*Social Policy & Society 9:1, 13–24*
 doi:10.1017/S1474746409990169

# The Risks of Managing Uncertainty: The Limitations of Governance and Choice, and the Potential for Trust

**Patrick Brown* and Michael Calnan****

**Research Associate, School of Social Policy, Sociology and Social Research University of Kent*
*E-mail: p.r.brown@kent.ac.uk*

***Professor of Medical Sociology, School of Social Policy, University of Kent*

*The inherent problems and limitations of managing risk and uncertainty are examined in a salient case setting – the English NHS. The 'dark-side' of simply trusting professionals to pursue their own craft, as acknowledged by Sennett, has been politicised to under-gird an increased use of quasi-markets, via the choice agenda, and governance. It is argued that these alternatives to trust – price and control – are further dysfunctional still. The innate tendencies of governance, and therefore choice, to lose sight of patient care are even more pronounced than the fallibility of professionals. A new, qualified form of trust is proposed in resolution.*

## Introduction – the 'dark-side' of work and trust

The management of risk has become the over-riding concern of late-modern social policy (Kemshall, 2002) in the UK and nowhere is this more evident than in the English National Heath Service (NHS). Notions of risk and corresponding uncertainty are at the very core of medical practice – in its application of evolving technology and expertise in seeking to alleviate morbidity and mortality. Whilst *prima facie* this management of the risk of illness to the patient is scientific, many have noted the 'artistry of medicine' (Schön, 1983), emphasising the extent to which medical knowledge is acquired and honed through hands-on practice (Nettleton *et al.*, 2008). Yet this craftsmanship of dealing with the risks of illness has been seen to produce its own risks. Sennett (2008: 6) notes the potential for work to become an end in itself to the extent that the over-arching effects of the craft come to be of secondary importance. Such unacceptable practice became all too evident within the infant cardiac surgery department at Bristol in the 1990s where mortality rates were far higher than should have been the case: 'A tragedy took place. But it was a tragedy born of high hopes and ambitions, and peopled by dedicated, hard-working people. The hopes were too high; the ambitions too ambitious' ('Learning from Bristol' inquiry report quoted in Alaszewski, 2002).

The Bristol disaster, along with other dysfunctions within the NHS in the late 1990s has led to an increasingly stringent form of risk management. Whilst medicine, as already stated, is inescapably about managing uncertainty, an increasingly systematic and expansive form of risk governance has been rolled out across the NHS in order to avoid repeats of situations where clinical craft loses sight of patient safety and quality of care. Whereas trust, on the one hand, deals with the inherent unknowableness of

the future (Keynes, 1921) by assuming away aspects of uncertainty (Möllering, 2006), risk management seeks to bring a certain degree of measurability to expectations, even though certainty about the future is impossible. In this way, risk reflects how 'the nature of modern culture, especially its technical and economic substructure, requires precisely such "calculability" of consequences' (Weber, 1978: 351).

Accordingly, an audit culture, centring round clinical governance, has enveloped the NHS as a means of holding practitioners accountable for the secondary consequences (patient outcomes) of their clinical work (Scally and Donaldson, 1998). The origins of this culture, and indeed clinical governance, are wider, more complex and date back further than Bristol and the mid to late1990s. Geographical variations in care as underlined in the Calman and Hine (1995) report, increasing litigation costs and a longer-running interest in performance monitoring, accountability and audit – as epitomised in New Public Management – were fundamental in the emergence of the audit society. Yet the risk-focused rhetoric and format by which clinical governance and associated policies have been implemented has been specifically politicised and driven as a means to warding against the risks clinicians have been perceived to pose (Alaszewski, 2002) – both to patients and an effective, efficient NHS.

From a 'transaction cost economics' perspective – where exchanges of goods, services or knowledge can be facilitated within a market (via price), organisation (through control systems) or via trust – there has been a move away from this latter mode due to the levels of uncertainty it assumes away. Hence, although trust is by far the most efficient of the three approaches (Arrow, 1974), acting as a lubricating force (Fukuyama, 1995), the risks of leaving clinicians to their own 'work' have come to be perceived as too great. Correspondingly distrust becomes a means of 'guarding against the abuse of power' (Gilson, 2006: 370) and in a late modernity, where danger and uncertainty are less tolerated (Furedi, 1997), governance frameworks offer a means of pursuing certainty and managing risk through calculability and stipulation.

This paper will look at the turn away from trust within the NHS and assess the effectiveness of its successors. Whilst Bristol and other disasters have highlighted the 'dark side of trust' (Connell and Mannion, 2006) – where the legitimacy and motivations of professionals have been questioned within a context of wider economic constraints – moves towards the increased use of control and quasi-markets have their own 'dark sides', which have received much less attention and scrutiny from policy makers. The problematic nature of organisational and then marketised approaches will be considered in turn. Le Grand (2007), in his case for the utility of the latter, argues that what is actually required is a combination of choice/competition, control *and* trust in the running of the NHS. A third section will consider this position, contesting the existing paucity of trust applied within the NHS and underlining the dangers of the other two modes.

## Command and control: medicine by numbers

*The New NHS: Modern, Dependable* (DoH, 1997) and key follow up white papers (DoH, 1998, 2000, 2001) have a particular understanding of how things have gone wrong within clinical practice, which is similar to the concerns raised by Sennett (2008) already referred to. Left to individuals and small clinical teams, the practice of medicine in its parochial, craft-like state was too dependent on local expertise; hence, the potential for losing sight of best practice and optimal patient outcomes. The solution proposed by these policies was



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

essentially the setting and monitoring of protocols, targets and performance measures in order to achieve a much more standardised, nationally homogenous practice of medicine across the NHS.

This move towards a more scientific-bureaucratic form of clinical practice (Harrison, 2002) has, therefore, sought to remove elements of uncertainty and variability associated with the craftsman-type model (Harrison and Smith, 2004) – in seeking to mitigate perceptions of risk associated with this. To the extent that medicine is not an art or craft, and that it is purely about the instrumental application of abstract knowledge, this move can be said to be purely positive. However, a number of critiques have highlighted the potential limitations of this bureaucratisation of medicine (Flynn, 2002) due to its inability to account for the wider, more human aspects of patient outcomes. Healthcare is inescapably about suffering, emotions, social values and norms, which the instrumental rationality of science and bureaucracy are unable to account for (Brown, 2008a). Thus, the argument develops that bureaucratised medicine is a poorer, reductive, least-worst quality of medicine, in that the aspects which are immeasurable, but are nonetheless exceedingly important to patient experience, are neglected. So whilst command and control may offer a more modern and dependable medicine, this might polemically be understood as leading to a one-dimensional (Marcuse, 1964) NHS: inhumane and valueless.

To return again to some of the notions raised by Sennett, whilst the possibility exists that the craftsman loses himself in the work to the extent that 'nothing else matters' (2008: 6), so too may notions of the human become lost in the midst of bureaucracy to the extent that only 'convention, efficiency and "internal coherence"' (Marcuse, 1989: 121) come to be of significance. Such an account is a classic tale of the Weberian iron cage where, as with craftsmanship, man-made things inherently develop dysfunctional tendencies. In the interests of patient outcomes, the fundamental assumptions behind the efficacy of command and control are (a) that the stipulations/protocols and targets/performance management are capable of accurately representing quality patient care, and (b) that these same protocols and targets are capable of achieving high levels of compliance/achievement amongst practitioners (Brown, 2008b).

Regarding the first of these suppositions, Rothstein (2006), amongst others, sets out a compelling argument of how the internal logic of risk regulation inherently tends towards the minimisation of risk posed towards the institution, rather than towards the individuals served by this institution. Risk is applied as a basis of governance due to its apparent incontrovertibility and probabilistic acknowledgment of the potential for failure in attempting to manage these problems. The more effectively and precisely such governance is carried out, the more sensitive institutions become towards the potential negative consequences of failing to successfully manage risks – '"good governance" gives rise to risk itself' (ibid: 217). Transforming a wide array of social problems into *problems of risk* assists the institutions with the accountability and liability of their decision making (institutional risk) though may compromise their ability to deal effectively with the practice on the ground (societal risks). Hence the effects of this defensive process are essentially two fold – an increasing 'risk colonisation' of institutions and policy on the one hand, and equally worryingly a tendency within this growth of governance to seek to minimise 'institutional risks' ahead of those risks faced by society on the other (Power, 2003).

This highly devolved, abstracted management promotes a closed, circularity of quality (Lindeberg, 2005), where the importance of the patient is lost under the multi-tiered bureaucracy of the system (Power, 1997). This means that assumption (b) (above) of



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

this form of performance and risk management is more likely to be flawed (Brown, 2008b). Command and control suggests just that; yet as a growing literature has shown, both empirically (e.g. Public Administration Select Committee, 2003; Som, 2005) and theoretically (Gallivan and Depledge, 2003; Bevan and Hood, 2006), there is a limit to the extent to which a culture of targets and audits can assure compliance and, therefore, performance. The undermining of control mechanisms is likely to increase where the new frameworks are seen to compromise the craftsmanship[1] or artistry of medicine (Brown, 2008b), as it is these aspects which give meaning to practitioners' actions and it is meaning, values and norms which govern individuals' actions (Habermas, 1987).

### Choice and competition: incentivising control

In summary, command and control approaches are based on the proposition that simply trusting in healthcare professionals to carry out their craft opens up the proverbial Pandora's Box (Sennett, 2008) of what happens when 'work' becomes separated from, and more important than, patients' best interests. Yet, as has been seen in the preceding section, the systems designed to safeguard against this happening are, by their very nature, subject to their own means of diverging from patient interest and, through their powers of compulsion, may engender larger numbers of professionals being distracted from optimal patient outcomes. For even where a lack of meaning within bureaucratic stipulations and measures compromises their power to compel compliance in a substantive sense, the bureaucratic burden necessitates a 'blind self-preservation' (Habermas, 1984: 398) form of superficial compliance within these structures. This distraction remains significant (Royal College of Nursing, 2008).

The limitations of command and control, and trust, lead Le Grand (2007) and others to advocate systems that seek to assure and improve healthcare quality primarily through choice and competition – the market. This model, it is argued, 'fulfils the principle of autonomy, and promotes responsiveness to users' needs and wants; it provides incentives for providers to provide both higher quality and greater efficiency; and it is likely to be more equitable than alternatives' (ibid: 42). Thus, whilst craftsmanship and bureaucracy are flawed through their human involvement and design, it would seem that the market – in its supra-human nature – is beyond these vulnerabilities.

Le Grand accounts for both those workers whose motives are keenly focused on the patient (knights) as well as those who have been distracted away from these interests (knaves): 'Knavish providers will want to attract users because their livelihoods and thus self-interest depends on it. But knightly ones will also want to stay in business so that they can continue to provide a service of benefit to users. So they too will want to provide services that attract users' (ibid: 44). Latent within this basis of arguments for market incentives is the assumption that the 'providers' who benefit from the market are synonymous with those 'providing' the healthcare.

Of course, this is far from the case and those who run the healthcare trusts (the local healthcare provider organisations in the UK) have a somewhat distanced relationship from the professionals on the ground. Nevertheless, as Le Grand describes, the incentive is there for the organisations to maximise the quality and efficiency of their provision. The dilemma remains as to how those responsible for the local providers (chief executives and senior management) ensure that practitioners on the ground practice in a way that offers sufficient quality and value for money. The answer is through control mechanisms and,



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

therefore, we return to the initial problematic nature of performance frameworks, merely at a different organisational level. For the 'invisible hand' is a human hand after all.

The alternative to such intra-organisational or intra-departmental command and control would be to invoke further internal competition and performance-related pay. Were this an industry dealing with the straightforward manufacturing of consumer durables, or aircraft maintenance (DoH, 2001), then such rewards/penalties would be straightforward. However, difficulties surrounding the comparability of cases and measuring 'quality' in healthcare make this massively complex. The choice of what to reward, and to what value, becomes a significant bureaucratic exercise in itself. Due to the humanity of not only the subjects but also the objects of this work, the likelihood of trade-offs between efficiency and safety and/or quality of patient experience remain high. The immeasurability of patient experience makes it inevitable that neither the market nor control mechanisms are sufficiently able to adequately ensure that what matters is rewarded or audited (Kennedy, 2004: 162) – such is the intricacy of health, illness and the subjective human disposition that experiences it. So whilst the choice and competition agenda might well be popular with the electorate (Le Grand, 2007), this should not be confused with popularity amongst patients. The vulnerability which separates the latter from the former necessitates a trust which is won through patient-focused care and embodied expertise (Calnan and Sanford, 2004) – two qualities which are not easily commodifiable.

The new GP contract and the associated Quality and Outcomes Framework (QOF) represent one apparent success story to the contrary. For in their largely self-employed position and the linking of 'performance' to pay (at least in certain respects) through QOF, the problematic distance between provider-as-contractor and provider-as-carer is minimal, and therefore there is no command and control required to link one to the other. Initial research in this area does suggest though that even in this context there are moves towards a 'top-down' approach within larger practices, with correspondingly negative effects on motivation (McDonald *et al.,* 2008). Moreover, the initial diagnosis/referral setting, public health goals and management of chronic illness typical within General Practice are arguably more amenable to standards, reward and risk-management protocols than is the case in acute healthcare. This means that GPs are better able to work within new governance frameworks, whilst maintaining a narrative of 'holistic practice' (Checkland *et al*., 2008).

This does not seem to be the case for hospital-based professionals (Brown, 2008c). In terms of the riskiness of acute medicine, Schön (1983) observes the frequency of anomalous situations that require a reflective, creative approach. Such scenarios for which protocol is insufficient (Alaszewski and Brown, 2007) underline the danger of an over-reliance on standardised (through bureaucracy or the market) means of delivering healthcare – for 'routines tend to become increasingly dysfunctional over time: not only do they fail to adjust to new circumstances but "shortcuts" gradually intrude, some of which only help professionals to cope with pressure at the expense of helping their clients' (Eraut, 1994:112). It is in this sense that the case for craftsmanship re-emerges.

### Markets, hierarchy *and* trust: towards the lesser of three evils

To err is human, as indeed it is to fall ill. So far, this paper has noted the potential for pathological tendencies to develop within trust, hierarchies and markets due to their



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

human components and therefore the likelihood of distractions away from optimal patient care – through too overt a focus on the craft itself, or through the need to satisfy performance measures/market pressures which are unable to adequately represent 'quality'. Given that each of the options when assessed separately is so clearly flawed, it is of little surprise that the current NHS employs a mixture of all three.

Indeed Le Grand (2007), in his treatise on the merits of choice and competition acknowledges the necessity and inevitability of a mixture of means of managing transaction costs, though he argues of course in the direction of markets. Similarly, Darzi (2008), in his NHS review, recommends the increased use of choice in driving NHS quality and in so doing fulfils Le Grand's criteria that such choice should be as free and informed as possible. Hence the proposition of hospital dashboards which would present neat accounts of a hospital's performance in areas such as Accident and Emergency waiting times, or infection control.

Media coverage over the last decade has made these two issues, perhaps above all others, fundamental to how hospitals are judged and critiqued. Ensuring that patients can choose to avoid an MRSA-ridden hospital would obviously send signals, via the invisible hand of the market, that serious action ought to be taken by managers. These managers would therefore, in consulting experts on infection control, realise that alcohol was the most cost-effective way of minimising MRSA and so administer a compulsory hand-washing scheme. This laissez-faire and risk-responsive system sounds ideal – until it is discovered that the distraction away from soap and water, combined with over-crowding to minimise waiting times, proliferates *Clostridium-difficile*.

Similarly with waiting times, it has become apparent that A&E staff, left to their own craft, develop inefficient tendencies which mean that patients wait overly long for treatment. By ensuring that patients wait no longer than a stipulated time (four hours), and attaching financial incentives/sanctions to this, efficiency is improved. Yet this also means that 'gaming' develops around this four hour time (Bevan and Hood, 2006) and that a patient with a minor complaint who has been waiting three hours 45 minutes is seen ahead of a more recently arrived patient with chest pains (posing very serious risk). Later on, this 'heart' patient is moved temporarily to a respiratory ward in order to clear beds, before later being finally moved to the appropriate unit. This bed shifting puts the patient at greater risk due to the lack of appropriate care in the respiratory ward and further fosters *C-diff* through the increased moving of patients.

These two anecdotes, based on interviews with professionals (Brown, 2008c), beg the question: Do the distractions (or risks) generated by markets and hierarchies develop to become more grievous than the initial risks associated with craftsmanship? Proponents of markets and hierarchies would no doubt acknowledge these weaknesses but point to the substantial efficiency gains, for example in reducing long waiting times. Yet the gaming referred to in the previous paragraph questions the validity of this evidence. That one third of A&E doctors admit to regularly fabricating figures (BMA, 2007) suggests the possibility of an epistemological fallacy surrounding the success of performance frameworks and/or market incentives.

The two examples also add credence to Rothstein's (2006) analysis suggesting risk-management practices tend towards deflecting institutional risk (towards political capital as a result of media criticism over waiting times or infections) rather than necessarily minimising risk to individuals in society – in this case the patient. Because institutional risks are not able to be reconciled with societal risks, in that the former are constructed



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

by the media and accordingly distorted, this inevitably leads to a divergence which in cases may well exacerbate risks to patients. However the need to be *seen* to be 'doing something' is one aspect where markets and hierarchies are strongly preferable, in that relying on trust as a means of fending against uncertainty inevitably tends, *prima facie*, towards doing very little. Risk management, on the other hand, is a visibly active (if often dysfunctional) way of seeking to deal with the 'unknowable' of the future (Keynes, 1921) – as applied explicitly through bureaucracy or as incentivised via choice and competition.

This tendency towards policy 'meddling'/risk deflecting, combined with the epistemological fallacy over the positive effects of market/control incentives, means that the efficacy of trust is over-looked and under-estimated. Thus, whilst a means of organising transactions facilitated purely by trust would be unfeasible and dangerous, the undervaluing of trust in current policy and proposals means the 'mixture' is skewed towards markets and hierarchy. As noted in the introduction, trust is cheaper than markets and hierarchies due to the lack of bureaucracy entailed, with the costs of the latter two mechanisms becoming further apparent when their multiplier effects are considered. Because trust and control are not simply alternatives but dialectically linked (Gallivan and Depledge, 2003), imposing control (or market) mechanisms erodes the trusting and altruistic behaviour of those working within these frameworks, changing the way they relate to these frameworks and thus undermining the application of the control mechanisms. As attempts at control (to combat this) are increased further, the more these mechanisms are seen as illegitimate and circumvented or subverted (Brown, 2008b). Whilst Le Grand (2003; 2007) acknowledges this possibility of knights being made more knavish, the seriousness of its impact is seemingly underestimated due to the epistemic problems already described.

The NHS has been discussed thus far largely in terms of its service provision, yet it is of course very much a *learning organisation* as well – this aspect being central to its ability to provide low-risk, high-quality healthcare. Although the inevitability of a mixture of markets, hierarchies and trust has been acknowledged, Pilgrim and Sheaff (2006) point out that in many cases the contradictory combination of increased marketisation and extended bureaucratisation leads to a paradoxical environment where 'organisations are permitted, nay encouraged to learn, but not too much and not too openly' (ibid: 10). Whilst trust may (again) be the most effective of the three bases for facilitating mutual learning within the 'knowledge economy' (Adler, 2001), clinical governance – which has been placed at the heart of recent knowledge and quality strategies within the NHS – fails to harness this trust, relying instead on the bureaucratisation of medicine (Flynn, 2002). The rhetoric around clinical governance would suggest it is a newer form of 'soft' (Ferlie and Geraghty, 2005) 'new public management', yet in practice – through its use of monitoring and surveillance and its perceived muddling with wider efficiency/performance drives – it manifests itself as a harder, more traditional form of NPM (Brown, 2008c).

## Discussion: promoting inclusion, consultation and ownership

Choice is an increasingly advocated basis of healthcare provision in several European welfare states (e.g. Blomqvist, 2004; Propper *et al*., 2006). In England, the recent review of the NHS also conceives choice as a key guiding principle to assure the quality of healthcare provision (Darzi, 2008). The Darzi review (ibid) further underlines the importance of listening to professionals and giving them an increased say in how services



https://doi.org/10.1017/S1474746409990169 Published online by Cambridge University Press

are organised and run. The arguments and evidence presented in this paper would suggest that these two tenets, whilst well intentioned, may lead to conflicting aims and muddled policies. For whilst choice and corresponding competition may, *prima facie,* offer patients better services (though evidence for this is limited and highly contestable), the dysfunctional attributes of command and control are inevitably incentivised through allowing patients to choose.[2]

These tensions become further evident when trust is brought into the equation. Recent UK policies have recognised the importance of the concept (e.g. DoH, 2007) not only in terms of patient experience, but also equally in facilitating professional autonomy to practice their craft. Yet this rhetorical stance is not reflected in the substance of policies which, through their monitoring, surveillance and requirements for revalidation, demonstrate the deficiency of trust in these same practitioners. The pressures exerted through the system in order to verify good craftsmanship and ensure competitiveness correspondingly affect trust between managers and professionals, professionals and patients and amongst professionals themselves (Calnan and Rowe, 2008). The transaction and checking costs are most visible in the bureaucratic and organisational distractions away from the patient. So whilst the patient may have greater choice in being able to avoid institutional risks and poor performance, because their individual experience is profoundly shaped by trust, which in turn is dependent on communicative interactions with their professionals (Brown, 2008a), their actual experience of healthcare is not necessarily enhanced. Rather it may in fact be compromised by choice (albeit indirectly), where 'choice becomes a "new paternalism" in which the availability of a patient-centred service, a high priority for users, does not figure on the agenda of providers' (Taylor-Gooby, 2008: 165).

Good healthcare, in order to be efficient, safe and effective must harness trust to a greater extent than is currently the case. It has been argued here that whilst pure reliance on trust may be ineffective at managing risk, performance and knowledge – the alternatives may be more problematic still. Hence, good governance – that which embraces trust – will be able to optimise efficiency (Arrow, 1974) and learning (Adler, 2001) through inclusion, consultation and therefore ownership. Such means of regulating the craft of medicine will be more effectual in reaching these goals through being more able to win the concordance and facilitate the cooperation of professionals due to the increased legitimacy of these frameworks (Brown, 2008b).

Rather than a mere reversion to old ways, a new form of 'conditional' (Calnan and Rowe, 2008) and 'reflective' (Adler, 2001) trust (i.e. informed rather than 'blind') – earned rather than assumed – would enable a more patient-centred form of care. Such trust fosters ownership, responsibility and community and is therefore 'increasingly recognized as the organizational principle most effective in generating and sharing new knowledge' (ibid: 220). Late modernity's heightened awareness of the fallibility of expertise, which has given rise to the governance and choice agendas, is precisely that which can enable this more reflexive (self-confronting) and risk-aware form of trust; one which is actively qualified in relation to specific risks, rather than blind (Lewis and Weigert, 1985) or ambivalent towards uncertainty.

As with any form of risk management, a more thorough analysis must include an understanding of the way risk has been politicised and applied in the first place. The use of Bristol and other dysfunctions in constructing a political problem around the dark side of trusting in/relying on the craftsmanship of medicine has created its own

Pandora's box, which, due to the manner in which risk management works to minimise institutional criticism (Rothstein, 2006), is less open to being politicised itself. Thus, there exist more fundamental questions towards medical regulation and professional autonomy than simply providing, or being seen to provide, the least 'risky' form of medical care. 'Thus tensions and conflicts of interests are deeply embedded in the demands on professions, and release ongoing dynamics into the health system and the health workforce. These tensions cannot simply be overcome by individual actors, whether professionals or service-users. They can, however, be reduced or reinforced by different models of state regulation' (Kuhlmann, 2006: 33).

These tensions, however, may have created, as Freidson (2001) has argued, a form of professionalism where the professional acts as a mediator officiating over the interests of the state and serving the needs and demands of the public. The benefits of such a role, according to Freidson (2001), are to ensure trust in public services and reduce the costs of governmental action and control. Thus, in the context of general practice in the English NHS a new type of GP may be emerging, such as a street-level bureaucrat (Checkland, 2004), who mediates between the managerial world of guidelines, evidence-based medicine and performance indicators and the professional practice of every-day medicine, or a public service entrepreneur, who adopts the values of the market to meet the needs of patients, while not being driven by the profit motive (Boyce, 2008). The latter would represent a hybrid of contrasting positions in the literature on professionalism, illustrating the view of occupations as driven primarily by self-interest and the need for power, status and material wealth and by altruism and the need to put the interests of the patient first (Saks, 1995; Calnan *et al*., 2000). This may account for the continued high level of public trust in clinicians, despite the change in the nature of trust relations between doctors and their patients (Calnan and Rowe, 2008).

In this light, the analysis presented here – in recognising the artistry (Schön, 1983), embodied learning (Nettleton *et al*., 2008) and craftsmanship of medicine – suggests that 'to ask why societies incorporate their knowledge in professions is thus not only to ask why societies have specialised lifetime experts, but to ask why they place expertise in people rather than things or rules' (Abbott, 1988: 323). Rules and mechanisms are clearly necessary, yet unable to account for, or ensure, the communicative aspects that are so crucial to positive patient outcomes. So whilst people are surely fallible, the increased application of a new form of late-modern trust – qualified and reflexive – may help attenuate the more significant risks of its alternatives.

## Acknowledgement

The authors are grateful for the feedback given when an earlier version of this paper was presented at the European Health Policy Group meeting at LSE, September 2008.

## Notes

1 The notion of 'craft' work in medicine applied here is in its broader sense, similar to that used by Sennett (2008), to refer to highly specialised *praxis* which draws on refined knowledge and extensive experience. It also includes a certain vocational and moral commitment from which status may be derived. In this sense it is not dissimilar to notions of professionalism, and indeed it could be argued that the professions are merely crafts which have been especially successful in resisting mechanisation/bureaucratisation.

2 Moreover. the evidence of patient and public support for choice is contestable (Calnan and Rowe 2008; Taylor-Gooby, 2008) and its successful implementation is highly complex (Entwhistle *et al*., 1998; National Audit Office, 2005).

## References

**Abbott, A.** (1988), *The System of Professions: An Essay on the Division of Expert Labor*, Chicago: University of Chicago Press.

**Adler, P.** (2001), 'Market, hierarchy, and trust: the knowledge economy and the future of capitalism', *Organization Science*, 12, 2, 215–34.

**Alaszewski, A.** (2002), 'The impact of the Bristol Royal Infirmary disaster and inquiry on public services in the UK', *Journal of Interprofessional Care*, 16, 4, 371–8.

**Alaszewski, A. and Brown, P.** (2007), 'Risk, uncertainty and knowledge', *Health, Risk and Society*, 9, 1, 1–10.

**Arrow, K.** (1974), *The Limits of Organization*, New York: Norton.

**Bevan, G. and Hood, C.** (2006), 'Have targets improved performance in the English NHS?', *British Medical Journal*, 332, 419–22.

**Blomqvist, P.** (2004), 'The choice revolution: privatization of Swedish welfare services in the 1990s', *Social Policy and Administration*, 38, 2, 139–55.

**BMA** (2007), 'Emergency medicine: report of national survey of emergency medicine', available at: http://www.bma.org.uk/ap.nsf/Content/Emergencymedsurvey07findings, accessed 6 December 2007.

**Boyce, R. A.** (2008), 'Professionalism meets entrepreneurialism and managerialism', in E. Kuhlmann and M. Saks (eds.), *Rethinking Professional Governance*, Bristol: Policy Press.

**Brown, P.** (2008a), 'Trusting in the New NHS: instrumental *versus* communicative action', *Sociology of Health and Illness*, 30, 3, 349–63.

**Brown, P.** (2008b), 'Legitimacy chasing its own tail: theorising clinical governance through a critique of instrumental reason', *Social Theory and Health*, 6, 184–99.

**Brown, P.** (2008c), 'The impact of clinical governance and the 'audit culture' on patient trust: the opportunity cost of instrumental rationality', Ph.D. thesis, University of Kent, Canterbury.

**Calman, K. and Hine, D.** (1995), 'A policy framework for commissioning cancer services', a report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales, Department of Health, London.

**Calnan, M. and Rowe, R.** (2008), *Trust Matters in Healthcare*, Buckingham: Open University Press.

**Calnan, M. and Sanford, E.** (2004), 'Public trust in healthcare: the system or the doctor', *Quality and Safety in Healthcare*, 13, 92–7.

**Calnan, M., Silvester, S., Manley, G. and Taylor–Gooby, P.** (2000), 'Doing business in the NHS: exploring dentists' decisions to practise in the public and private sectors', *Sociology of Health and Illness*, 22, 742–64.

**Checkland, K.** (2004), 'National Service Frameworks and UK general practitioners: street-level bureaucrats at work?', *Sociology of Health and Illness*, 26, 951–75.

**Checkland, K., Harrison, S., McDonald, R., Grant, S., Campbell, S. and Guthrie, B.** (2008), 'Biomedicine, holism and general medical practice: responses to the 2004 General Practitioner contract', *Sociology of Health and Illness*, 30, 5, 788–803.

**Connell, N. and Mannion, R.** (2006), 'Conceptualisations of trust in the organisational literature: some indicators from a complementary perspective', *Journal of Health Organisation and Management*, 20, 417–33.

**Darzi, A.** (2008), 'Our NHS, our future', available at www.networks.nhs.uk/news.php?nid=1802, accessed 18 July 2008.

**Department of Health** (1997), *The New NHS, Modern, Dependable* (Cm 3807), London: HMSO.

**Department of Health** (1998), *A first class service – quality in the New NHS*, available at www.dh.gov.uk/assetRoot/04/04/49/41/04044941, accessed 11 November 2005.

**Department of Health** (2000), 'The NHS Plan: a plan for investment, a plan for reform', available at www.dh.gov.uk/assetRoot/04/05/57/83/04055783.pdf, accessed 11 November 2005.

**Department of Health** (2001), *Building a Safer NHS for Patients: Implementing an Organisation with a Memory*', available at www.dh.gov.uk/assetRoot/04/05/80/94/04058094.pdf, accessed 11 November 2005.

**Department of Health** (2007), *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century*, London: TSO.

**Entwistle, V., Sheldon, T., Sowden, A. and Watt, I.** (1998), 'Evidence-informed patient choice: practical issues of involving patients in decisions about health care technologies', *International Journal of Technology Assessment in Healthcare*, 14, 2, 212–25.

**Eraut, M.** (1994), *Developing Professional Knowledge and Competence*, London: Routledge.

**Ferlie, E. and Geraghty, K.** (2005), 'Professionals in public service organisations: implications for public service reforming', in E. Ferlie, L. Lynn and C. Pollitt (eds.), *The Oxford Handbook of Public Sector Management*, Oxford: Oxford University Press, pp. 422–45.

**Flynn, R.** (2002), 'Clinical governance and governmentality', *Health, Risk and Society*, 4, 2 155–70.

**Freidson, E.** (2001), *Professionalism: The Third Logic*, Cambridge: Polity Press.

**Fukuyama, F.** (1995), *Trust: The Social Virtues and the Creation of Prosperity*, London: Penguin.

**Furedi, F.** (1997), *Culture of Fear: Risk Taking and the Morality of Low Expectation*, London: Cassell.

**Gallivan, M. and Depledge, G.** (2003), 'Trust, control and the role of interorganizational systems in electronic partnerships', *Information Systems Journal*, 13, 2, 159–90.

**Gilson, L.** (2006), 'Trust in health care: theoretical perspectives and research needs', *Journal of Health Organisation and Management*, 20, 5, 359–75.

**Habermas, J.** (1984), *Theory of Communicative Action, Volume One: Reason and the Rationalisation of Society*, Boston: Beacon.

**Habermas, J.** (1987), *Theory of Communicative Action, Volume Two: Lifeworld and System: A Critique of Functionalist Reason*, Cambridge: Polity.

**Harrison, S.** (2002), 'New labour, modernisation and the medical labour process', *Journal of Social Policy*, 31, 465–85.

**Harrison, S. and Smith, C.** (2004), 'Trust and moral motivation: redundant resources in health and social care', *Policy and Politics*, 32, 3, 371–86.

**Kemshall, H.** (2002), *Risk, Social Policy and Welfare*, Buckingham: Open University Press.

**Kennedy, H.** (2004), *Just Law: The Changing Face of Justice – and Why It Matters to Us All*, London: Secker & Warburg.

**Keynes, J. M.** (1921), *A Treatise on Probability*, London: Macmillan.

**Kuhlmann, E.** (2006), *Modernising Health Care: Reinventing Professions, the State and the Public*, Bristol: The Policy Press.

**Le Grand, J.** (2003), *Motivation, Agency and Public Policy: Of Knights and Knaves, Pawns and Queens*, Oxford: Oxford University Press.

**Le Grand, J.** (2007), *The Other Invisible Hand: Delivering Public Services through Choice and Competition*, Princeton, NJ: Princeton University Press.

**Lewis, J. and Weigert, A.** (1985), 'Trust as a social reality', *Social Forces*, 63, 967–85.

**Lindeberg, T.** (2005), 'The circularity of quality: a new relationship between auditing and society', paper presented at Risk and Regulation: Research Student Conference, CARR, LSE, 15 September 2005.

**Marcuse, H.** (1964), *One Dimensional Man: Studies in the Ideology of Advanced Industrial Society*, Boston: Beacon.

**Marcuse, H.** (1989), 'From ontology to technology: fundamental tendencies of industrial society', in S. Bronner and D. Kellner (eds.), *Critical Theory and Society: A Reader*, London: Routledge, pp. 119–29.

**McDonald, R., Harrison, S. and Checkland, K.** (2008), 'Incentives and control in primary health care: findings from English pay-for-performance case studies', *Journal of Health Organisation and Management*, 22, 1, 48–62.

**Möllering, G.** (2006), *Trust: Reason, Routine, Flexibility*, Oxford: Elsevier.

**National Audit Office** (2005), *Patient Choice at the Point of GP Referral*, London: The Stationary Office.

**Nettleton, S., Burrows, R. and Watt, I.** (2008), 'Regulating medical bodies? The consequences of the 'modernisation' of the NHS and the disembodiment of clinical knowledge', *Sociology of Health and Illness*, 30, 3, 333–48.

**Power, M.** (1997), *The Audit Society: Rituals of Verification*, Oxford: Oxford University Press.

**Power, M.** (2003), 'Evaluating the audit explosion', *Law and Policy*, 25, 185–202.

**Propper, C., Wilson, D. and Burgess, S.** (2006), 'Extending choice in English health care: the implications of the economic evidence', *Journal of Social Policy*, 35, 537–57.

**Public Administration Select Committee** (House of Commons) (2003), *On target? Government by Measurement*, London: TSO.

**Rothstein, H.** (2006), 'The institutional origins of risk: a new agenda for risk research', *Health, Risk and Society*, 8, 3, 215–21.

**Royal College of Nursing** (2008), 'Nurses spend more than a million hours every week on mountain of paperwork', says RCN, available at www.rcn.org.uk/newsevents/press_releases/uk/nurses_spend_more_than_a_million_hours_every_week_on_mountain_of_paperwork,_says_rcn, accessed 7 May 2008.

**Saks, M.** (1995), *Professions and the Public Interest: Medical Power, Altruism and Alternative Medicine*, London: Routledge.

**Scally, G. and Donaldson, L.** (1998), 'Clinical governance and the drive for quality improvement in the new NHS in England', *British Medical Journal*, 317, 61–5.

**Schön, D.** (1983), *The Reflective Practitioner: How Professionals Think in Action*, New York: Basic Books.

**Sennett, R.** (2008), *The Craftsman*, London: Allen Lane.

**Sheaff, R. and Pilgrim, D.** (2006), 'Can learning organizations survive in the newer NHS?', *Implementation Science*, 1, 27.

**Som, C.** (2005), 'Nothing seems to have changed, nothing seems to be changing and perhaps nothing will change in the NHS: doctors' response to clinical governance', *International Journal of Public Sector Management*, 18, 463–77.

**Taylor-Gooby, P.** (2008), *Reframing Social Citizenship*, Oxford: Oxford University Press.

**Weber, M.** (1978), 'The development of bureaucracy and its relation to law', in W. Runciman (ed.), *Weber: Selections in Translation*, Cambridge: Cambridge University Press, pp. 341–56.