital care, we have to ask them about it. However, to get reliable and comparable information, the questions need to be the same and they need to be asked in the same way—i.e., we need to have a standardized approach to asking patients what they think of their care. (NQF, 2005, p.i)

These metrics, it was suggested, could allow more discriminating patient choice, could be linked with reimbursement rates, and could name and shame providers into improving the quality of care (Barr et al, 2006; Walshe et al, 2001).

With such aspirations in mind, efforts were undertaken in the USA (and later the UK and other jurisdictions) to produce a national standardized survey of patient experience, first of medical care plans, and then of individual hospitals. The goals of the Consumer Assessment of Healthcare Providers and Services (CAHPS) project, and its hospital-focused counterpart (HCAHPS), emphasized the relationship between the survey and contemporary quality improvement aspirations.

Three broad goals have shaped HCAHPS. First, the survey is designed to produce data about patients’ perspectives of care that allow objective and meaningful comparisons of hospitals that are important to consumers. Second, public reporting of the survey results creates new incentives for hospitals to improve quality of care. Third, public reporting serves to enhance accountability in health care by increasing transparency of the quality of hospital care provided in return for the public investment. With these goals in mind, the CMS [Centers for Medicare and Medicaid Services] and the HCAHPS Project Team have taken substantial steps to assure that the survey is credible, useful, and practical. (HCAHPS, 2012, p.1)

The project, running in the USA from 1996 to 2012, developed the standard patient survey that is in use today, and which served as the model for national surveys in the UK and internationally.

¹⁵² The CAHPS website states: “In order to make ‘apples to apples’ comparisons to support consumer choice, it was necessary to introduce a standard measurement approach: the HCAHPS survey, [...] is a core set of questions that can be combined with a broader, customized set of hospital-specific items. HCAHPS survey items complement the data hospitals currently collect to support improvements in internal customer services and quality related activities” (HCAHPS, 2013, n.p.; also see Goldstein et al, 2005).

Although the survey development process was lengthy (lasting from 2002 to 2012) and occasionally contested,¹⁵³ the basic principles for survey development, methodological requirements for design, and standards for testing were, by this point, well-established norms. The survey development team¹⁵⁴ undertook a “rigorous scientific process, including a public call for measures; review of literature; cognitive interviews; consumer focus groups; stakeholder input; a three-state pilot test; extensive psychometric testing; and numerous small-scale field tests” (HCAHPS, 2012, p.1; Darby et al, 2005). In the process, they specified seven specific domains of patient satisfaction (adopted initially from a consensus statement issued by the IOM), determined the specific Likert-type questions that could be reliably asked about the experiences related to each dimension, undertook extensive factor analysis to adjust the groupings based on cognitive criteria, and undertook validity and robustness tests as specified in psychological testing. Procedurally, they submitted the survey design for comment from the National Quality Forum (which used the Consensus Development Process described in Section 2.3.2) and other stakeholders, and as a matter of procedural legislation, submitted the survey and its administration specifications for impact assessments and other reviews.

The final hospital survey, consistent with the developments outlined in the previous section, contained 27 items, measuring seven key aspects of performance. It asked two general satisfaction questions, but it placed most emphasis on the specific experiences of patients that providers could, at least in theory, improve upon (see Appendix 3.2 for full HCAHPS survey).

The core of the survey contains 18 items that ask “how often” or whether patients experienced a critical aspect of hospital care, rather than whether they were “satisfied” with the care. The survey also includes four items to direct patients to relevant questions, three items to adjust for the mix of patients across hospitals, and two items that support Congressionally-mandated reports. (HCAHPS 2012, p.2)

Although this final survey design was controversial enough to require a long development process, rigorous documentation, and lengthy consultation, it was in many

¹⁵³ In a review of the 25-item survey, for example, the NQF argued that “the seven domains of hospital care represented by items in the existing survey do not adequately capture the domains of patient experience for which publicly reported comparative information is important but lacking” (NQF, 2005, p.5). As a result, two new items were added to the final tool.

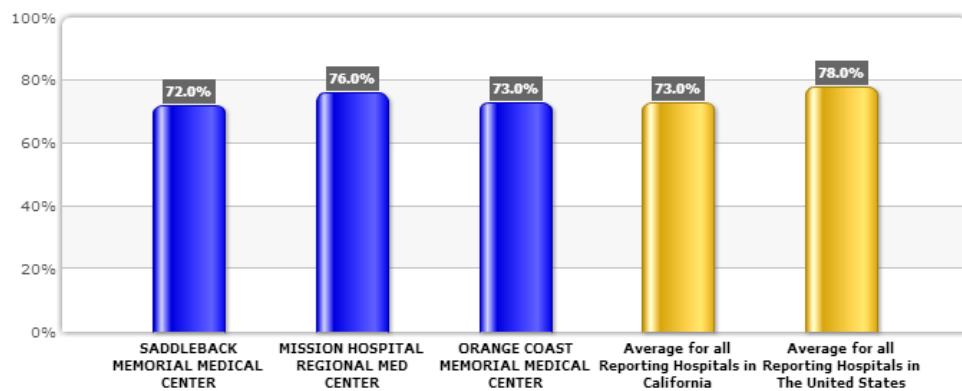
¹⁵⁴ The team consisted of a consortium of RAND, Harvard Medical School, Research Triangle Institute (RTI) and American Institute for Research (AIR) between 1996 and 2012.

ways already decided. As this chapter has shown, this particular means of knowing patients was a historically specific outcome of distinct preoccupations around quality, the consumer, and much else.

Although initially voluntary, participation in the survey was quickly tied to reimbursement rates from the government, thus ensuring widespread participation in the USA. From March 2008, the survey returns of 2,521 hospitals were reported quarterly on the *Hospital Compare* website (see Figure 3.11 below) (3,851 hospitals by 2012, of roughly 5,000 total). The site allows users to find hospitals and compare them on the basis of patient survey returns. The significance for hospitals of the survey returns was substantially bolstered, moreover, with the passage of the Patient Protection and Affordable Care Act in 2012, which required, as part of the value-based purchasing initiative, that performance on survey returns be linked with reimbursement rates.¹⁵⁵

¹⁵⁵ “The Hospital Value-Based Purchasing (Hospital VBP) program links a portion of [...] hospitals' payment from CMS to performance on a set of quality measures. The Hospital VBP Total Performance Score (TPS) for FY 2013 has two components: the Clinical Process of Care Domain, which accounts for 70% of the TPS; and the Patient Experience of Care Domain, 30% of the TPS. The HCAHPS Survey is the basis of the Patient Experience of Care Domain” (HCAHPS, 2012, p.3).

		SADDLEBACK MEMORIAL MEDICAL CENTER	MISSION HOSPITAL REGIONAL MED CENTER	ORANGE COAST MEMORIAL MEDICAL CENTER
		24451 HEALTH CENTER DRIVE LAGUNA HILLS, CA 92653 (949) 837-4500	27700 MEDICAL CENTER RD MISSION VIEJO, CA 92691 (949) 364-1400	9920 TALBERT AVENUE FOUNTAIN VALLEY, CA 92708 (714) 378-7406
		Add to my Favorites	Add to my Favorites	Add to my Favorites
		Map and Directions	Map and Directions	Map and Directions
Patients who reported that their nurses "Always" communicated well.	72%	76%	73%	
Patients who reported that their doctors "Always" communicated well.	76%	79%	77%	
Patients who reported that they "Always" received help as soon as they wanted.	56%	56%	61%	
Patients who reported that their pain was "Always" well controlled.	69%	72%	68%	
Patients who reported that staff "Always" explained about medicines before giving it to them.	55%	59%	58%	
Patients who reported that their room and bathroom were "Always" clean.	69%	73%	71%	
Patients who reported that the area around their room was "Always" quiet at night.	42%	50%	49%	
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	81%	79%	79%	
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	65%	75%	69%	
Patients who reported YES, they would definitely recommend the hospital.	70%	80%	74%	

Patients who reported that their nurses "Always" communicated well.[Why is this important?](#)

Patients who reported that their doctors "Always" communicated well.

[Hide Graph](#)

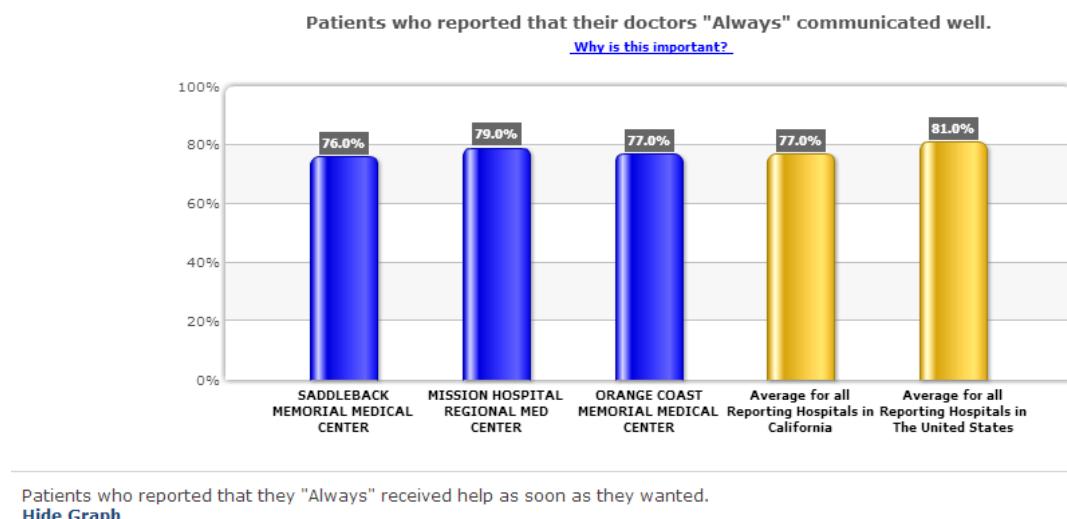


Figure 3.11: Survey performance reported publicly (from Hospital Compare website, 2012)

Tying HCAHPS performance to reimbursements rates gave the survey a significance not seen previously. Although it was highlighted that patients themselves were not likely to use the survey returns (Lake et al, 2005), their commercial significance forced hospital administrators to focus on these scores, understand their own performance based on the returns, and seek to know their patients through the surveys. Managing patient experiences moved from a matter potentially of reputational risk to one of commercial necessity. One report on the matter stated:

The current requirements to publicly report scores on [HCAHPS...] ties the amount of reimbursement directly to levels of service performance. This reporting requirement has spurred a groundswell of activity around managing the perceptions of patients and ensuring a top service experience. (Beryl, 2010a, p.1)

As Giordano et al (2010, p.29) summarize the situation: the debate has moved from one of limitations and refinement to “the HCAHPS scores themselves and ways to improve them”.

Indicatively, survey data from the US is beginning to show “patient experience” emerging as a primary objective for healthcare providers. One 2011 survey shows 21% of respondents ranking “patient experience/satisfaction” as their organisation’s number one priority for the next three years (falling just between ‘quality/patient safety’ with 31% and ‘cost reduction’ with nine percent). It also shows that patient experience is ranked in the top three priorities by 61% of respondents (Beryl, 2011, p.5).

This growing significance of the HCAHPS returns for commercial success has highlighted the specific way in which the scores embody the patient in provider organizations. It re-presents the patient inside healthcare organisations as *experiences* to be better understood, measured, managed, and improved upon. One commentator on the area highlighted this specificity to explain the challenges that the agenda presents to providers:

The fixation on patient satisfaction is one of the reasons hospitals are struggling right now to wrap their brains around the patient experience [...] Most hospital administrators assumed that patient satisfaction equated to patient experience. But with the recent passage of the Patient Protection and Affordable Care Act, the government has defined patient experience in terms of very specific actions and interactions. Hospitals that traditionally scored as top performers when measuring patient satisfaction are finding that measuring patient experience is a tougher standard, one now closely linked to some serious financial implications. (Beryl, 2010b, p.5)

A former Disney executive similarly explains to healthcare executives that, “you cannot manage perceptions in the same way that you manage outcomes” (Beryl, 2012, n.p.; see also Lee, 2004). As such quotes suggest, the new dimensions of performance that the surveys embody present a new patient to healthcare organizations, and create new distinctions in terms of quality among and between providers.

It is clear that responses to HCAHPS vary considerably between providers. For instance, the Beryl Institute suggests that “the heightened awareness of the issue of patient experience has caused many organizations to jump into action, while many still struggle with which direction to head or which steps to take first” (2010a, p.2). However, providers are increasingly dedicating responsibility for improving ‘experiences’ to a distinct position, with skills and expertise suited to managing this new dimension of care and performance. Thirteen percent of respondents to one survey indicated that their organization had a “Patient Experience Leader” with “primary responsibility and direct accountability for addressing patient experience” (Beryl, 2011, p.8). This study also finds that “organizations with a distinct leader and definitive time to commit to the patient experience tend to lead to better outcomes in both HCAHPS and internal satisfaction surveys” (ibid, p.9). Along these lines, a growing number of organizations have responded to these pressures by creating high-profile Chief Experience Officer (CXO) positions. The first such position was created in the Cleveland Clinic in 2008, and although there is no data about total numbers nationally, job advertisements suggest that the number of CXOs in healthcare organizations is

expanding rapidly.¹⁵⁶

With or without such a title, the need to manage experiences is creating the opportunity for new forms of expertise, new knowledge bases, and new types of interventions to become a part of healthcare provision. Indeed, the management of experiences is related historically to a distinct set of knowledge bases and interventions closely aligned with design and hospitality industries. The CXO position gained its significance first in the software industry, where close attention not just to technical capabilities but to the way that users interfaced with and experienced these capabilities came to matter significantly.

Interviews with current healthcare CXOs and others in the industry suggest that these past knowledge-bases and developments are being carried into healthcare as experiences start to be managed. In the same way that the software industry came to reframe technical specification in terms of their relationship of this to the user experience, Bridget Duffy (Cleveland Clinic's first CXO) argues traditional medical skills are increasingly being framed within patient experiences in healthcare:

It used to be that if you were a good enough surgeon, that was it, nothing else mattered. But actually now it does. Of course we need the best surgeons, but now we also look at their ability to understand and communicate with the patient.

Although wary of suggesting that other industries have ready-made solutions for patient experience, Duffy also acknowledges that Disney and the Ritz Carlton are common sources of knowledge about managing patient experiences in the industry. Her successor, James Merlino pushes this further, stating that in fact the CXO position in health care is “exactly the same role” as in any other sector, and that a successful CXO will actively look at other industries for interventions in healthcare:

We look at banking, car rental, all sorts of other industries. You have to look at other industries because they have been doing it for a long time; because customer experience has always been core to their business.

As Gustavsson (2000) has documented more generally, the movement of management from tangible outcomes to quality “in the eye of the beholder” gives rise to an active search for ever more “strategies and techniques aimed at what the customers’ experiences are, and even more important, what the customer would like them to be”

¹⁵⁶ Bridget Duffy (Cleveland Clinic's former CXO) notes an “explosion of interest”.

(p.178).

One research group, the Beryl Institute, is aiming to codify and eventually certify the core competencies of patient experience leaders. Following a literature review and a series of focus group discussions, they suggested fifteen key domains or areas of expertise that might constitute the ability to lead the patient experience agenda (see Appendix 3.3). These domains indicate a new blurring of health care expertise, as traditional management objectives like understanding regulatory issues, leadership, and communication come to sit alongside new capabilities such as “experience design” and “cultural competency” (Appendix 3.3). This highlights an important consequence of the rise of patient surveys in their particular form: the form of the surveys provides for new forms of expertise and ultimately new models of care to emerge. It is through these new forms of expertise that the patient is coming to be understood.

In summary, this history of the changing form of the patient survey illuminates new dynamics of the survey and the unfolding social, political, and professional relations and movements of which it is intimately intertwined. It has shown, as Bourdieu (1972) has noted, that surveys and their questions are never neutral. It illuminated this in the sense that ways of knowing the patient were always historically contingent on a complex of changing preoccupations, ideals, forms of knowledge, and events. In particular, this chapter highlighted a very interesting relationship between the contemporary embodiment of the patient and ideas and models of quality and quality improvement advanced by Avedis Donabedian (1988) and Donald Berwick (1989). It showed that in fact the things that are central to quality and upon which improvements are sought (in this case, patient perceptions of care) are themselves constructed on the basis of the requirements of those notions of quality and quality improvement. In other words, this chapter has shown how *knowing patients* and *doing quality improvement* are fundamentally intertwined in contemporary health care and reform. Knowing and improving quality necessitated the creation of new types of patients, as much as the other way around.

This interrelationship of knowing and doing quality has showed accounting for quality to be as much about changing social relations as it is about the nature of thing. Yet, as this chapter has suggested, and as the following chapters confirm, public measures of

quality present an authority and appeal which is difficult—indeed almost impossible—to refute (c.f. Espeland and Sauder, 2007). Although “invented”, they contribute to the construction of truth about care, quality, and patients (c.f. Rose, 1996, p.3). As this chapter has shown, with new measures of quality come new characteristics of patients, made up of a new language, evidence-base, form of expertise, and set of interventions based around experiences. Although some nurses, doctors, and administrators take part in efforts to measure and manage these experiences, many find that their language, their skills, and their expertise match only imperfectly onto the patient that presents herself in the new measures of quality. As such, they find themselves lacking a language to refute the measures. To argue against experiences as a basis for understanding the patient becomes an issue, in other words, of arguing against quality—and this is something that nobody wants to do. This is a dynamic that is explored in the chapters that follow.

Chapter 4

Remaking in the Name of Quality: Enacting quality in and around two NHS Foundation Trusts

Just a few years ago, physicians could be confident that they alone had a social mandate to judge and manage qualities of care. Now, that mandate is contested daily in industrial boardrooms, legislative-hearing rooms, and even medical-consultation rooms. The very language of current discussion about the quality of care leaves many physicians tongue tied and uncomprehending: Observed and expected mortality, outcomes and process measures, SF-36, case-mix and severity adjustments, profiles, HEDIS measures, control charts, continuous quality improvement, total quality management, critical paths, and appropriateness criteria. None of these terms showed up on blackboards when most physicians now in practice attended medical school. (p.891)

- Dr. Blumenthal (1997) *Quality of Care—What is it?*

4.0 Introduction

The preceding chapters have charted a confluence of movements in overlapping and heterogeneous fields that have come to make thinkable and possible this new world of quality that leaves Dr Blumenthal's anxious colleagues "tongue tied and uncomprehending" (Blumenthal, 1997, p.891). Chapter Two illustrated, for example, the constitution of quality as something that could be—and indeed had to be—measured in part from the perspective of the patient, on the basis of a mutual alignment between elements as diverse as costing systems, consumer ideas, and evidence-based medicine. In a complimentary manner, Chapter Three highlighted the constitution of the patient's perspective as something that could only be accurately measured through standardized surveys of their experiences of care, made possible through the forging of relations, and interlinkages between survey tools, ideas about improvement, cognitive testing techniques, and much else. These particular ways of thinking about quality and rendering calculations of it were not, these chapters highlighted, derived from the uncovering of some pre-existing essence of quality. Rather, these movements and their arrangement into an increasingly stable and self-sustaining assemblage were shown to literally, *make up quality* (see Section 1.3). They attributed to quality a particular set of

features, forms, and functions—a set of more or less exclusive properties among innumerable others.

As the opening quote from Dr. Blumenthal suggests, however, quality is something that is not just thought about and made calculable in a particular way. It is also and simultaneously something that is invoked, operationalized, acted upon, and enacted in very material, localized, and even personal ways. It comes, as Blumenthal highlights, to pervade “industrial boardrooms, legislative-hearing rooms, and even medical-consultation rooms” (*ibid*) through innumerable tools, techniques, requirements, and interventions. While deeply connected with and immanently inspired by the historically constituted ways in which it can be thought about and calculated, quality also has a material, programmatic and personal side that is something more. It presents itself as a series of programmes, interventions, tools, routines, situations and even experiences that succeed, fail, or do something altogether unexpected. These things, activities, and experiences of quality are therefore something that, as Dr Blumenthal’s colleagues know all too well, can be interacted with in any number of ways: they can be embraced, resisted, or redirected toward new ends. Indeed, the purpose of Blumenthal’s article is to address this myriad of possibilities and to urge his colleagues to “master the substantive issues that underlie current discussions about the quality of care” rather than resist them (p.891).¹⁵⁷

These things, activities, and experiences of quality—the ways in which quality is enacted¹⁵⁸—this research suggests, are not unrelated to, or merely derived from, the things that can be thought, said and done with quality, which have been examined in the previous chapters. Rather, they are part and product of the very same configuration and stabilization of elements that make up quality discursively. They are all elements that

¹⁵⁷Blumenthal continues: “Although it is understandable that so many physicians have reacted to the debate over the quality of care with anger, skepticism, or simply disinterest, such reactions are a luxury that physicians can no longer afford. The medical profession’s legal and economic privileges are granted by the public in the expectation that physicians have technical knowledge about medicine and will use that knowledge in the best interest of patients. If physicians cannot even understand, much less lead, the current debate about the quality of health care, their claim to technical mastery of their field — and thus, the special rights and responsibilities associated with their professional status — will be open to challenge by contending political and economic groups” (p.891).

¹⁵⁸The notion of enactment is, following Mol (2002), used to denote the open-ended and complex practices or doings of quality. She states: “It is possible to say that in practice objects are *enacted*. This suggests that activities take place—but leaves the actors vague. It also suggests that in the act, and only then and there, something *is*—being enacted” (p.33; see also Berg and Harterink, 2004).

need to be made to cooperate, and that need to be more or less successfully enrolled, reconfigured, and somehow sustained in order to make the promise of quality into the sort of reality that has been envisioned (see Callon, 1987; Mol, 2002). As such, the enactment of quality is inseparable from, and interacts dynamically with, the sorts of possibilities for the existence of quality and its calculations that we have investigated so far.

This research suggests, therefore, that it is only by illuminating and better understanding the historical making of quality as a concept or ideal, its programmatic and localized elaboration as a set of interventions, practices, and demands, *and* the interaction between the two that we can begin to more fully understand the phenomenon of the *contemporary promise of quality* that this research has sought to address. This chapter and the next aim to attend to this on-going dynamic and stability or otherwise between making up quality as a concept, set of measurement possibilities, and set of discursive terms, and its programmatic elaboration, technical specification, as well as its enactment in the delivery of care.

This chapter attends to these relations by following quality's most recent programmatic elaboration and operationalization in the UK National Health Service (NHS) in the 2008 *Darzi Review* and subsequent legislation. These reforms, outlined by the high-profile surgeon Lord Ara Darzi, drew consistently and repeatedly from the discursive possibilities and demands around quality and quality improvement documented in the previous chapters to articulate an extensive set of reforms that would "place quality at the heart of the NHS" (Darzi, 2008a, p.45). These reforms, as we will see, programmatically translated and extended the four historically distinct characteristics of the concept of quality illuminated in the previous chapters—as an accounting concern, patient centered, bottom-up, and experimental.

Darzi's propositions around quality were based on what had become matters of fact and were circulating internationally, and had been demonstrated by commentators on previous reforms to be both necessary and uncontroversial: quality would be understood and improved through its measurement, would explicitly include the perspective of the patient, and improvement would be undertaken from the bottom-up, by equipping everyone to engage in experiments of change. "If quality is to be at the heart of

everything we do,” Darzi stated, “it must be understood from the perspective of the patients” (ibid, p.47) and he continued, “we can only be sure to improve what we can actually measure” (ibid, p.49). On this basis he called for the continued standardization, managerialisation, calculation, and reporting of patient-centred notions of quality which had been underway in various forms since the late 1980s.

To make these things possible, Darzi called for an ever more elaborate measurement infrastructure: an increased use of patient surveys for understanding, regulating, and rewarding quality, the development of more clinical standards, and the replacement of politically-driven quality targets with a “National Quality Board”, regional “Quality Observatories” and a “Measurement Clearinghouse” to produce validated quality metrics that could be used as local organizations and professionals saw fit (ibid, p.11-15).¹⁵⁹ Moreover—and highlighting the extent to which accounting, and not just calculation, was becoming the model for understanding quality—he called for all providers of NHS care to produce “annual reports of the quality of their services, just as they produce financial accounts currently” (Darzi, 2009, p.25). These Quality Accounts, he argued, would “for the first time [...] systematically measure and publish information about quality from the frontline up” (Darzi, 2008a, p.8).

This calculative infrastructure, Darzi emphasized, was not an end in itself, but part of the construction of “enterprise and innovation culture” (2008a, p.56) and a “new professionalism” (ibid, p.73) focusing on quality. Eschewing the management-driven target culture of the previous reforms, and drawing instead on the more optimistic improvement ideals of “continuous improvement” which were increasingly seen to be necessary for lasting change (ibid, p.8; Berwick et al, 1992; Section 2.3.4), he stated that quality must become everyone’s business:

Quality must become *personal and individual to everyone working in the NHS* [italics added]. We must develop a culture inside organisations where quality is talked about – from every GP practice through to every hospital ward and every board. It means supporting staff as they step up to the challenge of raising quality, promoting dialogue and discussion about how things can be done differently and looking out to the communities we serve for our inspiration for change. High quality care for all will be accomplished through thousands of small changes, through the *courage and leadership of*

¹⁵⁹ As one commentator explained of the agenda: “Rather than being accountable to central targets, NHS services will be accountable to the patients and communities they serve and their peers as a result of publication of their quality outcomes” (Torjensen, 2008, no page)

frontline staff [italics added], sustained and supported by an NHS system with quality at its heart. (Darzi, 2009, p.40)

Reflecting on his own experiences, he described such demands as merely an extension of the professional ethos that existed already; delivering quality is “what [already] inspires me and my colleagues [in our work]” (Darzi, 2008a, p.8).

Further, referencing directly the “science of quality improvement” (ibid, p.21) that had developed in the USA and was circulating internationally (see Section 2.3.4), Darzi argued that;

There are fundamental principles applicable throughout—a systematic, team-based, problem-solving process to continually move up the level of care provided—to implement and test the effects of ideas on quality outcomes. (2008a, p.36)

On the basis of these fundamental principles, he described quality improvement as an individual prerogative: a matter of gaining new skills in the measurement and improvement sciences, and establishing new attitudes along the way. Quoting Donald Berwick of the Institute for Healthcare Improvement (IHI), Darzi explained these requirements as an emancipatory process:

One of the rewarding things about the science of quality improvement is how egalitarian it is that anyone can play a role in making meaningful changes given the time, the right tools, and motivation. (Berwick in Darzi, 2009, p.26)

Consistent with the discursive parameters of quality that existed internationally, its improvement was articulated as a positive and bottom-up process of change led by equipping professionals with the “right tools, and motivation” (ibid) to experiment and find out themselves about the “thousands of small changes” (ibid, p.40) that would raise the quality of care.

This chapter follows these reforms, which were carried forward largely unchanged and with little controversy, in the 2009 Health Act. It examines how they were operationalized, interpreted, responded to, and experienced by various authorities, organizations, and professionals across the NHS between January 2010 and July 2013. In order to do this, government publications, legislation, Department of Health (DH) circulars and consultation documents, popular press articles, and other such public data related to the reforms were gathered and analyzed. At the same time, over 75 hours of interviews and observations were undertaken with a range of regulators, consultants, survey developers, commissioners, speakers and attendees at quality-related

conferences, along with a variety of nurses, physicians, and administrators within NHS hospital trusts (see Appendix 1.2 for a full list of interviews and observations).¹⁶⁰ These activities helped to construct a picture of some of the various ways in which a whole variety of authorities were interpreting, responding to, shaping, and elaborating the reforms.

During this period, the activities around quality in two NHS hospital trusts were studied in a more detailed and intensive way.¹⁶¹ In these trusts, interviews were undertaken with those formally responsible for quality as well as with a number of other individuals involved in a wide range of work streams related to quality (such as piloting new quality improvement interventions, scorecard development, the implementation of new survey techniques, etc.). While these interviews took the researcher throughout various locations at the trusts, ultimately two specific points or locations were selected for more in-depth study. In each of these locations, the demands of quality were being brought to bear on the day-to-day lives of nurses and physicians.

In Trust One (T1) the researcher's investigations led him to a large gastrointestinal ward, where two Nurse Sisters, Sharon and Laura (not their real names), were the center of the trust's quality improvement activities and interventions. The Sisters and their 45-person team had first piloted many of the trust's quality improvement interventions, and were in the process of further developing many others. They were also responding to the trust-wide changes that had occurred in response to the Darzi reforms. Roughly 30 hours of interviews and embedded observations with the Sisters and many of their staff and patients were undertaken throughout the period in order to observe the way in which quality was coming to be enacted within the ward.

¹⁶⁰ The choice of interviewees stemmed from initial exploratory emails sent to people within NHS hospital trusts identified as potentially having responsibilities for quality from the trust websites. Initial exploratory interviews in three trusts, and with others familiar with the area, identified a number of organizations (such as the Kings Fund, Picker, and the NHS Confederation) and relationships (with commissioners, regulators and the Department of Health), and publications or conferences that have been involved in their understanding of quality. These references were then followed up, resulting in a further set of interviews, and in the case of conferences, observations.

¹⁶¹ Trust 1 (T1) is a large acute hospital trust in Central London comprised of six hospitals. It sees over 700,000 outpatients each year and has operating income of over £500 million. Trust 2 (T2) is a large acute hospital trust in Northern England. It sees over 300,000 outpatients each year, and has an operating income of over £300 million. They both have held Foundation status for a number of years, allowing them more commercial flexibility, such as the ability to borrow privately.

In Trust Two (T2) the researcher was led to a newly reworked and expanded training programme for consultants joining the trust. In the year-long New Consultant Development Programme (NCDP), trust executives, outside consultants and experts, as well as “quality leaders” within the trust, taught new physicians what it would take to become the new leaders that the trust required. Having been provided training with a number of quality improvement approaches, methodologies and tools, as well as general advice from colleagues and past graduates of the programme, the consultants were asked to undertake their own quality improvement interventions in order to take that first step towards being high impact leaders within the trust. The researcher observed a number of these training days and undertook a series of informal interviews with attendees when the opportunity presented itself.

4.1 Research approach

In order to study the unfolding and dynamic relationship between the ways in which quality and its calculation are constituted discursively and programmatically, and the various ways in which people and organizations come to interpret, experience, engage with, and respond to these terms, this chapter draws loosely upon three analytical concepts or points of reference.

First, and consistent with the broad methodological starting point outlined in Section 1.3, this chapter draws loosely from Miller and Rose’s (1990) elaboration of *governmentality* and their articulation of how rationales can come to configure subjects. It analyzes quality as a practice of “government” in the sense that Miller and Rose, following Foucault, understand it:

[As] the historically constituted matrix within which are articulated all those dreams, schemes, strategies, and maneuvers of authorities that seek to shape the beliefs and conduct of others in desired directions by acting upon their will, their circumstances, or their environment. (Miller and Rose, 1990, p.54)

Conceptualizing quality in this way draws our attention to distinctive processes that form such matrixes and in doing so constitute quality at multiple and overlapping levels and locations. It highlights, as elaborated in Section 1.3, the “problematisations” (*ibid*, p.61) of which government is part and product, the various “translations” that make such problems into “programmes” and “technologies of government” (*ibid*, p.61-4), and

the ways that these interventions can come to take part in configuring subjectivities (c.f. Miller and O’Leary, 1994a; Callon, 1998; Thrift 2000; Rose, 1991),

Second, acknowledging that such governmentality-inspired concepts and approaches tend not to focus on the localized situations in which individuals and organizations actually come to confront and experience programmes and technologies of government¹⁶², this chapter draws loosely also upon the concept of *performativity* (and non-performativity) advanced by Michel Callon (1998; 2008) and his colleagues (Cochoy et al, 2010). The notion of performativity, as elaborated in Section 1.3, draws attention to the relation between the notions of quality and their “worlds” (MacKenzie, 2003), and more specifically to the activities, instruments, and arrangements by which “favourable environment and institutional affiliations” to sustain such worlds are more or less permanently constructed into reality (Callon, 2008). Such an approach allows us to better understand the fragility and variation of programmes of government.

Third, this chapter draws from the notion of *enactment* that has been advanced by Annmarie Mol and others (Mol, 2002; Berg and Harterink, 2004) to conceptualize the intersection of “knowing” and “being” that takes place around bodies (Mol and Law, 2004, p.4). These studies highlight, as governmentality scholars would, that bodies are constituted through the knowledge and technologies that make them known. They also highlight, as performativity scholars would, that the constitution of bodies as known is inseparable from the processes, practices, and arrangements that make them knowable. The contribution, however, that they stress by attending to “enacting” or “doing”—the practices, that is, that take place in and around the body—is that such bodies are *multiple* or fractal. They show that they are constituted of multiple and overlapping knowledges and arrangements, some programmatic, and others more locally conceived. Moreover, they show that these practices do not make the programmes fail but more often than not in fact sustain and support them. Attending to these multiple enactments and multiplicities allows us to explore some of the ways in which the strong connectivities implied by governmentality and performativity concepts are messily expressed, problematized, and even problematically sustained at the level of practice.

¹⁶² This point is made by Ahrens and Chapman (2007) and others (e.g. Kurunmäki and Miller, 2011) who note that governmentality approaches tend to avoid “enquiry into the detailed practices through which accounting is mobilized by organizational members” (p.5).

These three theories or approaches, this research suggests, provide a means by which to investigate the things, activities, and experiences of quality in a way that extends beyond the “implementation studies” paradigm (Eccles and Mittman, 2006, p.1), which is common to most studies of the practices related to quality. Such studies draw from the standards and prescriptions of dominant models and programmes of quality and quality improvement in order to investigate the extent to which organizations and people succeed or fail (almost always fail) to live up to its prescriptions (e.g. Shortell et al, 1995b; Bummental and Kilo, 1995; Øvretveit and Gustafson, 2002). As a result, implementation studies confine their investigations of what is done around quality to the factors affecting the adoption or otherwise of the specific requirements that they chose to unproblematically privilege. While sometimes highlighting additional variables that need to be attended to in order to make quality happen, this approach typically lays blame for quality improvement failures squarely on the feet of professionals and organizations that are “stubbornly resistant to change” (Davies, 2002, p.141), without showing the distinct problematic inherent in the model of quality that they privilege.

The approach employed here, by contrast, conceptualizes and investigates implementation as a wider phenomenon, of which the stuff of implementation studies is only a piece. By investigating the programmatic and technological elaboration of quality, and its multiple and overlapping enactments, this chapter shows the doing of quality to involve far more diverse movements than are typically captured. This research shows that implementation involves substantial pre-figuring and formatting; the construction of a world of quality in which doing something about quality could be seen as a matter of mere implementation—of putting certain information systems, responsibilities, etc. in place. It is also shown to involve many imperfect translations and bundling (Kirkpatrick and Martinez-Lucio, 1995) which make quality something else (indeed many things) from that which is articulated discursively and elaborated programmatically. As such, instead of succeeding or failing, quality is shown to take part in the on-going production of new but surprising things.

This investigation is elaborated in the following five sections. Section 4.2, *Placing quality at the heart of the NHS*, illuminates the way in which Darzi’s programmatic ambitions and the attending technologies came to be translated into the national

normative, regulatory, and commercial environment of the NHS. It shows that despite a variety of different responses to these programmatic ambitions by different organizations, collectively they nonetheless put in place a series of arrangements that helped to perform the notion and aspirations of quality and quality improvement articulated in the Darzi Review.

Section 4.3, *Bringing the outside in*, shows the way in which this external environment was interpreted, responded to, and interacted with, by healthcare administrators in T1 and T2. It shows the way they worked within and in part outside the bounded notion of quality presented to them as a series of normative, regulatory and commercial demands and opportunities in order to show that they were doing something about quality. While illuminating distinct differences between what quality is for the two organizations, this section also highlights consistent activities and actions undertaken in both that brings the external and bounded notion of quality into those organizations in an even more specific form.

Section 4.4, *Doing quality improvement*, follows the more practical doing of quality and quality improvement within the two organizations. It investigates the operationalization of various interventions and activities (such as ‘training days’ and quality improvement tools) and the experiences of doctors and nurses with these efforts. It illuminates the differences in the way that these tools are presented to individuals, but also highlights the way they take part in constructing a distinctive new way of being a healthcare professional—a healthcare professionalism summarized as *homo-Ara Darzicus*.

Section 4.5, *Remaking organizations and professionals in the name of quality*, follows how this way of being a professional confronts nurses and doctors. It shows the emergence of tensions and overflows within the structure of this particular enactment of quality and professionalism. And it documents the way that such tensions problematize *homo-Ara Darzicus*, and allow nurses and doctors to again differentiate this way of being from the notion of quality that they also enact locally.

Finally, Section 4.6, *The discursive limits of quality*, with reference to recent high-profile quality failures in the NHS, follows quality’s on-going problematization and stabilization. It highlights both the durability and flexibility of this enactment of quality

and the things that it demands of people and organizations, while also highlighting its changing terms.

4.2 Placing quality at the heart of the NHS

“Placing quality right at the heart of the NHS” (Darzi, 2008a, p.45) required a series of normative, regulatory and commercial translations. As we will see, authorities at the national level responded to Darzi’s agenda and the legislation that followed by making quality into a series of tasks, regimes, measures, potentials and opportunities between 2009 and 2011. These translations, moreover, took part in performing the notion of quality that previously existed largely discursively; they started a reconfiguring of the world of healthcare quality in the name of a notion of quality that we have seen emerging over the previous two chapters.

So consistent with the discourse and popular images and aspirations of quality were Darzi’s programmatic announcements that his agenda was greeted across the popular and medical press positively and even with enthusiasm. Indeed, described by the Financial Times as “the world’s most ambitious attempt to raise the quality and effectiveness of an entire nation’s healthcare” (FT, 2008, n.p.), the infrastructure that Darzi called for was seen as a clear alternative to the politics and heavy-handed intervention that might have been expected. Dr. Richard Horton, editor of *The Lancet*, for example stated:

Darzi has wisely thrown out regulation as the organising principle of the NHS. He has replaced it with quality, by which he means clinical effectiveness, patient safety, and the patient experience. This cultural shift is a radical re-visioning of purpose for the NHS - away from the political command and control of processes and towards professional responsibility for clinical outcomes. (BBC, 2008, n.p.)

Niall Dickson, chief executive of the King’s Fund think tank similarly stated:

The good news is that there is no top-down re-organisation or any dramatic changes in direction. Instead the report is a sensible set of measures to improve quality and equity, and a clear signal that responsibility for shaping and leading health services lies with staff at local level. This will be a new era in which patients will be able to check on the quality of the services they are being offered from infection levels to success rates following operations. (BBC, 2008, n.p.)

Despite the clear programmatic elements of the Darzi reforms, in summary, the technologies and interventions that were proposed were greeted, not as new

technologies for control or political maneuver, but as clear articulations of what quality 'actually' entails.

The reforms were also positively responded to by most of the official spokespersons for the medical profession (Carvel, 2008). The Chairman of the British Medical Association (BMA) stated that "there is much [in the reforms] that could bring about improvement" and that, "we are pleased the government has stated its intention to move away from target-driven health policies and to focus instead on the quality of patient care" (BBC, 2008, n.p.). The Royal College of Nursing reacted equally positively.¹⁶³ It stating that the review was "its greatest opportunity in a generation" (McLellan, 2008), and aimed to articulate quality as a core domain of nursing over the following years (see Commission of the Future of Nursing, 2010).¹⁶⁴ Patient groups also responded favorably to the review, stating that "patients have waited too long for these changes" and expressing enthusiasm for the recommendations to be rolled out in full (Carvel, 2008, n.p.).

Such responses meant that the world of quality articulated by Darzi was made slightly more actual (see Callon, 2006, p.14); no longer simply an opinion or a piece of legislation, the notion of quality and things required to improve quality articulated by Darzi were becoming increasingly difficult to refute. This normative support for the review meant that the interventions and programmes outlined in the review became increasingly synonymous with quality and quality improvement itself. Indicatively, in May, 2010, the incoming Conservative Health Minister, Andrew Lansley, continued to offer full support for the reforms, and introduced a Quality Innovation, Prevention and Productivity (QIPP) scheme that, while having cost-cutting at the core, embraced and extended Darzi's ideas and language of quality.¹⁶⁵

¹⁶³ Peter Carter, General Secretary of the Royal College of Nursing, responded to the review by stating, for example: "The overwhelming majority of NHS care is safe, but we believe the ambition now must be to drive up patients' experience from 'safe' to 'high quality'. Fully implemented, these recommendations have the potential to achieve this ambition" (BBC, 2008, n.p.).

¹⁶⁴ Darzi encouraged this interpretation. Addressing the Royal College of Nursing, Darzi argued that they were well placed to push the agenda forward (McLellan, 2009).

¹⁶⁵ Consistent with the Darzi agenda, "The Quality, Innovation, Productivity and Prevention programme is a national Department of Health strategy involving all NHS staff, patients, clinicians and the voluntary sector. It aims to improve the quality and delivery of NHS care while reducing costs to make £20bn efficiency savings by 2014/15. These savings will be reinvested to support the front line" (QIPP, 2013, n.p.).

The regulator designated by the reforms as the sole quality regulator, the Care Quality Commission (CQC), while noting cautiously that the reforms were short on specifics (BBC, 2008, n.p.), responded largely by incorporating Darzi's ideas into their inspection and regulation regimes. It did this primarily by giving much more weight to survey and other patient-data in the Quality and Risk Profiles of each organization. Although this important inspection tool had always incorporated measures of quality, its increasing emphasis on patient-data quickly made these metrics central performance measures, and changed the way organizations could respond to them. In the past, the CQC Patient Surveys Lead explained, trusts would "act out from time to time" against the patient experience metrics by, for example, not undertaking the surveys (which are voluntary), but now such acting out would indicate organizational failure. Refusal to run the survey would now mean that "people would descend on you from the SHAs [strategic health authorities], and the DH, and even CQC inspectors and so on, because you would be flagged at risk. Not because you are at risk, but because you wouldn't be able to prove that you aren't".

The reforms, and their call in particular for "funding for hospitals [to] reflect [...] patients' own assessments of the success of their treatment and the quality of their experiences" (Darzi, 2008a, p.12) were translated into specific commissioning and commercial arrangements in the NHS in 2010 and 2011. The existing Commissioning for Quality and Innovation (CQUIN) framework, which linked hospital pay to performance, was expanded to represent more of each trust's income, and the QIPP commissioning arrangements were introduced to further incentivize performance around "quality, innovation, and productivity". Although the indicators used in the frameworks were chosen locally, they increasingly focused on the patient experiences that Darzi argued should be at the core of quality. As the aggregated CQUIN and QIPP indicators for 2010 and 2011 shows (Figure 4.1 below), patient experience metrics expanded and focused increasingly on experience outcomes, such as patient survey responses themselves. Such metrics were also given a greater prominence in the Care Directory and on the NHS Choices website, which provide information for patients to choose their providers. These metrics thus translated the notions of quality articulated by Darzi into a series of metrics of trust performance that had commercial relevance, in a similar manner as in the USA.

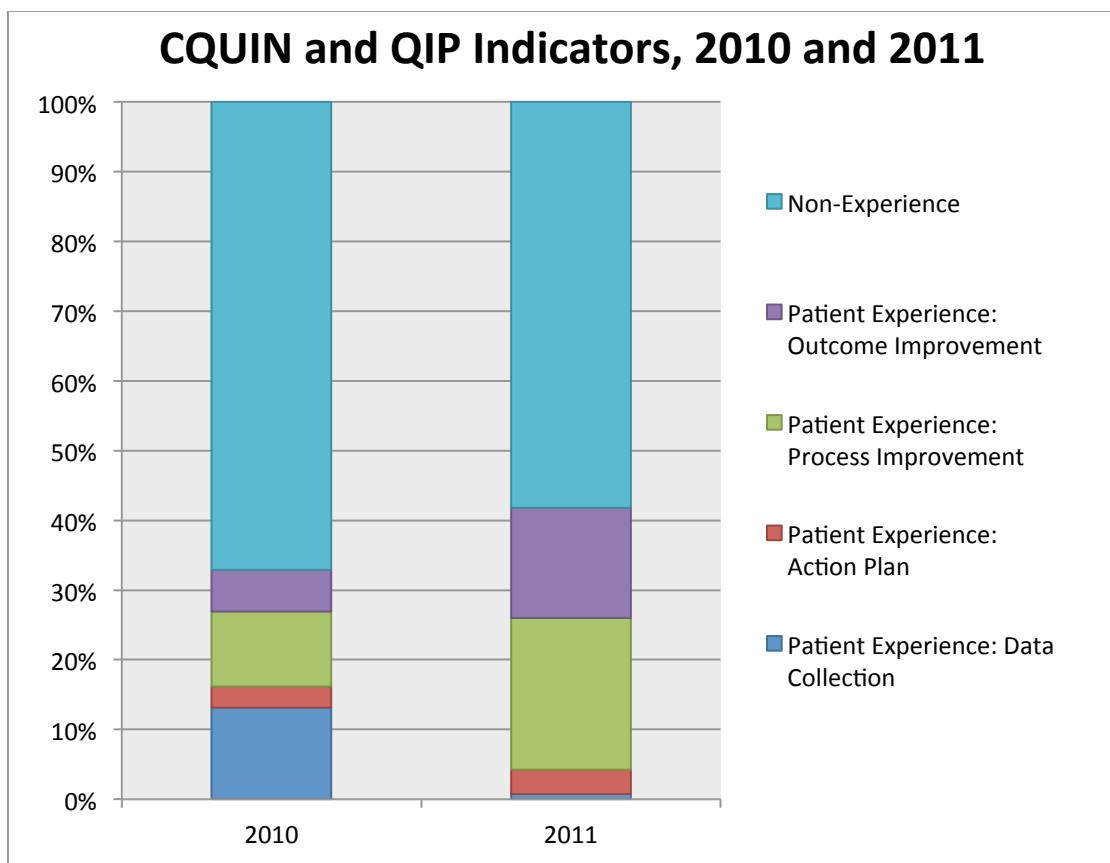


Figure 4.1: Types of CQUIN and QIPP indicators as a percentage of total (data from NHS Institute, 2013a)

Together, these new regulatory, commercial and normative pressures took part in the imperfect translation and tentative performance of the notions of quality and quality improvement whose emergence were documented in the previous chapters. By seeking to, as Darzi hoped, “place quality right at the heart of the NHS” (Darzi, 2008a, p.45), those authorities operating at the national level in the NHS began to construct a world in which the notions of quality circulating internationally represented actual performance (c.f. Callon, 2006, p.14). As regulations, commercial rewards, and media threats and opportunities, quality became something more than the aspiration it once was. Indeed, trusts could no longer afford to “act out” against the patient experience survey, arguing (as some had in the past) that the best way to learn about quality was to ask those who cared for the patients. It was also increasingly costly for them to insist that quality was far too multi-dimensional to portray in three to five measures (as Quality Accounts required), or that in-year performance was incompatible with lasting organizational change (as commissioners assumed), because these forms of knowledge were increasingly marginalized in a world dominated by the metrics and measures that Darzi

had linked to quality. Thus, through the construction of this environment, the discourse of quality was made more durable. Quality was not “just about anything anyone wants it to be” (Donabedian 1966, p.167); to the contrary, the ambiguities and alternative conceptions of quality that once existed were increasingly dismissed.

4.3 Bringing the outside in

At a corporate level, trusts brought this external representation of quality inside through risk assessment, strategic planning and Quality Accounts. In both T1 and T2, the reworked environment led “quality” to be escalated as a corporate objective because of its centrality to the risks presented by CQUIN failure, de-authorization, and patient choice (c.f. Power, 2007, p.34-65).¹⁶⁶ This re-prioritization led to rebranding, responsibilization and reorganization; in both trusts, board members were given official quality responsibilities, and roles around the metrics were distributed.¹⁶⁷ Quality Improvement strategies were devised or reworked, Quality and Safety teams were established or reformed, and Quality Accounts were dutifully produced for the first time.

All of this reworking was part of the process of seeking to place Darzi’s ideal of quality at the heart of everything trusts did. As both trusts’ literature proudly proclaimed:

Our vision for [T2] is of an organisation where everyone from the frontline staff to the Board of Directors puts quality first and makes the quality of care everyone’s concern. “Your Care, Our Concern” is [T2’s] new vision. (Corporate Strategy, 2010, p.3)

[T1] is committed to delivering top quality patient care, excellent education, and world-class research [...] Our vision is underpinned by a set of values and the [T1] service commitment, *Putting Patients First*. (Annual Review, 2010, p.3)¹⁶⁸

¹⁶⁶ Both trusts specifically identified the *Darzi Review* in the strategic context and highlighted its incorporation into regulation and commissioning. By 2010, “delivering high quality patient experience” became T1’s third priority (of 10) (Forward Plan Strategy Document 2010/11, p.13). T2 similarly had outlined a new trust vision that was “linked to the three domains of quality described by Lord Darzi in the Next Stage Review” (Annual Plan 2010/11, p.3).

¹⁶⁷ The roles and responsibilities of various organizational functions also changed. Of the many adjustments at T1, “quality improvement” was added to the Nursing Director’s role, and at T2 the Clinical Director’s role was expanded to include “Quality Improvement”. At T1 also, the Informatics Team was rearranged to have a specific team focused on quality metrics.

¹⁶⁸ Similar nominal movements were seen all across the NHS. The DH, for example, stated that it would “place patients at the heart of [its] business plan” for the 2013/14-2015/16 year, and made “satisfied

Indeed, across all NHS trusts, it became increasingly difficult to find organizations that did not proclaim loudly to place “quality” at the heart of their care in the years following the Darzi review.

These pronouncements by individual trusts not only signaled a commitment to national policies, and maintained a connectivity to the pronouncements of Darzi, they also entailed increasingly specific things. In the case of producing Quality Accounts, although they were intended to be locally developed, they could only be developed within ever stricter bounds. Regulators and commissioners, alarmed by the lack of comparability in the metrics used in the first pilot session, developed increasingly stringent assurance and standardization measures for Quality Accounts (Audit Commission, 2013). They required a description of internal controls to assure data quality, a signed statement of director responsibilities, and a limited assurance report from auditors (under ISAE 3000 requirements) to be included in the accounts (DH, 2012c). This meant that the wide variety of local indicators used in the pilots became, under this new regime, unfit representations of quality. Indicatively, once assurance was required, nearly 90% of the 141 trusts chose at least one identical indicator (Foot et al, 2011). Deluged by metrics imposed by regulators and commissioners, trusts found it difficult to think about quality differently. T1, for example, simply triangulated the metrics being used by regulators and commissioners in order to come up with its account (see Appendix 4.1).

By creating an infrastructure for producing notions of quality fit for external consumption that trust administrators were able to declare that “we’re measuring what matters now [...]. As the Director of Organizational Development at T2 continued:

[...] Now we’ve got a quality report to the board, an executive lead for quality improvement, as well as governance and quality assurance. We’ve got patient stories going to the board. All these things are hugely positive. Now the organization can see the things that matter. The newsletter has the quality strategy in it each month. So I think the whole organizational outlook is changing.

At T1, similarly, the Director of Safety and Quality explained of their reworked quality dashboard, which included the new quality metrics:

patients” its first priority (of eleven) using questions for the national patient survey to monitor progress (DH, 2013, p.5).

[It] is now looked at very closely by managers and service managers. It is not really performance management but it tells us very generally how well things are going. It tells me the areas I don't need to worry about too much and the things I need to focus on [...] We've had a big push recently to get people to acknowledge why it's important that they look at the BSC [balanced scorecard] and to make them aware that this is what senior managers are looking at when they make decisions about their areas.

Indeed, in both trusts there was substantial reworking of the information systems—the development of new patient feedback technologies, new balanced scorecard reports, new reporting systems, the reorganization of informatics teams, etc.—that was seen to be required to do something about quality. This again helped to perform a particular world in which quality was made in a distinctive form (c.f. Vikkelsø, 2005).

Such internal translations of quality, or what, drawing on Power (1999), might be called quality “implosions”, largely reformatted the organizations in order to fit the world of quality that was envisioned internationally. Simultaneously, however, quality was also being bundled up with other preoccupations and bent toward specific new preoccupations and ends at national and more local levels. The principle preoccupation faced by all trusts, and indeed the NHS as a whole, was the dire financial situation on the horizon. Over the coming years, trusts would be squeezed to make cost reductions as the tariffs were reduced at a scale that the NHS had never witnessed before (Appleby et al., 2009). In this context, the language of quality was seen by regulators and trust executives to provide a positive prism through which to discuss, investigate, and undertake cost cutting. So within the two trusts, and also in the NHS as a whole, quality took on an increasingly financial meaning almost immediately after the passage of Darzi's reforms.

In T1, quality and cost-saving were bundled together with the rebranding and re-launch of the existing “Trust Efficiency Programme” as the high-profile “Quality, Efficiency, and Productivity” (QEP) programme.¹⁶⁹ Introducing it to staff, the Chief Executive explained;

Increasing efficiency at the cost of quality is unthinkable; increasing quality at the cost of efficiency is unsustainable. This means that we have to do both together, that's the bottom line.

¹⁶⁹ To make clear that the notion of quality was in no way separate from efficiency, when explaining the programme, the Chief Executive presented the quote “quality must be at the heart of the NHS” highlighting that it was a phrase repeated in 2008 by Darzi, in 2009 by David Nicholson (the NHS Chief Executive), and in 2010 by Andrew Lansley (the new Minister for Health).

Within the trust, which had a reputation for strong management and performance measurement, the metrics around quality became increasingly coupled with those around financial performance.¹⁷⁰ The QEP team focused on what a Project Manager called “win-win-win opportunities”, although, on a less positive note, in a later QEP meeting, the Chief Executive used the language of quality to announce the need to make redundancies in the next two years in order to meet efficiency goals.¹⁷¹

At T2, quality was also being repackaged, but in a different way. To the executives there, some of the requirements around quality had seemed at odds with their understanding of how to achieve organizational change. They had, over years of short-term, management-driven, pressures, come to the conclusion that “sustainable change requires long-term cultural transformation and the development of ownership among staff”—something inconsistent with the in-year improvements required by commissioners. For these trust executives, who had begun to develop a long-term Quality Improvement strategy for the trust prior to Darzi, the Quality Accounts and CQUIN targets were seen to “get in the way a little bit”.¹⁷² The conflicting perceptions of change created a distinct challenge around quality for T2, which they described as being one of “feeding the beast” while at the same time “doing the right thing”. In order to do this, among other things, they decoupled their representations from their internal stretch targets, putting, for example, “the minimum we can get away with” in Quality Accounts so that their improvement efforts would not be turned into targets.

In both trusts, therefore, even while Darzi’s quality was being meticulously performed, it was simultaneously being translated into something different. Quality was being enacted in locally specific ways and bundled with local preoccupations (Kirkpatrick and

¹⁷⁰ Indicative of this culture and its tensions, one nurse who had been at the trust for five years explained that “[T1] loves meetings. It’s the buzz word around here. You have to have a meeting to schedule a meeting. It’s insane, and it takes so much of our time. It really winds me up because we’re supposed to be here with the patients, and now we can’t be.” The Chief Executive was unapologetic of this culture, stating that the motto of the trust was, “If it moves, we measure it and track it”.

¹⁷¹ According to a Freedom of Information request, T2 plans to reduce its staff by 444 in order to meet efficiency targets (Rogers and Ramesh, 2011).

¹⁷² They believed that their commissioners focused unrealistically on short-term transformation. They “look at performance in a very traditional way—the green, amber, red sort of thing—with no view or understanding of improvement or how that works” (Director of Organizational Development, T2). To deliver these in-year targets, it was understood that they could “apply strong management pressure”, but when this pressure was released, the organization would stop meeting these targets. Instead, they explained, “what we’ve been trying to do is small tests of change, establishing reliable processes, and doing it right—this requires a lot of time and patience” (Quality Improvement Manager, T2).

Martinez-Lucio, 1995). It was through these localized iterations that quality was being made something real and distinctive—something that fit within the world of quality constructed around them, but that was different from that which Darzi had imagined. Indicative of the fit of such local variations, T1's actions were praised by executives from the DH; at a QEP meeting, the Director of the national QIPP programme, Jim Easton, told the trust that “I encourage you to continue to push ahead with your measurement obsession”. Similarly, although T2 was not supportive of the in-year targets required by commissioners, the trust executives nonetheless maintained that the accounting infrastructure of quality was consistent with, even an opportunity for, “doing the right thing”.

Despite the occasional decoupling of Quality Account targets from the ambitions of the organization, and the translation of external demands around quality into other, locally-specific things, the infrastructure that was put in place to measure and know about quality nonetheless took part in constructing or embodying what quality was. The sort of information that was measured—the data “that matters” (Director of Organizational Development, T2)—increasingly constituted what quality could be and what trust performance could be comprised of.

This was clearly illustrated in the case of patient experience, which was deemed an essential dimension of quality (alongside patient safety and clinical effectiveness), measured and rewarded as part of CQUIN and QIPP contracts, and closely monitored by regulators. Although almost everybody advocated that the experience could and should be measured in a variety of qualitative and quantitative ways (through the use, for example, of Board Stories, Patient Diaries, and patient and staff surveys) the requirements of measuring and managing quality resulted in the metrics from the National Survey taking precedence and constituting quality performance. Given that the National Survey outputs were the basis of almost all external regulation and rewards, trusts installed real-time survey systems to reproduce these frequently, included these metrics in the ward-level balanced scorecard, and allocated strong managerial attention to their outcome (including appointing Directors or Heads of Patient Experience (see NHS Institute, 2013c)). In this specific context, quality was constituted strictly by these survey returns. The data contained in Patient Diaries (which both trusts were piloting) was seen by management, as one Nurse Sister at T1 explained, as “a sort of liability”,

and dismissed beyond the ward-level. They contained very valuable information about quality for the trust as a whole, like the entry that said simply “PLEASE READ MY DIARY!” However, trust boards, whose meeting documents were audited in order to assure the quality of the information they provided in their Quality Accounts, saw these erratic and potentially damning sources of information to be a potentially problematic barrier toward producing the unambiguous account of quality that the Quality Accounts required.

4.4 Doing quality improvement

Quality was now nominally at the heart of each NHS trust: it had been moved up the strategic priorities, action plans had been developed, measures defined, targets set, committees established, titles remade, and responsibilities outlined. Yet these representational and organizational changes still did not, by themselves, improve upon the measures of quality that they so specifically brought to life within the organizations. Indeed, those tasked with quality had much experience with managing the representational tasks; for years they had been ensuring that centrally driven targets were well-managed and met. But they had little experience managing quality’s new metrics (things like improving the patient’s experience) and had only tentatively ever attempted the cultural change and “leadership” that Darzi (2008a, p.65) articulated. As a consultant with close ties to many NHS trusts explained.

Converting the information you get from the patient survey into action and improvement is actually very difficult. It’s partly because it’s fairly new, but also because [those in NHS trusts are] not experts here. They are experts at infection control and all that, but dealing with human beings and responding to their particular experiences and needs is a very difficult task, especially when quite a lot of it is about changing how staff behave. Behavioural change is the most difficult thing. It’s fairly easy being in an infection control regime by comparison to changing the way that consultants speak to people [...] We’re talking about generations here [...] It’s not a one size fits all thing. In fact it is still rather woolly.

With transformed notions of quality taking shape in and around the trusts, and with CQUIN targets increasingly moving from data collection and action plans to demonstrable improvements in outcomes (see Figure 4.1), trusts faced the challenging and novel question of how to improve upon these terms.

To some extent, understanding what doing quality improvement entailed was imported through personnel replacement and promotion. Since the early 2000s, there had been small-scale quality improvement pilots that had produced pockets of expertise throughout the NHS, and there were also a small number of British health professionals that had spent time, perhaps as fellows or researchers, at American quality improvement organizations such as the Institute for Healthcare Improvement (IHI). Within this reworked environment, these people became central to quality improvement initiatives within the trusts. At T1, for example, the Director of Quality and Safety was seen to have been hired in 2010 on the basis of her “close and long standing ties with the IHI and keenness to try some of their ideas out” (Head of Quality Improvement). Similarly, the Head of Nursing was brought into the trust from the DH in January 2011, following her work at the NHS Institute on the quality improvement project, “High Impact Actions” (NHS Institute, 2012, n.p.). As one Nurse Sister explained to her staff:

[The new Chief Nurse] has a vision—she has lots of visions actually. She couldn’t be more different from [the last Chief Nurse]. She is keen on changing a lot of things here; she has lots of visions about where she wants to take nursing here. (T1)

This new QEP programme, moreover, was staffed with “information analysts, and various people from service improvement; people who are trained in LEAN, who can do SPC [service process control], people who are trained in various improvement techniques and have experience elsewhere” (QEP Project Manager). At T2, similarly, the two “quality specialists” that were at the trust on a part-time basis as part of a “safer patients initiative” were, with new funding from the commissioner, also taken on full-time. As a Senior Nurse explained; “while not looked well upon a few years ago, they are now actually core to the organization”.

People were also learning new ideas about what quality improvement entailed through conferences, reports, and re-training. Throughout 2010 and 2011, there were dozens of well-attended conferences throughout the UK on topics such as “measuring and improving patient experience” (29-30 June 2010), “mobilising the NHS workforce for quality and cost improvement” (15 July 2010), “measuring and monitoring patient experience” (30 Sept 2010), and “transforming patient and staff experience; what works?” (6 Dec 2010). At these events, many of the same individuals, along with visitors from improvement agencies in the USA, outlined not only visions and

approaches, but also the specific tools and methodologies for doing quality in the reworked world.¹⁷³

Following the reforms, the DH's NHS Institute also changed its strategic plan from "quality and value" to "*delivering* quality and value [italics added]" (NHS Institute, 2010, p.7). As part of this altered focus, it began providing specific guidance on how to "do quality" and developed the "Organising for Quality" programmes to this end (*ibid*).

The project stated:

The fundamentals for quality improvement provide NHS staff with a solid foundation in quality and service improvement methods and techniques and a range of tools with which to design and implement effective and sustainable improvement projects. (*ibid*, p.27)

Moving beyond the research on quality improvement that it had been publishing for the past few years, for example, the comprehensive but rather abstract handbook of quality theory and practice it had published in 2008 (Boaden et al), it began to develop, pilot, and refine specific interventions for quality improvement. Adapting lessons and methodologies from its American counterparts, it developed, for example, the Productive Series methodology and work stream. As the Institute explained:

The Productive Series supports NHS teams to redesign and streamline the way they manage and work. This helps achieve significant and lasting improvements – predominately in the extra time that they give to patients, as well as improving the quality of care delivered whilst reducing costs. (NHS Institute, 2013b, n.p.)

This sort of hands-on intervention (there were a number of other such work streams) went beyond the previous efforts of the Institute. Trusts, eager to do something about the agenda, quickly began piloting these interventions, hoping to become leaders in quality in its distinctive new form.

Thus, either because those tasked with quality and quality improvement brought specific improvement ideas to the role, or because they had gleaned what it entailed from conferences, reports, and interactions with others, what doing quality improvement in this re-worked environment entailed became increasingly clearer. This emerging clarity, however, did not constitute what authors such as Waring (2007) and Timmermans and Kolker (2004) had described as a distinct knowledge base upon which

¹⁷³ There were also a variety of private and non-profit organizations that presented at these conferences and that expanded in the years following Darzi. The LEAN Academy, for example, found its expertise increasingly in demand and Picker, an American company, opened a specific UK office.

to challenge professional ideas of quality and care. Instead, those who came to lead the quality improvement initiatives inside hospitals were typically far from outsiders with distinct worldviews and backgrounds (as the managers of the past might have been seen to be). Although increasingly backed by a very small team of specialists, the internal leaders of quality improvement were long-serving senior nurses, physicians, and administrators. They did not see themselves as quality people, but as nurses, doctors or administrators that wanted to refocus on the profession's age-old domain.¹⁷⁴ They were often, as one speaker at the New Consultant Development Programme (NCDP) in T2 introduced himself;

Consultant by day, Clinical Director by night, and now Quality Improvement, um... Fellow I think is what they call me or something like that. Guru works, yeah.

The titles of attendees at quality seminars held by the Foundation Trust Network between 2009 and 2011 demonstrated this point. Of the roughly 255 registered attendees only seventeen had "quality" cross-listed in their title (e.g. Chief Nurse and Quality Improvement Officer) and only one had a title listing only a quality function (e.g. Director of Quality Improvement). Quality improvement had become not so much a concern of one administrative function, but part of the caring process more generally.

Despite the diffusion of quality expertise into existing professional roles, knowledge about quality and quality improvement, and the "right tools, and motivation" (Darzi, 2009, p.26) to do quality improvement were understood, across the NHS, in a very specific way. These tools shared a common lineage and entailed a specific set of ideological attachments. Made valuable and usable because of the specific world of quality that was being made actual, they also played a part in constructing persons and subjectivities in line with the world of quality envisioned internationally. As we will see, these tools and the ways of being that they required helped to perform a conception of what quality and what a sufficiently motivated healthcare professional might be.

The tools and motivations that were seen to be valuable all derived, either directly or indirectly, from the American experience with quality and the activities of the IHI, Institute of Medicine (IOM), and other improvement organizations in America. Those

¹⁷⁴ As a Deputy Chief Nurse in another trust explained: "No this is not new. We've always supposed to be doing it [i.e. quality and patient experience], but this is just a new way of explaining what we're supposed to be doing".

pockets of expertise in the trusts, the NHS Institute, and conferences were dominated by those who were well-versed in the IHI terminology, aware and supportive of its various approaches to organizational change, and clear about the tools and technologies that had been developed to make this change possible. In the various seminars, conferences, and publications, the IHI approaches and tools, not to mention its logo and slide-sets, were presented repeatedly, often by those who had been trained at one of the IHI's programmes. The NHS Institute similarly modelled many of its interventions and tools (there are close to one hundred listed on its website) on the IHI models, and specifically cites Donald Berwick for their development (NHS Institute 2013b, n.p.). In a world configured in this way, these sources seemed to be the only knowledge base upon which to conceptualize quality improvement.

These American organizations had developed a distinct approach to quality improvement, derived from other industries, and remade within the healthcare sector (Berwick, 1989; Section 2.3.4). While there was a huge variety of tools and methodologies that emerged from this movement, as Walshe (2009) states, they are only "superficially different, particularly in the language or terminology they deploy and the way the ideas and methods are described or presented", and in fact share a "high degree of commonality of approach" (p.156). These characteristics include "making use of the idea of cycles of improvement" in the sense that improvement is always portrayed as continuous; making use of a small number of specific "diagnostic" tools throughout different stages of the improvement process, such as cause/effect or fishbone diagrams, process mapping and brainstorming; emphasizing the "involvement of front line staff", often using emancipatory language; and highlighting the need for "clear organizational commitment" to improvement ends (ibid, p.156). Indeed, the "right tools" that were promoted across the NHS shared these characteristics, and, as we will see, combined to present a specific new set of characteristics for being a successful healthcare professional within the NHS.

At the NHS Institute and conferences, presenters explained the benefits of everything from general improvement tools and information technologies such as the Plan-Do-Study-Act (PDSA) cycle, LEAN, Statistical Process Control, Six Thinking Hats, spaghetti diagrams, real-time patient feedback, bullet proofing, root-cause analysis,

Intentional Rounding, various creativity and brainstorming tools, and much else.¹⁷⁵ These tools were variously described as things that, “you simply cannot live without”.¹⁷⁶ More thorough and elaborate programmes such as the IHI’s Transforming Care at the Bedside (TCAB) approach, the NHS Institute’s Productive Series, and Exemplar Ward and High Impact Actions Initiatives were also widely disseminated. These packages for improvement brought a whole bundle of ideologies, methodologies, approaches, and tools to bear on healthcare practices and professionals (see Appendix 4.2).

At T1, a variety of these packages were rolled out under the heading of two programmes: the *Quality and Efficiency Programme* (QEP) and the *Energise for Nursing Excellence* agenda. As part of the QEP, a team of quality improvement specialists, well versed in quality improvement interventions, were brought together to coordinate and empower staff across the organization to drive quality and efficiency improvements. They aimed to equip nurses, doctors and administrators with the tools necessary to imagine, define, and undertake change programmes, and an annual QEP “marketplace” was established in order for these solutions to be shared, celebrated, and spread.¹⁷⁷ The Energising for Nursing Excellence programme (Figure 4.2 below) sought similarly to equip and activate its staff: the trust would pilot both the IHI’s TCAB and the NHS Productive Ward simultaneously “in order to determine what fits best, which has the best outcomes” and to “develop one way of doing things around here” (Head of Quality Improvement). Those piloting the TCAB, moreover, were said to have first adopted the approach alongside weekly conference calls with a partner hospital in the USA that had been using TCAB for years.

¹⁷⁵ These are all quality improvement tools developed in industrial manufacturing sectors (see NHS Innovation and Improvement, 2013). The PDSA cycle, for example, is a structured “framework for developing, implementing, and testing changes that result in improvement” (*ibid*, no page) and determining what evidence constitutes success. LEAN is “an improvement approach to improve flow and eliminate waste” developed by Toyota, which focuses on the customer value (*ibid*). Statistical Process Control (SPC) is a simple statistical tool for determining when data indicates a change or improvement. Six Thinking Hats is a tool based on the concept of “parallel thinking”, which “enables [people] to look at things in a collaborative way, beyond [...] normal perspective to see new opportunities” (*ibid*).

¹⁷⁶ This was a quote from an American presenter at a Foundation Trust Network conference, discussing the workings and benefits of SPC charts. Similar but less subtle statements were made of many of the other interventions and tools cited above.

¹⁷⁷ The marketplace consisted of a room and hallway filled with posters and nurses, doctors, and administrators presenting them. They aimed to ‘sell’ the interventions to their colleagues, convince them of the benefits, and that although challenging, such changes could be made to work in their wards too.



Figure 4.2: The Energise for Excellence Umbrella (T1)

T2 also put in place a number of these technologies and tools. They were piloting TCAB, the Productive Series, and intentional rounding in a variety of their wards and assigned a “Quality Improvement Facilitator” to each inpatient area that, like T1’s QEP team, aimed to “not just facilitate but at the same time build the capabilities of the teams” (Senior Nurse). Beyond this, however, they had also redesigned and expanded their New Consultant Development Programme (NCDP) in order to train up the next generation of clinical leaders. In the year-long programme, during which each of the approximately thirty consultants actually undertook change programmes of their own, they would learn about and gain experience with a number of the tools discussed above (see NCDP agenda in Appendix 4.3).

While this vast array of tools and technologies were drawn from a variety of settings and contexts (Zuiderent-Jerak and Berg, 2010), they took part in creating a distinctive world of quality and quality improvement, and more than that, the types of professionals that were envisioned to inhabit such a world. These tools and technologies shared important

characteristics that had distinctive subjectifying implications for those on the front line that needed to be equipped with “the right tools and motivation” (Darzi quoting Berwick, 2009, p.26) to do quality improvement.

Firstly, these tools and technologies all required the development and use of a specific ‘shared language’ through which quality could be represented, discussed, and managed. This formal and, with few exceptions, quantitative, language posits that there is no quality improvement and there is no quality unless it can be measured or demonstrated reliably and established consistently. This language favors certain forms of knowledge, and distinguishes and potentially marginalizes the local or idiosyncratic feelings and observations of quality.

In each trust, the technologies and tools that were put in place to do quality encouraged and even required the translation of quality into formal and quantitative terms. In each training session or pilot discussion, it was continually reiterated that, “just saying that it feels different isn’t enough” (Study Day Facilitator, T1). Rather, each tool, and the doing of quality more generally, required nurses, doctors, and administrators to “do the numbers”, to “formulate it in a language that matters to the managers” (NCDP Facilitator, T2). In the various TCAB study days that provided new training and skills for nurses at T1, “assessing and displaying baseline measures” was the first point of discussion. As the facilitator explained to the group of nurses:

This isn’t the most fun part, and it often slips, but when this happens people end up kicking themselves for it later, when they cannot prove that what they’ve been doing has been having any effect. (NCDP Facilitator)

Similar exhortations were visible with the implementation of any number of tools.¹⁷⁸

During a meeting to discuss the new Intentional Rounding programme, for example (this is a checklist approach to ward rounds in which the nurse asks, “is there anything else I can do for you; I have time” at specific intervals) a Senior Nurse explained to her staff that although there seemed to be changes as a result of rounding, it was not measured, and therefore didn’t count. “There is no use just putting the [new processes] in without checking that its being used and that it is reliable and that the process is reliable” she explained. A Nurse Sister, nodding her head reiterated, “if it’s not documented it’s not

¹⁷⁸ Indicatively, the *Energise for Nursing Excellence* umbrella even placed “measuring quality” right alongside “delivering care” as a central objective (see Figure 4.2).

done at all". With "safety crosses" similarly (these are calendars that mark each day of the month with green or red crosses to indicate if a particular negative event has occurred (see Figure 4.3 below), the representation of what was formerly a multi-dimensional situation as simply a red or green cross was essential. "There is no ambiguity any more. With safety crosses and the public measures board", the Director of Quality Improvement at T1 explained, "You can ask what happened here? What happened on the red date? And they'll be able to talk to you about it like they never were able to before". When pressed, he agreed that these tools were part and product of a new language in which to discuss quality and the nurses agreed, "more structured, more formal" (Nurse, T1). Almost without exception, the formalization of quality into these tools required its remaking into a new language of quality improvement.

Such requirements of the tools transformed the way in which quality might be understood and discussed in the sense that previous conceptions became idiosyncratic, unreliable, or just plain "hearsay". As one senior physician explained to his colleagues at a NCDP session, "this is why [the facilitator] says measurement matters. Otherwise you are relying on hearsay." If not demonstrated reliably, he reminded his impressionable colleagues, you are "simply jumping to conclusions; something unfortunately that we in the NHS do too much".¹⁷⁹ Another senior physician explained to the group, "Now people just laugh at me because I want to produce charts for everything. When I start running through the numbers with them, they just say 'stop, just tell me if it's any better'". Indeed, doing quality improvement in each trust required a process of isolating and even doing away with the local feelings and interpretations of quality through the implementation and internalization of the new quality tools and methodologies. Quality had become something that did not exist if it could not be measured reliably.

¹⁷⁹ Slides presented during the day also stated; "The Goal must be measurable", "If you are going to make things happen, you need to be able to say how much and by when", and "skipping the measurement is unacceptable". These were all presented as logical requirements of the "Model for Improvement" (Mfi), a change theory largely adopted from Demming. The Mfi asks three central questions: "What is the goal of the change? What are you going to measure to know if you have achieved the goal? And what are you going to do to make the impact you hope to achieve?"



Figure 4.3: Safety cross calendar for patient falls

This new language of quality improvement was seen to be valuable because of its consistency with the world of quality being constructed around it. Indeed, these were the sorts of representations of quality that could fit readily into Quality Accounts. In the training days, for example, facilitators implored nurses to use, or at least consider, the five key Quality Account metrics (time in direct care; falls; hospital-acquired pressure ulcers; staff vitality; and patient experience) to measure improvement on quality improvement interventions. The way in which the Senior Nurse at T2 explains the value of a NHS Institute pilot illustrates this relationship similarly:

It has made a huge difference *because* [italics added] of the way that we've been able to translate this with quality improvement specialists, people who understand measurement. It has meant a real tangible outcome.

It was a language, in other words, which worked in and helped to make Darzi's increasingly solidified world.

The second characteristic that these tools and interventions shared was a behavioral one: the “right tools” were inextricably related to the “right motivation” (Darzi, 2009, p.26) that Darzi and Berwick had advanced. The tools did not only require specifically motivated people to use, interpret and interact with them, but were more broadly bound up with a specific image of what it would take to be a healthcare professional. The right motivation was expressed as one in which physicians, nurses and administrators were

entrepreneurial beings constantly engaged with quality's new metrics and tools. The Medical Director of South London Healthcare NHS Trust, Dr Roger Smith, explained the difference on 23 March 2010, at a NHS Confederation conference on quality:

The engaged clinician will be aware of the national quality agenda; they know what's going on, and they are outward looking. They come to meetings. They take a personal responsibility for the services and have a strong sense of pride. They like to work as part of a multi-disciplinary team. They are probably busy clinicians, but they are organized. And therefore they have time to do these things. And if you engage in a discussion with them, they will be positive in that. So if you say, I can see from your data you are having a little problem with late discharges. They will say 'yeah, I've seen that' and you can work together to find out how to fix it. So their sense of identity will likely align with the organization's and with the NHS and patients as a whole. [...]

On the other end of the spectrum, we have guys that will be unaware of any current national agenda and any of the quality improvement initiatives. They will appear to be but might not be blind to deficiencies in the current system and their parts of it. If you try to engage them in a quality discussion, they are likely to become defensive and angry. They probably will not take much pride in their service and they display what I call an external locus of control. So if there is a problem in their service, it will have to do with something outside of their control. And if you talk about what we can do about it, it's always someone else's thing to do. And finally if you present them with the data, they don't believe it. They just find something wrong with it.

As speeches like this made clear, doing quality entailed not just tools, but also a certain style and willingness to engage with them—"We need to create a culture which encourages clinical engagement in quality measurement. Quality measurement must be embedded in the organization. Quality must be considered in every meeting in the trust" Dr. Smith concluded (*ibid*). It was, like any notion of culture, something that had to be defined with reference to things that were tangible. It was thus the tools people used, the way they acted, and the words they spoke that came to signify a culture of quality.

Many of these tools and methodologies that helped to enact quality were also fundamentally concerned with bringing about these new types of entrepreneurial professionals. As the NHS Institute's Productive Series states:

The key to the success of The Productive Series is that *improvements are driven by staff themselves*, by *empowering* [italics added] them to ask difficult questions about practice and to make positive changes to the way they work. The process promotes a continuous improvement culture leading to real savings in materials, reducing waste and vastly improving staff morale. (NHS Institute 2013b, n.p.)

Central to the IHI's TCAB, similarly, is “building capability of front line staff in innovation and process improvement” (IHI, 2008, n.p.). As such, it was made clear during TCAB training days at T1 that they would be about more than just tools. The facilitator opened the day stating, “I won’t make you do anything too embarrassing [...] But we’ve got to be upbeat and American about these things. So lots of high fives!”. At the end of the day, he reiterated that they “were speaking the right language now” and as such were “part of building a community”. In a similar way, T1’s *Energise for Excellence* scheme spoke directly to the target nurses themselves. The “call to action for nurses and midwives” sought to “harness [their] collective energy, commitment and expertise” in the name of quality. It told the nurses,

Under the Energise for Excellence umbrella we have gathered an array of tools, approaches, and measures that will help *you* respond to the call to action and decide what priorities *you* want to focus on so that *you* can be confident that your patients receive the best possible care [italics added].

With these tools and the right motivation, it is intuited, *you*, the individual nurses, would be empowered and freed.¹⁸⁰

The less elaborate tools also required engagement on particular terms. In order to use the numbers—and everybody is expected to use the numbers—one has to be motivated in a certain way. Tools such as SNORKELING and T5 (formalized ways of brainstorming/problem-solving and organizing the workplace respectively) were part and product of a “philosophy that you are the architect of change, and that change starts with you” (Head of Quality Improvement, T1). SNORKELING required brainstormers and T5 needed problem-solvers that would constantly seek out, specify, organize, and measure change. The public measures board and safety crosses required a similarly motivated being. At the minimum, they required a nurse that would update statistics and safety crosses each day. But at the most, the tool required that they be able to link the numbers to patients and situations, discuss improvement opportunities, and feel empowered to do something about it. Where there were data errors, they needed to know about them and be able to show why and where the numbers did not fully represent the situation; they needed to perhaps (as a facilitator said when it was pointed out that the data on his slides was wrong) use a SNORKEL session to work out what to do.

¹⁸⁰ This motivational element is also clear in the QIPP mission and language: QIPP is “about creating an environment in which change and improvement can flourish; it is about leading differently and in a way that fosters a culture of innovation; and it is about providing staff with the tools, techniques and support that will enable that to take ownership of improving quality of care.” (NHS Institute, 2009, no page)

The entrepreneurial demand of these tools is perhaps most clear in the Plan-Do-Study-Act (PDSA) cycle, an IHI-promoted model of change and improvement that was not only central to the methodologies such as TCAB and the Productive Series, but also a central stand-alone approach that was promoted repeatedly in quality conferences. In the PDSA cycle (Figure 4.4 below), one is presented with a series of questions that must be answered at each stage of the improvement process. While simply questions, they are incorporated into a continual PDSA ideology (Figure 4.5), which requires a user that never stops asking and evaluating, that seeks out the numbers aggressively, and scales up continually. As a NCDP facilitator explained:

[With PDSA] you do not wait a month; you don't even bother getting everybody back together. You evaluate rapidly, even instantly, and you ramp up the size of the test as soon as you can confirm you are getting the results you desire.¹⁸¹

It takes the tool *and* the motivation, in other words, to move from “hunches, theories and ideas” (the quality of the past) to “changes that result in improvement” (on the terms by which quality had now been defined).

¹⁸¹ Later the facilitator reiterated; “You develop theory, PDSA, you re-evaluate and rework, challenge yourself and your understanding of the process and the system”.



Figure 4.4: PDSA cycle (adapted from IHI, 2011, n.p.)

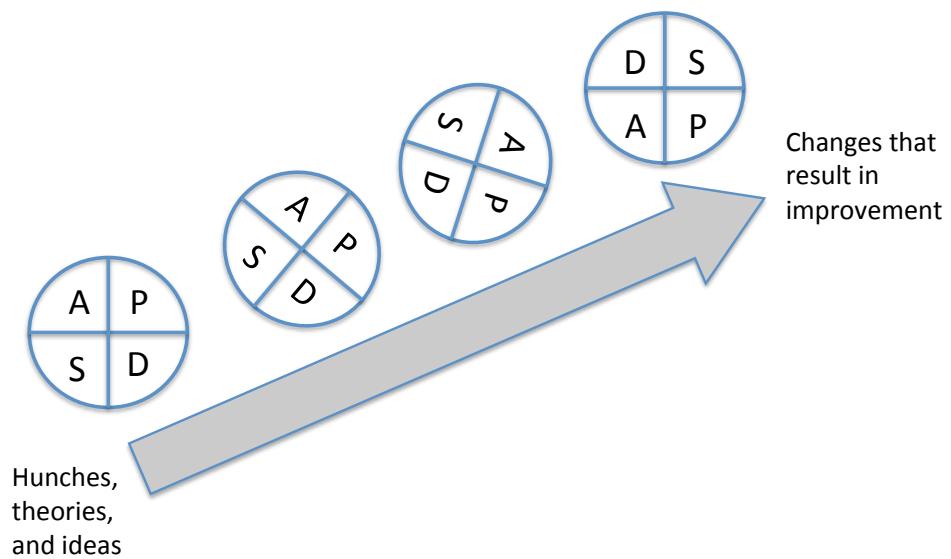


Figure 4.5: PDSA cycle movement (adapted from IHI, 2011, n.p.)

These tools sought to engender particular identities for healthcare processional. Not only would they be asked to become more “American about things” (Facilitator, T1), but they would also need to understand numbers, and themselves, differently. They would need to be leaders, but not as the medical leaders of the past had been. For nurses, the “caring gene” and the “ability to pick up on frustration, depression about [a patient’s situation] and their care”—the “key nursing skills” that sisters would define (Nurse Sister, T1)—became increasingly placed alongside what might be paraphrased as the ‘numbers gene’ and the ability to explain the trend lines, whatever they might mean. For physicians, the number-empowered and entrepreneurial professional began to replace the senior one “who ensures that everything is done exactly the way he wants it done; not necessarily because it is correct” (Facilitator, T2) as a model of professional success.

The infrastructure of doing quality created distinctions between the old and the new, between those for and those against quality. Doing something about quality became a matter of choosing between “heresy” (Senior Physician, T2) and “hunches, theories and ideas” (IHI, 2011, n.p.) or undertaking continual tests of change to determine “the changes that result in improvement” (ibid). Such an elaborate infrastructure enacted or performed a particular notion or reality of quality while also delineated a new type of professional. While there may have been many types of doctors previously, there was now the possibility and constant reminder of having “engaged clinicians” or “guys that are unaware” of the requirements of quality (Smith, 2010). Similarly, while nurses may have been seen to handle quality very differently, it became possible, even necessary, for them now to either manage the numbers, or to be seen to be ignoring them completely. Summarizing these demands on identity, this new healthcare professional envisioned and in part created within this changing environment of quality might be called *homo-Ara Darzicus*. This is a medical professional constructed in the image and aspirations of Darzi, one that understands patients and interventions through the numbers, and who engages with these numbers in a pro-active and entrepreneurial way, understanding each intervention to be a testable hypothesis which is repeatedly queried and adjusted.

While these new images and distinctions among healthcare organizations and professionals have been meticulously crafted and constructed, they are, however, neither fully realized nor unproblematic and necessarily stable. Indeed, as we will see in the following section, these particular ways of being healthcare organizations and being

healthcare professionals contain their own tensions and problematics and come to be interacted with differently.

4.5 Remaking organizations and professionals in the name of quality

The remaking of healthcare organizations and professionals in the NHS meant that trusts were required to produce ever more representations of quality, reporting annually in Quality Accounts, and quarterly and even monthly to commissioners and regulators. They were also required to re-align their internal information systems, reporting structures, and responsibilities around these representations, and to put in place the sorts of American-inspired tools and programmes that might result in improvements. By virtue of inhabiting an organization constructed in this way, healthcare professionals confronted a reality in which a particular way of being, the *homo-Ara Darzicus*, was differentiated and valued. This was a professionalism defined by a willingness to understand and engage with the quality numbers and representations that were valuable to the trust externally, to skill-up in the latest quality improvement technologies, and to act like the sort of entrepreneur that the improvement methodologies and tools required. However, as we will see in this section, this new reality produced specific tensions that presented such a world as in part problematic, and opened it up again to debate and change on the basis of what else quality might be.

One of the core tensions underlying this new word of quality, which was apparent prior to the reforms but increasingly highlighted once they had been introduced, was that the interventions of quality improvement did not necessarily result in actual improvements in quality. Indeed, a growing body of research on even the most accepted and widespread quality improvement methodologies and interventions consistent with this new world of quality showed that they do not necessarily result in sustained improvement. In fact the few randomized trials that were run showed no attributable impact on clinical outcomes of continuous quality improvement interventions (e.g. Shortell et al, 1995a, 1995b; Rathert et al, 2012). Summarizing this research since the 1960s, Brook (2010) writes:

More than 40 years later it is unclear what the quality movement has accomplished. Very little is known about how many dollars are invested to improve quality of care nationally or who makes that investment, and there is insufficient evidence about whether or how the quality of care has

actually improved. However, what is known is that there is a long way to go. There is no yearly clinically detailed comprehensive report on the epidemiology of quality. Quality can be defined with more reliability and validity, but there is little information about which mechanisms for improving quality work better than others. (p.1831)

This stubborn lack of improvement is very visible, if infrequently discussed, in case of patient experience in the NHS. Although, as we have seen, ever more attention, training, interventions, and money has been directed toward seeking to improve the patient experience, the national patient experience survey scores (see Figure 4.6 below) have not generally improved in statistically significant ways over the past five years.

						2011-12 95% confidence interval
	2007-08	2008-09	2009-10	2010-11	2011-12	
Access & waiting	83.8	84.9	85.0	84.2	83.8	S 0.19
Safe, high quality, coordinated care	64.9	65.3	64.4	64.6	64.8	0.23
Better information, more choice	66.7	67.7	66.8	67.2	67.2	0.26
Building closer relationships	83.0	83.2	82.9	83.0	83.0	0.16
Clean, friendly, comfortable place to be	78.1	79.2	79.1	79.3	79.4	0.14
Overall	75.3	76.0	75.6	75.7	75.6	0.15

Source: National Patient Survey Programme - Further details of the methodology can be found in the accompanying methodological issues paper.

Results marked with an S show a statistically significant change from 2010-11 to 2011-12

Figure 4.6: National inpatient experience scores (from DH, 2012a, p.5)

This lack of demonstrable quality improvement produced a distinctive dynamic around the enactment of quality, which plays out at different levels or locations. Discursively, this lack of improvement was, and continues to be, rationalized and diffused on the basis of the mainstream ideas about quality articulated by Darzi and internationally, that improvement is difficult to achieve, that a blame-free culture is required for improvement, and that failure is part of the process of learning what actions result in change. These are central principles of the IHI methodologies, and in training days and interviews it was repeated that “sustainable quality improvement is difficult to achieve” (Facilitator, T2), that “it will be difficult to demonstrate real progress from year to year” (ibid), and that “we’re still all learning how to do these things” (Head of Quality Improvement, T1). This lack of improvement is also rationalized and diffused on the basis of the distinctive conceptualization of numbers that quality improvement methodologies are built upon. “Measurement”, according to Berwick, “is necessary but no more sufficient than measuring a golf score makes for better golf” (Berwick et al,

2003, p.30). It is, in other words, something that can only be interpreted on the basis of the efforts and actions around quality improvement that it leads to.

As part of this narrative around quality improvement, failure or lack of improvement is ironically seen as acceptable and as part of the improvement process itself. The very numbers that had hitherto been afforded such primacy were seen as unable to provide insight about performance. This, in many ways, isolates this newly constructed world of quality from a critique of its non-performance. Indeed, across the NHS there has been almost no mention of this lack of improvement, even as the evidence has continued to grow. The National Survey reports often celebrate very small improvements that are not statistically significant, and while highlighting places where scores have worsened, do not discuss the overall picture of performance painted by the returns. The trust-specific scores, moreover, typically show no statistically significant change on the various dimensions, and therefore do not provoke attention (as the example in Figure 4.7 below illustrates).

Survey of adult inpatients

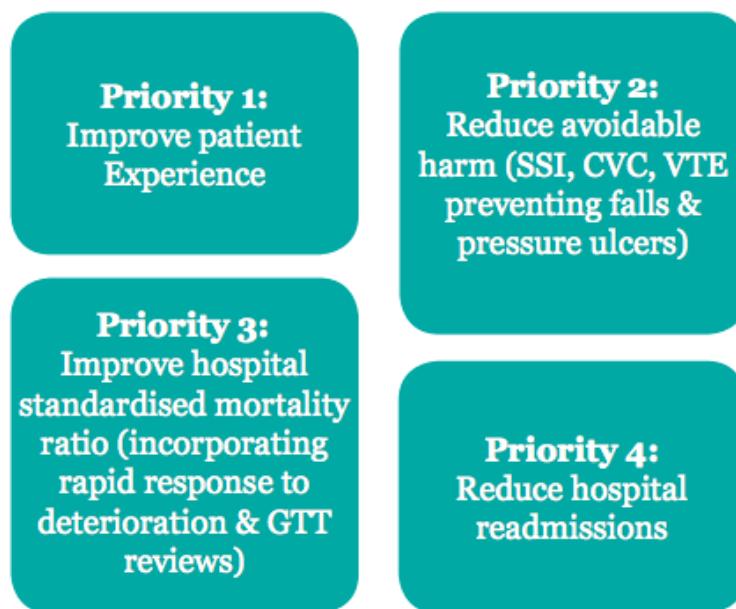
How this score compares with other trusts		Based on patients' responses to the survey, this trust scored
8.8 /10	Click to expand for questions about The Emergency/A&E Department (answered by emergency patients only)	
9.1 /10	Click to expand for questions about Waiting list and planned admissions (answered by those referred to hospital)	
8.4 /10	Click to expand for questions about Waiting to get to a bed on a ward	
8.4 /10	Click to expand for questions about The hospital and ward	
8.7 /10	Click to expand for questions about Doctors	
8.5 /10	Click to expand for questions about Nurses	
8 /10	Click to expand for questions about Care and treatment	
8.4 /10	Click to expand for questions about Operations and procedures (answered by patients who had an operation or procedure)	
7.5 /10	Click to expand for questions about Leaving hospital	
5.7 /10	Click to expand for questions about Overall views and experiences	

Figure 4.7: Example of hospital-specific patient survey performance (from CQC, 2013)

For healthcare organizations, this stubborn lack of improvement, coupled with the demand for ever more frequent representations of quality and demonstrations that providers are doing something about quality, has led them to undertake what might be summarized as *balance-sheet activities* in order to do something about quality. These activities involve the weaving together of narratives of improvement, providing ever more promises of improvement, and rolling out ever-more tools and interventions which, as Walshe aptly shows, involve “repackaging existing intellectual content” with “a different spin or fresh presentational gloss” (Walshe, 2009, p.156). These balance-sheet activities have a distinctively representational and second-order orientation (see

Power, 1997, 2007; Macintosh et al, 2000); they enact quality as a thing and a practice of producing narrative, accounts, and promises built on a self-contained and “hyper-real” justification (Macintosh et al, 2000, p.13).

These sort of balance-sheet activities are visible in the production of Quality Accounts. Required to provide representations of improvement in the patient experience of care, yet faced with an almost universal lack of consistent trust-wide improvement on its metrics, Quality Accounts increasingly center on the production from year to year of glossy and reworked visualizations of performance represented at a very abstract level, which allow the providers to weave together a narrative of improvement (see Figure 4.8). Where the stubborn lack of improvement is invariably documented (see Figure 4.9), showing that the trust is doing something about quality means articulating new promises for improvement, and (to do that) pointing to new tools and methodologies, developed within the existing improvement paradigm, which will be piloted and scaled up if successful.



A snapshot of our activity and performance

Last year



Figure 4.8: Examples of abstraction Quality Account (Guy's and St Thomas NHS Foundation Trust, 2012)

This image has been removed as the copyright is owned by another organisation.

Figure 4.9: Example of deterioration in patient experience

Quality, it appears, is enacted by weaving together improvement stories and by drawing upon and continually piloting ever-new improvement interventions. Activities that result in change are those, as a result, that result in representations and promises of improvement. However, the nurses and doctors required to roll out new improvement projects and to generate data about performance often see the representation and presentation of these things as secondary to, and derived from, rather than constitutive of quality itself.

In pilots of the interventions at both trusts, frustrations were frequently expressed by nurse sisters about the auditing and documentation requirements of the quality interventions that administrators tended to consider as quality itself. For these Sisters and their staff, the documentation requirements were seen to take away time from attending to patients, and as such were not constitutive of quality improvement. These different ideas about quality were made clear in a meeting between the Senior Nurse (an administrator with IHI training) and a group of Nurse Sisters that were piloting Intentional Rounding. After showing the Sisters a new auditing tool, the following discussion ensued:

Sister 1: Are we not auditing the audit rather than the outcome though, because the outcome is no pressure ulcers?

Senior Nurse: We need to audit that we've got reliable process, so are people routinely and reliably completing all of the checks [i.e. formally checking in on patients]

Sister 1: But that is auditing the tool, because, I suppose that what this does is give us reassurance that this is what we're trying to do to prevent pressure ulcers, but if we're not getting pressure ulcers, then isn't that what matters?

Senior Nurse: But what we need to know is whether this was because of the rounding or was it something else [...] we need to check that teams have the right process, and its reliable, and that then it is getting the right outcomes [...]

Sister 1: I guess I'm just saying that it is going to be very hard to motivate the staff to do an extra piece of work when the outcome is already there. I think that's a challenge on [my ward] now [...].

As this exchange demonstrated, there was a tension at the heart of quality that was being enacted or performed. While quality was being made in a particular way, it was also and simultaneously being forced to confront its innumerable alternatives.

This tension played out consistently in both trusts. In T1, many of the nurses were sceptical about the extent to which the things they were required to do in the name of quality—particularly as it became ever more bundled with cost saving and the target culture of the trust—was consistent with the caring activities that mattered most to them. Sharon and Laura agreed, for example, that the things that mattered most for the trust-wide quality programmes were only marginally related to the requirements of quality as they understood it:

Yes, it's pretty interesting that the only thing they [trust management] really care about consistently is pre-11 [am] discharge. We always get this report each week. But actually pre-11 discharge isn't all that related to patient care. There are things that are just absolutely central to care, things that people like us care about very much, that just don't really show up all that much, or they only get attention sporadically. It's all about the headlines there and then it seems. (Nurse Sister, T1)

Similarly, they noted the way in which representational activities around quality belittled the other information about quality they found valuable. As Sharon said:

We can see [the changes]. But, they [the management] don't measure the amount of complaints. I'm not going to say it [knocks on wood] but if we compared our formal complaints it would be night and day. That's not taken into account. (Nurse Sister, T1)

They also found doing quality to involve increasingly defensive actions. The two feared the numbers and the fact that they might be (and often were) skewed by some reporting error. As they explained:

Bosses see some negative scores, irrespective of sample size, and the next thing we know we're being dragged over the road [to the executive offices] to explain it [...] If they see a big fall in numbers they just call in the troops. It's never a calm reaction [...] when we get stuff in our inbox [about quality], our first reaction is always anticipation, we think, God, what is it going to say now. (Nurse Sister, T1)

It was thus at this localized level that the distinction, which was indistinguishable in Section 4.2, between quality and its multiple translations (into technologies, relationships, reporting requirements, etc.) came to present itself ever more visibly. Quality presented itself to nurses as something else—as a threat of being “dragged over the road” (*ibid*) and other such concerns—and this highlighted the extent to which it could be understood differently.

Such distinctions cast *homo-Ara Darzicus* as a more ambiguous and problematic figure. The Sisters in T1 each experienced and responded to these demands differently because, as they liked to say, “Sharon is the corporate one, and Laura isn't”. Laura was a young

sister that seemed less ambitious to remain in the trust and certainly did not see herself in a managerial role. She deplored the bundling of quality with the culture of the trust, and she saw it as her duty “to say things as [she] see[s] it, and not to play the political game”, which the new healthcare professional (at least in T1) was seen to require. Sharon by contrast was competitive by nature and wanted to move up in the organization, envisioning herself in a “quality type of role or something like that”. Thus, she saw the new professional distinction as a career opportunity. She voluntarily attended the QEP meetings and other events “because if it is something that mattered to the trust, [she] should at least be able to engage in a discussion about it, and understand what’s going on”. While she acknowledged the tensions around quality, she envisioned herself as a “translator or communicator” between the representational demands and political manifestations and the front line. As such, while carefully and powerfully constructed into reality, the *homo-Ara Daricus* remained an only partially realized—or at least differentially realized—figure.

4.6 The discursive limits of quality

While such tensions may continue to play out at these localized points, recent high-profile reports of neglect and mistreatment of patients has led to some re-consideration of the existing enactment of quality. Findings of widespread neglect and mistreatment of patients at Mid-Staffordshire NHS trust from January 2005 to March 2009 as a result of a major public enquiry (Francis 2013), of more isolated cases in fourteen hospitals in a follow-up review (Keogh, 2013), and of psychological and physical abuse of patients with learning disabilities at Winterbourne View Hospital in 2011 (DH, 2012b) highlighted some limitations of such an enactment. The reports showed that the aggressive pursuit of quality through its existing arrangements of enactment—that is, of documenting and representing improvement narratives—in fact led to ignorance and tolerance of mistreatment and preventable deaths. The Mid-Staffordshire reports showed that quality failings were in part connected with efforts from the trust to assure regulators that they had robust and effective quality assurance mechanisms in place as part of achieving the ‘Foundation’ status awarded to high performing organizations. As Francis explained:

The application for Foundation Trust status was pursued by the Board in part as a means of furthering the need for improvement in governance structures rather than ensuring that the Trust was in a genuinely fit state for

the application before embarking on it. [...] The pressures of the process are likely to have distracted the Board from other tasks. The Inquiry does not accept that the Board set out to deceive anyone with the application, but their declarations in relation to the quality of care provided at the Trust revealed a profound misunderstanding of their responsibilities. The focus seems to have been on processes not outcomes. (2013, p.22)

Sir Bruce Keogh's follow-up report of more recent quality failures also highlighted the limitations of such representational enactments of quality. His inspection used qualitative methods, relied more on professional discretion and subjectivity, and undertook extended in-person visits. His findings of quality failures despite a confusing mix of possible indications of these in the existing regulatory and representational scheme led him to recommend the regulator to change its inspection regime along the lines of his own (Keogh, 2013, p.10). The regulator, under new leadership, has launched a consultation on the possibility of making the changes summarized in Figure 4.10.

At a glance: What's changing in the way we regulate and inspect

From	To
<ul style="list-style-type: none"> Focus on Yes/No 'compliance' A low and unclear bar 	<ul style="list-style-type: none"> Professional, intelligence-based judgements Ratings – clear reports that talk about safe, effective, caring, responsive and well-led care
<ul style="list-style-type: none"> 28 regulations, 16 outcomes 	<ul style="list-style-type: none"> Five key questions
<ul style="list-style-type: none"> CQC as part of the system with responsibility for improvement 	<ul style="list-style-type: none"> On the side of people who use services Providers and commissioners clearly responsible for improvement
<ul style="list-style-type: none"> Generalist inspectors 	<ul style="list-style-type: none"> Specialists, with teams of experts Longer, thorough and people-focused inspections
<ul style="list-style-type: none"> Corporate body and registered manager held to account for the quality of care 	<ul style="list-style-type: none"> Individuals at Board level also held to account for the quality of care

Figure 4.10: CQC Consultation on inspection regime (from CQC, 2013, p.6)

While these calls to move from calculative and representational activities to judgment-based and more localized investigations and regulation of quality point to the instability and tenuousness of quality's existing enactment, they also highlight the stability and flexibility of the assemblage of which these enactments are part and product. Indeed,

even while the new regime aims to reinstate principles of peer review and subjective assessment, its primary mechanism for thinking about and assessing quality is still one of finding “simple, clear standards” (CQC, 2013, p.13). The problem is thus seen to be one of regulation and the regulatory principles through which the infallible notion of quality travelled—rather than the notion itself. This view was reinforced in a report on NHS safety undertaken by Donald Berwick at the request of the Secretary of Health. His report pressed that “quality of care in general, and patient safety in particular” needed to be the “top priority” for everyone concerned with the NHS (Berwick, 2013, p.4), and that concern for quality and safety means “engag[ing], empower[ing] and hear[ing] patients and carers at all time” (*ibid*, p.4), “abandon[ing] blame as a tool” (*ibid*, p.5), and “give[ing] the people of the NHS—top to bottom—career-long help to learn, master, and apply modern methods of quality control, quality improvement, and quality planning” (*ibid*, p.10), among other things. Thus, while he notes the need to “use quantitative targets with caution” (*ibid*, p.10), the notion of quality as an accounting concern, as patient-centered, as bottom-up and experimental, however, is still firmly at the core of the regulatory and programmatic changes that are unfolding. As such, the contemporary promise of quality lives on to present itself in ever-new forms. The historically constituted notion of quality described in the previous two chapters remains a matter of fact, even while the ways in which it takes a reality are constituted as matters of concern. As such, the contemporary promise of quality continues to act upon people and organizations, albeit never in a linear and direct way.

Chapter 5

Quality Improvement for All Seasons: An investigation of quality and the changing foundation of government reforms

5.0 Introduction

The previous chapters have illuminated significant aspects and characteristics of the emergence and consequences of the *contemporary promise of quality*. Chapters Two and Three documented the construction and at least temporarily stabilization of an historically-specific means of thinking about, and rendering calculations of, quality and quality improvement. This was shown to be a distinctive conceptualization of quality and its improvement, differentiated in time on the basis of four characteristics—as being conceptualized as an accounting concern, patient-centered, bottom-up, and experimental (see Figure 5.1 below). Chapter Four documented various ways in which these ideas and ideals of quality and quality improvement, repackaged and articulated as a series of programmatic aspirations and interventions, took part in reorganization of healthcare organizations and reformatting of healthcare professionals in the name of quality. It showed the programmatic elaboration of these specific quality and quality improvement ideals to have far-reaching consequences and effects, in terms, for example, of redefining activities that constitute care. It also showed these movements, at the same time, to highlight the tensions inherent in this particular conceptualization of quality, and to provoke alternative conceptions of what else quality might be and what other sorts of activities quality improvement might entail.

Traversing these chapters, the significance of the programmatic elaboration of quality and quality improvement for the contemporary promise of quality was highlighted. The programmatization of quality by reformers like Lord Darzi was shown to both draw from and translate the historically-specific means of thinking about quality and its improvement into a series of deficiencies, distinctions, requirements, and complex realities for healthcare organizations and professionals. As such, it served as an interlinking and translating element, helping to give a concrete and even personal expression or reality to the ideas and ideals that hitherto existed largely in the domain of discourse and aspiration. And, at the same time, it provided the conditions for the

difference between these ideas and ideals and the complex reality of healthcare to be seen, and for new ideas about quality, its calculation, and its improvement to be provoked.

This programmatic packaging and repackaging of quality, which was shown to be centrally implicated in the extension and on-going problematizing of the contemporary promise of quality, is the subject of this chapter. More specifically, this chapter considers how, why, and to what extent the characteristics of quality and quality improvement outlined in Chapters One and Two have come, and might continue, to be made into, the content and subject of public policy and programmatic intervention. It aims, in other words, to explore the relationship between the ideals of quality and doctrines of government reform, and the way and extent to which the two came to overlap and interact throughout time.

Characteristic/Doctrine	Meaning	Justification
An accounting concern	Must be defined, measured, commensurated, ranked, and reported to be sufficiently understood or improved. Favors comparability and impersonality over representational accuracy.	We can only improve what we can measure. Professional judgment is fallible. The patient knows best.
Patient or customer-centered	Discussions of quality must include some form of formal (ideally quantitative) patient representation.	The patient knows best. The customer is King.
Bottom-up	Improvement must become personal and individual to everyone in healthcare; it is 'everyone's business'. Improvement must be led by the front line.	Top-down and management-driven reform does not produce lasting improvement. Physicians and nurses really care about quality.

Experimental	There is no one right way to do improvement. Staff must be equipped with the skills and motivation to figure out what changes will result in improvement.	Improvement is difficult to achieve. Knowledge about improvement is imperfect There are ways of thinking about improvement that are applicable throughout healthcare.
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Figure 5.1: Doctrines of quality and quality improvement

This investigation is undertaken by analyzing healthcare policy and policy-making processes in the UK from the emergence of quality as an explicit object for government attention and intervention in 1985, to the latest quality-focused healthcare reforms undertaken in 2012. This research investigates the interactions in this period between the dominant and widely-recognized doctrines of government reform grouped under the title of New Public Management (NPM), and the doctrines or characteristics of quality and quality improvement that have been shown throughout this thesis to characterize their recent incarnation (see Figure 5.1).

As we will see, the emergence of quality as a programmatic object directly paralleled the emergence and operationalization of NPM in the UK, and indeed across a number of industrialized democratic jurisdictions.¹⁸² As a number of authors highlight, the “shopping basket” of doctrines provided by NPM (Pollitt, 1995, p.133) offered a powerful normative prism for thinking about and undertaking reform from the mid-1980s onward, and remained through the 1990s “the only show in town” (Dunleavy and Hood, 1994, p.10): a seemingly universal and apolitical set of solutions to any of the problems and failures that modernizing governments face (Pollitt, 1995).

Although far from universally understood or evenly applied, commentators such as Hood suggest that the normative framework of NPM can be seen as series of interconnected doctrines that dominate the way reforms have been contemplated and undertaken (Pollitt, 1995; Dunleavy and Hood, 1994; Hood, 1991). They note that these

¹⁸² The title NPM has been used to denote different sorts of things ranging from normative prescriptions about good government to empirical descriptions of what good government is seen to require (Barzelay, 1999). In this essay, NPM is used to describe the latter: a package of politically attractive doctrines that have been shown empirically to be central to policy-making and reform, in different jurisdictions and to different degrees throughout the past twenty-five years.

doctrines, summarized in Figure 5.2 below, came to offer a style of reform that is synonymous with the “administrative megatrends” of recent decades, and that satisfy distinct political preoccupations in areas such as accountability, efficiency, and control (Hood, 1991, p.3). Although there are starting to be questions about their durability (Dunleavy et al, 2006; Levy, 2010) and the analytical benefit of considering their various incarnations under the singular title of NPM (Barzelay, 2001), these doctrines continue to be seen to offer, to use Hood’s (1991) words, a reform solution “for all seasons” (Christensen and Lægreid, 2007).

Doctrine	Meaning	Justification
‘Hands-on professional management’ in the public sector	Active, visible, discretionary control of organizations from named persons at the top, ‘free to manage’	Accountability requires clear assignment of responsibility for action, not diffusion of power
Explicit standards and measures of performance	Definition of goals, targets, indicators of success, preferably expressed in quantitative terms, especially for professional services	Accountability requires clear statement of goals; efficient requires ‘hard look’ at objectives
Greater emphasis on output controls	Resource allocation and rewards linked to measured performance; breakup of centralized bureaucracy-wide personnel management	Need to stress <i>results</i> rather than <i>procedures</i> .
Shift to disaggregation of units in the public sector	Break up of formerly ‘monolithic’ units, unbundling of U-form management systems into corporatized units around products, operating on decentralized ‘one-line’ budgets and dealing with one another on an ‘arm’s length’ basis	Need to create ‘manageable’ units, separate provision and production interests, gain efficient advantages of use of contract or franchise arrangements inside as well as outside the public sector
Shift to greater competition in the public sector	Move to term contracts and public tendering procedures	Rivalry as the key to lower costs and better standards
Stress on private sector styles of management practice	Move away from military-style ‘public service ethic’, greater flexibility in hiring and rewards; greater use of PR techniques	Need to use ‘proven’ private sector management tools in the public sector

Stress on greater discipline and parsimony in resource use	Cutting direct costs, raising labour discipline, resisting union demands, limiting ‘compliance costs’ to business	Need to check resource demands of public sector and ‘do more with less’
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Figure 5.2: New Public Management doctrines (Hood, 1991, p.4-5)

Healthcare reforms in the UK since 1985 have been heavily influenced, if not singularly dominated, by the administrative doctrines and reform ideals of NPM. While some have identified successive “ages” or “stages” of NPM (Hood and Peters, 2004) in healthcare reforms during this period, most commentators nonetheless highlight that almost all reforms during this period can be understood as efforts to operationalize different elements of the NPM agenda (Salter, 2004, p.193; see also Humphrey et al, 1993; Walsh, 1995; McLaughlin et al, 2002). Dawson and Dargie (2002), for example, show these doctrines to be central to a series of recent UK healthcare reforms, and conclude that the sector has “undergone some of the most extensive NPM reforms in the UK” (p.34). Others such as Ferlie and Fitzgerald (2002) suggest that the UK health sector offers an exceptional example of an area that has been fundamentally reshaped in the ideals of NPM. They state:

Despite the views of many early sceptics, the evolution of the NPM archetype within the UK health care sector [...] can be seen as an example of a largely successful archetype change (Greenwood and Hinings 1993), based on the twin guiding principles of managers and markets. This transition took almost twenty years. (p.343)

These accounts suggest that the doctrines of NPM and their attending interventions have powerfully impacted upon the NHS since the mid-1980s, replacing, with more or less success, the traditions of “administration, hierarchy and professionalism” with administrative forms more consistent with markets, accounting, managerialism, and privatization (Gabe et al, 1994, p.3; McSweeney, 1994).

The documentation of this strong and consistent interaction between generic NPM administrative norms, and the forms and function of reforms in the UK health sector, provides a helpful backdrop against which to consider the changing relationship between policy-making and the doctrines of quality and quality improvement outlined in Figure 5.1 above. Such studies suggest that the programming of quality is simply the product of NPM doctrines and reform ambitions. They suggest, in other words, that

reforms undertaken in the name of quality are merely a continuation of NPM-inspired reforms executed under the new title of the quality of care.

This chapter investigates this proposition, however, and suggests a somewhat different interpretation, namely that the programming of quality is not simply a matter of relabeling reforms that draw upon the NPM doctrine summarized in Figure 5.2, but instead is a matter of substituting these NPM doctrines with those of quality and quality improvement summarized in Figure 5.1. It illuminates a distinctive trajectory and interaction between NPM, quality, and healthcare reforms, highlighting the way in which attempts to operationalize NPM, and in particular market-based and managerial ambitions, bring problems related to the quality of the product that is being produced, purchased, and managed to the fore. Attempts to resolve these problems, this chapter suggests, have resulted in quality and quality improvement supplanting or subsuming generic NPM doctrines that hold out the promise of addressing the core problems of government.

This chapter also shows the way these doctrines of quality come, like those of NPM previously, to provide a set of seemingly apolitical and inherently progressive means for thinking about and undertaking ‘good’ reforms. Not only are these doctrines seen to be apolitical, optimistic, and intended to address the seemingly pressing concerns of quality, but they are also, this research shows, highly attractive to politicians and policy-makers.

The illumination of these relations between the doctrines of quality and quality improvement and the policy-making process indicates, this research suggests, that the contemporary promise of quality is deeply intertwined with more general norms for contemplating and undertaking reform. The characteristics of quality provide, that is to say, a reform solution *for all seasons*, much like NPM in the previous decades. This reinforces the stability of the contemporary promise of quality by providing a location for the failures around quality that continue to emerge (see Section 4.6) to be attended to and addressed (through the elaboration of yet more reforms built upon the same four characteristics of quality). It also indicates a movement in the location of global administrative norm-making from the administrative megatrends and political

ideological shifts of the 1980s (Hood, 1991) to the geography of quality that has been charted throughout this thesis.

This argument will be outlined in three sections. Section 5.1 traces the emergence of both quality and NPM doctrines in UK health policy between 1985 and 1996. While the reforms in this period were mostly, if not entirely, the product of NPM doctrines, it highlights the challenges presented by a rarefied, professionally-controlled and largely incalculable notion of quality to the reform agenda. Section 5.2 follows the reforms of the ‘modernizing’ Labour government, between 1997 and 2007, as emerging notions of quality intersected with the ideals and aspiration of quality in unforeseen ways. Section 5.3 shows the emergence of the doctrines of quality as a model of administrative reform in the policies of both the Labour government between 2007 and 2010, and the coalition government between 2010 and 2012. Section 5.4 considers what might be at stake and involved in this movement in the nature and location of reform ideas, ideals, and norms.

5.1 Healthcare reforms, 1985-1996: The co-emergence of NPM doctrines and the problem of quality

Although quality concerns are argued to be “as old as medicine itself” (Maxwell, 1984, p.1470), “quality” only explicitly entered health policy discourse and policy-making in 1985. Beginning with Griffiths’ (1983) review of NHS management, the prescriptions for the NHS market articulated by Enthoven (1985), and the Conservative government’s healthcare reforms throughout the early-1990s, quality was “effectively launched” as an object of direct and explicit administrative reform (Shaw, 2005, p.224). In contrast to post-1996 reforms, these efforts were firmly based on the distinct ambitions to operationalize the twin managerialist and public choice schools of thought, the “marriage of opposites”, that formed the intellectual and operational foundation of NPM (Hood, 1991, p.5).

The publication of Griffiths’ 1983 review was an important moment in establishing both quality and private sector managerial ambitions that would underpin NPM doctrines and ideals as core government concerns for the first time.¹⁸³ These two issues, of quality and

¹⁸³ Although Scotland may have had a similarly-argued report calling for general management, in 1968, this was, “swiftly ignored and forgotten about” (Gorsky, 2010, p.42). Griffiths’ report was different from similarly critical civil service reviews of the past, such as the Plowden (1967) and Fulton (1968) reports,

managerialism, were articulated by Griffiths on the basis that the NHS had much to learn from the private sector. As a Managing Director of the supermarket chain Sainsbury's, Griffiths argued that the differences between the NHS and business are "greatly overstated" and that in fact the "clear similarities between NHS management and business management are much more important" (Griffiths, 1983, General Observations (GO), para. 1). The clear similarities between the sectors, and the aspirations toward which they should both be concerned, he argued, were with "levels of service, *quality of product* [italics added], meeting budgets, cost improvement, productivity, motivating and rewarding staff, research and development, and the long term viability of the undertaking" (ibid).

The "most immediate observations from a business background" (ibid, GO, para. 4) that the report highlighted were persistent failures in managerial functions, expertise, and control.¹⁸⁴ "In the private sector", it stated, "the results in all these areas would normally be carefully monitored against pre-determined standards and objectives" (ibid, GO, para. 1). But in the NHS, clear goals were seen to be lacking, responsibilities were left undefined¹⁸⁵, and little purposive change was able to be achieved as a result. In summary, it stated:

Absence of this general management support means that there is no driving force seeking and accepting direct and personal responsibility for developing management plans, securing their implementation and monitoring actual achievement. (ibid, GO, para. 6)

On this basis, it called for the development of managerial functions and responsibilities throughout the NHS: the creation of a central policy and strategy unit, a new Management Board to operationalize these strategic plans, and general managers at every level, held together by strong accountability structures, specific performance priorities, budgets, and other private sector performance measurement tasks (Rivett, 2013). These recommendations, consistent with both the ideological attachments of the Conservative government and the wider macro-trends in public administration, were well received and quickly, if problematically, operationalized in the following years.

which, despite proposing some ideas consistent with NPM, did not explicitly address or focus on the notion of quality.

¹⁸⁴ It continued: "By general management we mean the responsibility drawn together in one person, at different levels of the organisation, for planning, implementation and control of performance" (Griffiths, 1983, GO, para. 4).

¹⁸⁵ Griffiths argued famously that "if Florence Nightingale were carrying her lamp through the corridors of the NHS today she would almost certainly be searching for the people in charge" (1983, GO, para. 5.a).

Quality, as it emerged in the *Griffiths Report* and the reforms that followed, was thus articulated primarily as a product of the effective managerial systems seen in the private sector. Quality was not a primary or likely even secondary concern (the emphasis at the time being one of efficiency and more “responsiveness” to the patient), yet it was a concern, according to the report, that had at least in part to be addressed if the public sector was going to be managed like the private sector organizations that it was called upon to emulate. It stated, for example, that “sufficient management impression must be created at all levels that the centre is passionately concerned with the quality of care and delivery of services at local level” (Griffiths, 1983, Background to Recommendations, para. 12a). The relationship between the ideals of administrative reform and the notion and operationalization of quality, as such, was very much a unidirectional one in which the managerialization of bureaucracy was something that would bring about attention to and improvements in quality.

As noted by a number of commentators, the managerial ambitions articulated by Griffiths were intertwined with a growing model for doing administration and reform more generally (Gorsky, 2010, p.17). Similar managerial solutions were being proposed in other sectors (eg. the *Jarrett Report* in education, 1985) and other jurisdictions at the time (Pollitt 1995, p.137). Despite the challenges that these reforms faced as they were operationalized, academics such as Peters and Waterman (1982) were articulating such managerial principles as central requirements for effective administration more generally (Pollitt et al, 1991). This “business-type managerialism” was, according to Hood (1991), one partner in the “marriage of opposites” (*ibid*, p.5) that established NPM as a dominant model of reform.

Quality and the managerialist elements of NPM were thus born at the same time, and on the basis of a directional relationship in which managerial reforms are made central to government best practice, and quality improvements expected to result unproblematically. This relationship between managerial ideas and the quality of care came to be repeatedly established as an administrative argument par excellence in the 1990s (see Pollitt, 1995). Summarizing this view in 1994, Hunter explains:

Strengthening management, raising its profile and status, developing management skills and competencies, investing in management information systems and so on are seen as crucial to the success of policies directed

toward securing value for money and *improving quality of care* [italics added] for a given budget, while holding individuals and organisations responsible for what they do. (Gabe et al, 1994, p.2)

Quality was seen to be a product of operationalizing certain norms and doctrines associated with 'good' styles of reform, rather than the other way around.

If the managerialist logic of NPM might be seen to have been given practical significance in the NHS through the *Griffiths Report* (1985), then the other partner to the marriage of opposites that constituted NPM's intellectual core, "neo-institutional economics" and the "mechanisms of the market" that it inspired (Hood, 1991, p.5), gave practical significance in the NHS with the arguments set forth by the American Economist Alan Enthoven in 1985 and the reforms that followed (i.e. in the NHS and Community Care Act 1990).

As the Griffiths recommendations were being put to work, commentators such as Enthoven were arguing that more fundamental and far reaching changes were required to allow managerialism to effectively motivate change, to realize the scale of efficiency savings that were envisioned, to make the service more responsive to users, and to produce the high quality care that was held to be synonymous with the private sector. In his review of the NHS, undertaken for the Nuffield Trust in 1985, Enthoven argued that while the recommendations of Griffiths were all "very sensible ideas" (Enthoven, 1985, p.1),¹⁸⁶ a focus on management alone could not "motivate quality and economy of service" (ibid, p.42). Echoing much of the neo-liberal economic thought of the period (e.g. Niskanen, 1971), he argued that without clear benefits or incentives to do otherwise, managerialism would merely serve the interests of the professionals:

I am referring to the pressures to favour inside suppliers in the interests of keeping peace in the family, pressures for the District to use its own personnel rather than declare them redundant and spend the money elsewhere, pressures from consultants to develop a full range of services in the District for the sake of autonomy, control and prestige, etc. (Enthoven, 1985, p.41)

"This is perhaps", he concluded, "the central problem for the NHS today, the problem of any monopoly provider of services" (ibid, p.41).

¹⁸⁶ He continued: "without something more fundamental done about incentives, the change will be largely cosmetic" (Enthoven, 1985, p.21). Malmrose also explains that Griffiths' ideas "laid the foundation for the focus on quasi-market methods in the health care sector" (2012, p.58-9).

Confronting such a problem, he argued, required the development of “market forces” (ibid, p.42) of some kind. Surveying the American experiences with Health Maintenance Organizations (HMOs), he concluded, “there is nothing like a competitive market to motivate *quality* [italics added] and economy of service” (ibid, p.42).¹⁸⁷ It was only by uniting managerialism with market-like forces, he suggested, that both the quality of care and the efficiency promised could finally be delivered. On this basis, he articulated a series of interventions that could remake the NHS as something like a market with discriminating purchasers and motivated providers of care.

Such prescriptions proved intellectually appealing to the then Conservative government that was keen to disrupt professional control of services, and to shrink the size of the state. Therefore, although the government was wary of disrupting a cherished UK institution, its healthcare reforms in the early 1990s directly built upon the managerial and market-based model that Griffiths and Enthoven had articulated and developed (Rivett, 2013).¹⁸⁸ The 1989 *Working for Patients* White Paper called for the development of a “quasi-market” within the NHS and increasing managerial operations (Brereton and Vasoodaven, 2010, p.12). As Rivett (2013) summarizes, the legislation that followed (the 1990 NHS and Community Care Act) assigned funds regionally on a capitation basis, replaced the NHS management hierarchy with a “local dynamic” (ibid, n.p.) that would be more focused on local needs, separated purchasers and providers, and allowed providers to become “self-governing” units capable of competing with each other for contracts, and devolved some budgets to GPs who could purchase services on the behalf of their patients (ibid).

These reforms, consistent with the managerial and neo-institutional economic logics, were intended to “create an NHS where competition between providers would compel greater efficiency and sensitivity to the requirements of patients” (Klein, 1995, p.302),

¹⁸⁷ Such a line of reasoning was, as Ferlie et al (1996) explain, a dramatic departure from previous economic thinking: “Enthoven’s “elegant attempt to increase value for money, to sharpen incentive structures and to quicken the pace of organizational change [...] “vividly contrasted with earlier accounts from other economists such as Arrow (1963) who had argued that it would be unwise to introduce market principles into the health care sector because of the consequent dangers posed by high levels of uncertainty, consumer risk aversion, and producer opportunism. In the new world, the American HMO was taken as an exemplar of a new form of purchaser organization that faced strong incentives to ensure provider performance and had the market power to effect change” (p.68).

¹⁸⁸ *Caring for People* (DH, 1988) explicitly states “building on the valuable work of Sir Roy Griffiths, the white paper expands [...]” (p.3).

where “development of services would no longer, as in the past, be driven by the medical profession and other providers [...] new NHS Trusts would have not only the freedom but also the incentive to innovate, once they were emancipated from bureaucratic control and able to devise their own strategies” (ibid). These reforms collectively expressed the core NPM doctrines and ideals, advancing the seemingly apolitical need for hands-on professional management, explicit standards and measures of performance, greater emphasis on output controls, disaggregation of units, greater competition, stress on private sector styles of management practice, and stress on greater discipline and parsimony in resource use (Hood, 1991; see Figure 4.2).

These sorts of reform ideals were not simply confined to the NHS. The Thatcher government that introduced these market reforms was also, at the same time, reforming education (Education Reform Act 1988), public housing (Housing Act 1988), and the local governments (Local Government Act 1988) along these same lines. As Ferlie et al (1996) explain of the wider programme:

Where privatization was not possible the aim was to make the public sector ‘more business-like’ and the means chosen was the transfer of existing concepts, models, and personnel from the private to the public sector. There was an increased emphasis on financial control, such as securing efficiency, effectiveness, and value for money. Administrators became managers. Where markets did not exist, quasi-markets were introduced. As with other aspects of the new public management, it is not clear that the transfer of models from the private sector to the public was well thought through. In this new enterprise culture (Keat and Abercrombie 1991) markets are preferred to politics as a means of allocating resources and distributing welfare. In the UK this represented a unifying theme in policy-making and is exemplified in the sustained nature and wide scope of public sector reform. (p.31)

Although heavily wedded to political ideology and political economic shifts, these reforms were constitutive of a new set of norms for thinking about and undertaking reform.¹⁸⁹

With an emphasis on efficiency and responsiveness, quality was again not the central concern of these reforms. It was, however, seen as one of the many benefits expected to emerge (Rivett, 2013). It was consistently argued that replacing provider and medical professional discretion with market-like competition and managerialism would “reduce

¹⁸⁹ Ferlie et al (1996) state that the legislation, “taken together [...] can be seen as a bold and dramatic attempt to restructure the British Welfare State” (p.56).

costs, provide incentives for improvement, and raise quality" (Ferlie et al, 1993, p.235; Judge, 1989; Klein, 2010). According to the 1989 White Paper, the reform was explicitly geared toward realizing the sort of quality that Griffiths had envisioned: "Clarifying responsibilities, establishing where accountability for service delivery lies and specifying service requirements for contracts" it stated, "will all help to keep attention focused on the quality and suitability of services" (DH, 1989, 5.2).

The operationalization of the two core intellectual features of NPM, managerialism and neo-liberal economics, helped establish and shape the subject of quality as intertwined with management and marketization reforms. It emerged, however, and was attended to in a very specific, unidirectional way: quality was one of the many private sector attributes that was promised to arise from the adoption and operationalization of NPM doctrines and reforms.

This unidirectional relationship between operationalizing NPM ideals and the pursuit of high quality care began to show its limits, however, almost immediately. While quality was intuited to be a product of market reforms and, by association, the necessary restriction of professional discretion and control, it was also increasingly clear that 1990 NPM reforms alone could not guarantee a high quality of care in a system reliant upon knowledge about quality contained within the "professional enclosures" (Kurunmäki and Miller, 2011, p.222) that dominated the NHS. Following the recent Health Maintenance Organization (HMO) experiences in the USA, it was noted that NPM reforms, with an emphasis on cost-cutting, could encourage or even force providers to sacrifice quality in order to achieve the efficiency targets and outcomes (LeGrand, 1999). This meant that, while management and market reforms claimed to produce quality and efficiency, they also highlighted the need to ensure that one was not pursued at the expense of the other.

This made quality as much a problem as an outcome of reform. To ensure quality was not the victim of cost competition, it seemed increasingly to require active measurement and management too. "The need to measure the quality," one commentator explained, "derives from recent NHS reforms, which included the creation of a 'managed market [...] in which...] information on quality of performance is, potentially, an important factor when purchasers are seeking and renegotiating contracts with providers" (Hill

and McCrory, 1997, p.231). As such, while quality was at once articulated as a product of NPM interventions, it was also shown to need reworking, explicit attention, and improvement, in order to allow the NPM interventions to deliver their promises.

The need to measure and manage quality brought into sharp relief the measurement challenges it presented to the NPM ideas and doctrines (c.f. Walshe, 1991). Reflecting on this challenge, the same White Paper that was operationalizing NPM reforms stated: “A patient’s primary concern, of course, is to be given a correct diagnosis and then receive the best possible treatment” (DH, 1989, 5.3), while intuiting the obvious—that service quality of this sort was something that (at that point in time) couldn’t be specified in contracts and performance and measurements. Reflecting a well-established view at that time, the paper highlighted that “medicine is a very inexact science, often lacking generally accepted measures of the benefits to patients from different techniques and services” (*ibid*, 5.5), and that, as such, “the quality of medical work should only be reviewed by a doctor’s peers” (*ibid*, 5.8). This meant that the NPM doctrinal requirements of contracting, managerial oversight and control, and performance specification were difficult if not impossible to apply in the domain of quality. Quality thus presented a significant challenge to NPM doctrines and ideals, as much as it was a promise of them.¹⁹⁰

Reflective of this tension, the 1989 White Paper articulated another way in which quality might be realized, although it sat uneasily alongside the NPM ideals that dominated the reform. Drawing again on the US experiences with HMOs, it called for all hospital doctors to undertake “medical audit”, or “the systematic, critical analysis of the quality of medical care” (DH, 1989, 5.3). Such a scheme was consistent in some ways with the managerial zeal of NPM. Readers were reminded repeatedly that peer review was a form of “audit”; one headline, for example, read, “to ensure that all concerned with the delivery of services to the patient make the best use of resources available to them, quality of services and value for money will be more rigorously audited” (*ibid*, 1.9). However, the paper also highlighted the differences between value for money and quality concerns. In contrast to the former, which was achieved by

¹⁹⁰ Indeed, a number of authors noted the challenges related to observing quality in a market of this type (e.g. Propper, 1993). As one commentator noted: “The Americans, who have been in this business for far longer than we have, have not yet solved these problems (Demone and Gibelman, 1989)” (Gelnnerster, 1994, p.135).

removing professional discretion and empowering the market, the paper noted that, “medical peer review is essentially a professional matter” (DH, 1989, 5.4), that “the system should be medically led” (*ibid*, 4.8), and that it “must be developed and implemented with care” (*ibid*, 5.5).

Such inconsistencies highlighted that quality was not just a product of NPM, but a distinct challenge for it. As these reforms were operationalized, and the government pressed ahead with others based on NPM doctrines, the challenge of quality became increasingly visible. In-depth studies of the 1990 reorganization highlighted frequently that purchasers and providers were unable to build quality into contracts in any meaningful manner (Ferlie et al, 1996, p.83). Instead, as Klein (1995), explains, “the definition of quality used in contracts [was] often one dimensional, concentrating on such matters as waiting times rather than requiring specific standards in the delivery of clinical services” (p.314).¹⁹¹ Inability to distinguish what exactly quality was meant that in most cases markets and management focused on cost and activity issues (Ferlie et al, 1996; Klein, 1995).

Reflecting upon this period and its reforms, Enthoven was quick to highlight measures of cost and quality as the “oxygen of the market” (1999, p.28) required to deliver the promises that he envisioned. As he stated in 1999:

Without information on quality and costs, markets cannot do the good things we ascribe to them. It seems hard to understand how purchasers can do other than wander around in the dark or proceed on the basis of guess and gossip if they do not have access to reliable information on the quality of the would-be providers of services and the costs of the services [...] Poor performers cannot be motivated to improve if they have no idea where they stand. The situation remains today that quality-related information is virtually absent. (p.28-9)

Such reflections highlighted the way in which quality was rendered both an output of and a necessary input into the NPM reforms. Only markets and management could deliver high quality care, but at the same time markets and management (indeed the very programme of NPM) required something like quality to incentivize and manage. Quality was thus cast in a somewhat cumbersome manner as both a product and a problem in NPM reforms.

¹⁹¹ As Ferlie et al (1996) further note: “the finding was that cost and activity criteria were decisive in the letting of contracts, and that quality criteria were in the end of secondary importance” (p.83).

Indeed, while the forms of NPM pursued during the period displaced the need to trust the medical profession, to rely upon professional discretion, and to manage by consensus, they also highlighted the need for all these mechanisms to understand what quality itself entailed. These reforms created, as Enthoven reflected, “a whole class of people who needed [information about cost and quality] for their jobs” (Enthoven, 1999, p.59), but in some sense these people also needed the existing class of professionals to understand the thing that they needed to manage.¹⁹² This ambiguous status of quality alluded to deep tensions within NPM reforms and a rift that we will see changing the directional relationship between the notions and ideals of reform embedded in NPM and the notion and requirements of quality.

5.2 Healthcare reforms, 1997-2008: Extending NPM in pursuit of quality

While the reforms from 1985 to 1996 were undertaken largely on the basis of a problematization of bureaucracy and the state, the reforms from 1997 to 2008 were undertaken on a problematization of the delivery of quality itself. Indeed, for the incoming Labour government in 1997, the challenge presented to the NHS was articulated as one of delivering the “high quality care” (DH, 1998a, 1.1) that the previous reforms had suggested was possible, but had been unable to deliver. Arguing that market competition and the focus on cost had distracted the NHS from what really mattered, the ambitious and “modernising” (see Parsons, 2002) Labour government argued for quality to be placed firmly at the heart of care.¹⁹³ “For too long”, the agenda stated, “the emphasis has merely been on counting numbers, of measuring activity, of logging what could be logged, but this ignored the real needs of patient” (DH, 1997,

¹⁹² Similarly, Klein explains that the 1990 reforms, although not having the impact intended by the architects of the reforms, they “created a much more self-aware organization” (2001, p.202). “Even though information systems continued to be inadequate, and even though the meaning of much of the data was often ambiguous, statistics and figures became part of the NHS vocabulary. In turn this meant that the NHS inherited by Labour was a much more exposed (and politically vulnerable) organization: its performance (and inadequacies) were much more open to public inspection—an effect compounded, as in the case of rationing, but greatly heightened media interest in the service” (2010, p.179).

¹⁹³ One of the central principles underlying reforms would be a “focus onto the quality of care so that excellence is guaranteed to all patients, and quality becomes the driving force for decision-making at every level of the service” (DH, 1997, 2.4).

Forward).¹⁹⁴ The real needs of the patients, it was stated, were about delivering *high quality care*:

Every part of the NHS, and everyone who works in it, should take responsibility for working and improving quality. This must be quality in the broadest sense: doing the right things, at the right time, for the right people, and doing them right—first time. And it must be quality of the patient's experience as well as the clinical result—quality measured in terms of prompt access, good relationships and efficient administration. (DH, 1997, 3.2)

On this basis, the government embarked on what was described as the “most ambitious, comprehensive, systemic and intentionally funded effort to create predictable and sustainable capacity for improving the quality of a nation's health care system” (Leatherman and Sutherland, 2003, p.1) seen to date.

While the reforms that were rolled out in the following years were billed as a break with those of the past, the solution to the problem of quality that was advanced was one largely characterized by an extension and elaboration of the same NPM doctrines that had been operationalized in 1991. Indeed, although the government was critical of the inequalities caused by the market reforms, the solution proposed was a matter of extending the same NPM ideals into the domain of quality itself. In order to ensure that “quality becomes the driving force of decision-making at every level of the NHS” (DH 1997, 2.4), the reforms articulated in *The New NHS: Modern, Dependable* (1997), and later *A First Class Service: Quality in the new NHS* (1998a), retained a purchaser-provider split, reiterated the need for explicit performance measurement and managerial responsibilities, and maintained the need for the introduction of private sector managerial interventions. They argued, in summary, that quality would need to be made visible, discernible, subject to management and measurement, and bound up with private sector ideals, like much of the rest of healthcare had been in the years before. Indeed, the transition from the “internal market” to “integrated care” (see Figure 5.3 below) was an attempt to refute the past politically, while preserving the principles of reform that had been employed.¹⁹⁵

¹⁹⁴ While Thatcher had invited Sir Rayner, the Managing Director of Marks and Spencer to suggest ways of *improving value-for-money* in the public sector, Blair invited the head of Virgin, Sir Branson to advise the government on ways of making the NHS more *customer-focused*.

¹⁹⁵ As Klein notes, “even while denouncing the Conservative record, the Government was preparing to build on it” (2010, p.192). LeGrand et al (1998) similarly note a fair degree of consensus between political parties” at this time “about the value of keeping the basic features of the 1991 reforms” (p.14).

How we are replacing the Internal market with Integrated Care

Internal Market	Integrated Care
Fragmented responsibility between 4,000 NHS bodies. Little strategic planning. Patients passed from pillar to post	Health Improvement Programmes jointly agreed by all who are charged with planning or providing health and social care
Competition between hospitals. Some GPs get better services for their patients at the expense of others. Hospital clinicians disempowered	Patients treated according to need, not who their GP is, or where they live. Co-operation will replace competition. Hospital clinicians involved
Competition prevented sharing of best practice, to protect 'competitive advantage'. Variable quality	New mechanisms to share best practice. New performance framework to tackle variable standards of quality
Perverse incentives of Efficiency Index, distorting priorities, and getting in the way of real efficiency, effectiveness, and quality. Artificially partitioned budgets	Efficiency Index replaced by new reference costs. Broader set of performance measures. Budgets unified for maximum flexibility and efficiency
Soaring administrative costs, diverting effort from improving patient services. High numbers of invoices and high transaction costs	Management costs capped. Number of commissioning bodies cut from 3,600 to 500. Transaction costs cut
Short term contracts, focusing on cost and volume. Incentives on each NHS trust to lever up volume to meet financial targets rather than working across organizational boundaries	Longer term service agreements linked to quality improvements. NHS trusts share responsibility for appropriate service usage
NHS trusts run as secretive commercial businesses. Unrepresentative boards. Principal legal duty on finance	NHS trusts with representative boards and end to secrecy. New legal duties on quality and partnership

Figure 5.3: From internal market to integrated care (adapted from DH, 1997, p.16)

To place quality at the heart of the NHS, the 1997 reforms outlined new ambitions to standardize quality measures, develop clinically endorsed guidelines, and establish systems of measurement and management. They articulated "a framework through which NHS organisations [would be] accountable for continuously improving the quality of their services and safeguarding high standards of care" (DH, 1998a, 1.16). The standard-setter NICE (National Institute for Clinical Excellence) was envisioned to

“produce clear guidance for clinicians about which treatments work best for patients” (DH, 1998a, 1.15). The regulator CHI (Commission for Healthcare Improvement) was envisioned to “offer an independent guarantee that local systems to monitor, assure and improve clinical quality are in place” (DH, 1997, 7.3). A “new system of clinical governance” (DH, 1998a, 3.1) was proposed. In this system, Donaldson explained:

It is envisaged that there will be an ‘accountable officer’ in each hospital [...], that boards will receive monthly reports, and that annual reports will be made available to the public. The clinical governance role will be wide ranging and include ensuring that: quality improvement processes are in place and integrated with the quality programme for the organisation as a whole; that evidence-based practice is in day to day use with the infrastructure to support it; that good practice ideas and innovations are systematically disseminated and applied; that poor clinical performance is promptly recognized and dealt with to prevent harm to patients; and, that the quality of data collected to monitor clinical care is itself of a high standard” (Donaldson, 1998, p.74).

In 1998, a National Framework for Assessing Performance was established to specify key deliverables from the NHS as a whole, to which trusts would be accountable. All of this involved ever tighter specifications of performance, the intensification of the reporting and patient choice and devolved decision-making within the framework of tightly set standards and performance targets, as these propositions became operational from 1999 onwards. With these new mechanisms in place, however, it was argued:

For the first time, the NHS will be required to adopt a structured and coherent approach to clinical quality, placing duties and expectations on local health care organisations as well as individuals. Effective clinical governance will make it clear that quality is everybody’s business. (DH, 1998a, 3.8)

Reforms up to 2008 continued the general thrust of these efforts. In 1999, the government pledged a substantial increase in funding and asked for major targets around quality to be met as a result. *The NHS Plan* (2000), and subsequent proposals (DH, 2001; DH, 2002) and legislation (2002 NHS Reform and Health Care Professionals Act), initiated in the wake of the high profile failures at the Bristol Royal Infirmary (see Dingwall and Fenn, 2000), while articulating a need to move beyond managerial heavy-handedness, largely intensified the managerial and performance measurement. They established further targets and performance contracts and tinkered with different numbers of independent purchasers and providers of care. Reforms between 2003 and 2005, as outlined in *Creating a Patient-led NHS* (2005), reinforced the market mechanism by expanding patient choice. New GP and consultant contracts

implemented in 2004 extended performance measurement efforts, and specified an elaborate set of quality indicators with the input of the profession (DH, 2003). The Quality and Outcomes Framework (QOF) contract for GPs was seen as the first performance contract to explicitly aim to reward quality of care (Leatherman and Sutherland, 2008).

This package of reforms from 1997 to the late 2000s amounted to an extension of NPM doctrines under the title, and into the domain, of *quality*.¹⁹⁶ The reform discourse emphasized core Liberal notions like “fairness” (DH, 1998b, foreward) and was continually updated with new preoccupations such as population health, prevention, and “joined-up working” (DH, 2000a, 2.8). On the whole, however, this package of reforms amounted to, as Klein notes, the creation of a sort of system that Griffiths and Enthoven would have welcomed. It consisted of:

[...] mixture of improved performance measurement backed by the threat of central intervention of performance fell short of expectations [...] An expanded, more sophisticated set of PIs [...] designed to measure the various dimensions of NHS performance [...] a hierarchic structure of accountability for performance with sanctions for failure. [And a centre playing] a more active role in shaping the performance of the periphery. National service frameworks [providing] templates for the organisation of services. (Klein, 2010, p.196)

Even Enthoven himself, Rivett notes, “described the [NHS Plan (2000)] as a bold wide-open market, more radical than the previous Tory version of an internal market system” (Rivett, 2013, n.p.).

As before, these reforms were part and product of much wider changes in the norms of administration and reform in the UK and internationally. They were consistent with those being advanced in other sectors, and, Klein notes, “faithfully reflected the aspirations and ambitions of the new Third Way public philosophy” (2001, p.215). This “modernization” project (Parsons, 2002), undertaken largely in the name of quality, highlighted the solidification of NPM doctrines not as a product of ideological zeal, but as seemingly rational truths for thinking about and undertaking reform (Hood and Peters, 2004; Newman, 2002). Commentators were thus quick to praise the reforms for being consistent with the dominant NPM vision of administration increasingly espoused by international bodies like the World Bank. Citing one such report, *The State in a*

¹⁹⁶ Indicatively, “quality” was mentioned 163 times in *The NHS Plan* (DH, 2000a) alone.

Changing World (WHO, 1997), one commentator argued, for example: “In seeking a fundamental redefinition of the duties and accountability of public sector bodies in Britain, the new Labour Government is in harmony with the task of rethinking the role of the state the world over” (Donaldson, 1998, p.74).

The endurance of NPM administrative doctrines ensured that the relationship between quality and reform norms continued to be a largely unidirectional one. Quality, during this period, continued to be framed primarily in terms of operationalizing NPM doctrines. Consistent with NPM doctrines, the reforms stated clearly, for example, that the “only routes to consistent, prompt, and high quality services throughout the NHS” were “setting standards, delivering standards, and monitoring standards” (DH, 1998, 1.18), even if the specification of those standards with respect to quality remained elusive.

This package of reforms, articulated and rolled out from 1997 to 2008, however, began to establish a tighter and more significant link between NPM and quality. Instead of casting quality as a necessary exception from the administrative rule of managerial control, these reforms were built on the argument that quality must be made amenable to the NPM doctrines. Indeed, while previous reforms begrudgingly suggested that quality could only be understood by locally situated medical professionals, in operationalizing clinical governance, these highlighted that this would no longer be true. Drawing upon changes within the medical profession itself,¹⁹⁷ these reforms suggested that with the input of medical professionals, quality could be made into something that everyone could define, measure, address, and improve. In a review of the 1998 reforms, Leatherman and Sutherland (1998) explained:

'Quality' is properly and explicitly recognized as a defining attribute of the NHS alongside efficiency, effectiveness and equity. This is challenging for a number of reasons, not the least of which is that quality may be even harder to define than the other abstract concepts. These other three have, however, been sufficiently defined in the NHS to allow them to become

¹⁹⁷ As Klein notes: “If the introduction of the reforms advertised the impotence of the profession to the national policy arena, subsequent developments suggested that the NHS’s dependence on doctors for the implementation of policy remains almost as great as ever [...] the monument to the 1991 reforms may turn out to be—somewhat unexpectedly—the medical profession’s new-found enthusiasm for setting and monitoring its own standards” (Klein, 1995, p.325).

both goals and design factors. Quality can likewise be both conceptualized and operationalized. (1998, p.13)¹⁹⁸

Spurred on by high profile failures of the medical profession and a new acceptance among some medical professionals of standardization, reforms therefore met the challenges of quality presented in the previous set of interventions, with more aggressively deployed NPM doctrines.

In doing so, however, they began also to indicate a new directional relationship emerging (in rhetoric at least) between the two. Although the principles of good administration remained firmly grounded in the same NPM doctrines, a consequential rhetorical switch between the periods was beginning to emerge. In previous years, administrative reforms and norms were instituted *in order to deliver high quality care* (alongside the more pressing concern of efficiency). From 1997, however, “delivering high quality care” or “continuously improving the quality of care” were the titles given to the interventions and norms themselves (e.g. DH, 2000a, 1.21-1.23; DH 1998b, Ch. 1). In other words, while pre and post-1997 periods entailed largely the same sorts and styles of reform, those undertaken from 1997 were the product of promises of quality. A modern and world class NHS, it was emphatically stated, was one that had quality at its core. As we will see, this was a small but significant change in the relationship between quality and the nature and norms of reform.

This changing rhetoric reflected not just a discursive change in the UK political landscape, but also changing normative guidelines developing internationally. Indeed, the World Health Organisation (Nichols 1999; WHO, 1983), the Organization for Economic Cooperation and Development (OECD), and other international bodies began, in the mid and late 1990s, to intuit that *good administrative reform required close attention to quality*. The Council of Europe (COE), for example, issued a notice to all members requiring “that the governments of the member states create, where appropriate, policies and structures that support the development and implementation of ‘quality improvement systems’ (QIS), that is, systems for continuously assuring and

¹⁹⁸ For example, Leatherman and Sutherland’s articulation of the sort of quality governance that “any world-class healthcare system requires” explained the notion of healthcare quality this way: “Healthcare quality is an arena that must rely on objectivity and rational measurement. It is essential to make explicit the objectives of, and rationale for, a quality agenda as well as to specify the expected contributions of quality evaluation and improvement” (1998, p.18).

improving the quality of health care at all levels” according to a series of elaborately specified design principles and guidelines (COE 1997, p.89-91; see also Section 1.2).

In this repositioning of terms, a new directional relationship between the doctrines of administrative reform and the notion of quality began to emerge. Although these quality reforms articulated the same sorts of interventions seen in the preceding years, many of the details of the reforms drew from the international discourse surrounding quality and quality improvement. *A First Class Service*, for example, emphasized “continuous quality improvement” (CQI) (DH, 1998a, 1.16). “Backed by a new statutory duty of quality”, clinical governance was seen to require the introduction of a “system of continuous improvement into the operation of the whole NHS” (DH, 1998a, 1.16). Although the embrace of CQI was consistent with the move to adopt private sector management practices into the public sector (a key doctrine of NPM), at the time it was much more firmly connected with debates about quality and quality improvement. CQI was a philosophy of improvement recently popularized in the health sector debates by Donald Berwick of the IHI in the USA, and it was becoming increasingly central to debates about healthcare quality internationally (see Section 2.3.4). As Klein (2010) notes, its incorporation in the 1998 reforms had much to do with the specific views about quality held by the Chief Medical Officer, Sir Liam Donaldson, on the basis of his medical experience (p.209), rather than on the basis of more abstract ideas about good reform.

Hints of this new directional relationship were also visible in the definition of quality that was articulated. Although broadly conceived as “doing the right things, at the right time, for the right people, and doing them right—first time” (DH, 1997, 3.2), the White Papers between 1997 and 2008 repeatedly emphasized that the patient’s perspective needed to be included in quality. Throughout the early 2000s, a consistent emphasis on the consumer’s perspective of quality was stressed, a national standardized patient survey was initiated, and a dizzying array of new patient and public involvement groups were created on the basis that reforms had to manage a notion of quality that “included the patient or carer experience” (DH, 1997, 4.49; see also DH, 2000b, 2003a, 2003b, 2004, 2005).

This emphasis on the consumer's view was again consistent with the NPM doctrines particularly around adopting private-sector management practices (see Figure 5.2). But, this preoccupation was also if not more closely connected with the discourse around quality and quality improvement propagated internationally. As documented in Chapter Two, at the end of 1990 and beginning of the 2000s, international organizations argued that any comprehensive definition of quality needed to include the patient or carer's view (e.g. Kelley and Hurst, 2006; WHO, 1999). Leatherman and Sutherland (2003), reiterating this point to the UK audience, explained:

[The] technical field of quality measurement and advancement is reaching international consensus in defining its scope. It typically includes the domains of effectiveness, equity, access, *responsiveness/patient-centeredness* [italics added] and safety. Across the many countries placing a high priority on quality, the issues are quite consistent. (p.4)

As such, as much as NPM doctrines might have suggested the need to include the customer's view in any set of reforms, the increasingly stabilized doctrines of quality improvement highlighted that the customer's view *needed* to be included, if quality was going to be addressed.

The experiences with these reforms throughout the late 1990s and early 2000s were, unsurprisingly, mixed (Leatherman and Sutherland, 2008; Appleby, 2005; Mays et al, 2011). Alongside a major injection of funds and substantial capital development projects, there were significant improvements in headline quality indicators such as waiting times and indications of improvements in efficiency. Moreover, the reforms seemed to encourage the medical profession elites to become more willing to engage in the standardization and peer review activities than before (Klein, 2010). A new breed of physicians that had grown up versed in evidence-based medicine, and that had experienced changes in clinical practice based on non-medical concerns (such as non-invasive surgery), were much more willing to engage in standardization and take the patients' perspectives on care seriously. They became important leaders in the medical hierarchy during this period. There was evidence also that some of the nurse managers similarly had found the management-led notions of quality a helpful language in which to assert themselves and find common ground among their physician colleagues, although the reactions overall were decidedly mixed (see Rivett, 2013; Lenehan and Watts, 1994; Traynor, 2002).

There was a growing frustration expressed by many on the front-line, however, that the centrally-mandated and managerially-led indicators of quality belittled their own perception of what delivering high quality care operationally entailed. The seemingly politically-driven quality targets, passed down to local managers, resulted in some of those on the front line experiencing quality improvement as tedious management threats, decoupled from the everyday practices that they saw as quality and care (Kurunmäki, 2004; Kitchener, 2000). Evidence emerged of widespread “gaming” and “hitting the target but missing the point” (Hood, 2006, p.516) across the NHS (Bevan and Hood, 2006; Mays et al 2011, p.129).¹⁹⁹ By 2006 this potential decoupling of management-driven quality activities from the practices and activities of those delivering care was clear. The Chief Medical Officer for England, Sir Liam Donaldson, stated, “More needs to be done to develop the quality framework and make its key elements a day-to-day reality for patients and staff” (quoted in Leatherman and Sutherland, 2008, p.77).

There were also political worries that the centralization of control (around the setting of minimum standards in particular) created a political liability for failure and unhealthy incentives for political meddling (Mays et al, 2011, p.127). As Klein (2001) notes, the managerial infrastructure created and perpetuated ever more intensive opportunities for scrutiny:

With performance measures multiplying, with the Commission for Healthcare Improvement’s inspectors identifying shortcomings, with the activities of the medical profession subject to ever more rigorous examination, the NHS was becoming increasingly transparent [...] If there were shortcomings, if there were failures in quality of treatment offered, if waiting lists and variations persisted, they would be exposed to the public’s gaze. (Klein, 2001, p.217)

Central government management of seemingly every measure of quality meant that failures could no longer be blamed on problem doctors or incompetent bureaucrats. Rather, quality failures would suggest that the government had failed to provide the care that had been promised.

¹⁹⁹ QOF encountered its own set of challenges related not just the metrics and indicators, but the thresholds as well. In many years, nearly all the GPs were achieving 100% performance (for full analysis see Leatherman and Sutherland, 2008, p.42).

It was in this context that further new rounds of healthcare reforms were undertaken between 2008 and 2012. As we will see, these reforms altered, if not reversed, the direction of influence between the notion of the quality and the doctrines and ideals of government reform. The form and function of the reforms that followed were based not on principles and interventions of good government articulated within the dominant NPM paradigm, but on the basis of certain principles and norms regarding what quality in healthcare entails and how it can be improved. These doctrines of quality became, we will see, largely irrefutable doctrines for intervention and reform, as the doctrines of NPM had been previously.

5.3 Healthcare reforms 2008-2012: A substitution of doctrines

Indicating an acknowledgement of the discontent expressed locally in professional circles, the incoming Labour Prime Minister, Gordon Brown, tasked a high-profile London surgeon, Lord Ara Darzi, in 2007 with undertaking a review of the NHS and outlining a vision for the service over the decade to come. As a model of the new breed of physicians mentioned above, Darzi was well-versed in evidence-based medicine, thoroughly convinced of the need for a measurable and managed notion of quality, accepting of the need to understand care “through the patient’s eyes” (Gereteis et al, 2002), and connected internationally with the growing “quality improvement movement” (Øvretveit, 2000, p.74).²⁰⁰ With this sort of background and keen to avoid seemingly political debates about the appropriate form and function of the state, Darzi stated that “quality” would be the organising principle of his review and reforms. “My career”, he stated, “is dedicated to improving continuously the quality of care we provide to patients. This is what inspires me and my colleagues, and it [will be] the guiding principle of this Review” (Darzi, 2008a, p.8).

²⁰⁰ This background and the impact on Darzi’s review were clear in interviews he gave during the period. In one he explains: “[I] recognised that we were going through an interesting evolution in surgery, which is moving from open surgery into keyhole or laparoscopic surgery. There was tremendous excitement about the potential of keyhole surgery to reduce the physical and psychological trauma of surgery. But on the other hand, there was significant resistance from a large number of very senior colleagues, some of them were actually my tutors who said that this should never happen because it is bad for patients, and no good for surgery. So I remember this as being my first interaction with resistance to change. We could see on one hand some of the advantages from the patients’ perspective, but on the other hand we were much more resistant to that change as a profession” (Darzi, 2008b, n.p.).

In Darzi's view, and drawing on the input from thousands of colleagues, the goal of truly continuous quality improvement remained unmet because previous reforms were driven by political prerogative rather than a concerted emphasis on quality (which was seemingly apolitical). The problem, Darzi seemed to suggest, was that quality had been wrongly attended to on the basis of political and NPM-inspired doctrines. It was for this reason, he suggested, that quality had been narrowly defined. Pointing out that at the same time as large improvements were achieved on quality metrics, patient and staff perceptions of quality remained the same, he argued that *real* attention to quality meant "analysing and understanding patient satisfaction with their own experiences" (Darzi, 2008a, p.47). Past reforms around quality, he also noted, meant that a full understanding of, and responsibility for, quality remained piecemeal and spread patchily across the system. In place of fragmented NPM interventions, he argued that *real* improvement could only be achieved by freeing and empowering professionals. Reflecting on his own experiences, he stated, "We try to improve our practice [...] but we need the freedom and opportunity to do so" (Darzi, 2008a, p.59).

In summary, Darzi argued that the problem facing the NHS was the form and function of past reforms. In order to finally do something about quality, reforms needed to be based on the knowledge about quality and the "science of quality improvement" (Darzi, 2009, p.36) that was developing in the USA and circulating internationally (see Section 2.3.4). This was more than an idiosyncratic opinion of Darzi. Authors like Leatherman and Sutherland (2008) noted in the run-up to the *Health Act 2009*, which enacted Darzi's proposals, that they needed to be judged on their contribution to quality improvement. They stated:

The Government has asserted that the NHS aspires to be a 'world class' health system. To be legitimately considered as such a health system – particularly one organized as a national health service – requires a well-defined and competently executed programme to boost quality of care. (p.xiv)²⁰¹

Such a program required "a set of reliable reforms that use evidence, rather than ideology, to drive the quality agenda" (p.xiv). This meant outlining a set of reforms built firmly and directly on the doctrines of quality and quality improvement, outlined in Figure 5.1.

²⁰¹ They continued: "This programme should have two fundamental objectives: 1. Developing a coherent and integrated approach to improving quality. [...] 2. Refining a set of reliable reforms that use evidence, rather than ideology, to drive the quality agenda. [...]" (Leatherman and Sutherland, 2008, p.xiv)

The reforms that Darzi outlined in order to place quality “right at the heart of the NHS” (Darzi, 2008a, p.45), as we saw in Chapter Four, involved a large number of interventions throughout the system that were emblematic of those four characteristics outlined in Figure 5.1 above. On the basis that “you can only improve what you can measure”, Darzi called for the development of a comprehensive programme to “bring clarity to quality”, “measure quality”, “publish quality performance”, “recognize and reward quality”, “raise standards”, and then “safeguard quality” (Darzi, 2008a, Ch.4). To achieve this he called for a National Quality Board to coordinate and develop quality activities (linking them with OECD benchmarks if possible), argued for a new centralized national quality measurement clearinghouse, and pressed for NICE to develop quality standards while incorporating PROMS (patient-reported outcome measures) into effectiveness reviews. He called for all providers of services to publish annual Quality Accounts of the services they provide (summarizing their performance in the domains of patient safety, patient experience, and clinical effectiveness), and for the regulator, the Care Quality Commission, to report annually to Parliament on the provision of care. He argued for more performance metrics and rewards around quality to be incorporated into commissioning arrangements, and for these to be developed locally to reflect preoccupations and concerns.

Beyond this, he argued for clinical engagement, incentives for team working to be aligned and a “new professionalism” to be fostered (Darzi, 2008a, p.73). All clinicians, he explained, should become “practitioners, partners, and leaders”, as “exemplified by Kaiser Permanente’s approach in the United States” (*ibid*, p.60). Quoting Donald Berwick, of the IHI in the US, Darzi projected a vision of quality improvement as an empowering one, grounded in the fundamental matters and preoccupations of medical professionals (2009, p.26) and suggested that local organizations and units be helped to develop their own clinical dashboards and other measurement tools and be given more training in quality improvement. This would ensure, he argued, that everyone was “pulling in the same direction” (Darzi, 2008a, p.59), that the NHS was “unlocking

talent" (ibid, p.59), "empowering staff" (ibid, p.61), and "creating a new accountability" (ibid, p.61).²⁰²

These reform ideals were, in some respects, a continuation of the NPM doctrines. Measurement, accountability, patient choice, responsiveness, and strong management were all big themes throughout his review. However, Darzi's reforms were also significantly based on a discernible set of preoccupations and doctrines related to quality and quality improvement in health care. The extension of measurement, accountabilities, and management oversight was based not on the abstract benefits of private sector principles or neo-institutional economics, but on their distinct ability to operationalize the pathways, so carefully illuminated by Donald Berwick and others, through which measurement could result in quality improvement.

Indeed, Darzi conceptualized measurement and management in a way that was distinct from the way they had been understood under the NPM doctrines. Measurement and management, in his conception, were about equipping individual healthcare professionals to undertake changes that lasted in improvement, much more than measuring absolute performance. His quality measurement approach was explained in this way:

Evidence shows that high-performing teams are characterized by the use of measurement to support improvement. Our vision therefore starts with local teams and health systems, and works upward from there. [...] Local teams and organisations will have the freedom to determine which metrics they want to measure internally, supported by valid and appropriate measures for benchmarking regionally, nationally, and –where possible—internationally (Darzi 2008a, Appendix 1, para. 1).

This way of conceptualizing these terms was based firmly in the quality improvement literature and doctrines. As stated by authors like Berwick, "measurement is necessary but no more sufficient than measuring a golf score makes for better golf" (Berwick et al, 2003, p.30), and management is about facilitating a culture of improvement rather than rooting out bad apples (Berwick, 1998). Such conceptions are very different from the way they might be understood under NPM: where measures are seen to be about

²⁰² He also stressed the importance of systematically incorporating the patients' perspective of care at every level and called for the introduction of an NHS Constitution to highlight the legal rights patients already had.

absolute performance and comparison and management is about controlling professionals and costs (Exworthy, 2010).

While consistent with some NPM doctrines, Darzi's reforms indicated a substitution of these doctrines with those of quality and quality improvement. The quality improvement doctrines, upon which Darzi drew, were self-styled as universal, apolitical, and rational alternatives to the political meddling of the past. Grounded firmly in the "science of quality improvement" (Darzi 2009, 0.26), and therefore seemingly devoid of deep political or ideological attachments, Darzi's reforms were greeted well across the political spectrum and the NHS.²⁰³ The seemingly apolitical nature of doctrines and their enduring centrality for contemplating reform was highlighted by the reforms rolled-out by the incoming coalition government in 2010.

Indeed, even as Darzi's reforms were getting off the ground in 2010, the incoming Conservative minister, Andrew Lansley, outlined a series of NHS reforms built upon these same quality doctrines. Lansley called for the NHS to be separated from political ministerial control by establishing an independent NHS Commissioning Board directed by a series of outcomes established yearly by Ministers. He argued for most of the existing commissioning infrastructure to be abolished, for GPs to take primary responsibility for commissioning care from any willing provider, and for local authorities to more closely manage the health and social care interface. He called for regulators to be split between quality and economic functions, maintaining standards on the one hand, while facilitating economic competition on the other. He called for a new patient organization, Healthwatch, to consolidate and build upon the existing organizations (DH, 2010). All of this, it was suggested, would cut management costs and produce sustained savings, while at the same time improving the quality of care and preventing the sort of quality failures that recent scandals had revealed (see, for example, the Francis, 2013).

²⁰³ Commentary following the review often greeted the reforms as a "welcomed relief" from "politically-motivated" or "top-down" reform (see Section 4.2). One commentator, for example stated: "The long awaited report from the health minister Lord Darzi did not set any new national targets or herald any substantial reorganisation for the NHS but instead emphasised the need to improve quality of care after a decade of investment in services" (Coombes, 2008, n.p.).

These reforms were ambitious in scope and pace, and they generated an extraordinary amount of controversy and resistance.²⁰⁴ Behind the controversy—which commentators note was due more to the management and communication blunders of the government (Timmins, 2012)—however, were appeals to the same doctrines of quality and quality improvement in order to motivate and specify the reforms. Indeed, despite the change in government and Lansley's specific ideological attachments, the reforms were a product of the same quality and quality improvement doctrines that Darzi drew from previously.

Throughout the policy documents and speeches between 2010 and 2012, the need for the reforms was articulated on the basis of the principles that permeated the quality improvement literature. The motivation, set out clearly in the foreword, stated:

First, patients will be at the heart of everything we do. So they will have more choice and control, helped by easy access to the information they need about the best GPs and hospitals. Patients will be in charge of making decisions about their care.

Second, there will be a relentless focus on clinical outcomes. Success will be measured, not through bureaucratic process targets, but against results that really matter to patients – such as improving cancer and stroke survival rates.

Third, we will empower health professionals. Doctors and nurses must be able to use their professional judgment about what is right for patients. We will support this by giving front-line staff more control. Healthcare will be run from the bottom up, with ownership and decision-making in the hands of professionals and patients. (DH, 2010, Foreword)

These three aims—of putting patients at the heart of care, focusing on measures of quality and performance that mattered to patients and professionals, and empowering professionals to drive change—were the same requirements for quality improvement that Darzi had first articulated in the UK in 2008, and that were central doctrines of quality and quality improvement internationally.

Throughout the document, these relationships were repeatedly made clear. Not only was it stated explicitly, for example:

²⁰⁴ They were described accurately as “the biggest structural upheaval in the health service’s history [...]” (Timmins, 2012, p.15) and they generated a huge amount of controversy. “Initial concerns were over the scale of reorganization, and the nature of GP commissioning, in the face of demands for huge efficiency savings. When the bill emerged, the focus shifted to furious debate about the scale and nature of competition in the NHS, with the charge of ‘privatisation’ coming to the fore. Finally, there was to be a long argument over whether the bill retained a requirement for the health secretary to provide a comprehensive NHS.” (ibid, p.69)

Building on Lord Darzi's work, the Government will now establish improvement in quality and healthcare outcomes as the primary purpose of all NHS- funded care (DH 2010, 3.1)²⁰⁵

The reforms of the *Health and Social Care Act 2012*, which operationalized these ideals, were in large part enactments of the doctrines for quality improvement outlined by Darzi.²⁰⁶ The desire to establish the NHS as an arms-length body, for example, was justified by the need to separate political meddling once and for all from the professional business of providing high quality care. The policy stated:

We will replace the relationship between politicians and professionals with relationships between professionals and patients. Instead of national process targets, the NHS will, wherever possible, use clinically credible and evidence-based measures that clinicians themselves use. The Government believes that outcomes will improve most rapidly when clinicians are engaged, and creativity, research participation and professionalism are allowed to flourish. (DH 2010, 3.4)

This justification was not Conservative by nature but ostensibly apolitical in the sense that it merely drew from the science of quality improvement, which highlighted the need for change to be led from the front-line.

Similarly, the devolution of budgets to groups of GPs was undertaken on the basis that decision-making at the local level was the only way to provide for a responsive service capable of delivering high quality care. The White Paper stated:

The Government's reforms will liberate professionals and providers from top-down control. This is the only way to secure the quality, innovation and productivity needed to improve outcomes. We will give responsibility for commissioning and budgets to groups of GP practices; and providers will be freed from government control to shape their services around the needs and choices of patients. (DH, 2010, 4.1)

While many commentators were quick to point out that the origin of fund-holding dated to the Thatcherite attack on professionals and the state, in fact the justification was one grounded firmly in the doctrine of quality improvement. As Timmins (2012) points out, all these aspirations were already being operationalized under Darzi: practice-based commissioning, foundation trust status, and CQUIN commissioning were all built upon the same quality improvement doctrines as the GP fundholding proposed by Lansley. It

²⁰⁵ Similarly, it stated: "We will build on the ongoing good work in the NHS. We recognize the importance of Lord Darzi's work, in putting a stronger emphasis on quality" (DH, 2010, 1.7).

²⁰⁶ Timmins explains: "In other words, to many observers what Cameron and Lansley were proposing looked to be broadly a faster extension of where Blairite policy was already heading" (2012, p.30).

was this continuity with the norms of quality and quality improvement, Timmins suggests, that contributed to the seemingly abrupt emergence of the reforms.

As such, there was a strong continuity in doctrinal elements of the reforms initiated between 2008 and 2012, despite the changing governments and concerns. Throughout this period, and irrespective of political persuasion, contemplating and undertaking reform of the healthcare sector became a matter of drawing from the doctrines of quality and the science of quality improvement, rather than the doctrine of good reform that are often summarized under the heading of NPM. Good reform became a matter of doing quality and quality improvement, rather than operationalizing market or private sector trends. Indicative of this shift, during this period, measures of quality became important variables not just for assessing healthcare system performance, but also for re-assessing the importance and effectiveness of marketization more generally (see, for example, Propper et al, 2010; Propper and Dixon, 2011).

5.4 Quality improvement for all seasons

From the emergence of quality as a programmatic concern in 1985, to its most recent articulation in 2012, this chapter has examined the changing relationship between the doctrines of NPM and those of quality in UK healthcare reforms. It has highlighted a distinctive trajectory in the relationship of NPM, quality, and government reform throughout this time. Reforms undertaken between 1985 and 1996, it has been suggested, were based upon and motivated by, and indeed helped to construct, the doctrines of NPM. Through their creation of contracts and markets, moreover, these reforms quickly gave rise to the policy problem of quality. Seeking to address this new problem of quality, this research showed reforms between 1997 and 2007 to extend NPM doctrines and interventions toward the management and measurement of quality itself. The inability of these doctrines and interventions to attend to quality, however, and the emergence of increasingly stable doctrines or norms for thinking about and attending to quality and quality improvement, were shown to lead policy-makers, between 2008 and 2012, to draw directly from such doctrines to contemplate and undertake reform. The quality and quality improvement doctrines, like those of NPM in the previous years, were shown to have universal and apolitical appeal, presenting a

ready made model for thinking about and undertaking reform: a *reform solution for all seasons*.

The movement in the doctrines and locations for thinking about and undertaking reform that this chapter has documented is, of course, a very tentative and emergent one. It is something that we are only beginning to be able to document empirically, and it is something that this chapter has not investigated beyond the UK and the healthcare domain. While mindful of the dangers of speculation, this concluding section suggests that this movement in the location of policy-making norms is one that may continue, and be repeated in other jurisdictions and domains. This is because, in the same way that NPM doctrines were shown to spread and persist on the basis of the politically-appealing solutions that they offered (Hood, 1991), the specific doctrines of quality and quality improvement offer an appealing means for policy-makers to respond to challenges while depoliticizing the rationales and mechanisms.

These doctrines are politically appealing for four specific reasons. First, they offer politicians and policy-makers the same sort of explicit representations of measurement, performance management, and accountability that made NPM interventions attractive, and that authors such as Power (1997; 2007, p.50-53) have shown to be hugely comforting and politically appealing in modern society. However, they do so without requiring policy-makers and politicians to specify performance themselves, and to take responsibility for the incompleteness of the measures that are used to capture the full range of dimensions of performance that matter to citizens. This makes reforms based on the doctrines of quality much less politically risky than their previous NPM variants, in which outcomes had to be specified by the reformers themselves.

Second, and relatedly, this model of reform helps to neutralize and depoliticize quality failures. The doctrines of quality improvement state that failures are inevitable and part of the learning process, and that lasting improvement is difficult to achieve. They also state that a blame-free culture is necessary in order to produce lasting and fundamental changes. The solution to failures of quality, thus conceptualized, is one of focusing ever more on empowering, equipping, and training the front-line professionals to be even better at quality improvement, without dwelling on where to lay blame for past problems. Moreover, as Walshe (2009) shows, quality improvement interventions of

this sort are continually being repackaged and reinvented; through a process of “*speudoinnovation*”, ever new sets of interventions, based on the same doctrines, become available for doing something about quality (p.153-9). For policy-makers faced with quality failures and scandals, the doctrines of quality thus offer both a relatively optimistic justification for failure, and ready-made solutions for improvement that focus on the re-equipping of staff rather than fundamental paradigm shifts in regulation or policy.

Third, the doctrines of quality improvement do not specify any one professional knowledge base upon which to rely. In contrast to the close relationship between NPM and managers and management knowledge, the doctrines of quality and the science of quality improvement are argued to be things that any evidence-based profession should be willing and able to adopt. All professionals, according to these doctrines, are supposed to be equipped with the right tools and motivation to take responsibility for quality. This logic is particularly appealing to policy-makers in societies that are sceptical of professional knowledge bases (c.f. Beck, 2009; Beck et al, 1994). It is also particularly appealing to policy-makers aiming to cut costs or make other politically unpopular moves using the doctrines of quality. As closely related to healthcare professionalism, reforms in the name of quality, whatever their interests, spread responsibility for action among all NHS professionals.

Fourth, as the recent incarnations of these doctrines in the UK illuminate, they are flexible and accommodate a variety of interventions and political aspirations. Although they prescribe to a particular world view, this view is one that any political party, and any set of preoccupations, can at least in principle draw upon to envision and undertake new reforms. Indeed, Chapter Four showed that while the doctrines of quality improvement were called upon by Darzi as the seemingly natural next step to increasing levels of NHS funding, they were quickly and for the most part seamlessly redeployed toward or aligned with cost cutting and efficiency savings as the NHS funding shortfall became known. Like the NPM doctrines before them, the quality improvement doctrines are extraordinarily specific in the sort of thinking and intervening they make possible, while also providing a flexibility that makes them appear the seemingly only form of rationality that could be possible.

This political attractiveness, it is suggested, provides the engine behind the trajectory charted over the course of these past three sections, and provides the conditions for the doctrines of quality to potentially supplant those of NPM.²⁰⁷ This political appeal also perhaps helps to account for the stability and persistence of the *contemporary promise of quality*. Despite the tensions and contradictions inherent in the particular historical rendering of quality seen in Chapter Four, this chapter has shown that this particular conception of quality also has characteristics that make it politically appealing and resistant to critique. Containing its own justification for, and solution to, failure, the contemporary promise of quality becomes almost self-contained and self-sustaining.

Reflecting back on the previous chapters, it seems that such a movement—toward an self-contained and self-sustaining quality—might give rise to the distinctive practical consequences and effects documented throughout this thesis. It would likely continue and accelerate the movement of public service activity toward balance-sheet activities, and direct it toward increasingly representational activity (see Chapter Four). It would encourage the implementation of re-packaged quality improvement interventions that make new distinctions between healthcare professionals. It would continue to re-orient public services more directly toward the ‘experiences’ and other such representations of the customer that can be captured and made into calculations of quality. It would also change the location of the emergence of global policy norms from the geographical and conceptual locations of NPM (Clarke, 2004) to the distinctive geography of quality outlined throughout this thesis.

²⁰⁷ These conditions seem possible, even likely, to emerge outside of the UK health context—indeed, there is some limited evidence that these conditions and the resulting dynamic are visible in healthcare reforms in Denmark (c.f. Malmrose, 2012) and in the UK education (c.f. Brown, 2004) and prison (c.f. Mennicken, 2013) sectors.

Chapter 6

Making Up the Contemporary Promise of Quality: A conclusion

6.0 Introduction

This thesis has aimed to document the emergence and significance of a distinctive phenomenon in political, social, professional, and organizational life, summarized as *the contemporary promise of quality*. In order to do this, as stated in Section 1.3, two methodological propositions were advanced. Firstly, it was stated that quality is *made up* in the specific sense of being part and product of recursive processes of being made to fit into the world in a particular way. Secondly, it was stated that quality is made up in part through processes and practices of *accounting for quality*. It was stated, in other words, that the complex fitting that takes place in making up quality goes hand in hand with the construction and stabilization of the particular accounts of quality, be they closer to judgment or formal calculation, that are rendered.

These propositions allowed us to study quality and its calculation in a specific manner. Rather than seek out the true essence of quality, this approach directed our attention to the processes and dynamics of *qualitization*—that is, the processes by which quality is rendered thinkable and constructed into reality in a particular way at a particular place and point in time. Rather than attend to the immediate functional explanations of why such an understanding of quality was necessary, or why such a means of calculation was seemingly required, this approach directed our attention to the confluence of movements that have come to link quality and its calculation with a particular set of ideals, ideas, or preoccupations, so as to establish a functionality that can then be attributed to them. Finally, rather than investigate the success or failure of health systems, organizations, and professionals to live up to the requirements of the newest quality improvement ideals, this approach directed our attention to the range of transformations and preparations that had to be put in place in order to establish these ideals as matters of fact and as requirements for care. It highlighted, more generally, the need to investigate the emergence and stabilization of particular *calculative assemblages* in order to understand quality and its calculation. These are historically

constituted arrangements of elements, operating at different levels or locations, which interact and cohere so as to render a specific form and functionality for quality and its calculation.

This approach allowed us to illuminate a phenomenon, initially indicated simply as the proliferation of discourse about “quality” in healthcare (see Figure 1.1), which was part and product of diverse and significant movements that reached far beyond the domain of quality as such—a movement that was part and product of the emergence of a whole new world of healthcare described and differentiated in time as *the contemporary promise of quality*. The past four chapters have documented the boundaries, dimensions, and significance of the contemporary promise of quality as consisting of multiple and overlapping material, discursive, human, even subjective movements, unfolding in diverse fields and with distinctive effects.

Chapter Two illustrated the contemporary promise of quality to be closely inter-twined with the emergence and stabilization, since 1985, of specific new ideas about what quality is and how it can be accounted for. These ideas—summarized as an accounting concern, as patient-centered, as bottom-up, and experimental (see Figure 1.2)—were shown to constitute a unique and stable packaging of quality. These terms established historically distinct conceptual and discursive boundaries around what could be said and done with quality, the way it could be acted upon, and the various ambitions toward which it could be connected and enacted.

Chapter Three showed this phenomenon to be part and product of a changing form and function of the patient survey, and the simultaneous transformation of the characteristics and significance of the recipients of care. It illuminated, specifically, the stabilization of a set of survey questions and characteristics attributed to patients based around the discreet *experiences* that patient had with individual healthcare providers. The existence and the growing importance of these “experiences”, and their incorporation into ever more regulatory and commercial arrangements, was shown to have gone hand in hand with the rise of Chief Experience Officers, and their design-based expertise and interventions, in healthcare organizations in the USA.

Chapter Four illustrated the contemporary promise of quality as inextricably related to the constitution of a whole new world of healthcare practice and changing expectations for healthcare organizations and professionals. This was shown to be a world in which quality was enacted as a matter of undertaking balance-sheet activities and producing representations of performance and that required a healthcare professional in the image of Lord Ara Darzi in order to attend to quality. This specific enactment of quality was shown to both act upon organizations and professionals and simultaneously to produce new opportunities for alternative conceptions of quality to emerge. It was shown that these alternatives were often quickly absorbed within the flexibility provided by quality's contemporary conceptualization, but that they also highlighted the potential for more quality failures and scandals, like those illuminated recently in the UK NHS (see Section 4.6) to occur.

Finally, Chapter Five highlighted the emergence of an increasingly close relationship between such movements and the changing terms and norms through which healthcare reforms are contemplated and undertaken in the UK. It demonstrated how ideas about quality and quality improvement came to supplant or subsume those of public administration and reform provided by the doctrine of New Public Management. As a deeply programmatic endeavor, the contemporary promise of quality was shown to be inseparable from a movement in the location of the production of public administration norms, and for form and function of the norms and doctrine themselves.

Each of these sets of movements was shown to be important and consequential in its own right. However, they were also and perhaps more significantly shown to be part and product of a mutually interconnected but never fully stable whole—a calculative assemblage—that momentarily cohered so as to constitute and reconstitute quality and the elements that were part of it. Because of the diagonal research design employed (see Section 1.2), this thesis was able to illuminate ways in which each chapter and each set of movements drew from, interacted with, and recursively acted upon, each other. It showed discursive conditions of quality, for example, illuminated in Chapter Two, to both inspire and be made possible by the calculations of quality and the re-presentation of the patient illuminated in Chapter Three. It showed also, in Chapter Four, how the programmatic elaboration of quality and the associated demands on organizations and professionals were linked up with the particular ways of thinking about quality and

doing its calculations highlighted in Chapters Two and Three, while simultaneously contributing to a problematization of such discourses and calculations, and presenting new opportunities for them to change.

This research highlighted, moreover, that such interlinkages and relationships are neither derivative of these movements nor inconsequential to their formation. Rather, they were shown to be the very content and force of qualitization and therefore constitutive of both quality and its accounts and these other such movements. It showed, for example, that it was not the existence of a set of measures of the patient's experiences alone, nor the idea or ideal of quality as something that needed to be understood from the perspective of the patient that constituted quality in a particular way, but the forging of a relationship between the two; it was the linking up and mutual fitting of the measure and the ideal that simultaneously constituted quality, the measure, and the ideal in a particular way. Indeed, each of these chapters illuminated a similar sort of constitutive and mutually-presupposing dynamic, wherein a set of movements relied upon, and fed back into each other, so as to stabilize the contemporary promise of quality in its distinctive form.

As such, this thesis highlighted that the formation of this matrix of relationships, to state it provocatively, constitutes the ever-elusive essence of quality that has left researchers such as Pirsig (1974) so frustrated (see Section 1.3). It has shown, in other words, that it is the stability, complexity, and scale of these relationships and the assemblages that they constitute which allows quality to appear to have an 'essence' that is derived from the nature or reality of the world, while also taking part in the unfolding of the multiple and simultaneous movements described in the chapters above.

By attending to the ways in which the multiple manifestations of quality interacted and intertwined with each other throughout time, this research has sought to illuminate distinctive findings about quality and its calculation, thereby hopefully contributing to a more general theory of quality and calculation in society. These more general findings, and reflections on the challenges of conceptualizing and investigating quality and its calculation in this way, are the topics of this concluding chapter. Section 6.1 recounts and reflects upon some of the findings illuminated through this thesis regarding the way in which quality and its calculations move between time and place. Section 6.2 then

reflects on some of the core challenges that undertaking such an approach to the study of quality raise. Section 6.3, finally, considers the strengths and limitations of this approach in order to clarify the distinctive value that is added by this thesis and by research that might build upon these findings.

6.1 A new history of quality and its calculation

The distinctive approach to the study of quality and its calculation has, as recounted above, facilitated a wide-ranging investigation in diverse areas and with diffuse but distinctive effects. The aim of this section is to reflect more specifically on the dynamics of both quality and calculation that this approach has illuminated. It reflects on three aspects or dynamics of quality and its calculation that are rarely acknowledged or explored in the existing literature.

Firstly, this thesis highlighted specific and largely under-acknowledged dynamics of the relationship between quality and its calculation, as they moved hand in hand together throughout place and time. Chapters Two and Three illustrated quality and calculation to typically (if often implicitly) be described and studied as if they are derived functionally from each other. They showed that quality is commonly described as the product of ever more precise calculations or measurement of its underlying reality (see Section 2.0), while successful or accurate calculations are commonly seen to derive from their ability to measure that pre-existing quality that they set out to measure (see Section 3.0). This thesis has, it is hoped, contributed to our understanding of this seemingly circular set of arguments by drawing attention to the dynamic interactions between quality and its calculations, and the multiple and changing configurations of external elements that help to establish and stabilize specific relationships and interactions between the two.

This thesis showed, as other studies have, that calculations and the domain of the calculated continually interacted and co-constituted the other (c.f. T. Porter, 1994; Power, 1996). It showed that quality and calculations of quality continually interact with each other, and provide tentative foundations for the other to be advanced and stabilized. Chapter Three, for example, highlighted an on-going and recursive interaction between the discourse of quality and means of its measurement. It showed

the same survey technology that ultimately was seen to have ‘solved’ the problem of capturing the patient’s perspective on quality that was being articulated discursively, to have also given rise to the idea that there was a patient with a distinct and discernable perspective to be captured at all. Chapter Four, similarly, showed the advancement and implementation of new measures of quality on the basis of a newly uncovered reality of healthcare quality, to themselves provoke and highlight alternative conceptions of what else quality might be.

It also, however, showed this interaction and recursivity to never be the product of the force of calculation or quality alone, but instead to be the product of the forging of relationships between quality, calculation and some *other* set of elements that connected a particular way of calculating with an equally particular conception of quality. Indeed, this research showed quality and calculation to be stabilized and made accurate, not on the basis simply of each other, but instead through their alignment and mutual-constitution with a variety of other elements (c.f. Rose and Miller, 1992, p.190-191). This was illuminated starkly in the account provided of Codman’s efforts to measure and define quality (provided in Section 2.1.2). While he was shown to illuminate a new reality of quality and the end-results of care with measures that were as elaborate and sophisticated as many of those that came to constitute quality decades later, his findings and the ideas that they inspired were curtly dismissed by Boston General peers when they were advanced in 1916. The very proposition of the existence of such a measure of quality led to “disgrace, a loss of friends, resignation” and much else (Donabedian, 1989, p.235). As his experiences showed, it was not the case that quality simply emerged from accurate measurement or that measurement success was declared on the basis of its ability to capture that newly defined thing. Rather, Codman’s calculations failed (and then in the 1970s succeeded) on the basis of a changing relationship between an assemblage of other elements relating quality to calculation—of changing levels of trust in medical professionals, social acclaim for science, significance of technological associations, concerns about cost, and no doubt much else besides (see Section 2.4). Accurate measures or precise ideas about quality were thus shown to be inconceivable alone, but instead to be constituted through the connectivity or mutual fitting achieved between these things and some other set of changing preoccupations, ideals, and things—a matter not simply of making something calculable, or calculating something in particular, but of making up the calculations and the things at the same time.

Secondly, this thesis highlighted a wider distribution of agency in the movement of quality and calculation between time and place than is commonly acknowledged (c.f. Callon, 1987; Callon and Muniesa, 2005). Common accounts of advancements in the fields of quality and its calculation, as explained in Section 2.0, suggest that they are the product of both a confluence of macro demands (such as the consumer movement in healthcare, for example, or the growing complexity of medical science), and the work of specific “quality gurus” who heroically overcame the barriers that had been standing in the way (Robkey and Itani, 2009, p.S3). This research, however, highlights that we cannot account for quality on the basis of such macro changes or individual actions alone, nor even on the basis of the two combined. Instead, it illuminated multiple forms of agency, including individual programmatic, technological, and even ideational interacting with macro-changes such as a consumer movement and quality heroes such as Donald Berwick to translate and establish them as two sides of the same coin, as matching problems and solutions, for example, to questions of quality. A diversity of elements, to use Callon’s terms, were shown to produce specific arrangements or *agencements* that endowed individuals and seemingly-macro movement with the capacity to act (Çalışkan and Callon, 2010, p.8-10).

Such constituting, linking, and agencing elements (c.f. Miller and O’Leary, 2007) were illuminated clearly, for example, in the simultaneous constitution of Avedis Donabedian as the “father of quality measurement” (Varkey et al, 2007, p.735) and the seeming need for quality to be made measurable. Chapter Two showed that Donabedian elaborated his structure-process-outcome model for measuring quality as early as 1966, and that the confluence of factors commonly cited as calling for the measurement of quality—declining trust in the medical profession, increasing costs of care, and greater technological complexity of medicine—were thoroughly apparent from 1975 (see Section 2.2). However, Donabedian and these movements were shown only to be made to connect with each other from the late 1980s, as a diversity of ideational, technological, and other such elements emerged to translate and constitute them as part and product of the same thing. Only with these other elements, such as the development of tools like the standardized patient experience survey and the emergence of the idea of public reporting and consumer choice as a means of improving care, could Donabedian’s actions and ideals about the measurement of quality come to fit together.

It was only, in other words, in these multiple translations and relationships and, to use Deleuze and Parnet's terms, the "mutual presupposition operations" (1988, p.33) between them all that, this chapter showed, macro movements and quality gurus were co-constituted as central actors in quality's changing configuration (c.f. Latour, 1988; Callon and Muniesa, 2005).

Illuminating such a wide distribution of agency in changing conceptions and calculations of quality paints the heroic action of quality gurus in a new light. In particular, it shows that people are made central to quality and calculation not on the basis of what they do, but on the basis of what others make them mean. It showed, also, that to be made part of the transformations and connections that constitute assemblages, the heroes of the quality movement had to give up some sense of who they were. This process of mutual-making helped make sense of Avedis Donabedian's wistful change of tone that we saw in Section 2.0. Speaking in 1988, well before his ideas had been taken to their most extreme, the central figure of the modern quality movement remarked that efforts to measure the intricacies of quality had been taken "too far" (Donabedian 1988, 1743). "Those who have not experienced the intricacies of clinical practice," he lamented, "demand measures that are easy, precise, and complete—as if a sack of potatoes was being weighted" (*ibid*).²⁰⁸ Such statements highlight a dynamic that is inherent to an assemblage; a position of centrality in any assemblage, like that afforded to Donabedian or Pasteur (to use Latour's (1988) example), does not mean a more concise or full expression of a solution or control over the movement of which he is a part, but enrolment into more and more diverse and disparate hopes and dreams.²⁰⁹

Thirdly, this thesis showed quality and quality improvement to entail movements, actions, and consequences that extend far beyond the success or failure of systems, organizations and professionals to adopt and implement the latest quality improvement

²⁰⁸ Speaking a decade later, Donabedian had become yet more dismayed at the movement that was undertaken in his ideas' name; "If I were you, I wouldn't worry about the failure of the accursed structure-process-outcome paradigm to meet your needs. As I have repeatedly said: structure-process-outcome is a servant, not a master. I never intended to build my reputation on this paradigm. I only offered it as a handy classification scheme. I know that it has a deeper meaning [...]" (Donabedian, March 2000 in Harteloh, 2003, p.259).

²⁰⁹ Callon (1986, p.14) makes a very similar point when he says and then shows in the case of humble scallops that, "to speak for others is to first silence those in whose name we speak". Those parts of the assemblage, he says must be "cornered" or enrolled in new schemes, their attachments severed. No elements ever, in this sense, speak for themselves.

methodologies and tools, as commonly documented in so-called implementation studies (see Section 4.1). Indeed, this research highlighted the substantial investments, movements, and consequences that occurred not simply to implement the latest quality improvement intervention or best practice, but to constitute certain practices and interventions as synonymous with quality and seemingly necessary for ‘success’ (c.f. Power, 1996). Chapter Four highlighted many instances of this pre-figuring and arranging. It showed that even before quality improvement interventions were constituted as necessary, ideas and ideals about quality were first translated into a series of movements; they were made into part of the existing regulatory and commercial systems and enacted as a set of requirements for health provider organizations to undertake more patient surveys, for example, to spend more time and money producing narratives and representations of performance, and to redesign information systems so that a distinctive notion of quality could be measured and attended to. These actions, moreover, were far from inconsequential. Rather, they took part in the construction of a world of quality which helped to actualize the ideas and discourses about it that were described in Chapters Two and Three, establishing distinct ways in which quality at an ever more local and even personal level could be attended to and discussed. Such movements, which take place largely before and around the point of implementation, are shown throughout this thesis to be an important and commonly overlooked dimension and consequence of quality.

By attending to this pre-figuring and arranging, this thesis showed some specific ways in which quality and its calculations were intertwined with changing subjectivities and demands upon identity. It illuminated the continuation of post-Fordist quality ideals that call for the active involvement of every worker in the pursuit of quality as the customer understands it (see Wilkinson and Willmott, 1994, p.9-10), and the extension of new technologies and interventions, adapted somewhat to the healthcare sector, to help being such ideals about (see Sections 2.3.4 and 4.0). It also, however, illuminated movements beyond these technologies and interventions, as such, which placed demands on identity and produced distinctions between organizations and people. Chapter Four and Five highlighted a more subtle and diffuse process by which the constitution of quality as synonymous with performance among healthcare systems, organizations, wards, and individuals, produced distinctions that changed the way they could be (c.f. Miller and O’Leary, 1994). Chapter Five, for example, showed the way that national rankings of

healthcare quality constructed distinctions between ‘good’ or ‘modern’ administrative reform and its backward other. Similarly, Chapter Four showed the construction of a situation where, regardless of how professionals actually used and internalized quality improvement tools, they were already distinguished as ‘for’ or ‘against’ quality on the basis of their willingness (or otherwise) to show themselves willing to train up in such tools—to be the “engaged clinician” or the “guys [sic] on the other end of the spectrum” (Smith, 2011).

Finally, and more generally, this thesis helped to illustrate some underlying dynamics by which quality and its calculation move between time and place. By illuminating the dense web of connections and relays that constitute quality at any given time and place, and by highlighting their relationship not just to the world as it is but to dreams and schemes for how the world might be, this thesis helped to account for the eternal optimism and inherent goodness that is often attributed to quality (see Pfeffer and Coote, 1991). As both part and product of a diverse set of changing elements, quality is at least temporarily constructed in step with the rationality and aspirations that it also takes part in constructing. The illumination of such a web of connections and relays also helps to account for the fragility of quality and the perception that it “can be almost anything anybody wishes it to be” (Donabedian 1966, p.167) despite being continually constructed in very specific terms. As made up and sustained on the basis of connections that are heterogeneous and simultaneously macro and micro, its essence is always, at least theoretically, available for transformation on the basis of the limitless alternative combinations of elements that might make up quality differently. Some of these limitless alternative possibilities, moreover, are shown to be provoked and to emerge through the unavoidable process of qualitization—that is, through the “overflows” that are generated by making quality what it is (see Callon, 1998, p.244-270). As such, quality and its calculation are shown, like desire, to be, “in itself an immanently revolutionary process” (Deleuze and Parnet, 1987, p.71) constantly becoming, to borrow from Hopwood (1987), what they were not.

6.2 Making things up

The distinctive approach to the study of quality and its calculation employed in this thesis has, as already recounted, produced often-overlooked findings regarding the

movement and significance of these phenomena in society. However, the process of undertaking this investigation has also simultaneously illuminated challenges and limitations of this particular approach. This section highlights three central challenges that were encountered, and some of the ways in which attempts were made to address them.

Firstly, this research approach raised the challenging issue of defining and selecting the boundaries of the object of study. While one of the core benefits of the approach undertaken here was to highlight and investigate the dynamic contingency of the objects of study, it also raised the question of where an investigation of something with no inherent essence might begin and end. The solution initially adopted here, which was inspired by similar moves undertaken by Hacking (1986) and Power (1994, 2007), was to investigate and follow the label of “quality” in healthcare. While the initial choice of starting and ending dates (1945-2010) was somewhat arbitrary (see Section 2.0), this allowed the researcher to identify and track movements in the ongoing constitution and reconstitution of quality and its calculation throughout time.

Such a move, however, led progressively to the identification of a new object of study. An initial investigation of “quality” as an inherently open-ended phenomenon led to a focus on and description of the more specific *contemporary promise of quality*. This new object emerged from, and was defined on the basis of, distinctive historical changes in the qualitization of quality that emerged from patterns of difference found in the discourse surrounding the concept of quality throughout time. Despite being grounded in a concern to take the objects of study as contingent, however, this object, like the “Audit Society” (Power 1994), was literally made up by the researcher. This provided a way of categorizing and analyzing a particular instantiation of quality and its calculation that has distinctive dimensions and effects. It drew attention to an object that goes by the name of “quality” but is not all of quality, that is distinctive in many ways but only imperfectly historically and geographically specific, that manifests itself in particular forms but that is composed of elements that are in many cases pre-existing, and that despite its specificity continues to transform throughout time.

The identification and analysis of this made up object is, perhaps, the core contribution of this thesis. It is shown to constitute a distinctive change in contemporary society that

could only be identified by appreciating and attending to the historical contingency of quality and its calculation. However, the definition of its boundaries creates new challenges itself.

As empirically-derived but analytically-stabilized, it raises the question of what it would take to demonstrate its continuation and attenuation as a phenomenon, or even its fundamental transformation. As we saw, particularly, for example in Section 4.6, the boundaries of the contemporary promise of quality are constantly being rethought and tweaked as overflows are generated by its elaboration. New regulatory principles around quality, for example, are currently being tested, and journalists, families, and others formerly external to the assemblage are increasingly bringing together whole different conceptions of quality that do not rely on the same calculative characteristics (see Section 4.6). Are these, one might reasonably ask, movements within the contemporary promise of quality, or constitutive of the emergence of a new quality altogether? To answer such questions, we might quibble about their consistency with the characteristics of the contemporary promise of quality outlined in Chapter Two, but ultimately this question cannot be settled simply empirically. As made up by the researcher, it is at least in part an analytical choice whether such borderline changes are viewed as internal or external to the new object of study. This means that the contingency of the object of study that was so important to this study runs the risk of being interpreted as or substituted for a stable object that is merely defended.

By analytically stabilizing the contemporary promise of quality, this research also parcels up the possibilities for studies of quality in a specific way. It produces certain analytical characteristics and distinctions that matter, and in doing so creates the possibility that, if carried forward unproblematically, might obscure more about quality as a historically-contingent phenomenon than it illuminates. Indeed, if future research treats the differentiation of the contemporary promise of quality from the more general quality as a means of investigating and thinking about quality, then the concept might in fact distract from the empirical constitution and reconstitution of quality that it was so specifically designed to appreciate. While this is not an automatic or necessary consequence of this approach to quality, it is suggestive of the underlying problem of how and in what ways such findings can continue to be engaged with and developed in reference to the original domain of quality over time.

These issues might be seen as important to those who wish to study quality and calculation on the basis of stable distinctions about what they are, and who see this research as a contribution to such a pursuit (see, for example, Maltby, 2008 on the Audit Society). However, this research aimed to do something else with quality and calculation. It aimed to appreciate their continual and contingent constitution in order to illuminate *something more*; to illuminate and better appreciate the emergence of something that is necessarily temporary and always changing but nonetheless consequential to social, political, organizational, and professional life. There might be, this research suggests, new and different calculative assemblages to document and describe emerging every day and in every location. Such assemblages and the one described in this research are neither mutually exclusive, nor should they be seen to explain everything about quality. Rather, by developing more and different empirically-based descriptions of what quality and its calculations *do*, this research hopes we can better understand its ongoing role in society, without ever assuming that we know *what quality is*.

Secondly, this research approach highlighted specific challenges and tensions inherent to the exploration and illumination of assemblages and their formation. One of the primary challenges relates to the theoretical and empirical specification of the things and processes that constitute the linkages, relays, connections, and inter-linkages that are seen to be so central to the formation of assemblages. These terms were used to represent the bringing together and mutual exchange, or the “mutual fitting” (see Hacking, 1986), of things—a “mutually presupposing operation” (Deleuze and Parnet, 1988, p.33) in which two elements draw from and recursively construct the other. Despite the seeming ability of these terms to draw attention to these constitutive associations, however, they were used in a largely metaphorical way, without, in themselves, specifying what such bringing together entailed. Do such terms entail, one might reasonably ask, geographical proximity, repetition, a shared genealogy? Are things literally tied together?

This research has grappled to answer such questions as it has sought to describe many instances of what naively initially seemed to be clear and empirically grounded cases of mutual fitting or intertwining. In the process, it became clear that such metaphors are far

too abstract to accurately capture the diversity of things and complexity of processes that mutual fitting entails. Much of this challenge stemmed from the existence of different forms of elements that compose assemblages—they were shown to be, for example, discursive, ideational, material, personal, emotive, programmatic, and entailing and constituting agency in differing forms—and only a limited language for capturing association between different forms. While there exists a quite advanced language to describe the way that discourses, people, programmes, or machines act upon their own kind, there is a less developed language for describing the relationships that might exist between a machine and a discourse, or a programme and an agent.

In order to identify and describe some of these intra-form relationships, this research drew from governmentality, performativity, bibliometrics, actor-network theory, and other related theories and concepts. They each contributed in distinctive ways to the specification of such intra-form relations that were found throughout this research. Challenges arose, however, in a number of instances where they met a more messy empirical reality. This occurred, for example, in Chapter Four where it was shown that distinct ideas and ideals about quality improvement were being performed into reality through their being made to fit into multiple tools and technologies, but that this singular reality was simultaneously fracturing and multiplying, so that it became unclear how ideas and people were relating. In this case, and others, it became difficult to specify what was acting upon what, and how. Without a theoretical foundation through which to help describe the complexity of relations between forms, it became difficult to specify, on the basis of the empirical material, how things were or were not fitting together—and thus what sort of assembling was taking place.

Another challenge related to the on-going constitution and reconstitution of assemblages was presented by the non-linearity and recursivity of the relations between the elements. The notion of an assemblage is unique and analytically valuable because it highlights the recursive relations between elements, and the sense in which they continually adjust to and act upon each other. A thorough empirical description of this recursivity, however, which shows movements between elements to be on-going, but more than simply contingent, is difficult to achieve.

Throughout this thesis, the challenge of describing recursive relations in a linear piece of writing has required temporary bracketing and simplification of the notion of assemblage. In Chapter Two, mutual relations had to be described as two separate unidirectional ones. The co-elaboration of, for example, trust in the medical profession and judgment-based calculations of quality had to be described, first as a process by which trust in the medical profession acted upon a notion of quality, and then as a process by which a judgment-based calculation of quality acted upon trust in the medical profession (as if each were unidirectional and separate). In order to describe the confluence of multiple movements at a particular point in time, moreover, a number of different relationships that had been unfolding at different tempos and that had different historical roots had to be described as if they merely existed within the particular period where these relations all converged. In Chapter Two, for example, the sociological reconstitution of the patient was described as part and product of an assemblage of elements between 1975 and 1985, and the consumerist movement in healthcare was described as part and product of an assemblage of elements between 1985 and 2010, despite the fact that the two elements had been interweaving and mutually-constituting each other in different ways from as early as the 1950s. These periodizations were not factually inaccurate, and they helped to understand changing relations between elements throughout time, but they necessarily simplified the dynamism, contingency, and complexity that the notion of assemblage draws our attention to.

Such simplification produces the risk that this complex theory of history, and of quality and its calculation, might come to be seen as simply the idea that the world is historically-contingent on many things. By not fully specifying what the relations between things consist of, and how these relations are built, it runs the risk of suggesting that something is the way it is because something else is the way it is because something else is the way it is, etc. However, the value and richness of this approach lies in its rejection of this sort of unidirectional contingency or functionality. Indeed, the notion of an assemblage pushes us to attend to the complex reasons and processes through which something and something else *in particular* are made to act upon and associate with another in a *particular way*. It asks us to explicate and better describe, in other words, the phenomenon of contingency itself. This is an ambition, as we have seen, that outstrips the language, theories and tools that we have to fully accomplish such a task. However, this thesis has sought to demonstrate that however

imperfect our tools, this is an ambition that is worth pursuing, and one that can illuminate aspects of the world commonly overlooked.

6.3 Conclusion

This thesis has illuminated important aspects of quality and its calculation by documenting the emergence and significance of the contemporary promise of quality. This was shown to be a multiple yet distinctive phenomenon: a set of movements overlapping and unfolding across heterogeneous locations and domains that constituted quality and its calculation in a particular way. As this concluding chapter has highlighted, the documentation of such a phenomena has entailed the adoption of a specific approach to the study of quality and its calculation, which has come with its own set of challenges and limitations.

These analytical benefits and challenges, moreover, are inter-related, and revolve around core tensions inherent to the methodological and theoretical ambitions of the study. They revolve around, firstly, the ambition to forego assumptions of stable units interacting with each other, while at the same time aiming to document something particular and distinctive about some aspect of the world. They revolve, secondly, around the ambition to move beyond functional explanations of change, while at the same time aiming to explain specifically how one thing acts upon the other. And they revolve, thirdly, around the ambition to illuminate the existence of multiple paths and possibilities without reducing such multiplicities to a matter simply of historical contingency.

In order to at least in part resolve some of these tensions, this research suggests, two things are needed. Firstly, this research suggests the need for a recalibration of expectations around how to accumulate and advance knowledge about quality and its calculation. It posits the benefits of a research agenda in which we learn about quality by enquiring into and highlighting the multiple and complex ways in which quality is constituted and reconstituted over time, rather than seeking to uncover once and for all what quality and its calculations *really are*. Secondly, this research highlights the need for further development of language, theories, and concepts through which to explore and better understand the ways in which elements of particularly different forms come

to relate to and act upon each other. It is only, this research suggests, by explicating the movements and processes that constitute interlinkages, recursive relations, and other such connections, that we can move beyond unidirectional contingency models of change without seeming to suggest that movements are merely historically contingent.

It is hoped that this thesis helps not just to clarify but to advance both of these objectives. By demonstrating some of the benefits of thinking about and investigating quality and its calculation in this way, it is hoped that this thesis has indicated the benefits of a research agenda around quality and its calculation consistent with that specified above. By illuminating the complex empirical reality of the relations between different forms of elements in the forming of assemblages, and by advancing diverse theories and concepts to help clarify and explain (however imperfectly) these relations, it is hoped that this thesis contributes toward the development of a richer language through which to overcome unidirectional functionalist and historical contingency models of history and change.

**Appendix 1.1 Examples of national quality legislation, strategies and initiatives
(from WHO (2003) and other sources)**

Country	Year	National Quality Activity
Argentina	1997	Decree 1424: quality assurance of medical care to be compulsory in all national health establishments; national commissions to be set up for professional (re)certification and accreditation of health establishments
Austria	1993	Hospital and Clinics Act (KAG) specifies hospital patients' rights, comparative external evaluation, internal quality systems, quality assurance committees
Brazil	1995	National Quality Assurance Programme "five tracks strategy" published by Ministry of Health
Chile	1991	Project for the evaluation and improvement of quality (EMC); focus on primary care, assisted by QAP, funded by USAID
China		Independent regulation requires providers to demonstrate quality assurance system; National patients' charter
Costa Rica	1992	Ministry of Health programme for Continuous Quality Improvement (PMCC), supported by QAP and USAID, to integrate quality initiatives that had been fragmented by externally inspired reforms (110); training, quality policies, web site
France	1991	Law requires hospitals to define and demonstrate internal quality systems
	1995	National Programme for quality assurance: safety and continuous quality improvement projects in public hospitals
	1996	Ordinance of 24 April requires mandatory quality improvement, hospital accreditation, patient surveys in public and private hospitals
Germany	1989	Health Reform Act requires quality assurance for hospital and out-patient care; physicians to ensure that care meets standards (§70) and to be held responsible for imperfect and unauthorized treatment (§75); mandatory benchmarking of hospital process and outcome (§137); sick funds responsible for quality assurance (88)
	2000	Health reform requires patient choice, cost-effective clinical practice
Israel	1995	National health insurance law demands that service providers have quality assurance systems, use approved guidelines and review appropriateness of care
Lithuania	1992	Health reform law requires quality indicators, mandatory accreditation by Regions of public and private sector

	1998	Institutions required to have quality assurance systems and to monitor services; compliance reinforced by State Medical Audit Inspection including access, appropriateness and cost effectiveness.
Netherlands	1996	Care Institutions Quality Act prescribes patient involvement, clinical guidelines and protocols, staff training in quality, internal monitoring, external assessment, annual quality report
Philippines	1995	Republic Act 7875 mandated all health care providers participating in National Health Insurance programme to take part in quality assurance programmes
Portugal	1998	National health strategy and quality policy published.
Sweden	1993	National Strategy for Quality Improvement published
	1997	The Health and Medical Services Act requires that all personnel should systematically improve the quality of their performance; self-assessment, evidence-based practice, risk management, outcomes assessment, continuous quality improvement
Thailand	1995	Ministry of Public Health launched the Quality Hospital Policy and mandated general hospital to implement total quality management
United Kingdom	1992	Patients' Charter, national benchmarking
	1999	National survey programme of patient experience
	2009	Health care providers to provide annual Quality Accounts of services. National health Service constitution for patients.
United States	1986	Peer Review Organization legislation replaces Professional Standards Review Organizations set up in 1973; established federally funded agencies, mandated to assure quality and efficiency of care provided under Medicare and Medicaid
	2010	Patient-Centered Outcomes Research Institute established. Value-based purchasing to tie patient survey returns to reimbursement. Secretary of HHS to establish a National Quality Strategy.
Zambia	1994	National quality assurance plan, developed with LSTM and DANIDA published

Appendix 1. 2 Interview Schedule

Key: Interview (I), observation (O), and participation (P)

Organisation	Attendees and titles	Date	I/O
NHS Confederation	Conference: <i>Foundations of Quality</i> Sample of speakers: Toby Lambert, Policy Director at Monitor Sir John Oldham, National Clinical Lead for Quality, DH	24 Feb 2010	O
Kings Fund	Conference, <i>Foundations of Quality</i> Sample of speakers: Penny Dash: Partner, McKinsey & Co. Lesley Brownett, Deputy Secretary, M&S Toby Lambert, Group Director, Monitor Sir John Oldham, GP and National Clinical Lead for Quality and Productivity, DH	24 Feb 2010: 13:00-19:30	O
South West Quality Observatory	Pesheya Doubleday, Programme Manager	1 Mar 2010	I
Kings Fund	Catherine Foot, Point of Care Programme	22 Mar 2010	I
Kings Fund	Conference, <i>Applying Quality Measurement to improve health care services</i> Sample of speakers: John Stewart, Quality Framework and QIPP Programme, DH Mark Jennings, Director of Health Care Improvement, Kings Fund Bevin Manoy, PbR Programme Manager, Audit Commission Dr Roger Smith, Medical Director, South London Healthcare NHS Trust	23 Mar 2010 9:30-16:15	O
T1	Director of Quality and Safety	2 Oct 2010	I
ISQua	Annual Conference Sample of speakers: Atul Gawande, Professor of Surgery, Harvard Medical School Robert Brook, Director of Health Programme at RAND	10-13 Oct 2010	O

Jason Leitch, Clinical Director of the Quality Unit in Health and Social Care Directorate, Scotland

Marian Walsh, CEO Bridgeport Health

T1	Head of Analytics, Performance Team, Quality	20 Oct 2010	I
T1	Head of Quality Improvement	6 Nov 2010	I
T1	Deputy Chief Nurse	15 Nov 2010	I
Care Quality Commission	Neil Prime, Head of Analytics Alex Mears, Measurement Policy Manager	18 Nov 2010	I
T2	Director of Organisational Development Associate Director of Risk Management Informatics Manager Quality Improvement Manager Senior Nurse	23 Nov 2010	I
T2	Pressure Ulcer Collaborative Meeting: Senior Nurse Nurse Sister 1 Nurse Sister 2 Nurse Sister 3 Nurse Sister 4 Informatics Team member	23 Nov 2010	O
T3	Deputy Chief Nurse	30 Nov 2010	I
T1	Nurse Sister 1	2 Dec 2010	I
NHS Confederation	Policy Manager	8 Dec 2010	
Picker Institute and CQC	Ian Seccombe, NHS Patient Surveys Lead (CQC) Joan Walsh, Head of Quality Improvement, Picker Judy Shipwar, Senior Project manager, Picker Steve Sizmur, Survey Statistician, Picker Danielle Swain, Quality Improvement Manager, Picker Dianna McDonald, Director of Survey Implementation, Picker	10 Dec 2010	I

Quality Health	Reg Race, Managing Director	23 Feb 2011	I
T1	Nurse Sister 2	28 Feb 2011	O
T1	Q.E.P meeting/conference: Chief Executive Chief Nurse Jim Easton, NHS National Director for Improvement and Efficiency, DH Medical Director, Specialist Hospital Board Director of Education	28 Feb 2011	O
T1	TCAB study day	4 Mar 2011	O
T1	Q.E.P Project Manager	7 Mar 2011	I
T1	Nurse Sister 2 Infection Control Meeting Ward Rounds Nurse 1 Patient 1	18 Mar 2011	O, I
T2	Nurse Nurse	18 Mar 2011	I
Health Experiences Institute	Conference, <i>Do we know what patients want?</i> Sample of speakers: Ann McPherson: MD and founder of CIPEX Ray Fitzpatrick: Prof. of Public Health, Oxford Jocelyn Cornwell: Point of Care Programme, Kings Fund Paul Streets: Director of Patient and Public Experience, DH Penny Woods: Chief Exec, Picker Institute	22 Mar 2011: 9:30-17:15	I, O
Picker Institute	Chris Graham, Director of Survey Development Steve Bough, Project Manager (staff survey) Sheena Mac Cormick, Senior Researcher Bridget Hopwood, Senior Project Manager, Children and Young People Research Team	29 Mar 2011 12:00-15:00	I
T1	Ward observation	19 May 2011	O
T2	Consultant Leadership Development Programme	26 May 2011	O

T1	Nurse 2 Nurse 3 WS 1 WS 2	27 May 2011	O
T1	WS 2	2 June 2011	O
T1	Staff meeting: WS 1 WS 2	3 June 2011	O
T1	Ward observation	8 June 2011	O
T1	Ward observation	16 June 2011	O
T2	Consultant Leadership Development Programme	21 June 2011	O
T1	Ward observation Nurse 4	23 June 2011	O, I
T1	TCAB study day	1 Jul 2011	O
T1	Ward observation	6 July 2011	O
New York Presbyterian Hospital	Hussein Tahan, Corporate Director of Nursing Education and Research Charlotte Cabello, Patient Care Director	7 Sept 2011 9:30-14:30	I
Fast Forward Consulting	Anthony Cirillo, Healthcare Experience Consultant	20 Oct 2011	I
Cleveland Clinic	Dr James Merlino, Chief Experience Officer	24 October 2011 14:30-15:45	I
Experia Health	Bridgett Duffy, Chief Medical Officer at Vocera and former Chief Experience Officer at Cleveland Clinic	17 Nov, 2011 11:30-13:30	I
Beryl Institute	Jason Wolfe, President and CEO	22 Nov 2011	I
St Andrews University	Making Healthcare Safer: learning from social and organizational research Conference 2012 Sample of speakers: Dr Brian Robson, Executive Clinical Director, Healthcare Improvement Scotland Dr David Steel, formerly Chief Executive, NHS Quality Improvement Scotland	15-26 June 2012	O

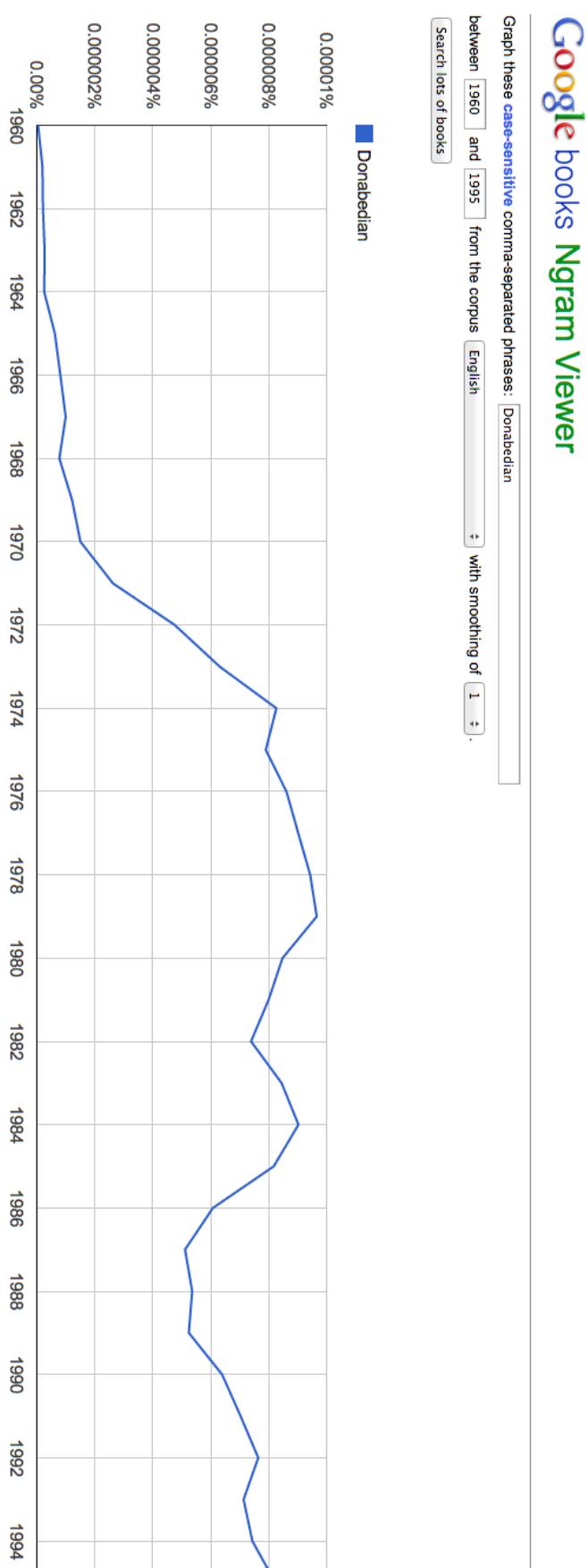
Kings Fund	Chris Naylor, Fellow, Health Policy	25 Jan 2013	I
Beryl Institute	Patient Experience Body of Knowledge Virtual Focus Group	14 Mar 2013, 11:00-13:00	O, P
Beryl Institute	Patient Experience Body of Knowledge Virtual Focus Group	19 Mar 2013, 11:00 – 13:00	O, P
Beryl Institute	Patient Experience Body of Knowledge Virtual Focus Group	29 Mar 2013, 11:00-13:30	O, P
Beryl Institute	Patient Experience Body of Knowledge Virtual Focus Group	4 Apr 2013 11:00 – 12:00	O, P
ExCel Centre	International Forum on Quality and Safety in Healthcare (BMJ and IHI) Sample of speakers: Donald Berwick, MD Robert Francis QC Professor Lord Ara Darzi	16-19 Apr 2010	O
Cumberland Lodge	The Many Meanings of Quality in Healthcare conference Sample of speakers: Dr Jocelyn Cornwell, Director, Point of Care Foundation and Senior Associate, The King's Fund Dr Deborah Swinglehurst, NIHR Academic Clinical Lecturer, Queen Mary, University of London Dr Joe Maybin, Fellow in Health Policy, The King's Fund	4 June 2013	O, P

Appendix 2.1 Google Books Ngram Timeline for Donabedian

The chart below shows the number of times a word is mentioned in the approximately 5.2 million books (roughly 360 billion English words) that Google has catalogued in each year of publication. The percentage indicates the word's frequency as a percentage of total words published each year. The results are adjusted for the increasing number of books published each year.

This chart shows, therefore, that “Donabedian” was mentioned roughly 912 times in 1965 and 30,908 times in 1980, adjusting for the change in overall numbers of publications.

For more information, see Michel et al (2010).



Appendix 3. 1: Official HCAHPS Development Timeline (from CMS, 2013, p. 13-17)

HCAHPS Development, Data Collection and Public Reporting Timeline

The following timeline outlines major events in the HCAHPS development process, as well as anticipated dates for future national implementation events.

2002

- *July 2002* – AHRQ publishes call for measures in the Federal Register
- *Fall 2002* – The CAHPS team reviews the literature and response to the call for measures on patient assessment of hospital care related to survey content, sampling, data collection, and reporting
- *November 2002* – AHRQ and CMS hold a Stakeholders Meeting
- *November 2002* – AHRQ and CMS hold a Survey Vendors Meeting

2003

- *February 2003* – A Federal Register Notice is published soliciting comments on the draft pilot instrument
- *June 2003* – Data collection begins for the CMS Three State Pilot (Arizona, Maryland, and New York)
- *June 2003* – A Federal Register Notice is published soliciting comments on the draft HCAHPS survey and requesting input on implementation issues
- *Fall 2003* – CMS selects Health Services Advisory Group (HSAG), the Arizona Quality Improvement Organization (QIO), to coordinate the National Implementation of HCAHPS. HSAG assembles a team comprised of the National Committee for Quality Assurance (NCQA), RAND, Westat, and expert consultants from Harvard Medical School to support the National Implementation.
- *October 2003* – Six consumer focus groups are conducted in California and Maryland to obtain consumer feedback on the HCAHPS survey content and domains

- *November 2003* – HCAHPS Stakeholders Meeting is held to provide an update on the development process and to discuss implementation issues

- *December 2003* – CMS publishes the draft 32-item HCAHPS instrument in the Federal Register

- *December 2003* – The Three State Pilot Final Report is issued

2004

- *January 2004* – AHRQ begins additional HCAHPS testing at five sites

- *February 2004* – AHRQ announces Pre-National Implementation Testing in the Federal Register

- *March 2004* – Additional consumer focus groups are held in Arizona and Florida to address issues raised in comments to the initial National Implementation of HCAHPS Federal Register Notice

- *June 2004* – AHRQ Pre-National Implementation Testing begins

- *November 2004* – CMS issues second 60-day Federal Register Notice announcing the National Implementation of HCAHPS (25-item HCAHPS instrument)

- *November 2004* – CMS submits HCAHPS to the NQF's Consensus Development process for its endorsement

- *December 2004* – The NQF Review Committee recommends adding the “doctors and nurses showing courtesy and respect” items back into the HCAHPS survey, which increases the number of survey items from 25 to 27

2005

- *January 2005* – The second Federal Register Notice closes; CMS proceeds to respond to the public comments received through the Federal Register

- *March 2005* – NQF public comment period

- *May 2005* – The four NQF Member Councils and Executive Board formally endorse HCAHPS

- *November 2005* – The final Federal Register Notice, a 30-day notice, is published

- *December 2005* – HCAHPS receives final clearance from OMB

2006

- *February 2006* – The first *HCAHPS Quality Assurance Guidelines* manual is released

- *February 2006* – The first *HCAHPS Hospital/Survey Vendor Training* sessions are held at the CMS Central Office in Baltimore, and also via Webinar

- *April-June 2006* – The first HCAHPS Dry Run is conducted, which allows hospitals to test the survey and data submission process without public reporting

- *April 2006* – The second *HCAHPS Hospital/Survey Vendor Training* is conducted, via Webinar

- *October 2006* – Data collection for the National Implementation of HCAHPS for Public Reporting commences

March 2013	Introduction and Overview
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2007

- *January 2007* – The *HCAHPS Quality Assurance Guidelines V2.0* is released
- *January 2007* – The third *HCAHPS Hospital/Survey Vendor Training (Introduction to HCAHPS Training)* is conducted, via Webinar
- *March 2007* – A second HCAHPS Dry Run is conducted, for hospitals/survey vendors that did not participate in 2006
- *May 2007* – A Chinese translation of the survey instrument is made available for Mail Only mode of survey administration
- *May 2007* – The first *HCAHPS Update Training* sessions are conducted, via Webinar
- *July 1, 2007* – HCAHPS Data Collection and Public Reporting for Annual Payment Update purposes (APU era) begins
- *August 22, 2007* – The Final IPPS rule is published, which stipulates that IPPS hospitals must participate in the Spring 2006 or March 2007 HCAHPS dry run to qualify for their full APU for FY 2008

2008

- *January 2008* – The *HCAHPS Quality Assurance Guidelines V3.0* is released
- *January 2008* – The fourth *Introduction to HCAHPS Training* and second *HCAHPS Update Training* sessions are conducted, via Webinar
- *January 17 – February 15, 2008* – First preview period for HCAHPS public reporting
- *February 2008* – OMB re-approved HCAHPS
- *March 28, 2008* – The First Public Reporting of HCAHPS results (Patients discharged October 2006 – June 2007) on the Hospital Compare Web site
- *July 2008* – Data collection begins for Mode Experiment II
- *August 2008* – Second Public Reporting of HCAHPS results (Patients discharged October 2006 – September 2007)
- *August 19, 2008* – The final IPPS rule is published, which stipulates that IPPS hospitals must continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines posted on www.hcahpsonline.org
- *September 2008* – Third Public Reporting of HCAHPS results (Patients discharged January 2007 – December 2007)
- *October 2008* – CMS releases *HCAHPS Bulletin 2008-01*, “Application of the HCAHPS Lag Time Variable”
- *December 2008* – Fourth Public Reporting of HCAHPS results (Patients discharged April 2007 – March 2008)

2009

- *February 2009* – The *HCAHPS Quality Assurance Guidelines V4.0* is released
- *February 2009* – *Introduction to HCAHPS Training* and *HCAHPS Update Training* are conducted, via Webinar
- *February 2009* – Russian and Vietnamese translations of the survey instrument are made available for Mail Only mode of survey administration
- *February 2009* – CMS releases *HCAHPS Bulletin 2009-01*, “The Use of HCAHPS in Connection with Other Hospital Inpatient Surveys”

<u>Introduction and Overview</u>	<u>March 2013</u>
<hr/>	
➤ <i>March 2009</i> – Fifth Public Reporting of HCAHPS results (Patients discharged July 2007 – June 2008). IPPS hospitals must report their HCAHPS results, and can no longer suppress public reporting.	March 2013
➤ <i>May 2009</i> – CMS releases <i>HCAHPS Bulletin 2009-01 Revised</i> , “The Use of HCAHPS in Conjunction with Other Hospital Inpatient Surveys”	March 2013
➤ <i>July 2009</i> – Sixth Public Reporting of HCAHPS results (Patients discharged October 2007 – September 2008)	March 2013
➤ <i>August 27, 2009</i> – The final IPPS rule is published, which stipulates the continued requirement for IPPS hospitals to continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines posted on www.hcahpsonline.org	March 2013
➤ <i>September 2009</i> – Seventh Public Reporting of HCAHPS results (Patients discharged January 2008 – December 2008)	March 2013
➤ <i>December 2009</i> – Eighth Public Reporting of HCAHPS results (Patients discharged April 2008 – March 2009)	March 2013
2010	
➤ <i>March 2010</i> – The <i>HCAHPS Quality Assurance Guidelines V5.0</i> is released	March 2013
➤ <i>March 2010</i> – <i>Introduction to HCAHPS Training</i> and <i>HCAHPS Update Training</i> are conducted, via Webinar	March 2013
➤ <i>March 2010</i> – Ninth Public Reporting of HCAHPS results (Patients discharged July 2008 – June 2009)	March 2013
➤ <i>April 2010</i> – HCAHPS is named in Section 3001 of the Patient Protection and Affordable Care Act of 2010	March 2013
➤ <i>June 2010</i> – Tenth Public Reporting of HCAHPS results (Patients discharged October 2008 – September 2009)	March 2013
➤ <i>August 16, 2010</i> – The final IPPS rule is published, which stipulates the continued requirement for IPPS hospitals to continuously collect and submit HCAHPS data to the QIO Clinical Warehouse by the data submission deadlines posted on www.hcahpsonline.org	March 2013
➤ <i>September 2010</i> – Eleventh Public Reporting of HCAHPS results (Patients discharged January 2009 – December 2009)	March 2013
➤ <i>December 2010</i> – Twelfth Public Reporting of HCAHPS results (Patients discharged April 2009 – March 2010)	March 2013
➤ <i>December 2010</i> – CMS releases the <i>HCAHPS Bulletin 2010-01</i> “HCAHPS and Hospital Value Based Purchasing”	March 2013
2011	
➤ <i>March 2011</i> – The <i>HCAHPS Quality Assurance Guidelines V6.0</i> is released	March 2013
➤ <i>March 2011</i> – <i>Introduction to HCAHPS Training</i> and <i>HCAHPS Update Training</i> are conducted, via Webinar	March 2013
➤ <i>April 2011</i> – Thirteenth Public Reporting of HCAHPS results (Patients discharged July 2009 – June 2010)	March 2013
➤ <i>May 6, 2011</i> – The final Hospital Value Based Purchasing rule is published (<i>Federal Register / Vol. 76, No. 88 / Friday, May 6, 2011 / Rules and Regulations</i>)	March 2013

<u>March 2013</u>	<u>Introduction and Overview</u>
	<ul style="list-style-type: none"> ➤ <i>July 2011</i> – Fourteenth Public Reporting of HCAHPS results (Patients discharged October 2009 – September 2010) ➤ <i>August 18, 2011</i> – The final IPPS rule is published (<i>Federal Register / Vol. 76, No. 160 / Thursday, August 18, 2011 / Rules and Regulations</i>) ➤ <i>October 2011</i> – Fifteenth Public Reporting of HCAHPS results (Patients discharged January 2010 – December 2010)
2012	
	<ul style="list-style-type: none"> ➤ <i>January 2012</i> – Sixteenth Public Reporting of HCAHPS results (Patients discharged April 2010 – March 2011) ➤ <i>March 2012</i> – The <i>HCAHPS Quality Assurance Guidelines V7.0</i> is released ➤ <i>March 2012</i> – <i>Introduction to HCAHPS Training and HCAHPS Update Training</i> are conducted, via Webinar ➤ <i>Spring 2012</i> – Seventeenth Public Reporting of HCAHPS results (Patients discharged July 2010 – June 2011) ➤ <i>July 2012</i> – Eighteenth Public Reporting of HCAHPS results (Patients discharged October 2010 - September 2011) ➤ <i>July 1, 2012</i> – <i>Voluntary use of the HCAHPS Expanded survey begins with July 1, 2012 discharges</i> ➤ <i>August 31, 2012</i> – The final IPPS rule is published (<i>Federal Register / Vol. 77, No. 170 / Friday, August 31, 2012 / Rules and Regulations</i>) ➤ <i>October 2012</i> – Nineteenth Public Reporting of HCAHPS results (Patients discharged January 2011 – December 2011) ➤ <i>December 2012</i> – Twentieth Public Reporting of HCAHPS results (Patients discharged April 2011 – March 2012)
2013	
	<ul style="list-style-type: none"> ➤ <i>January 2013</i> – Required use of the 32-item HCAHPS survey ➤ <i>March 2013</i> – The <i>HCAHPS Quality Assurance Guidelines V8.0</i> is released ➤ <i>March 2013</i> – <i>Introduction to HCAHPS Training and HCAHPS Update Training</i> are conducted, via Webinar ➤ <i>April 2013</i> – Twenty-first Public Reporting of HCAHPS results (Patients discharged July 2011 – June 2012) ➤ <i>July 2013</i> – Twenty-second Public Reporting of HCAHPS results (Patients discharged October 2011 – September 2012) ➤ <i>October 2013</i> – Twenty-third Public Reporting of HCAHPS results (Patients discharged January 2012 – December 2012) ➤ <i>December 2013</i> – Twenty-fourth Public Reporting of HCAHPS results (Patients discharged April 2012 – March 2013)

Appendix 3.2: March 2013 HCAHPS English Survey Tool (from HCAHPS, 2013)

HCAHPS Survey**SURVEY INSTRUCTIONS**

- ◆ You should only fill out this survey if you were the patient during the hospital stay named in the cover letter. Do not fill out this survey if you were not the patient.
- ◆ Answer all the questions by checking the box to the left of your answer.
- ◆ You are sometimes told to skip over some questions in this survey. When this happens you will see an arrow with a note that tells you what question to answer next, like this:

Yes
 No → **If No, Go to Question 1**

You may notice a number on the survey. This number is used to let us know if you returned your survey so we don't have to send you reminders.

Please note: Questions 1-25 in this survey are part of a national initiative to measure the quality of care in hospitals. OMB #0938-0981

Please answer the questions in this survey about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

¹ Never
² Sometimes
³ Usually
⁴ Always

2. During this hospital stay, how often did nurses listen carefully to you?

¹ Never
² Sometimes
³ Usually
⁴ Always

3. During this hospital stay, how often did nurses explain things in a way you could understand?

¹ Never
² Sometimes
³ Usually
⁴ Always

4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

¹ Never
² Sometimes
³ Usually
⁴ Always
⁹ I never pressed the call button

YOUR CARE FROM DOCTORS		YOUR EXPERIENCES IN THIS HOSPITAL	
<p>5. During this hospital stay, how often did doctors treat you with <u>courtesy and respect</u>?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>		<p>10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?</p> <p> ¹<input type="checkbox"/> Yes ²<input type="checkbox"/> No ➔ If No, Go to Question 12 </p>	
<p>6. During this hospital stay, how often did doctors <u>listen carefully to you</u>?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>		<p>11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>	
<p>7. During this hospital stay, how often did doctors <u>explain things</u> in a way you could understand?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>		<p>12. During this hospital stay, did you need medicine for pain?</p> <p> ¹<input type="checkbox"/> Yes ²<input type="checkbox"/> No ➔ If No, Go to Question 15 </p>	
<p>8. During this hospital stay, how often were your room and bathroom kept clean?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>		<p>13. During this hospital stay, how often was your pain well controlled?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>	
<p>9. During this hospital stay, how often was the area around your room quiet at night?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>		<p>14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?</p> <p> ¹<input type="checkbox"/> Never ²<input type="checkbox"/> Sometimes ³<input type="checkbox"/> Usually ⁴<input type="checkbox"/> Always </p>	

15. During this hospital stay, were you given any medicine that you had not taken before?

Yes
 No ➔ If No, Go to Question 18

16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?

Never
 Sometimes
 Usually
 Always

17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?

Never
 Sometimes
 Usually
 Always

WHEN YOU LEFT THE HOSPITAL

18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?

Own home
 Someone else's home
 Another health facility ➔ If Another, Go to Question 21

19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?

Yes
 No

20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

Yes
 No

OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

0 Worst hospital possible
 1
 2
 3
 4
 5
 6
 7
 8
 9
 10 Best hospital possible

22. Would you recommend this hospital to your friends and family?

- 1 Definitely no
- 2 Probably no
- 3 Probably yes
- 4 Definitely yes

**UNDERSTANDING YOUR CARE
WHEN YOU LEFT THE HOSPITAL**

23. During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

- 1 Strongly disagree
- 2 Disagree
- 3 Agree
- 4 Strongly agree

24. When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

- 1 Strongly disagree
- 2 Disagree
- 3 Agree
- 4 Strongly agree

25. When I left the hospital, I clearly understood the purpose for taking each of my medications.

- 1 Strongly disagree
- 2 Disagree
- 3 Agree
- 4 Strongly agree
- 5 I was not given any medication when I left the hospital

ABOUT YOU

There are only a few remaining items left.

26. During this hospital stay, were you admitted to this hospital through the Emergency Room?

- 1 Yes
- 2 No

27. In general, how would you rate your overall health?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

28. In general, how would you rate your overall mental or emotional health?

- 1 Excellent
- 2 Very good
- 3 Good
- 4 Fair
- 5 Poor

29. What is the highest grade or level of school that you have completed?

- 1 8th grade or less
- 2 Some high school, but did not graduate
- 3 High school graduate or GED
- 4 Some college or 2-year degree
- 5 4-year college graduate
- 6 More than 4-year college degree

<p>30. Are you of Spanish, Hispanic or Latino origin or descent?</p> <p> ¹<input type="checkbox"/> No, not Spanish/Hispanic/Latino ²<input type="checkbox"/> Yes, Puerto Rican ³<input type="checkbox"/> Yes, Mexican, Mexican American, Chicano ⁴<input type="checkbox"/> Yes, Cuban ⁵<input type="checkbox"/> Yes, other Spanish/Hispanic/Latino </p> <p>31. What is your race? Please choose one or more.</p> <p> ¹<input type="checkbox"/> White ²<input type="checkbox"/> Black or African American ³<input type="checkbox"/> Asian ⁴<input type="checkbox"/> Native Hawaiian or other Pacific Islander ⁵<input type="checkbox"/> American Indian or Alaska Native </p>	<p>32. What language do you <u>mainly</u> speak at home?</p> <p> ¹<input type="checkbox"/> English ²<input type="checkbox"/> Spanish ³<input type="checkbox"/> Chinese ⁴<input type="checkbox"/> Russian ⁵<input type="checkbox"/> Vietnamese ⁶<input type="checkbox"/> Some other language (please print): _____ </p>
--	--

THANK YOU

Please return the completed survey in the postage-paid envelope.

[NAME OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

[RETURN ADDRESS OF SURVEY VENDOR OR SELF-ADMINISTERING HOSPITAL]

Questions 1-22 and 26-32 are part of the HCAHPS survey and are works of the U.S. Government. These HCAHPS questions are in the public domain and therefore are NOT subject to U.S. copyright laws. The three Care Transitions Measure® questions (Questions 23-25) are copyright of The Care Transitions Program® (www.caretransitions.org).

Appendix 4.1: Quality Account Indicator Matrix (Adapted for display)

Developing our quality account 2010/11						
	Quality Accounts 2009/10	Trust Priority	CQUIN indicator	Operating Framework	NHS Quality Standard	NHS Outcomes Framework
1	VTE	✓	✓	✓	✓	✓
2	CHAI	✓	✓	✓		✓
3	Pressure Ulcers	✓	✓	✓		✓
4	Improving Pat Exp	✓	✓		✓	
5	End of Life care	✓	✓	✓		
6	Dementia		✓	✓		✓
...	Patient Experience		✓	✓	✓	✓

Appendix 4.2: TCAB and Productive Series Modules

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Annex 4.3: New Consultant Development Programme Agenda (adapted)

Consultant Leadership Development Programme 2010									
Session 1	Session 2	Session 3	Session 4	Session 5	Session 6	Session 7	Session 8	Session 9	Session 10
Th. 14 Jan, 9am - 5pm YMCA	Th. 11 Feb, 12:30am - 5pm	Fr. 5 Mar 12:30pm - 5pm	We 21 Apr, 9am - 5pm Th 22 Apr, 9am - 1pm	Tu 18 May 12:30pm - 5pm	We 23 Jun 12:30pm - 5pm	Tu 20 Jul 9am – 5pm YMCA	We 8 Sep 12:30pm - 5pm	Tu 5 Oct 12:30pm - 5pm YMCA	Mo 22 Nov 10am – 6pm, 6pm – 10pm
Launch (includin g LEA briefing	Understa nding Myself	Improvin g Commun ication and influenc ing skills	LEA Feedbac k	Doctors and manager s working together	Understa nding change	Improve ment Methods	Negotiat ing skills	Understa nding the money	CLOSE
Contributors Confidential									

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