Allocation of scarce resources in health care: An ethical review. The West Glamorgan experiment.

Jarvis, R. C. M

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ALLOCATION OF SCARCE RESOURCES IN HEALTH CARE:

AN ETHICAL REVIEW.

THE WEST GLAMORGAN EXPERIMENT.

R.C.M.JARVIS

MPHIL 1996

To Eliza,

who always believed in me.

DECLARATION

This work has not previously been accepted in substance for any degree and is not being concurrently submitted for any degree.

Signed...(candidate)

Date 16 January 1996

STATEMENT 1

This thesis is the result of my own investigations, except where otherwise stated. Other sources are acknowledged, giving explicit references. A bibliography is appended.

Signed...(candidate)

Dated 16 January 1996

STATEMENT 2

I hereby give consent for my thesis, if accepted, to be available for photocopying and for inter-library loan, and for the title and summary to be made available to outside organisations.

Signed...(candidate)

Dated 16 January 1996

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February 1996,
Swansea
AMDG

Summary

The National Health Service (NHS) is seen by many as being at a time of crisis. Demand for care outstrips the human and financial resources available, and the choices that are having to be made with regard to selective funding of treatments are becoming both more public and more tragic. Increasingly, there are calls for informed public debate about prioritising treatments, or rationing.

This thesis argues that the foundation and various reforms of the NHS have all aimed at one common goal: to make health care provision in Britain more efficient. I argue that underpinning the establishment and reforms of the health service has been the mistaken idea that the scarcity of supply relative to demand (and the consequent need to ration care) can be eliminated with more efficient procedures.

Faced with the service's continued failure to align supply with demand, unable to gain clear and consistent advice from central agencies, and unwilling to take the drastic step employed by some health commissioners of decommissioning entire areas of treatment, the health commissioners in West Glamorgan took the initiative and established a Local Ethics Committee (Purchaser Advice) to review and give advice relating to commissioning and purchasing issues within the county.

This thesis charts the development of the first three years of that unique committee, giving an insight into the processes and methods by which health care is rationed in West Glamorgan. It discusses the philosophical foundations of the review, examines the workings of the committee from the standpoint of the participant observer, and suggests that, as the problems faced by the West Glamorgan health commissioners are those facing commissioners nationwide, the model of ethical review proposed is one that could profitably be adopted elsewhere in the health service.

Chapter I

Situating the LEC(PA)

That men do not learn very much from history is one of the most important lessons that history has to teach.

Aldous Huxley

1. Rationing and the NHS

The world does not need another history of the National Health Service (NHS). There already exist numerous analyses of the debates, values and processes that culminated in the vision of a unified, country-wide, state-run organisation designed to serve the health care needs of the entire population in 1948. It would be otiose to add another.

Similarly, there are already available many thoroughgoing discussions of the 1974 NHS reforms and their implications both for the original conception of the NHS and the way in which that conception came to be realised in the light of lessons learned in its first twenty-six years of operation.

The 1991 reforms of the NHS gave rise to no fewer studies of their intention and effect. Many of these are written with a more or less hidden agenda, either that of the apologist or of the protester. It is perhaps inevitable that such an ideologically driven exercise in reform should give rise to discussions that are grounded in unwavering support or dogged - and at times dogmatic - objection.

This discussion is neither a survey nor an exegesis of the reforms. Rather it is an examination of one Health Authority's attempt to come to grips with the problem of allocating scarce resources for health care. As I shall argue later, one of the effects of the 1991 reforms was to introduce an enhanced degree of tranparency into the rationing debate, so that decisions and policies that formerly could have gone uncontested were opened up to questioning. As one commentator observed after a particularly public example of rationing, "fifty years of muddling through elegantly are now definitely at an end." (*HSJ* editorial, 1995: 17). I shall argue that although the problem itself is not a new one, its *public* recognition is a relatively recent event in the history of the NHS. How that recognition came about, and its implications for the organisation of the health service, constitutes the background to the discussion of the West Glamorgan experiment. It is this background that I intend to present in this chapter.

The founding principle in 1948 was that the newly created National Health Service would be exactly that - national:

> The care that it made available was available to all (more or less). The NHS was a state organisation which could be organised to serve all the population. (Strong & Robinson, 1992: 11)

From the convoluted pageant of voluntary hospitals, municipal hospitals, mental asylums, sanatoria of various kinds, and fiercely independent general practitioners would come a single, coherent service.

> Freed from the contingencies of local history and parochial vision, a national service might be planned to coordinate all its resources in the most fruitful way. (Strong & Robinson, 1992: 11)

This is an important principle for two reasons. Firstly, it is one aspect of the notion that there should be equality of access to health care irrespective of income, desert, or (in this case) location. No matter what you earned, who you were, and where you lived, the new NHS was to be for everybody. There were to be no exclusions,

> no limits on availability, e.g. limitation based on financial means, age, sex, employment or vocation, area of residence or insurance qualification. (Ministry of Health, 1946)

Secondly, the notion of using resources "in the most fruitful way" immediately introduces the notion of efficiency, of not wasting health care resources. The rambling, incoherent spread of health care provision that pre-dated the establishment of the NHS meant that money was simply being wasted, often through absurd duplication of effort and services:

> The fragmentation and inequities of prewar arrangements were highlighted in 1937 by an influential report from the Department of Political and Economic Planning but it took the Second World War and the Beveridge Report of 1942 to change perceptions sufficiently to legitimise a greatly enhanced role for the state in the provision of health care. Beveridge provided a rationale based on concepts of national efficiency, rationality and the rights of citizenship. (Ranade, 1994: 9)

The new NHS, a planned service, rather than one that had just developed in an unruly, organic fashion, would eliminate that wastage and bring in a more streamlined, more modern service fit to meet the needs of all.[1] The elimination of inefficiencies and duplication of services would so free up money that was already being (mis)spent on health care that a vastly increased quantity of care could be provided without increasing health care spending. Instead of the minority spending too much money on an inadequate amount of care, everyone would contribute to the funding of the service through taxation and everyone would be entitled and able to make use of its resources. As a result of eliminating replicated spending, new services could be funded which would better meet the needs of the entire population.

The foundation of the NHS, then, relied on a notion that the only obstacle to the possibility of dealing with the ill-health of the nation was the means by which health care was delivered. Eliminate unnecessary effort, prevent duplication, streamline the provision of health care by introducing a planned system, and everything that needed to be done would be done.

Of equal importance in the foundational philosophy of the NHS was the idea that it should be free at the point of delivery. We have already seen that the principle that lack of disposable income should not be a barrier to the availability of adequate health care was in part a manifestation of the new communitarian ethos in post-war Britain, but there was more to the abolition of the fee-for-service basis of previous health care provision than that.

Fee-for-service is a notoriously wasteful way to run a health service. George Bernard Shaw, thirty-seven years before the establishment of the NHS, had already noted that it was an absurd basis on which to fund health care provision:

> That any sane nation, having observed that you could provide for the supply of bread by giving bakers a pecuniary interest in baking for you, should go on to give a surgeon a pecuniary interest in cutting off your leg, is enough to make one despair of political humanity. (Shaw, 1958: 9)

The point is not simply that unnecessary amputations cause unnecessary suffering, although that is self-evidently the case, but that the money that would have been spent on an expensive surgical intervention could more fruitfully (that word again!) have been directed towards other forms of health care. Without increasing health care expenditure one iota, more health care could be provided simply by streamlining the service and eliminating wastage within it.

Lying behind this foundational optimism and the faith in the inevitable benefits of a planned service was the belief that there was a finite quantity of ill-health in the population that could be dealt with and eliminated by sufficient, and sufficiently planned and coherent, expenditure.:

> One of the assumptions made in the Beveridge Report was that expenditure on health services would decline once the backlog of ill health which was thought to exist in the community had been eradicated. (Ham, 1992: 38)

However, Ranade (1994: 11) argues that

> 1940s optimism about a finite amount of ill-health and disease susceptible to a comprehensive health care system was ... based on erroneous concepts of health and illness. Far from being static these are redefined over time in line with economic and social change.

This redefinition is an important factor in the developmental increase in demand for health care, and is an idea to which we shall return.

It followed from this assumption that the issue of resource allocation - how much money to spend and where to spend it - resolved simply into a question of ordering: which parts of the backlog to treat first. Resource allocation, that is, was barely an item on the agenda for the founding fathers of the NHS. Chocolate might be rationed, but health care - now that its provision had been streamlined and rationalised - would be available to everyone.

"*Tout amour comporte sa jeunesse, son âge mûr, sa vieillesse.*" (Radiguet, 1983: 59). The assumption made in the first flush of the love affair between the health planners and the NHS, of a finite quantity of ill health that could be eradicated by adequately targeted funding, was a youthful infatuation that could not last for ever. Love may be blind, but given the extent to which health care expenditure rose inexorably from 1948 onwards, it is remarkable that the honeymoon should have lasted so long. Expenditure has increased steadily both in absolute and real terms since 1948:

> Over the same period [1949-88], the real cost of the Service has increased fourfold, and the NHS share of total public expenditure has risen from 11.8 per cent in 1950 to 14.7 per cent in 1988 ... the proportion of Gross Domestic Product consumed by the NHS has increased from 3.9 percent in 1949 to 5.9 percent in 1988. (Ham, 1992: 38)

Why should this be? Ham (1992) suggests three main reasons for the increase in expenditure. Firstly, there are jointly far more interventions which are severally far more expensive today than was the case in 1948. CAT scans, PET scans, immunosuppressive drugs to enable transplant operations, the list is, if not endless, at least gruellingly expansive. The upshot of this expansion is that there is simply a wider range of more expensive options on display at the health care stall.

The second reason for the expansion of health care expenditure is a demographic one: since 1948 the age distribution profile of the population has altered dramatically, and there are now approximately twice as many people past working age as there were in 1948, both in absolute and percentage terms.[2] Since it is a truism of health economics that demand for services increases with age, it is clear that this ongoing alteration in the age profile of the demographic pattern of the population will result in increased expenditure.

As a footnote to this demographic factor in the expansion of the NHS, it is worth pointing out that the *entire* population - not just the proportion of it aged over 65 - has expanded during the lifetime of the NHS: in 1948 the population of the UK was 50.2 million, today it is 56.5 million, an increase of 11.2 per cent. This increase inevitably results in greater total demand, although to an extent this should be offset by a parallel increase in taxation revenue.

The third plank of Ham's explanation of the ever-increasing costs of the NHS concerns the public's expectations of the service and the levels of information to which they have access. Not only are new medical technologies discovered, they are also widely publicised, both in the medical and the general media. There are few GPs who are not familiar with the patient who not only says "I know what's wrong with me, Doctor," but also "and I know what treatment I need, because I heard about this new drug on the wireless this morning. You must know the one I mean." The fact that medical advances are made in the - not always unwished for - glare of the public eye means that demand for them both filters into the system all the more quickly and is all the greater. The silver lining of a better educated population is revealed to have a cloud of an increased burden on the NHS.

The point that Ham does not bring out clearly enough in his discussion is a conceptual, not an empirical one. The shortage is not dependent on the contingencies of scientific discovery or media generated awareness. Evans (1994) makes it clear that there is a "legacy of need" that is created by successful health care delivery that means that increased activity necessarily results in the creation of new demand: as people are enabled to live longer as a result of successful health care interventions, so the number of years for which they represent a draw on health service resources, and the quantum of that draw both increase.

While mankind remains mortal, there always remains something further that could be done. If an individual does not die in infancy, then he will represent a demand for health care in childhood and thereafter. If the diseases of middle life are eliminated, then he will continue to make demands on the supply of health care into old age. The cost of saving lives is to be reckoned not by calculating the cash price of a given intervention, but rather by reckoning the quantum of *increased* demand that a saved life represents on future resources. The Secretary of State for Health may have taken pride in the fact that:

> for £4 the NHS can immunise one child for a lifetime against measles, mumps and rubella. That represents good health value. (Bottomley, 1993: 30)

What she did not point out was that it also represents an enormous increased burden on the future resources of the NHS. If an individual does not die of rubella in childhood, then s/he represents *new* demands on health care providers: Mason and McCall Smith (1991: 272) make precisely this point when they remark that:

> Every sudden death in late middle age that is prevented is potentially a long-term occupancy of a bed in a psychogeriatric ward ...

This burden of increased demand is an inevitable result of successful health care delivery. It is also potentially infinite.

> [In Norway], The result of all these efforts [to eliminate waiting lists] was not that fewer people ended up on waiting lists, but that many more patients were treated than before. Again, supply seems to have created demand ... many believed, mistakenly, that each waiting list reflected the real distance between objective need and real capacity, and that problems in health care could be solved by channelling more money to the hospitals to wipe out waiting lists. They were surprised that the waiting lists did not decrease as a result of the extra funding. (Government Committee on Choices in Health Care, 1992: 100)

To the extent that there is no limit to the number of medical interventions that could be discovered and therefore demanded, and inasmuch as death is seen as the ultimate failure of health care, there is always, *always* something more that could be done, if not now, then in the future. To take an extreme example, if the techniques of cryonic suspension are further refined, so that it becomes possible to freeze a patient with a currently untreatable condition and then revive him successfully at some time in the future when medical science has caught up, then it is strikingly clear that any *individual's* demand for health care would be actually infinite: the well-worn "I'm sorry, there's nothing more we can do" would always be false.

Successful cryonic suspension and revival techniques may not be available today, but they are not unthinkable. And in medicine, even the unthinkable has a habit of becoming a reality. Whitehorn (1993: 107) quotes the story of

> the old islander who was asked what on earth they did before the helicopter service: what happened when they were dangerously ill? "We mostly died," he said calmly.

Demand, we might say, is not for that which is acknowledged to be impossible to provide: it is for that which you do not have *but could envisage having*. Demand, in this sense, is for that which is just out of reach.

The problem is that in a research based profession such as medicine, there is *always* something that is just out of reach, and that therefore could reasonably be the locus of reasonable but unmet demand. 150 years ago it was reliable anaesthesia, today it is a cure for the common cancers. Today we take novocaine for granted, and there is little unmet demand for it. But the backlog of demand for a cure for cancers or any of the expanding canon of chronic and degenerative illnesses continues to grow. The twin dynamics of a colossal research drive within medicine, coupled with a public which is increasingly informed of any research finding that offers the slightest chink of light in the quest for a cure for one of the *fin de siècle* diseases, mean that the range of conditions which are no longer simply accepted as terminal is increasing almost daily. Whitehorn's islander may have been particularly stoical - apocryphal old islanders usually are - but he is representative of a familiar idea: when there was not the *slightest* hope of a cure, people just got on with it and died. A crusading medicine, determined to slay every etiological dragon known and several still to be discovered, coupled with a credulous public cheering from the lists, however, has had its inevitable effect: while medical research may have resulted in more conditions being treated, it has also meant that there are more *identified but untreated conditions* as well, and it is in these that unmet demand for health care is primarily located.

Indeed, even this analysis is in danger of missing an important reason for the immense expansion of health care activity and expenditure since 1948. Lefever (1990: 75) argues that the problem with the NHS is not that it is underfunded, but that it is *undefined*. That is to say, the necessity for rationing arises not because of governmental or electoral parsimony, but because of what we might call the ragged edges of the notion of health, what activities are considered to fall within the description "health care". In a more God-fearing age than ours, psychiatry would have had no place; or rather, what we now call the work of the psychiatrist was undertaken by a different agency entirely. It is not that the mad and the depressed went untreated, but rather that their problems were not seen as *medical* problems at all, and therefore the means by which they were addressed were similarly non-medical.

It should be clear that this redefinition of terms and problems so as to draw them into the canon of health care is closely linked with advances in health care technology and efficacy. The claims of the health care professions to have something to say about the problems of what used to be called demonic possession are dependent on their ability to address those problems in a convincing way. Moreover, it should also be evident that such redefinition is by no means confined to health care's more distant history. The medical problem that we now know as infertility was until relatively recently not a *medical* problem at all. To be sure, there was a social problem known as childlessness, and we can find biblical references to barren women, but theirs was not a *medical* problem. That is to say, because medicine had nothing to offer those women (whose suffering may have been every bit as great as that of a contemporary infertile couple), their problem was not seen as being a concern for *medicine* at all. Once the problem could be addressed by *medicine* however, it became not a problem but a *condition*.[3]

But the distinction is not merely in terminology. With the change to a medical description of the phenomenon came another change. If childlessness is thought of as a divine curse, then fertility is best sought by making reparation and sacrifice; if it is perceived as a social condition, then its fiercer pangs can be alleviated by adoption. But if it is thought of as a *medical* problem, then the duty to address it falls within the remit of health care provision. By defining a problem as a medical condition, it is brought within the remit of health care and consequently within the health care budget. As I argued, following Lefever, in Jarvis (1996: 183):

> the fact that there is no clear or static boundary around the notion of health means that there are no limits to what can be demanded in the name of health care.

In Lefever's terms, the fact that the NHS is undefined, that "it has never been specific about what it means by health" (1990: 75), means that the first stage in health care rationing must be such a definition, that is, a statement of what is and what is not held to be health care activity. As Smith (1993: ix) argues:

> no health care system will be stable unless it answers the question of what is covered.

The demand for health care, then, that the NHS was designed to meet, is potentially infinite. Its necessary elasticity means that the foundational vision, of a "backlog of ill health which was thought to exist in the community" (Ham, 1992: 38) was mistaken. Moreover, the fact that there were only finite resources available to meet this potentially infinite demand

> means that rationing - deciding who shall get and who go without - is an inescapable part of planning health care. (Jarvis, 1994: 17)

In the next part of this chapter, I shall go on to look at the attempts to come to terms with the implications of this realisation, and the scope of the acceptance of the idea itself.

The belief that a definable backlog of ill health existed which could be addressed and eliminated, to be replaced by a scenario in which the NHS could be left just ticking over, was not only false, it was eventually recognised - at least in the rhetoric of the health service - as false:

> the demand for health care is always likely to outstrip supply and ... the capacity of health services to absorb funds is almost unlimited. Choices have therefore to be made about the use of available funds and priorities have to be set. (Royal Commission on the NHS, 1979: 51)

The 1979 Royal Commission's report is an important development in the understanding of resource allocation within the NHS in that it represents the first public acknowledgement that "choices have ... to be made". It did not spell out which choices might have to be made, nor how such choosing might be organised and grounded, nor what might have to be forgone as a result of such choosing, but the report did recognise that health care demand is potentially infinite, and that therefore not everything that could be asked for in the name of health care could necessarily be provided. This represents a considerable move from the foundational principles of the health service outlined above, that health care was to be available to everyone, with no exclusions.

In this sense, the 1974, 1982 and 1984 reforms of the NHS can be seen as marking a new period of realism with regard to the possible scope of activity of the service and therefore by implication the necessity for a policy by reference to which limited resources could be allocated. Despite the belief in 1948 in the desirability and utility of a *planned* service as opposed to an *ad hoc* organic happening, such was the strength of the belief that the backlog would shortly be cleared that no consideration was given as to how to *manage* the system of health care provision in Britain. What we now think of as the management structures of the NHS had merely an administrative function at its inception. They were there to oversee the paying of the bills and the movement of patients between arms of the service.

The 1974 reforms were, to say the least, dramatic:

> Whereas the old district administrators simply chaired the meetings of the management team, each general manager was a real boss, in charge of the treasurers, the cleaners, the nurses, the doctors, the personnel department - the lot. Here, then, was a revolution. (Strong & Robinson, 1992: 23)

The revolution consisted in large measure of a removal of exclusive power from the hands of the clinicians, who hitherto had taken such allocative or ordering decisions as were necessary, and instead concentrating it in the hands of the newly created general managers. 1974 and later 1984 saw the dismantling of the old belief that demand for health care would manage itself and its replacement by a more interventionist management process:

> the NHS was given a new corporate structure, devised in key part by management consultants and modelled on modern business lines ... The new management tiers had, in turn, a new management ethos .. An elaborate planning system was created, based on current management fashion ... Both medicine and nursing now had a new administrative cadre, planners and leaders taken from within the clinical professions but trained in the new management skills that the new service required. (Strong & Robinson, 1992: 16-7)

Gradually, it was being accepted that choices would have to be made about what was and what was not going to be made available on the NHS, and that demand for the new services was going to have to be managed rather than simply administered. That is, the support services in the NHS were going to have to take a more active hand in apportioning resources: deliberate rationing was born.

At the centre of the debate about rationing in the NHS was and still is the economist's notion of opportunity cost. This is to be distinguished from the idea of budgetary cost. The budgetary cost of my summer holiday is the actual sum of money I have to part with in order to secure my travel and accommodation. The *opportunity* cost is quite different, and arises only in a scenario of limited resources.

Let us assume that I can take three weeks holiday in the summer. I have long harboured a desire to watch the sun go down over the Serengeti, and so I decide to book my safari holiday. However, the day before I set out for the travel agent, I see an article on the prospects for salmon fishing on the Tweed, which owing to unprecedented weather are particularly good this year. Salmon fishing is, we shall assume, my passion in life.

It is quite clear that if I spend my three weeks trekking in the foothills of Kilamanjaro, fulfilling my long-held desire to gaze on impala and wildebeest, then I shall miss the salmon season of a lifetime. And *vice versa*. I cannot do both. That is, given that my resources, in this case of time rather than money, are limited, there is an opportunity cost attached to either decision, which is the thing that I have to forgo in making my choice.

Opportunity cost, then, arises only in a situation in which resources are limited. If my time were my own, and money were no object, then there is no reason why I should not both observe the impala and pursue the salmon. In that case there would be no opportunity cost - that is, there would be nothing lost by electing to choose one rather than the other. In a scenario of limited resources, however, this is not the case. Every positive choice to direct resources in one direction is concomitant with and automatically entails a parallel deprivation of another bidder for those resources.

Once it is realised that, given the necessary strictures under which the NHS operates, *every* decision to invest in one area deprives another of funds, it becomes clear why the notion of rationing is so central to health care planning. If an authority decides to invest in cardiac services, then it has that much less money for public health. Every investment decision in the NHS carries with it an opportunity cost.

With this in mind, it is easy to see how a service pressed for funds and with increasing and competing claims on its purse could come to be as obsessed with the notion of efficiency as has the NHS. A process is more or less efficient according to how much output is obtained for a given unit of input resource. So for example, a factory that can turn out 10,000 loaves for every ton of flour is ten times as efficient as one that can only produce 1,000 - assuming that the loaves are the same size. The 1974, 1982 and 1984 reforms were about making the service more efficient, just as the NHS was itself set up in order to make the medley of replicated individual services more efficient. They were designed to allow more health care activity to be engaged in without an increase in budgetary cost.

Even though the 1974, 1982 and 1984 reforms represented "a huge and perhaps irrevocable change" (Strong & Robinson, 1992: 27), they were not the end of the attempts to make the NHS more efficient. Almost as if there was a lingering suspicion of the NHS, a deep-seated belief that the system was somehow being almost wilfully inefficient with its resources, in 1991 a system of "managed competition" was introduced by a government committed to the belief that the key to increasing efficiency and quality of service was the introduction of competition. This was effected by creating a divide between the providers of health care and its purchasers.

It is not my purpose to lay out the detail of the 1991 NHS reforms, nor particularly to analyse their effects. I have suggested that they arose at least partly as a result of a suspicion of nationalised monopolies and a belief that a system into which competition had been introduced would inevitably be more efficient that its non-competitive counterpart. Unlike many commentators on the 1991 reforms, I am not even particularly concerned, at least not in this context, as to whether this is true or not. I am not concerned because, as I shall demonstrate, for our present concerns it does not matter.

The guiding principle behind the 1991 reforms, when all the rhetoric of accountability and Patient's Charter targets has been cut away, was to increase efficiency in the health service by the introduction of competition. The problems implicit in the - by now widely recognised - resource shortfall would be addressed by a more efficient deployment of the same health care resources: no more money would be made available for health care, but that money that was already committed would be invested more wisely - that is, more efficiently. Instead of perpetuating the systems which contributed to inefficient practices, the reforms would take up the slack that was thought to exist. By doing so, of course, they would release more money for direct patient care. If unit costs were lowered, then obviously more care could be provided for the same quantum of investment. The 1991 reforms, therefore, can be seen as yet another attempt to address the problem of incomplete health care coverage by the introduction of measures designed to increase the efficiency of the system or systems by which health care demands are met. On this analysis, far from being a break with the NHS's past, they are on a direct continuum with it.

There can be no doubt that there was - and still is - wastage in the NHS. This seems so self-evident that there is no need to advance disputable figures as to the exact quantum of the waste; it is sufficient simply to state that in the country's single largest public sector employer, an organisation with an annual budget of £28,536m in 1990 (see Chew, 1992), it is inconceivable that there should not be some wastage in the form of duplication of effort, inappropriate prescribing or interventions, petty or not so petty pilfering, and so on. It would be plainly absurd to maintain that there is no inefficiency in the health service, or indeed in any comparable organisation.

It is the job of the economist, the management scientist, and the student of organisational behaviour to tell us whether the 1991 reforms were effective in reducing waste, that is whether there was a net gain of resources saved calculated against the investment necessary to implement the reforms. Philosophy cannot reveal whether savings made as a result of information gleaned from clinical audit and the introduction of competition between providers outweigh the costs of setting up those systems.

What philosophy can show, however, is the indisputable logical point that the mere clawing back of savings - however large - from an already squeezed service is never - logically never - going to eliminate the problem of the scarcity of resources to meet demand for health care. As I argued above, the potential infinity of health care demand and the elasticity of perceived need is a logical point: if people do not die of influenza at fourteen, then they will go on to need expensive interventions when they are eighty. Saving lives, which is at bottom the business of any system providing health care, doesn't just cost at the time of the intervention, it goes on costing as the saved individual goes on ageing and ailing ever more expensively.

The 1991 reforms of the NHS were designed to address the problem of a shortage of resources to meet the health care demands of the nation. The means by which this shortage was to be addressed was the creation of a more efficient service as a result of the introduction of competition. Put like that, I hope that it is clear why the question of whether competitive services are more efficient than their non-competitive counterparts is an irrelevance. The central point is that no matter *how* efficient provision of health care becomes, it *necessarily* operates on a stage of limited resources. The belief that the problem of scarce resources for health care can be addressed by eliminating waste and inefficiency is a *logical* mistake: the reason that resources are inadequate to meet health care demands in the UK is not that we are particularly parsimonious or inefficient with our health care spending, but that *there never can be enough to go around*. Resources for health care are logically limited, and demand for those resources is logically infinite: simply flushing the pipes through to get them running more cleanly will never - can never - eliminate the problem.

To the extent that the 1991 reforms evince a belief that health care demand could be met by a more efficient deployment of resources, then, I suggest that they represent a return to the foundational optimism of the NHS; in their failure to recognize that the limiting factor is neither the scale of resources available, nor the efficiency with which those resources are deployed, but rather a logical necessity, they commit the same fallacy as the Beveridge Report, assuming

> that expenditure on health services would decline once the backlog of ill health which was thought to exist in the community had been eradicated ... This assumption turned out to be false ... (Ham, 1992: 38)

The Dutch inquiry into priority setting in health care chaired by Professor Dunning argued that

> to ameliorate pressures on the [health care] system, there are three choices:
> 1. make more money available for health care ...
> 2. become more efficient. The committee gives a high priority to this option, and feels that much can be done, *but it also recognizes that increased efficiency cannot prevent the necessity for choice.*
> 3. make explicit choices about health care. (Government Committee on Choices in Health Care, 1992: 14, emphasis added)

I suggest that the 1991 reforms, in common with all other reforms of the NHS, can be thought of as putting their trust in the second of these options. There were no plans to make more money available, and choices simply were not made. Efficiency became the great white god which would redeem the service.

However, while the 1991 reforms evinced a belief that increased efficiency was the way forward in problems of resource allocation, they did not appear to take seriously the Dunning Report's warning that "increased efficiency cannot prevent the necessity for choice". Rather they suggested that there was such an excess of slack in the service that *simply* promoting efficiency would in and of itself release sufficient resources to meet all needs and demands:

> We are convinced that NHS funding in Wales - and elsewhere - is sufficient to eliminate waiting lists in less than a year, and to avoid any need to deny effective healthcare for the forseeable future.
> The problem is not insufficient funds but poor management ... (Roberts, 1995: 15)

They were wrong.

If the only sin that the 1991 reforms had committed was an academic one, it might reasonably be asked what all the fuss was about. Unfortunately, that is not the end of the matter. By creating an environment in which efficiency was the measure of all, the reforms drew attention away from the central problem at the very nub of any health service that arises from the tension between the two given parameters of provision, that resources are finite and demand potentially infinite. What the reforms forgot, or ignored, or deliberately hid from, depending on one's perspective, was something that everyone involved in health care provision from consultants and general managers to observers and journalists know to be an inescapable truth: a truth that had been acknowledged by the Royal Commission in 1979, that demand for health care is potentially limitless - there would always, *always* be something more to do. Simply increasing efficiency within the service would not avoid the implications of that truth, it merely pushed back the point at which it bit. At some stage, someone would have to stand up and admit that although the party wasn't over, the hall was full, and some of the would-be revellers were going to have to go home without a dance. Not every Cinderella service *could* go to the ball. Rationing is unavoidable.

I hope that it is clear by now that there is no *terminus ad quem* of health care provision on either an individual or a general basis: there is *always* something more that could be done. That is hardly news. But the problems of the NHS with respect to coverage of the population and the scope of the services on offer have festered because of a basic unwillingness to acknowledge the problem publicly. This is not for medical, nor philosophical reasons, but purely pragmatic, political ones:

> Politicians know that not everything can be a priority but tend to feel queasy about the word rationing. (Smith, 1993: viii)

It is no exaggeration to say that the principle of universal coverage, free at the point of delivery that grounded the NHS, as one of the central planks of the welfare state which in Britain we take for granted, has become, as far as the politicians are concerned, a sacred cow. Questioning it seems politically unthinkable:

> The reason we cannot have the truth is that neither the Tories nor Labour can tell it, solely because the first side to tell it would be loudly, shrilly and hysterically ... denounced as the party which snatched the false teeth from the very gums of every Chelsea pensioner in the land. (Levin, 1994: 14)

The point is clear enough: that although the necessity of rationing is *privately* acknowledged, it would be politically inexpedient - if not disastrous - to accept it publicly. However, this failure publicly to acknowledge what is known privately to be the case itself carries with it an opportunity cost, in that it leads to rationing taking place behind closed doors and being presented to the public under the guise of medical necessity, rather than being a process of informed debate culminating in responsible and generally accepted working solutions being implemented. Pretending that rationing is avoidable does not take away the necessity to determine who shall and who shall not be treated:

> Rationing is unavoidable, and if we want a service that uses the public's money to promote health in an efficient and equitable way we should not just sit back and accept it as a necessary evil. Instead, it is important to get involved in rationing to ensure that it occurs in a responsible and just fashion rather than the current process, which is largely unchartered and the product of clinical discretion which creates major variations in practice and patient access. (Sheldon & Maynard, 1993: 12-13)

It is axiomatic in counselling for alcoholism that there is no possibility of the alcoholic recovering until s/he *acknowledges* that s/he is an alcoholic: the possibility of successful behavioural alteration

> will require an admission by the individual that a behaviour (or set of behaviours) which previously has been considered normal and usual is now viewed as 'the problem'. (Baldwin, 1991: 40)

Until what Sacks (1985: 68) calls "the actual moment of discovery ... seeing for the first time exactly what is wrong ... this *is* the therapeutic moment" has been reached, all the potential cures or fixes in the world will not help. In the same way, it is only once the inevitability of shortage and the concomitant need to ration services has been acknowledged that the substantive task can begin of deciding which services are to be limited, which patients deprived of care from which they could benefit.[4] For that is the harsh task of rationing health services: deciding which patients, or which categories of patients are to be excluded from the canon of NHS treatment *despite the fact that their conditions are medically treatable*. The upshot of rationing in the NHS is that some patients will have to be told "Your condition is treatable, but the treatment you will receive (if you receive any at all) will be less than the best available because we've spent the money on other things."

Having argued that moves designed to increase the efficiency of the NHS were conceptually flawed to the extent that they were an attempt to ensure universal meeting of perceived health needs, it must be acknowledged that a more efficient health service is both a more responsible and ethically a preferable use of scarce resources. Again, I do not wish to get into a discussion of whether the 1991 NHS reforms *actually* resulted in greater efficiency or not, because it is something of an - albeit important - side issue. What is worth stating is that inefficient use of limited resources is at least morally questionable. If there is not enough to go round, then it is important that what is available is worked as hard as possible. It might even be held that it would be at least *prima facie* objectionable to use scarce resources in a less than maximally efficient way.

Such an argument is relatively easy to advance in the case of manufactured or physical goods, where it is possible to quantify not only the resource input into any given process, but also the output: in the bakery example I discussed earlier, to assess efficiency we would simply count the loaves. This assessment of efficiency is possible only because we are by and large agreed on what a loaf *is*, notwithstanding the "hard cases" that some philosopher can always be found to advance ("Is a bagel a loaf? What about a short baguette?"). We know what loaves look like, and we are quite happy about counting them.

The problem faced in the case of assessing the relative efficiencies of various systems of health care provision is that we simply do not know what health *is* with any precision, much less how to count it. Indeed, it is far from clear that it makes any sense to talk of "counting" health. Enough work has been done on examining what might be meant by "health" (see e.g. Payer, 1989, Griffin, 1986, van der Steen & Thung, 1988) to give rise to the suspicion that the term is what Hart (1993: 125) calls "irreducibly open textured". If that is so, if there is no possibility of drawing up a list of individually necessary and jointly sufficient conditions which define what we mean by health, then it is quite clear that the possibilities for outcome evaluation of health care activity are severely curtailed.

Although the implications of this point are daunting, it is not, I hope, a difficult one to grasp. Consider the range of activities undertaken by the NHS: everything from transplant surgery to preventative dental counselling, from diabetes management to rehabilitation therapy, from monitoring incidents of notifiable diseases to pain management in terminal cancer care. It is immediately obvious that the goals of these multifarious activities are enormously different: what counts as success in the operating theatre is very different from the objective in the counselling room. Indeed, even within what is apparently one activity, there are potentially different players with different goals: the anaesthetist's sole concern in the theatre is to maintain the patient's anaesthesia while not suppressing any vital functions; the surgeon, however, is only indirectly concerned with the patient's pulse, and is instead concentrating on his or her own task; the theatre nurses will have different concerns again.

With each of these different roles comes a different set of objectives, and therefore a different assessment of what counts as success or failure in any given activity. It is because of this multi-facetted nature of the evaluation of health care that it is possible to make sense of such apparently paradoxical utterances as "the operation was a success but the patient died." While odd, it is not, given the plurality of viewpoints I have outlined, a solecism.

Nor is there any reason to suppose that even in a simple binary activity where the only players are the patient and the health care professional there is necessarily any congruity of views of success and failure. Consider the depressive patient who is warned that the ECT which she is about to undergo is fatal in about 1 in 3000 cases (Fink, 1979: 48) and who replies "I hope I'm the one." Or the response - hardly unknown - "if that's the cure, I'd rather stay ill". What are we to say is to count as success or failure in these cases? And how (we are closer to the health planning bone now) are we to compare the output of nursing services for the confused elderly with that of the family planning consultant, and that of the intensive therapy unit (ITU)? Ham (1993: 61) identifies this conceptual difficulty when he argues that it is difficult (he might have added, impossible) to evaluate outcomes between different services

> because there is no common currency for making these broad comparisons. Weighing the priority that should be given to health promotion as against additional operations to reduce waiting times for surgery or higher quality of care for people with learning difficulties is like comparing apples, bananas and kiwi fruit.

Of course, it is possible, in the terms of Ham's analogy, to take *a* parameter as the common currency and to compare the different fruits with respect to that. So for instance we could rank apples, bananas and kiwi fruit in terms of their vitamin C content. But it would be plainly absurd to think that by doing so we had said anything very significant about them. We would certainly not have identified which was the *fruitiest*. Put baldly in this way, it is inconceivable that anybody could subscribe to the idea that something as complex as fruits could be evaluated in this fashion. Yet it is exactly this line of argument that those who maintain that different forms of *health activity* can be compared and evaluated in a common currency - typically the quality adjusted life year (QALY) - do believe. The danger, as ever, with playing with operational constructs like vitamin C content or the QALY is that eventually it is easy to lose sight of the fact that they *are* operational constructs and to mistake them for the real thing (See Wilson, 1967: 207). It would, given sufficient information, be relatively easy to assess various activities that come within the remit of the NHS and to evaluate their score in QALYs, but it is not in the least bit clear that in doing so we would have done anything particularly useful. Certainly, we would not have said anything about which activities "produce more health", whatever that may mean.

As a footnote to the forgoing discussion, it is worth pointing out that it is possible that we could compare two rival procedures, the intended outcome of which is common to both: indeed, this is exactly what happens in many clinical trials, where different ways of achieving the same end are compared and evaluated. However, there are two points to be made in this regard.

The first is that even a detailed comparison could not alone tell us which is the *better* therapy, merely which one is more efficient (that is, which one achieves the intended goal for the least resource input). Which intervention is to be preferred, for instance by a commissioner, remains an open question, for the simple reason that it depends on factors other than cost: degree of discomfort to the patient, nature and severity of side effects, availability of staff skilled in the procedure, and so on and so forth. Unless it has already been decided that all we are interested in is the efficiency of a procedure - and it would be a very odd health service indeed that decided that - simply doing the sums tells us very little.

Secondly, and more fundamentally, although it is possible to weigh up two procedures aiming at the same goal, or two systems of management of the same condition, what this evaluation cannot tell us, and what is absolutely central to the debate about rationing health services, is whether the goal is worth aiming at in the first place. Every QALY table that was ever published shows that the cost per QALY of hospital haemodialysis is about five times that of kidney transplantation, but what no amount of QALY-type calculation can ever tell us is whether renal services - dialysis or transplant - should be preferred to rehabilitating young victims of stroke. If the money can only be used once, and we are aware of the opportunity cost, to whom are we to say "I'm sorry, there's somebody else we'd rather treat"?

2. Market theory and the NHS

We have been examining the indefinability of the notion of health and the consequential impossibility of evaluating different types of health care in a common currency within the context of the 1991 NHS reforms and their establishment of "managed competition" within the health service. However, there are reasons other than simply conceptual difficulties about the nature of the concept of health for concern over the introduction of a competitive, market-type ethos into the health service; and these worries, just as much as - if not more than - the conceptual problems provided the background to this study. It is therefore in order to rehearse those concerns briefly.

It is axiomatic of the 1991 NHS reforms that managed competition results in a qualitatively better service. By creating competition between providers and allowing purchasers a choice in the care provided, it is believed that standards of care will automatically rise as providers strive to offer the most attractive service to consumers. I suggest that there are at least two problems with this belief,[5] one of which raises questions about market theory in general, while the second queries its application to the NHS.

Economic theorists and market analysts know better than philosophers whether competition necessarily drives prices down: anecdotal evidence from lawnmower advertisements each summer suggests that it does. However, it is clear that the introduction of a financial imperative may carry with it a high cost in terms of a reduction of quality of goods or services provided. If providers accept Friedman's assertion as correct, that

> there is one and only one social responsibility of business - to use its resources and engage in activities designed to increase its profits (Friedman, 1962: 133)

then it is far from clear how standards of quality are to be maintained. Of course, laws can be passed prohibiting the adulteration of flour and the exploitation of cheap child labour, but these laws hardly prevent such practices, they merely allow those responsible to be prosecuted - if they are detected.

The equation is simple, even in the case of manufactured goods: if a farmer is given a financial interest in supplying as large a tonnage of potatoes as cheaply as possible, then it is clearly in his interests to ensure that when they are weighed, there is as much soil adhering to those potatoes as possible. Competition gives providers a reason for keeping costs as low as possible, not for maintaining high standards.

It is only fair to point out that even in a potato market, there will be a niche for those producers who specialise in tubers of exceptionally high quality, no doubt washed and peated, and probably with obscure but reassuringly expensive names. That is, *some* producers will have a financial interest in maintaining, or even driving up, standards. But who is it that buys them? Certainly not the single mother trying to eke out her social security to feed three hungry children. That is, while competition may assure some standards, those areas where quality is so assured are accessible only to those with sufficient disposable income.

The second problem with the notion of a market in the NHS concerns the terms of the analogy. In the idea sketched of the market place, clinical and other services are identified as the providers of care (producers), while commissioning authorities and GP fundholders play the role of purchasers (consumers). The problem is obvious: there is no room for the patient who is, one might otherwise think the central player in the exercise - the locus of operation, the person to whom it all *happens*. If there are two fish shops in my high street, and I do my own shopping, then (doubts about the preservation of standards of provision and quality aside) we might expect that they would both have an interest in providing as good a service at as low a cost as possible, for fear of my defecting to the competition.

However, let us redraw the illustration to bring it slightly more into line with the reformed NHS. Now, instead of my doing my own shopping, I employ someone else to do it for me because, for one reason and another, I cannot get to the shops. This person whom I employ, moreover, is given stewardship of part of my finances. Let us assume that this person, call him Campbell, is entrusted with £40 per week to buy me fish. Being a good Calvinist, Campbell is no great eater of fish, and therefore has not the slightest interest in ensuring that his purchases are fresh and of good quality. However, owing to the terms of his employment, whatever surplus money there is out of the original £40 at the end of the week is his to keep. Campbell owes me no particular allegiance, and it is extremely likely that even if I dispensed with his services, somebody else would employ him. There are, we shall stipulate, in the interests of keeping our illustration lifelike, a great number of people who cannot get to the shops.

Now it seems clear that only if Campbell has my best interests at heart will I get the high quality fish I want. If he buys sub-standard, desiccated cod, ammonia scented skate, rank mackerel, it is not he who eats it. I am the only person to suffer as a result of his (self-serving) penny pinching. That is to say, he has no self-regarding interest in ensuring that his purchases are of the quality that I would wish. If I am unfortunate in my choice of steward and Campbell turns out to be selfish, mean and conniving, then my diet is going to be a poor one. And there is little or nothing that I can do about it.

I am aware that there are certain differences between the illustration I have sketched and the way that the market reforms in the NHS are intended to operate, not least that the surplus health budget does not go straight into the commissioner's pocket.[6] However, I hope that the central point is clear, that by driving a wedge between the purchasers of health care and those who experience it, the reforms have removed any incentive (other than altruism) that the purchasers might have in operating so as to drive up standards of health care provision. Purchasers, in effect, are not identical with consumers. This division means that the tendency of market forces to reward cost cutting at the expense of standards is exacerbated by giving purchasers an interest only in lowering costs, and not in raising standards. This danger is summed up by Abouna *et al* (1991: 167):

> The philosophy is obvious: Once payment is made, get rid of the patient as soon as possible to cut costs and increase profits

and is neatly captured in the now familiar label "quicker and sicker".

The second and third general concerns with the effect of the introduction of market economics into the field of health care provision are in a sense linked, although independent one of another. They concern respectively the fates of services that are expensive to purchase, and those that have a "return" that is either low or difficult to quantify.

In a market economy, it is in the interests of the purchasers to buy those services which represent both the best value for money and the lowest budgetary outlay, and there is no guarantee that value for money will take precedence over budgetary cost. At a simple level, £60,000 may or may not represent good value for money for a new Porsche, but for the majority of us the question is an unreal one: not having that kind of money to spend on a car, the question of *value* does not arise. That is to say, the sheer scale of the outlay involved precludes any further consideration of the question.

The problem for the market reforms of the NHS is that just the same considerations may arise in the context of planning to purchase expensive services. Again, it is important to point out that the purchasers of the services are not those who consume the purchases: they are not buying for themselves, and therefore their interests in purchasing in this case expensive care are one stage removed from the activity. If it is a commissioning authority's duty to refrain from profligacy with its limited resources, then it is clear how pressure could be brought to bear on a commissioner to refrain from investing in such expensive services as PET scans when they benefit so few (although the potential benefit to a given individual may be great).

It is important to note that in a scenario of limited resources, the elimination of *waste* must be counted a good thing: good not just economically, but morally as well, since it allows for a more just distribution of resources across the spectrum of potential consumers.

That is, if the services discontinued as a result of market reforms were luxuries, the opportunity cost of which was the non-provision of necessities elsewhere in the service, then their cutting would be eminently defensible.[7] However, if the pressure on resources combined with the impetus to pare costs wherever possible means that services are denied to those in need,[8] then it is less clearly to be desired.

Linked with but (as I suggested above) independent of this concern is the misgiving that services whose "output" is perceived to be low or incalculable, such as health education or community based care of the elderly, might also be discriminated against as a result of market orientated reforms which emphasise quantifiable *results*. Such inevitably nebulous exercises as health promotion might well be thought to be under threat from the introduction of market analyses into the provision of health care. It is a truism of business ethics that in the market place, a conscience is a luxury that few can afford. (See for example Velasquez, 1988)

There had been one notable attempt to ensure that the managers and commissioners of the service did not allow notions of efficiency to run away with them before: namely in the form of the establishment of Community Health Councils (CHCs) as part of the 1974 reforms. Opinions differ as to the exact role of the CHCs, but most commentators agree that they were developed in response to a realisation

> that something was missing: an element which could be presented and seen as providing a degree of local democracy, consumer participation or public involvement in the affairs of the NHS. (Klein & Lewis, 1976: 11)

The perception of the problem was roughly this: that

> although health authorities are bound to be concerned about interests of patients, their main job is to manage in a professional and efficient way the resources available to them to provide health care to the populations they serve. (Levitt, 1980: 41)

In other words, while the newly formed management structures of the NHS ought to have one eye on what patients wanted, their main task was to get on with the managing, and they ought not to be too squeamish about cutting services that were seen to be inefficient. A conscience was not a luxury that they were to be permitted.

Whether the CHCs have fulfilled their role as the champion of the public, indeed, whether most of the public that they are supposed to represent even know of their existence, is a difficult question to answer, and not one with which we need be concerned here. The important point is that the intention behind the establishment of the CHCs, insofar as there *was* a clear intention, was that they should serve to temper and where necessary, modify, the harshness of management decisions made with efficiency as the main criterion.

The 1991 NHS reforms had no statutory body parallel to the CHCs to oversee the effects of the introduction of a market philosophy into health care provision. Possibly it was felt that none was needed: perhaps it was thought that none was desirable. Either way, after 1991, commissioning authorities were left largely on their own both to seek the most efficient solution to the problem of health care investment and provision in a scenario of limited resources, and to look out for the moral and humanistic implications of their work as well.

3. Executive power, moral authority and health care planning

The realisation of the necessity of rationing in health service provision coupled with the need to provide checks and balances against unfeeling economic considerations, then, provides the background against which this study must be viewed. It was onto this stage that the West Glamorgan Local Ethics Committee (Purchaser Advice) (LEC(PA)) was introduced. In this section, I want to sketch some thoughts as to how the LEC(PA) might be thought of, and to look at some paradigms for its macro-operation.

As ever, it is much easier to say what something is not than to identify what it *is*. My starting point, then, in considering the question of how we are to think of the LEC(PA) is that it is not to be thought of as another CHC: it was not set up to represent the public's opinions.

This can be to an extent seen in the make-up of the committee (see Appendix I) in which it is clear that the lay public is barely represented. Unlike the CHCs, where only one sixth of the members are nominated by the Health Authority (see Levitt, 1980: 11-12) the LEC(PA) is more to be identified with and implicated in the *process* of health care planning. Its role, as may readily be discerned from its title, was to *advise* the purchasers of health care in West Glamorgan.

Hallas (1976: 36) writes of the CHCs' first years of operation that:

> one of the most common complaints made by professionals against councils is that they will support any good cause and at their meetings and in their annual reports they do tend to give this impression.

As (at least in theory) a vehicle of public opinion, the CHCs are at liberty to support any good cause, not least because every good cause - and quite a few dreadful ones - can find public support if only they look hard enough. CHCs can (and indeed should) represent this diversity of opinion because it not their role to resolve issues (in this case in funding decisions) on behalf of the commissioning authorities. They are in no way responsible for any investment - or disinvestment - decisions taken. That is to say, although CHCs stand at something of an awkward interface of management structures within the hierarchy of the NHS and pressure groups outwith it, they can nonetheless be more clearly identified with the latter than the former. At the end of the day, it is their role to oppose solutions that they see (in their role as guardian of the public's interests and good) as unworkable or unacceptable.

The LEC(PA), by contrast, is not in such a position, and is to be distinguished from the CHCs in a number of regards. Firstly and most obviously, it is not a statutory body. It owes its existence to the vision and initiative of individuals within West Glamorgan Health Authorities. Secondly, and more importantly, its function is to *advise*, not to represent outside interests. The Authorities may take or leave the advice given, since the committee has no right of veto over any proposal (see Jarvis, 1994), but they will be advised nonetheless.

It is an important factor of advice, and one too rarely appreciated, that it needs to be realistic. If that sounds too defeatist in the face of councils of perfection, perhaps it can be rephrased to say that advice must at least be *possible* to carry out.[9] That is to say, if the LEC(PA) is to advise the Authorities usefully, it must take account of the parameters within which the commissioning process takes place, and the given factors that contribute to the problems faced by the Authorities. As the committee's discussion paper of August 1994 (LEC(PA), 1994b: 2) puts it:

> The committee may not like the waiting list initiative, but the Health Authority has to live with it and make it work. Given the fixed points outlined in the companion paper, what recommendations does the committee have for ethically responsible practice *within* the boundaries imposed by the Welsh Office?

In this important sense, the committee can be seen as bridging a gap between the practice of academic philosophy and the messy world in which health care planners actually operate. In the context of the waiting list initiative, the drive announced by the Secretary of State for Wales to make the reduction of waiting times the top priority for health care investment in Wales, the response of the academic might have been to demonstrate the conceptual absurdity of the drive in view of the logical elasticity of health care demand, or to rail against centralist directives which take no account of local needs and initiatives, and to leave it at that. The LEC(PA) however, was charged, or charged itself, with a rather different task: to take on board the limiting factors which determine the flexibility of the Authorities' response, and to advise how best (best, that is, from a moral point of view) to proceed *given those strictures*. This point is brought out in a letter from AW to the members of the committee dated 9 September 1994:

> As a result of the meeting RJ will be asked to compile a paper to present to the joint boards. The paper must provide advice on appropriate action given the apparent conflict in the drive to reduce waiting lists. As RJ says in the accompanying paper, there is a need for a positive response. The boards are unlikely to welcome just a restatement of the problem or a destructive rather than a constructive approach.

It is this function of the committee, as standing only partly outside the process of health care planning and advising how best to operate within the (possibly undesirable but nonetheless inescapable) parameters, that should suggest a model by which we can understand its function and nature. Evans (1994) suggests that it should be thought of as "a health care planner's conscience". This vision of a kind of prosthetic conscience, distinct from but linked with the agent, is perhaps a startlingly dualistic one, recalling Ryle's picture of conscience as a sort of umpire or judge, other to our motivational faculties and desires, pronouncing judgements on our actions and behaviour (Ryle, 1971: 185ff), but one which is helpful in constructing a picture of the role of the LEC(PA).

Importantly, Ryle argues that the faculty of conscience "is awake only where there is such a conflict" [i.e. between a disposition to act in accordance with a moral principle and some contrary inclination. In the case of the Health Authorities and the LEC(PA), a moral or other principle might (as was in fact often the case) be in tension with external political pressures. What Ryle's discussion of conscience and moral convictions makes clear, and a point to which we shall return when we come to discuss an evaluation of the committee's work (see below p139ff) is that:

> The test for the existence of such a conflict is the occurence of attention to the problem of what is to be done. Pangs or qualms of conscience can occur only when I am both disposed to act in one way and disposed to act in another and when one of these dispositions is an operative moral principle (Ryle, 1971: 189) .

"The occurence of attention to the problem of what is to be done": conscience is not to be discerned in action, but in the debates and doubts prior to acting. If the LEC(PA) gave the Authorities pause for thought before they enacted policies, irrespective of whether those policies were themselves changed or not, then it was performing its task as conscience admirably.

If we think of a conscience in this sense then we can make sense of the idea that the LEC(PA), partly removed as it is from the actual *planning* of health care provision, can nonetheless be thought of as acting as the voice of conscience for those actually involved in the process. To the extent that any superintendent, any foreman is both to be counted as part of the group whom s/he oversees and yet at the same time can be seen as distinct from them, it should not be surprising that the LEC(PA) both is and at the same time is not part of the process of planning patterns of health care provision in West Glamorgan. That is, there is nothing immediately contradictory about saying that the committee can act as a conscience for some other group.[10]

Moreover, this idea is strengthened by consideration of what might be thought of as the proper role of the health care planner.[11] There is a long line of thought within the capitalist tradition that the role of a player in the market is not to be concerned with right and wrong, good and bad, but rather to maximise outputs or returns as appropriate. This line of thought is famously summed up in Vanderbilt's dictum "the public be damned, I'm working for my stockholders". It is by no means universally accepted as a principle (see for example French, 1984) but echoes of it remain nonetheless.

Given the market ethos that was introduced into the NHS by the 1991 reforms, it is easy to see that it could be thought inappropriate for health care planners and commissioners - as players in that market with aims and objectives of their own - to indulge in moral reflection qua health planners. The same argument that holds that "there is one and only one social responsibility of business - to use its resources and engage in activities designed to increase its profits" (Friedman, 1962: 133) could maintain that misgivings derived from moral uneasiness, as opposed for instance to doubts about the economic efficiency of an investment proposal, are not a luxury in which the health care planner can afford to indulge. That is to say, the very nature of the market enterprise, its rules of engagement, if you like, preclude the adoption of purely *moral* restraints on conduct or activity.

On this account, the proper role of the health commissioner is to make use of options presented as a result of market induced competition so as to maximise the amount of health care activity for a given resource input: to gain maximum efficiency. The problem is that those activities that are computed (on one particular value base) to be maximally efficient are not necessarily the same as the ones that either clinicians or the public want to see receiving greater investment. The results complied following the widespread consultation in Oregon, for instance, show that community and hospital based services for the housebound and the mentally ill were among the most highly rated services, and such services are notoriously difficult to evaluate in terms of efficiency, not least because the goals are difficult if not impossible both to define and to measure (cf pp24ff above). There is no reason to suppose, therefore, that if the only factors by which investment decisions were taken were economic ones, such services would receive the funding that the medical establishment appear to think them worthy of.

Of course, it would be naive to suppose that economic considerations ever *are* the only ones taken into account. As Sheldon and Maynard point out (1993: 4):

> ... rationing processes reward some and penalise others - that is, some providers win access to funding and the capacity to provide care and others fail. Those who fail will use personal advocacy, rhetoric, and shroudwaving in the media to highlight the deficits in funding and the "errors" of the purchasers.

However, it is important to be aware that rationing decisions taken on such bases are both informal and open to abuse leading to injustice. On a very simple level, if shroudwaving is known to be an effective lobbying tool in the enterprise of gaining more funding, then it is clear that certain services, for instance renal dialysis, children's hospitals, particularly those dealing with child cancers, and hospices have, through a combination of historical accident, natural empathy and astute marketing, gained a considerable advantage in an emotion-led race for funding. It is a simple truth that Ben Hardwick's search for a liver donor attracts more sympathy than a physiotherapy unit's quest for funds; and while it is by no means rare to see public appeals in aid of a local hospice, particularly if it admits children, house to house collections for the local STD clinic are unlikely to become an everyday phenomenon.

While the use of economic considerations alone, then, has the capacity to produce unjust and counterintuitive responses to the dilemmas surrounding limited health care investment, nevertheless the traditional alternative - informal lobbying using a wide range of techniques and appeals - seems no more designed to yield a just and desirable result. Whitehorn's (1993: 108-9) analysis of the partiality of interest groups is, I take it, not intended to be an attack on them *per se*, but rather on those who think that their involvement is an adequate counter to the inequalities engendered by crude economic rationing:

> They [self-help groups] are partial and blinkered, in exactly the same way as the desperate individual; they think, inevitably, that their illness is the one that really matters most. As do, of course, the specialist consultants ... their claims are just, but they aren't the people to balance them against all other claims.

If neither patients, nor consultants, nor self-help groups, all of whom are bound to be partial in their outlook, can be trusted to ration justly, and turning the matter over to a plebiscite *à la* Oregon is seen to be no better, and yet there is a need for something other than mere rationing by efficiency, then something else has to be brought into place. In West Glamorgan, that something else was the LEC(PA).[12] It was designed, I suggest, to address anxieties felt by those individuals involved in the commissioning process who were qua professionals not entitled to rely on moral qualms to take rationing decisions (see above), and yet as - at least - minimally decent human beings nevertheless were concerned about the inescapably moral dimension to their work which could not be satisfactorily addressed within the institutions and processes of health care planning in place at the time.

I want to tease out one or two further implications of the status of the LEC(PA) as both separate from and linked with the joint Authorities, because I believe that they give an important insight into the thinking that led to the establishment of the committee.

A clear implication of the committee's being separate from the Authorities is that it is able to criticise proposals put forward by them. Because the committee is not involved in the early planning and drafting of documents and proposals, there is no possibility of a conflict of loyalty implicit in criticism of them. Not being part of the initial planning process, the committee members do not feel that they have a stake in the ownership of the documents under discussion.[13] This therefore ensures that the criticism has some teeth.

On the other hand, the fact that the committee is - albeit peripherally - involved in the process of health care planning means that, while being sufficiently robust to make the consultation exercise worthwhile, the criticisms adduced by the committee cannot be so thoroughgoing as to be unimplementable by the Authorities: as I argued above (p36ff), the committee's recommendations needed to be such that the Authorities - restricted to some extent by centralist directives - were able to work within them. This requirement of realism can also partly be derived from the openness in terms of access to information and personnel that the Authorities granted to the committee. It is reasonable to expect, given the sound informational basis on which the committee's decisions and recommendations were grounded, that they should reflect the operational constraints imposed on the Authorities. In essence, the committee's access to information meant that its recommendations had to be equally based in hard facts: ignorance was not an available plea to excuse a lack of realism.

This dual nature of the LEC(PA), then, as both separate from and linked with the Authorities which established it, meant that the expression of reservations about (partly dictated) Authority policy was facilitated, but such criticisms were not identified as coming from dissentient voices from within the Authorities themselves, nor as a marginally hypocritical exercise in public conscience salving by the Commissioners. Rather, the LEC(PA) can be seen as a vehicle for reservations and worries that *any* well informed and minimally decent, concerned individuals - health planners or no - would have felt in the circumstances in which the Authorities found themselves required to operate.

Put another way, the individual members of the commissioning Authorities, both as loyal representatives of that joint organisation and also with an eye to the fact that public and maverick criticism of centralist proposals is hardly conducive to the formulation of successful bids for funding in subsequent years, were effectively unable or unwilling to voice what must have been, and indeed proved to be, concerns that they must have felt prior to the establishment of the LEC(PA). Even if you're left feeling a bit hungry, you don't bite the hand that feeds.

With the establishment of the LEC(PA), however, came an opportunity to publicise concerns and criticisms arising from the imperatives drawn for instance from imposing Welsh Office directives (cf p96ff). Since the committee was given almost unlimited access to the Authorities' information resources, it can be assumed that the criticisms were at least well founded as far as the facts of the matter were concerned. It therefore followed that those recommendations and reservations that the committee expressed which were in accordance with pre-existing worries felt by the Authorities' members either jointly or severally could be endorsed or given more or less tacit approval, for instance by the silent mothballing of proposals whose validity or application was questioned by the committee, or by incorporating the committee's advice or responses into future versions of documents or more generally into the thought culture of the organisation as a whole. The partial linkage between the Authorities and the committee, then, enabled the Authorities to associate themselves with the committee's expressed position as and when they found such alignment to be valuable (cf p98).

4. The place of the LEC(PA) in health planning

With this theoretical framework in place, then, it is time to look at how the committee operated in practice. Its micro-operation as observed during the course of its meetings is the subject of the following chapter, and so need not be discussed here. However, it is both helpful to readers not already familiar with its patterns of operation to do some scene setting, and also instructive to consider its paradigmatic operational dynamics to glean some insights into the nature of the committee.

Observation of the committee's activities suggests that there are fundamentally two standard paradigms which its dynamics follow, a re-active and a pro-active pattern. In the re-active pattern, the committee's response is determined with regard to timing, form and content by a pre-existing proposal or document already tabled by the Health Authorities. The perfect illustration of this pattern is in the consideration of the annual, biennial and other periodic Health Plans that form the value base and priority identification structure, by reference to and within which actual individual investment decisions have to be taken. These plans are drawn up and published by the Health Authorities (with reference to externally imposed parameters and priorities), and are then made available for public and other consultation in accordance with a strict (although not always clearly identified) timetable.

It is in this consultation period that the LEC(PA) has made available to it copies of the provisional plan. Its members must read the plan, the researcher then drafts a discussion paper to focus the debate in the meeting, a sub-committee meets to consider the draft discussion document, and the document is redrawn with regard to recommendations made in the sub-committee.[14] The paper is then circulated to the entire committee prior to the full meeting, where - at least in theory - it provides a focus and format for debate. Following the meeting, the researcher then produces an output paper which distils and enunciates the committee's deliberations and clarifies its recommendations. This paper - depending on the timetable - may or may not be circulated to the chairman and / or other members of the committee for comments before redrafting and final submission to the joint Boards of the Authorities, who will consider the committee's comments and incorporate them within the final version of the Plan as they think fit.

All this takes place within the period allowed for consultation in the timetable governing the production of the plan in question. It will therefore readily be appreciated that this paradigm of action is not always borne out in the actual *practice* of the committee's work, where prior reading of documents by busy professionals often takes place in the first five minutes of a meeting, and the preparation of and consultation over the format or wording of a document can be hurried and conducted late at night or over the telephone, rather than in the relative calm of an agenda-driven meeting.

Given the sheer scale of the exercise of constructing a Health Plan, the number of personnel involved in its drafting and the quantum of hours invested in its preparation, it should be obvious that there is only so much that can be changed at a late stage as a result of reactions from a non-statutory committee. The investment of time and resources that a nearly completed Plan represents means that the cost of drastic rewriting virtually precludes complete rejection by the LEC(PA). This is another fact about the reality of health care planning which the committee has to face up to: to use a buzz word of modern philosophy, only so much is up for grabs.[15]

This means that the timing of the papers produced by the LEC(PA) is vital. Suppose we assume a willingness on the part of the Authorities to listen to what the committee has to say - a assumption which is, I suggest, reasonable in view of the fact that it was the Authorities themselves who were responsible for the institution of the committee. Even given this assumption, unless the committee made it possible, in terms of the timing of its response relative to the development of a Plan or initiative, for its reactions to be incorporated without too high a cost in terms of input resources scrapped in redrafting, then its effect, however much both it and the Authorities may have wished otherwise, was bound to be muted. If the response was late, then there was little or nothing that could be done to take account of it, however much anybody might have wished to the contrary. Institutional inertia is a powerful factor even in the best intentioned processes of reform and revision.

The second paradigm for the committee's action, the pro-active pattern, is to be distinguished from the first by the locus of the original identification of the issue. In the re-active model, the Health Authorities identify an issue on which the LEC(PA) is to comment, and events then unfold more or less as outlined above. In the pro-active model, however, the issue for discussion and review is identified not by the Authorities but by the committee itself: that is, within this model the committee sets its own agenda for discussion and its own remit and terms of reference.

On this model, an issue is identified as one that the committee could usefully comment on at a full meeting and the researcher is directed to work up linked briefing papers to facilitate discussion. The first paper is an assessment of the *status quo*, a sketch of the problem as it is identified and the fixed given parameters within which any discussion and putative recommendations must be drawn (the requirement of realism again). This is circulated to key Health Authority personnel for their comments on its accuracy as they perceive it, and is redrafted in accordance with their suggestions. It is then examined by the sub-committee with a view to planning and maximising the possibilities for debate in full session. The revised briefing paper is then circulated to all committee members in advance of the meeting, together with a companion document prepared by the researcher, providing headers for ethical discussion. It is intended that, by flagging up the areas of ethical concern that arise as a result of the situation identified in the briefing paper, this second document will provide a starter and framework for discussion. As a result of the meeting, an output paper is then prepared which is submitted to the Health Authorities. Since there are fewer constraints related to the time of any such submission, unlike the re-active model of operation, more extensive consultation is possible on the nature and content of this output document.

This process developed in response to a number of potential or actual difficulties in discussion that were identified. Firstly, the need for any recommendations to be realistic and capable of implementation that has already been discussed generated a need for a mechanism by which such realism could be ensured. This need was met by the preparation of a briefing paper setting out the unalterable limiting factors which were not open to debate or questioning. Not only did this have the benefit of ensuring the applicability of the committee's recommendations, it also meant that valuable discussion time was not spent lamenting the unalterable.

The second requirement that the briefing paper was designed to fulfil was that committee time should not be spent in relatively fruitless disagreement about purely factual matters. It is again important to stress that the role of the committee was to provide *advice* to the Authorities on the commissioning process. This advice was unlikely to be forthcoming if the members of the committee became bogged down in the minutiae of factual disagreement.

The second of the two input papers was designed to meet a rather different need. Given that it was in the nature of the issues identified by the committee to be broad and to touch on many different areas of health provision, it was felt to be important to focus the debate in a way that was both conducive to a productive outcome whilst at the same time not being unduly stifling of members' input. As well as excluding those areas of the discussion that were not open to change or questioning, then, there was an identified need to maintain the focus of the debate if the committee was to avoid merely repeating the problem: what was wanted was *advice*. This perceived need gave rise to both the agenda planning meeting of the small group, and the preparation of the pre-circulated issues paper.

Unlike the CHCs, then, which largely adopted, or were forced to adopt, an almost exclusively re-active model of practice, the LEC(PA) was able to operate in both a re-active *and* pro-active fashion, both responding to presented issues and documents, and also setting its own agenda for discussion.

There is, however, always a danger associated with free-ranging agenda setting. Given the need I have outlined for the committee to restrict its comments to those areas of Health Authority practice that were thought of within the Authorities as being open to change, "up for grabs", the committee always ran the risk of overstepping definite but nonetheless ill-marked boundaries (cf p50ff below). If these boundaries, dividing those activities or practices which are taken to be fundamental from those which are regarded as more peripheral, were transgressed, then the LEC(PA) would court disaster in the form not only of revealing itself as being culpably out of touch with the realities of planning for health care provision, but also, like the boy who cried "Wolf!", lessening the impact of its recommendations. As a new initiative, the LEC(PA) had to establish *ab initio* that both it and its recommendations were to be taken seriously.

Just as the re-active paradigm carried with it a danger of the committee's response being produced too *late* to be taken into account, so the pro-active model gave rise to the potential problem that the committee would question areas of practice and activity of the Authorities *before* the managerial and conceptual climate had evolved to make such questions a realistic possibility. In this sense, although I have characterised the second paradigm as pro-active, allowing the committee completely free rein to set its own agenda, it would be simplistic to suggest that there were no constraints on the committee's areas of discussion. In one sense, of course, there were not, in that "no part of [the Authorities'] investment - or disinvestment - proposals will be exempt" from examination by the committee. (Jarvis, 1994: 18). However, the requirement to question only those areas of practice that could realistically be altered or redefined in accordance with the recommendations of the committee meant that certain areas of health policy were *effectively*, so to speak, out of bounds.[16]

This limitation, and the requirement for the committee to tune its debates to the prevailing climate of discussion and perceptions of which, if any, parts of the process and practice of health care provision were open to change, calls to mind Fuller and Myers's discussion of "the natural history of a social problem". They argue that:

> Every social problem thus consists of an objective condition and a subjective condition. The objective condition is a verifiable situation which can be checked as to existence and magnitude (proportions) by impartial and trained observers ... The subjective condition is the awareness of certain individuals that the condition is a threat to certain cherished values.
>
> The objective condition is necessary but not itself sufficient to constitute a social problem. Although the objective condition may be the same in two different

> localities, it may be a social problem in only one of these areas ... *Social problems are what people think they are* ... (1941: 320, italics in original)

In the terms of the present discussion, we can say that those areas *and only those areas* of health service activity whose validity is considered to be open to question fall within the LEC(PA)'s remit. That is, the LEC(PA), while it could decide to raise questions other than at the behest of the Authorities, was not *completely* free in its choice of subject, which was limited by prevailing ideas and preconceptions.

Given Fuller and Myers's strongly subjective assessment of the defining characteristics of a social problem ("*social problems are what people think they are*"), it is easy to see that as there are differing groups of individuals, differing classes of players in the health care planning game, so also there will there be different views as to what constitutes a problem: that is, which areas of the Authorities' activities are open to question. However, there is every reason to presuppose a degree of homogeneity of belief structure within a given institution such as the joint Health Authorities in West Glamorgan, to whom the LEC(PA) reports. That is, the committee's remit, in terms of what it could reasonably question or recommend, was constituted in a relatively firm base of ideas: most of the key players within the Authorities would tend to have similar opinions on these important issues at any one time.

But note that this is not to say that the boundaries defining the given from the questionable can never shift, nor that the (albeit homogeneous) perception of the status of various areas of health care activity is set in stone. It is quite clear that there are some questions being asked now about health care provision that could not have been asked twenty years ago. "Could not", that is, in the sense of "could not productively and with a reasonable hope of being taken seriously". The shift is in patterns of response to both objective and subjective conditions. So for example, the objective, externally verifiable, conditions such as patterns and quantum of resource input, scale of demands as a result of the introduction of new technologies, demographic patterns, and so on may all change, and give rise to a new conceptual framework within which decisions are taken. But in addition to that conceptual change, there is the possibility of a *per*ceptual shift which reflects on the subjective conditions of identification, such as the estimation of the duties of health care providers or the extent of the claim rights and reasonable expectations of health care consumers.

Given the possibility of this twin shift in both conception and perception, it follows that on a longer term diachronic view the situation within which social problems and areas of health care activity up for grabs in the funding debate are defined changes: that is, the circumstances are fluid. And it is reasonable to suggest that ideas emanating from such bodies as the LEC(PA) might well form one factor that may be important in prompting a re-evaluation of both conception and perception, of the climate of ideas in which health planning takes place.[17] That is to say that, while the committee's freedom to set its own agenda is in one sense limited by the climate of opinion to which it reports, the influence is not unidirectional; the mere fact of certain values and presuppositions being questioned can in and of itself render them questionable, that is, open to being questioned. But notwithstanding this long term fluidity, at any one time, given the homogeneity of belief inherent in the notion of an institution, the parameters are, although not necessarily clearly marked, nonetheless rigid and inflexible, and cannot profitably be challenged.

1. This faith in the virtues of a planned service was by no means restricted to the field of health care provision:

> [the post war years] began on a note of professional confidence and [town] planning was swept along in a vigorous stream of new-found importance. (Cherry, 1974: 139).

It is no coincidence that The Town and Country Planning Act came into force just four days before the National Health Service Act, in July 1948.

2. In 1948 there were 5,275,000 pensioners in Britain, in 1991 there were 10,584,000. (Whitaker's Almanac, 1950: 639 and 1994: 118-9). This represents an increase from 10.5% to 18.7% of the total population.

3. The committee discussed precisely this aspect of the continual redefinition of health and subsequent health demands in precisely this context. Its recommendations for the commissioning of infertility services (LEC(PA) 1995b) suggested that the character of the need for infertility services could most helpfully be envisaged as a mixed medico-social need, deriving from the suggestion that childlessness represents a social need that is susceptible to a medical resolution.

4. It is worth pointing out that one implication of this is that there is not the least point in philosophers, economists and journalists continuing to call for an informed, explicit debate of the issues in rationing - as they are so wont to do - until the inevitable context of resource shortfall has been not only established, but *accepted*.

5. Work done on a conceptual analysis of what health is, and in what ways (if any) it can be considered as analogous with manufactured goods, the provision of which the theory of the market was originally designed to govern, suggests that there may be more problems than I have time to discuss (see for example Greaves, 1993: 79, and Devlin *et al.* (eds.) (1990)). Since this discussion is intended to be an exercise in scene setting, however, I can do little more than to note that these questions have been raised.

6. This particular objection could be overcome if instead of pocketing the surplus, the parsimonious Campbell were allowed to distribute it where he wished. If we allow that he is actually capable of an unselfish action, and has a weakness for ailing donkeys which leads him to syphon off as much as possible of the initial £40 to the local donkey sanctuary, then we will perhaps have a fairer picture. NHS purchasers may not themselves receive the benefits of cost cutting, but costs cut do enable them to redistribute funds into preferred areas.

7. For the moment I leave aside the obvious and intractable problem of assessing what is a luxury and what is a necessity in health care.

8. Again, some conceptual analysis is going to have to be left undone.

9. This is in accordance with the well-established principle that no-one can be obliged to perform the impossible: "ought" presupposes "can".

10. I discuss the question of whether it makes sense to think of the committee as the Authority's conscience further in chapter IV.

11. I should emphasise that the picture I sketch here of the proper nature of health care planning is by no means the only possible one: the intention is to lay out what I take to be a predominant idea of the role, which, moreover, holds most strongly that ethical considerations are none of the business of the health planner. This is not, it should be evident,a position I hold, but I hope this discussion does give those who might hold it their metaphorical day in court.

12. I have examined attempts within the Dutch and New Zealand health care systems, as well as the Oregon experiment, in Jarvis, 1996b: 183-5.

13. This point is amplified in the discussion (p102ff) of the resignation of CB, who - as a consultant in public health medicine - *was* involved in the preparation of some of the documents and proposals discussed by the committee, and who as a result felt a conflict of loyalties and interests which was not shared by other members of the committee. It is interesting to note that the same reservations appeared to be felt by CB's successor on the committee, BL, who as the Director of Public Health was both implicitly at least partly responsible for the content of documents such as the Health Plans, and an executive member of the Health Authority. In the meeting of 11 May 1995 it was noted by several of the committee members as well as by the observer that BL felt compelled to defend Authority policy in the face of its being questioned by the committee, suggesting that he too felt a certain difficulty in effecting that separation between his professional persona and his membership of the committee which would allow him to voice criticisms of the Health Authority. Such reluctance was itself criticised by Wilson *et al* (1967: 432):

> Part of the trouble seems to be due to an extreme form of the view that one cannot be a member of an institution and yet criticise it in the world outside ... It is rather like saying that you can't honestly play a game unless you think that all of the rules are sensible, or that you can't be a loyal member of a society unless you think that all the laws are right. The result is to produce a state of affairs ... which conveys a sense of inertia and dead weight: often combined with a certain uneasiness, characteristic of those who sometimes think that they may be sitting on the edge of a volcano but prefer to tell the outside world that it is a mountain just like any other for the sake of public relations.

14. In fact, the sub-committee, established in order to preview the business of the upcoming meeting, was allowed to wither after only a few meetings. This meant that the only input into the meeting apart from any official Health Authority documents was the paper(s) prepared by the researcher.

15. It is interesting to note that a similar problem faced the newly formed CHCs studies by Klein & Lewis. They cite Burnley, Pendle and Rossendale CHC's comments (1976: 128):

> Whilst the Council appreciate the natural caution of professional officers in admitting amateurs to their councils, they must ask that time is given to the Council for proper administration of plans which are put before them ... If we are to make a meaningful contribution to planning, we need to be brought into the planning process at as early a stage as possible.

Levitt (1980: 45) identifies a similar problem:

> There is, understandably, such strong commitment on the part of the health authorities to sticking to what is in the published plans that they are unlikely to take much notice of any radical suggestions for change coming too late in the day.

16. The following excerpt from the notes made of the meeting of 24 March 1994 gives an example of precisely this kind of implicit ruling by the committee:

HW Could we look some time at the issue of whether West Glamorgan patients should be treated in preference to ones referred from Powys simply because Powys have overrun their budget? This appears to be a clear example of clinical decisions being over-ruled by financial ones: I'm having to prioritise treatment in accordance with an Authority's ability to pay, not an individual's need - I'm taking financial decisions as a clinician.

DG This is an important issue, but it's a national one. Even if we considered it, would there be anything that could be done at a *local* level? We should stick to discussing things that the Health Authority *can* change [general agreement].

The meeting of 24 March had also heard that the Health Authorities had been instructed to abandon the Provisional Health Plan that had been the subject of the previous meeting's discussions and to represent the information it contained in an entirely different format. One member suggested that it would be appropriate for the committee to criticise this revision, on the grounds that "given that an adequate Provisional Health Plan [ie the discontinued Plan] has already been produced, it would be unethical to commit limited resources to something that is nothing more than an exercise in redrafting." This view was, however, rejected on the grounds that "the Authority hasn't asked to do this redraft - it's been imposed on it from Welsh Office: there's no point in just criticising things they couldn't change even if they wanted to."

Similarly, in the meeting of 22 September 1994 discussing the Waiting List Initiative, one member suggested that any response to the Initiative should include reference to the problems implicit in "private medicine and queue-jumping", but this was immediately rejected by the committee on the grounds that "this has been a problem since the NHS was instituted, and it's hardly a problem that West Glamorgan is going to be able to solve."

17. For further discussion of this notion of a gradual alteration in the climate of decision making that may arise as a result of the kind of examination that the LEC(PA) was able to undertake, see p164-170.

Chapter II

Observing the LEC(PA)

Oh wad some Pow'r the giftie gie us,
To see oursels as others see us,

Robert Burns

1. Problems in research methodology

A central theme of much moral philosophy is the impossibility of a conceptually neutral observation post from which to observe the world, an Archimedean point from which everything can be seen moving of its own accord. Observation is not like that: there is no view from nowhere (see e.g. Nagel, 1986: 25). Whatever eyes I look at something through, I cannot but look at it with *some* eyes. However much I may try to shuffle off my preconceptions when observing anything, I cannot see it *neutrally*. To be sure, I can move from seeing it as an outsider to seeing it as an initiate, as Cartry did when he came to understand the importance of taboo names in the *bu'mpo* song of the Gurmanceba (Cartry, 1992: 30-36), but Cartry wasn't understanding the text *neutrally*, without any (in this case cultural) preconceptions: he was merely seeing it *as a Gurmanceba*, rather than as an outsider. The search for total objectivity, for the conceptually neutral view, is logically doomed from the start. To be sure, we can distinguish accounts of action that are reasonably even-handed and fair from those that are rankly biased and prejudiced, and it has obviously been my task to ensure that this discussion falls within the first, rather than the second group. But we should be wary of moving from the observation "this is not prejudiced" to the suggestion that "this is the objective truth of the matter" - a view can be subjective without in any way being perniciously biased.

Given this, I have not even tried to be conceptually neutral about this research. Obviously, I think it is important, otherwise I would not be doing it. But there is more than that to my preconceptions. I am interested in what the committee is doing, that is to say, whether it is "doing ethics" (whatever that means), and I am interested in how it comes to do it. I have perhaps paid closer attention to the themes of emerging rituals and myths than others would have had they been in my shoes, in the belief that such rituals reveal important truths about the committee's construction and performance of its tasks, but I hope not to the exclusion of other (equally interesting and revealing) themes. But perhaps the most important assumption in this research is that it is possible at all: that is to say that the committee can be observed usefully and without dramatically altering the character of either its deliberations or its decisions. I am aware that this supposition will not be shared by everybody. As Punch (1979: 195) notes: "There is, too, always the question mark surrounding the extent to which individuals modify their behaviour in the presence of the observer."

I will not argue for this point at length, partly because beyond the limits necessary to set up this research, I am not unduly concerned with second-order questions about the nature of sociological observations and the material to which they give rise, but also because I consider the view that Punch, following Becker (1971), suggests to be common sense:

> ... people do not keep up such an act for long, and ... what they are engaged in is often more important to them than the fact that an outsider is present. A policeman may speak more politely to a citizen because a researcher is at his elbow, but in many situations he does not have time to think but must react instantly. In any event, my appearance became so commonplace that after a while I did not believe that people noticed me during routine cases.

Although the kind of immediate reaction demanded of a drugs officer with the Amsterdam police force is rather different from that required in open debate in committee, I believe that the main thrust of Punch's argument holds: put bluntly, that life is too short to be for ever worrying about the observer.

However, I suggest that there is a significant discontinuity between the kind of observation of which Punch's is an example and the present research, and it has important repercussions for the issue of the external validity of the data gathered. The Amsterdam police force was fully operational long before Punch hove into view with his notebook and his awkward questions, and it continued similarly once he had gone. That is to say, it - or rather the specific patrol group that was the subject of his study - had clearly defined operational parameters and methods of achieving their objectives already in place. Knowing what we do of human nature and the character of grass roots subgroups within rigid institutions, it is likely that their methods did not always wholly accord with the official directives handed down from on high. Put another way, the patrolmen on the beat may have found it necessary to bend the rules a little from time to time. They had a job to do, and they wanted to do it. What could be more natural than that they should have to be somewhat approximate in their interpretation of certain rules in their pursuit of that aim?

It is entirely understandable this should be so, and it is no less clear that the individuals in question might have felt that they had an interest in modifying their (tacitly accepted by their peers, but officially condemned) behaviour in the presence of an outsider, particularly given the fact that the results of his research might well become public knowledge. More specifically, the boss might get to hear about it. In this sense, it is perhaps arguable that Punch's apparently common sense view is little more than wishful thinking. Perhaps in the scenario where the established *modus vivendi* is at odds with the official line, behaviour *is* modified in the presence of a clearly identified outsider, and the experiences to which Chenitz and Swanson (1986: 52) refer are more representative: "... the nurse field researcher was greeted with teasing behaviour when she appeared on the ward: 'Here comes the spy!'"

The point here is that in both cases, and I suggest that these are almost paradigmatic for much social research, the groupings and their patterns of operation are clearly established long before the researcher comes onto the scene. That is, the subjects know that they are *subjects*. To some extent, therefore, it is perhaps inevitable that there will be some modification of behaviour on their part in the presence of an identified outsider, at least initially. As Chenitz (1986: 51) puts it:

> [w]e have learned that until you have established some trust and are accepted by the persons in the setting, it is not uncommon for you and your purpose to be held suspect. No matter how well you have engineered your presentation of self and described your purpose, you will still be defined and perceived within the frame of reference of 'the other'.

This behaviour modification may be limited in its scope, as in Punch's example of the policeman being more polite in his questions, or it may be so extreme as to eliminate the possibility of any observation whatsoever, as in Humphreys's discussion.[1] The quantum of alteration may differ, but the principle remains the same: there is something which we may reasonably refer to as the observational effect.

How is it that I can be so blasé, then, to suggest that my presence at the meetings of the committee did not distort the data gathered? Put in its strongest terms, this objection to the whole enterprise of this research goes something like this. "You want this research to be taken seriously, and by that you mean that you think that it has important implications beyond the narrow focus of its immediate subject. You claim that your findings deserve to be taken account of beyond the boundaries of West Glamorgan. If that is to be the case, then you have got to show us, the reading public, that your observations are not restricted to this specific scenario. If we are to believe that the things you say are indicative of the kind of things that might be said about *any* similar committee, then you will need to convince us that these observations do not simply apply to a committee observed as yours has been. We are not interested in what a child *says* about valuing honesty in a classroom discussion, what we want to know is whether he *actually* owns up when he's broken a window. If we are to take what you say seriously, then we will need to be sure that the whole exercise hasn't been carefully stage managed."

Before I explain why I think that this putative objection to my research is misguided, I shall take a little time to explore it further. Having said that I have not even attempted to be neutral in my observation of the committee, the least I can do is to give my theoretical objectors their day in court, and to express what I imagine to be their misgivings as best I can. Those who can imagine the full force of the objection, and who are not interested in the detail of *how* the observation was carried out, can skip the next section with impunity.

At this point, it is perhaps appropriate to explain the actual quotidian detail of how the research was conducted. From the very first, it was clear that I would need accurate records of the meetings, not only to analyse for this research, but also to enable reports and working papers to be constructed that accurately reflected the discussion and the views expressed in the meeting. It was also clear that, given the size of the committee and the length of the meetings, these records would need to be contemporaneously made. It would be absurd to try to hold the discussion in my mind until the next morning and to write it up then.

This then presented me with something of a problem. To begin with, it would have been impossible (practically and ethically) to make such records without the knowledge and consent of the members of the committee. Concealed microphones were out of the question, not simply because the recording thus produced would have been in all probability inadequate for my purposes, but because there is something obviously objectionable about the covert recording of - especially important - deliberations. Or indeed, any other conversation.

This left us with two possibilities. One was to place recording equipment in full view of the committee, and to transcribe the recording thus made. This would have had the advantage that the transcripts would have been as full and accurate a version of proceedings as possible. It would also have made the research virtually impossible.

To begin with, there is the sheer scale of the material in question:

> Transcribing tapes is an extremely time-consuming and tedious task. Listening to the tape takes as much time as making the original recording - hours of interview data require hours of listening. Transcribing tapes adds another dimension to the concept of time consumption. (Fetterman, 1989: 82)

Added to this would have been the unwieldy nature of the finished transcript when it eventually appeared. Anyone who has ever tried to find anything in *Hansard* knows that a verbatim record of proceedings, although *de natura* accurate, is not by any means the most convenient tool for research.

However, there is a more important reason why this was felt to be a poor way of proceeding. One of the themes of this chapter is the extent to which this research mirrors the paradigm of sociological observation, and the extent to which it differs from it. I suggest that one important difference is that - perhaps more than many research subjects - the members of the committee are people with something to lose. I discuss what I mean by this later, and attempt to defend the idea against some stout objections, but for the moment it is enough to note that, unlike many research subjects, the members of the committee do not have the cloak of anonymity to protect them in this discussion: if I refer to an individual member, then I have no choice but to do so if not by name at least by initials. There is no question of coyly cloaking the member's identity by making "slight changes ... in the transcript in order to hide the identity of the respondent and other persons involved" if I am to "remain faithful to all items that have implications for this research and its application" (Humphreys, 1970: 90). To this extent, then, the meetings of the committee, although not taking place in the public eye in the same way that the meetings of the Health Authorities are conducted in public, are nonetheless eventually open to public scrutiny, for even a thesis is a public document.

Given this, it is important to realise that this research is set apart from a considerable part of other sociological research. Its central characters are identifiable: indeed, they are expressly identified within the document itself. Moreover, many of them are high-ranking professionals, whose pronouncements on the kind of issues that they are expected to deal with in committee will be taken seriously.[2] Importantly, there is the possibility of a dissonance between the privately expressed opinions of the members and their public roles. Even a brief look at my notes from the meetings is enough to show that there have been occasions when certain members have voiced opinions that would sound odd if they had been publicised.[3]

I feel particularly strongly that there is something almost uniquely threatening in this kind of situation about a tape recorder. If there is the ever-present fear that outspoken views expressed in discussion are going to achieve magnetic immortality and may come back to haunt their author, then it is quite clear that the presence of a tape recorder will have an inhibiting effect on discussion. Even in the early days of this research, when neither I nor anybody else involved had a particularly clear notion of what its eventual aim was, it was clear that one thing that had to be avoided at all costs was my presence as an observer having a dramatic and detrimental effect on the discussion. Neither I as observer nor the committee as people with a job to do could afford this, so the idea of a tape recorder, seductive though it was in its offer of unflinching, tireless accuracy, had to be put aside.

This left me with only one practicable option in terms of making an adequate record of the events of the meetings, which was to make a written, contemporaneous note of every comment made at the meetings. These notes aimed to reproduce the spirit as well as the content of the discussion: *Hansard* might not approve, but its advantages were many. Firstly, it made possible the production of a reasonably complete version of events without demanding absurd amounts of clerical effort. Secondly, the completed record was kept to a manageable size for future reference. Thirdly, it allowed the interpolation of impressionistic comments, either at the time, or when the notes were written up the following morning, which - perhaps more than a mere sound recording - served to capture the atmosphere of the meeting. Lastly, but by no means least importantly, the method was both sufficiently open to give notice to the committee members that their discussions were being documented, but not so interventionist in its character that the discussions would be significantly affected by the process of recording.[4]

I began each meeting with a pad of blank paper, with a wide margin ruled down the left hand side. Each time one of the members made a contribution to the discussion, I noted down the initials of the person concerned, and the *flavour* of their remark.[5] Sometimes this would be by paraphrasing a question, sometimes by rapid note-taking, sometimes by a combination of the two, with a direct quotation, often the last sentence, added to capture the tone the more accurately. This method is necessarily highly impressionistic, and I am the first to admit that it would be highly surprising if my version of events were to be identical with that of someone else performing the same task. As Webb *et al.* (1966: 114) noted,

> [t]he biased-viewpoint effect includes what we have discussed under the label of intra-instrumental processes. The instrument (the human observer) may selectively expose himself to the data, or selectively perceive them ...

To the extent that from the time of my appointment, there were no meetings of the committee either in whole or in part at which I was not present, the first danger, of selective exposure to the data, can safely be discounted. In this respect, the research is significantly unlike the kind of observation that Webb *et al.* had in mind, where time sampling seems to have been a significant problem. They remark:

> "It is not possible to know all about college students if observations are limited to afternoons in the fall; when these observations fall on Saturday, worse yet." (Webb *et al.*, 1966: 140)

There was no time during the period of this research at which the committee did its work unobserved. In this way, the project was unusual, and the research subject unusually observable.

Having said that, the problem of selective perception of data remained an ever-present one. This was not simply because there was the danger of my losing concentration during the discussion, which was - by the very nature of the method of recording chosen, the repeated notation of each and every remark during the course of a two hour meeting - almost impossible.[6] The point is that in a two hour long interaction between up to sixteen people, there are *so many* things that I could have observed, only a tiny fraction of which I could actually take into account. So for instance, there was no possibility of my adapting Galton's (1884) suggestion of a way to measure "the inclination of one person toward another" by fixing pressure gauges to measure the stress on the chair legs on the side nearest the interlocutor (Webb *et al*, 1966: 151). With so many things crying out to be observed, I had to decide somehow how to direct my attention. Indeed, my *embarras de riches* to some extent echoes the very problem that gave rise to the committee's inception: the resources (in this case the attention of the observer, rather than financial reserves) are simply too meagre to meet all the claims made upon them.

So some kind of selectivity was inevitable. Indeed, it might be argued that, since social research can be likened to panning for gold, with a considerable quantity of dross having to be eliminated before a particularly choice nugget is found, a measure of selectivity is perhaps not such a bad thing after all, particularly when the research instrument is something as finely tuned and as able to make infinitely many and small adjustments as a human observer. But there remains the danger of specific tints to my observational spectacles: of perceiving what is sought. Buy a Volvo, and you will suddenly see that the streets are full of them. Take a dog for a walk for the first time in a park familiar to you, and you will notice, and talk to, dozens of other dog owners previously invisible. A psychiatrist sees madness all around him. If I find evidence in the meetings to support my hypotheses it may well be because they are just that - *my* hypotheses, and I am looking for something to support them. In case this should be thought an objection to the research, there are two points to make in my defence.

The first is that such selectivity is inevitable. By this I do not just mean practically inevitable, in that there is just too much empirical data to be observed. In theory, it would be possible to pack the room - if it were large enough - with enough observers to provide a complete record of what went on in the meeting. But it would be a mistake to think that this would be the same as eradicating the necessarily subjective character of the observations. Multiplying the number of observational bases would merely multiply the number of biases and hypotheses being tested. It is a mistake to confuse wide-ranging subjectivity with objectivity. What is *the truth* about one of these meetings? I cannot believe that there is one. All I can hope to do is to record *my* truths about them. In the same way, a geologist, a mountaineer and a watercolourist will all tell you very different things about Ben Vorlich, and only a fool would suppose that any one of them could tell you *the* truth about that magnificent hill: but it remains true that each account is both truthful and valuable in its own way, that is, from its own perspective. The geologist will give us geology's partial truth, the mountaineer (if he is reasonably competent) that of the climber. This is not a limitation; it is simply a logical point about the necessarily situational character of any observation or remark. If the artist declares that the mountain is a mysterious beauty, and the mountaineer that it is a savage beast, there is no disagreement between them. They are merely putting into words different responses to a complex stimulus. If a mountain can be that complex, how much more so can a committee meeting? As Charsley (1992: 127) argues:

> The potential for symbolic interaction here is striking therefore. What is argued, however, is that such interpretation, far from representing the discovery of some underlying reality, is the way human imagination may play amongst the plethora of materials for interpretation thrown up by the patterns of repetitive action found in all societies.

Given this, it is not surprising that over time I have shifted the focus of the operational parameters of my research: what I have been looking for. Not only is it not surprising, moreover, I suggest that it is all to the good. In those cases where an hypothesis has been revealed to be a poor one, I have been able to discard it and replace it with a modified, or on occasions, completely new one. One of the overarching strengths of the method of participant observation is that hypotheses and theories can be strengthened, adapted and discarded as they come into conflict with the data.[7] Given this, it would be exceptionally surprising if my operational parameters had *not* shifted in their focus during the course of the research, and I regard it as a sign of progress that I have developed hypotheses that I did not have at the outset. Change in hypotheses as a result of new data is not in and of itself negative. Indeed, given that the research took the form not just of observation but of action research, that is to say not a mere verbatim reporting of events, but an attempt quite deliberately and with the approval of those observed, to interpret, evaluate and help to develop the work of the committee, it is in no way surprising that both the form of the action observed and recorded, and the hypotheses arising from such observation, should over time have themselves developed and altered. Central to the enterprise of action research's interpretation, shared evaluation and feedback from observer to observed and *vice versa* is the idea of the observer having some kind of influence on the action observed (cf p143ff below). If these two influences, of the subject on the observer and of the observer on the subject observed, is not to be negligible, that is to say, if the research is to be action research in any substantive way, then it is to be expected that various dimensions of the research will develop and change over the period of the observation. If an influence is to be effective, a change is inevitably to be expected.

Moreover, I suggest that my previous inexperience in this type of empirical research was in this respect an advantage rather than a handicap. I remarked above that at the outset of the research, neither I nor anyone else concerned had a particularly clear idea of what the research was to achieve, beyond some rather hazy notions of "charting the development of the committee and its activities, together with publicising its work in a wider context". I suggest that this lack of preconceived ideas about the purpose of the research and the course that it was likely to take is a strength rather than a weakness, in that models and hypotheses had to emerge from the data, rather than being imposed upon it from above, simply because at the beginning of the research, I did not have the theoretical models at my fingertips to distort the data. It was only once I had collected data from several meetings that I began to see certain patterns and themes emerging. Unwittingly, I had followed Polsky's advice: "Initially, keep your eyes and ears open, but keep your mouth shut." (McNeill: 1990). As Humphreys (1970: 22) remarks: "Hypotheses should develop *out of* such ethnographic work, rather than provide restrictions and distortions from its inception."

2. The committee - researcher relationship

I said above that I granted the force of the objection that this research needs to justify its applicability beyond the boundaries of West Glamorgan: that is to say, I readily accept that if it can be shown that my findings can be applied only to such committees as are subject to the kind of observation that this one has operated under, then the *practical* import of this research might be somewhat limited.[8] However, while accepting its force, I nonetheless reject its applicability to the present case. *If* my views of the committee were distorted because they were formed as a result of a particularly careful - and extraordinarily extended - piece of what Goffman terms "impression management" (Goffman, 1982: 116), then their value beyond West Glamorgan might be limited. But I do not believe that this is the case, and this is why.

My reasons go well beyond the common sense reply that sixteen busy professionals in the field of health care planning with an agenda to meet and important issues to discuss have simply got better things to do than to launch a sustained and demanding attempt to pull the wool over the observer's eyes for nearly three years. They concern the self-definition of the committee; or more specifically, the identification and labelling of the outsider. They touch on several themes drawn from classical anthropology, including the way in which boundaries are drawn by a group, the problem of access negotiations to gain permission to study a research subject, including the role of a research facilitator or gatekeeper, and the concept of rites of passage.

I argued above that one of the significant differences between the present research and what might be thought more paradigmatic social research is that the subject group in question was newly formed at the beginning of the project. Unlike groups whose identity is more clearly established and whose culture, *modus vivendi* and argot has to a great extent ossified, the LEC(PA) was, at least in the earlier stages of the research, still in the process of self-definition. Its task, alongside the more formally expressed aims of advising the Health Authorities on the ethical issues surrounding their spending plans, was to develop for itself both an identity and a way of proceeding that was satisfactory both to itself and to the Authorities. In a classic demonstration of the existentialist's dilemma, first of all it was, and only then did it purpose to be: its existence preceded its essence.

Two distinct implications follow from this observation. The first is that I have been able to observe not just the *existence* of boundaries, rites, and all the other attitudinal and behavioural processes that combine to produce a group's identity, but also *the very processes by which these came into being.* The second, however, is even more important for the present purposes, since it concerns the reaction to and effect of an outsider as an observer on the committee's meetings and development.

I have already argued that complete openness in note-taking was the only practicable and acceptable way of proceeding "in the field" as it were. To an extent, the problems and opportunities facing me echoed those of Wilson (1977):

> The decision to record and take notes in full view of the interactants was in part a consequence of the structure of the setting and in part a consequence of an attempt to avoid the sociopsychological risks of secretive behaviour on my part. Unlike a hospital, a 16 room house full of people offered little opportunity for slipping off to a cafeteria or restroom periodically to record from memory. (Wilson, 1977: 107-8)

It is clear that almost exactly the same restraints on note-taking applied to the present project: the sheer volume of material meant that there was no prospect of having anything more than an impossibly sketchy and impressionistic memory of events without making some kind of contemporaneous record of them, but just as clearly there was no possibility of my disappearing off to the loo in the middle of a meeting - hardly unnoticed, one would think -

to jot down a particularly revealing or significant remark. This kind of woefully inadequate attempt at secrecy would have been effective neither in concealment nor in building up the all-important trust between observer and subject which Strong and Robinson argue is such an important part of social research:

> In the natural sciences, observation of the data, and reflection on it, is a matter solely for the scientist. Electrons cannot give physicians a helping hand; algae never talk back. But all human beings are social scientists - of a kind - and have to be, simply to get by in life. So in some forms of social inquiry, the objects of the study simultaneously serve as fellow researchers, as unpaid colleagues. (Strong & Robinson, 1992: 7).

Similarly, Pandey suggests that:

> in the field the most critical factor responsible for making a callow observer into an anthropologist is the relationship he builds with his informants. He enters the field as a stranger, and it is only with the help of his informants, who are also strangers that he comes to acquire knowledge about them and their way of life. (Pandey, 1979: 246)

In the end, Wilson took her openness so far as to make her field notes available to whoever was interested in looking at them. She remarks that "every staff member availed themselves of this offer and some responded jokingly with comments such as 'Well, it's accurate, but it's boring as hell." (Wilson, 1977: 108).

However, I suggest that the benefits of this complete openness in note-taking were more wide-ranging than simply in the ability to produce a workable description and record of the meetings, and extended rather to play a considerable role in determining the way in which I was perceived by the embryonic committee:

> Hoffman's discussion dramatically focuses attention on the relationships between 'access', the fieldworker's perceived identity, and the data that can be gathered. (Hammersley & Atkinson, 1983: 63)

I suggest that just as Humphreys's "cover" for his observation of homosexuals in public lavatories was the role of "voyeur", "a role" which is, he remarks dryly, "superbly suited for sociologists", (Humphreys, 1970: 28), so also my "cover", to borrow a term from sensationalist spy fiction, was that of committee servant.

There are two distinct points that I wish to make in respect of this idea of my cover as committee servant. The first is that its inception was, although not contemporaneous with the genesis of the committee, at least unusually early on in its development. That is to say, unlike Punch (1993), I was not in any way attempting to worm my way in from the outside into a group that was already clearly established and like Jerusalem, "at unity in itself". Mine was not the role of the newcomer at the party, who has somehow to break into the conversation and cause a re-adjustment of relational patterns. Rather, being part of the committee almost *ab initio*, I came to be seen not so much as a watchbird, watching them, but part of what Humphreys (1970) calls "the action" itself. From October 1993 until February 1996, there was no point at which the committee met - either in whole or in part - without their observer.

It is worth noting that the very nature of the research subject in this case meant that it was all the easier to ensure that the observation was total (in this temporal sense), since a committee, unlike a street gang, or a patrol group, exists for only very limited and clearly-defined periods of time. This meant that I could be sure that, given the provisos outlined above about the necessarily partial nature of any observation, my account of the activities of the committee was exhaustive: there was no possibility of my missing something through being on the wrong street corner, or in another ward, or tailing the wrong car.

I suggest that the fact that almost from the very beginning of the committee's existence there had been an observer in their midst led to a much closer identification of myself *with the committee itself*, rather than as an outsider distinct from it. Punch (1993: 196) believed that his "appearances were so commonplace that after a while I did not believe that people noticed me *during routine cases*" (emphasis added). The significant difference between Punch's and this research, however, is that unlike him, I was present at *all* meetings. There was no question of my only being admitted to "routine", or non-sensitive business. To that extent, there was no separation between the committee and the observer: the one had no existence without the other.

The extent to which this assimilation of the observer within the constructed identity of the group took place can be seen in the discussion of the establishment of a sub-group which took place at the meeting on 24 March 1994. The idea was first mooted by AW in order to reduce the load of detail that fell on the main committee. PW, chairing the discussion, introduced the agenda item at 8pm, asking for general reactions to the idea of the establishment of such a group. The only proviso that he gave was that if both he and AW were to be among the members of the sub-group, then its meetings would have to take place during the working day. The transcript records the discussion as follows:

> BB: My time during the day is booked solid until next month at least: I'd need a lot of notice if I were to be on the group.
>
> JD: There's no point, given the desirability of keeping the group as small as possible, in having both myself and BB on the group, because our input would be virtually identical qua members of the Health Authorities.
>
> AW: It would probably be useful to have the same people on the group each time, rather than rotating the membership with each meeting, to provide a sense of continuity. I suggest myself, PW, RJ of course, and either JD or BB. [general agreement, except for JD and BB who felt that they would not be able to give sufficient time to the group.]

This easy acceptance of the inclusion of the observer into even the inner circle of the committee is significant. It suggests that I had been granted almost honorary membership of the committee, as if I were not perceived as an outsider, as Other, at all.[9] If, as Hoffman (1980) suggests, there is a direct correlation between the perceived identity of the observer and the quality of the data that can be gathered, then it is reasonable to suggest that an observer who is perceived as within, as "one of us", will be admitted into the greatest confidence of the group, and will consequently be able to gather the most revealing data.

The second point that is worth observing about the nature of my role of committee servant as well as observer is that it is a classically symbiotic one. In a sense, this should come as no surprise. In his role of lookout, Humphreys provided a valuable service to the homosexuals he was observing. They in turn, although unwittingly, provided him with observational data.[10] Similarly, Turner suggests that:

> entrée to performances, and access to exegesis, was no doubt helped by the fact that, like most anthropological field workers, we distributed medicines, bandaged wounds, and, in the case of my wife, (who is a doctor's daughter and bolder in these matters than I,) injected with serum persons bitten by snakes. Since many of the Ndembu cult rituals are performed for the sick, and since European medicines are regarded as having mystical efficacy of the same kind as their own though greater in potency, the curative specialists came to regard us as colleagues and to welcome our attendance at their performances. (Turner, 1991: 9)

As Srinivas comments "[u]nlike primitive tribesmen, members of literate societies expect that the fieldworkers' stay will result in some kind of benefit to them, whether individually or collectively." (Srinivas, 1979: 11)

If symbiosis is characteristic of the relationship between observer and subject, then this research is in no way an exception. Indeed, the only marginally unusual aspect of it might be thought to be the fact that the duality of the role of the observer was so clearly identified from the very beginning. The "Proposal for future working of the committee" (22 September 1993) "discusses methods to support the future working of this committee and specifically proposes the finding of staffing support at a cost of £12,000 per annum for three years." It was proposed

> that the Centre for Philosophy and Health Care in Swansea University College [sic] is asked to appoint a research assistant to support the committee. That post will be for 20 hours per week and will provide:
> - Formulation of papers and issues for the committee.
> - Formulation of reports and statements by the committee.
> - Consultation on issues with committee members between meetings.
> - Research material to support the committee's work.
>
> *It is likely that the postholder could combine these duties with a research based higher degree* (emphasis added).

The italicised phrase makes it perfectly clear that a symbiotic relationship was envisaged between the committee and myself. I formulated papers as both an input resource and a reporting mechanism for the committee, and provided such philosophical research as they found necessary and helpful. In return, I would not only be admitted to the meetings, in itself a considerable privilege for an unknown research student, but I would also be presented with the Holy Grail of research, funding. Perfect symbiosis.

However, it should not be thought that this mutually profitable trade-off, although envisaged from the beginning of the project, was arrived at without some kind of what Barbera-Stein (1979) calls "access negotiations" to facilitate it. My first contact point with the committee was at a meeting on 30 November 1993 with AW, who had been involved with the committee since its inception. This meeting took place shortly before the first full session I attended on 16 December 1993.

One of the practical results of this preliminary meeting, apart from discussing in exceptionally general terms the broad remit and methodology of the research, was that apart from DG, AW was the only member of the committee whom I had met before the meeting on 16 December. In his opening remarks at that meeting, which he chaired, he introduced me to the other members, reminding them of the purpose - such as it was perceived - of the appointment, and explaining that we had had a preliminary meeting to discuss the project. He also explained that I would be taking comprehensive notes of proceedings to facilitate the formulation of reports and statements by the committee both for circulation within the Authorities and - subject to his express approval - for wider publication.

It is instructive to consider the implications this brief introduction conveyed. Firstly, there is the subtle reassurance that the then chairman and *de facto* founder of the committee had already met this potentially disruptive outsider[11] and laid down some ground rules for his conduct. Similarly, the methods he would be using were explained and justified: the note-taking was necessary to enable accurate reports to be constructed. And lastly, but by no means least importantly, the overt system of checks on material being made public was described: nothing would be issued in the name of the committee that AW had not passed. In effect, he had to some extent vetted the outsider and was, at least in some measure, answerable for him.

To anyone familiar with anthropological writings, this will come as no surprise: AW was performing the long-established role of the gatekeeper. Chenitz and Swanson (1986: 49) refer to the utility of identifying such an individual:

> Should you know someone in the setting in which you wish to gain entrée, a useful approach is to have him or her make one or two preliminary contacts for you with key

> persons in the institution as a way of 'breaking the ice'. If the person whom you select is well-thought of in the institution, all the better, for this tends to insure [sic] others of your trustworthiness. This person serves, in effect, as your sponsor.

It need hardly be added that as the founder and co-ordinator of the subject group, AW was *par excellence* "well thought of in the institution." Fetterman (1989: 43) offers similar advice:

> An introduction by a member is the ethnographer's best ticket into the community. Walking into a community stone cold can have a chilling effect on ethnographic research. Community members may not be interested in the individual ethnographer or in the work. An intermediary or go-between can open doors otherwise locked to outsiders. The facilitator may be a chief, principal, director, teacher, tramp, or gang member, and should have some credibility with the group - either as a member or as an acknowledged friend or associate. The closer the go-between's ties to the group, the better. The trust the group places in the intermediary will approximate the trust it extends the researcher at the beginning of the study. Ethnographers thus benefit from a halo effect if they are introduced by the right person. Group members will give the researcher the benefit of the doubt, sight unseen. As long as ethnographers demonstrate that they deserve the group's trust, they will probably do well. A strong recommendation and introduction strengthen the fieldworker's capacity to work in a community and thus improve the quality of the data.

It is interesting to note that in this particular case, the notion of the outside researcher benefiting "from a halo effect" is especially clear. I take it that the idea behind Fetterman's metaphor is that the group members think of the observer as part of the gatekeeper's penumbra, as if in some way attached to him.[12]

In this study, this effect was heightened by the fact that the overt duties of the researcher - producing research material, formulating discussion documents and writing up reports for circulation - had previously been the responsibility of AW himself. This had a doubly powerful effect on the group members in terms of their willingness to accept a supernumary outsider "sight unseen". Firstly, AW implied that the observer could be given responsibility for duties which are plainly fundamental to the success and good running of the committee: indeed, the "Proposal for future working of the committee" (22 September 1993) identified the problem that:

> "it is clear from the first year of operation that this workload cannot be managed by the committee alone. The employment of an expert in medical ethics[13] to formulate questions and material for the committee would seem to be a prerequisite."

The implication is that not only is this a position of some responsibility, it is also, so far as the continuation of the committee was concerned, a vital one.

Secondly, the fact that some of the duties of the gatekeeper were directly transferred to the observer meant that the "halo effect" was even more apparent: the partial replication of roles induced a parallel partial identification between the two. The tendency that Fetterman identified - "[t]he trust the group places in the intermediary will approximate the trust it extends the researcher at the beginning of the study" - was thus heightened by the partial replication of roles.

Note, however, that this extension of trust is focused on the *beginning* of the study: it is a deliberate suspension of judgement, a chance for the outsider to prove him or herself, to demonstrate that he or she is worthy of being counted at least an honorary member of the group. But the honeymoon period is finite: the halo may lose its shine. Irresistibly, the discussion is being led in the direction of what van Gennep (1960: 10) identified as rites of passage, that is "the ceremonial patterns which accompany a passage from one situation to another or from one cosmic or social world to another."

Before launching into this discussion, however, it is as well to be reminded of the general proviso that governs the whole discussion of the early days of the committee, that just as it was still in the throes of becoming, of purposing to be, so also it would be unreasonable to expect a clearly delineated *lebensforme* to have emerged immediately. One dynamic permeating the whole of this study is an examination of the way which the committee came, jointly and severally, to define its role. Given that this process of self-definition and discovery was an ongoing one, a continual journey of creation, self examination and re-creation, it is to be expected that the rites and rituals evinced in the early days of the committee should be neither clear nor consistent. I hope that what follows, far from giving rise to questions about the imprecision of the identification of the rites, rituals and myths of the committee, will be surprising in the extent to which certain patterns of quasi-magico ritualistic operation arose almost *ab initio*.

Van Gennep (1960: 15) argues that what he calls territorial rites of passage can be seen as paradigmatic of all other similar rites: "[t]erritorial passages can provide a framework for the discussion of rites of passage that follows." He goes on to note that:

> The territory occupied by a semicivilized tribe is usually defined only by natural features, but its inhabitants and their neighbours know quite well within what territorial limits their rights and prerogatives extend. The natural boundary might be a sacred rock, tree, river, or lake which cannot be crossed without the risk of supernatural sanctions. Such natural boundaries are relatively rare, however. More often the boundary is marked by an object - a stake, portal, or upright rock (milestone or landmark) - whose installation at that particular spot has been accompanied by rites of consecration.

I argued above that one significant difference between the present study and other ethnographies was that the subject of these investigations had no existence beyond those times when it was studied: that is, unlike a group which goes about its business whether it is observed or no, the committee existed *only* at those times when it was observed. Allied to this is the notion that - unlike most social groupings - the committee's existence was temporally, not spatially defined. That is to say, the group of disparate individuals who together comprised the committee existed *qua* committee *only* at those times defined as meetings. The definition was necessarily and sufficiently temporal. It was necessary, in that had the members of the committee - by chance as it were - met together at a time not defined as a meeting time, then they would still not have constituted the committee, although the composition of the groups would have been identical one with another. So for example, even if - by a fabulous coincidence - all the committee members had been in the supermarket at the same time, this would still not have constituted the committee.

Similarly, the temporal defining characteristic is sufficient in that so long as a quorum of the individuals gathered together at the appointed time, they did constitute the committee, *irrespective of the location of the meeting*. For example, the meeting of 16 March 1995 took place not in the boardroom of Singleton Hospital, as had previously been the case, but in Cefn Coed Hospital. But there was no question that the committee was the same, and existed by virtue of meeting at a time, not a place.

The second characteristic of any committee is that much of its work is done on paper and in discussion rather than in the public eye. I discuss the idea of what Goffman (1982) calls "backstage areas" in greater detail later on in this chapter, but for the moment it is sufficient to note that although it would be an overstatement to say that it is a defining characteristic of a committee that the bulk of its work - that is, the thing that separates it from other entities, its defining characteristic - is done on paper, it is at least a reasonable observation to make.

Given these twin definitional factors, the temporal constitution of the committee and the fact of its working with words and written reports, it is to be expected that any rites involving the re-definition and incorporation of an outsider should parallel this twofold structure.

This said, however, whilst I was trying to gain acceptance as an honorary member of the group, I was in no way attempting to *become* a member of the committee. I sought to gain acceptance from, but not to be identified as one of, the group. To take an analogous case, an observer of homosexual society aims to be accepted by the group he studies, but does not - necessarily - seek to be seen as "one of them". In the jargon, he hopes to become of "the wise", rather than himself to become homosexual. In just the same way, I was not aspiring to be counted *as one of the committee*, but rather to be accepted by them.

Acceptance, however, is necessarily acceptance *as*. That is to say, before I could be accepted by the group, it was first necessary for my role and existence to be defined and delineated. To an extent, this had already taken place in the terms of reference outlined in the "Proposal for future working of the committee" (22 September 1993). This is not to say that this was the end of the matter: on the contrary, the process of self definition is, as I argued above, a continual one of definition, examination, negotiation and re-definition. However, I suggest that the fact that my presence even at the initial meetings was backed by written terms of reference meant that my identity was - at least in part - established.

I suggested above that the role constructed for me in the committee's work was that of the committee servant. My job was to an extent a dual one, in that I was charged both with facilitating the work of the committee and with attempting to publicise its work outwith the Health Authorities. Given this duality of role, it is significant although perhaps not surprising that my rite of passage should itself have been a bi-dimensional one. In the first place I provided, as originally envisaged, documents to support and summarise the committee's discussions, thus establishing my credentials as facilitating the committee's work, while in the second place at the meeting of 24 March 1994 I distributed copies of an article that had appeared in the previous month's edition of the *Bulletin of Medical Ethics* (Jarvis, 1994).

It is particularly significant to note that there was a positive response to the publication of this article, no doubt due in part to the members of the committee being pleased that their innovative work was receiving attention from a wider audience. More importantly for our present concerns, the positive reaction also had the effect of more fully welcoming me into the work and activities of the committee: of pronouncing my rite of passage over.

One question which remains is this: why did such an elaborate rite of passage develop so quickly? Why was it so important to the barely defined group that unsuitable outsiders were not admitted? The answer, I believe, lies in the idea of risk and stakes: of what the committee felt they had to lose.

I first canvassed the notion that there was a difference between the present study and much ethnography in this sense in a research memo dated 28 January 1994:

> This whole theme centres on the idea that the subjects of this research are - I suggest unusually - *people with something to lose*. I shall have to defend this implied claim that most research subjects do not have anything to lose, and I think it's at this stage rather overdrawn, but nonetheless I think it can be argued that these subjects have

> something to lose in a direct and immediate sense that perhaps others do not. And, perhaps more importantly, they *know* that this is the case.

I do not propose to launch into a notional defence of the idea that most research subjects have nothing to lose, which I still think is overstated, but I shall argue for this point to the following extent.

It is characteristic of much ethnographic research that the subjects of the research are not identifiable to the vast majority of the readers of the ethnography. This may be a purely contingent matter of topographical location: the chance of any British reader having met the individuals from the Tobelo tribe that Platenkamp (1992) discusses is remote in the extreme. Alternatively, the impossibility of identifying individuals in the report may be a result of a quite deliberate attempt by the ethnographer to preserve the anonymity of the subjects: this is obviously particularly the case in ethnographies of so-called "deviant" groups, whose behaviour is stigmatised or illegal. Humphreys's explicit anonymisation of his data to protect his subjects is a case in point:

> I have tried to make it impossible for any close associate to recognise the real people behind the disguised composites portrayed in this chapter. But I have worked equally hard to enable a number of tearoom players to see themselves in the portrait of George, and others to find their own stories in those of Dwight, Ricky, or Arnold. If I am accurate, the real Tom will wonder whether he is trade or ambisexual; and a few others will be able to identify only partly with Arnold or Ricky. (Humphreys, 1970: 129)

In his postscript, "a question of ethics", Humphreys re-emphasises this effort, claiming that he took:

> every possible precaution to protect the identities of my respondents and the confidential nature of their communication with me ... I have exercised great care to conceal all identifying tags. This is not always an easy task when one is also concerned with avoiding distortion of the data, but it is an essential one. (Humphreys, 1970: 171-2)

Plainly, as a student of covert deviant behaviour, Humphreys saw the protection of confidentiality and the safeguarding of the identities of his subjects as paramount.

It is fairly clear that if the subjects of the present research have something to lose, it is not the same kind of something whose loss might have been feared by the habitués of the tearooms: for one thing, their behaviour, although odd in the sense that it is without institutional precedent, is not - even on a particularly straightlaced conception of health care - actually *deviant*. Nonetheless, we should not lose sight of the fact that at the beginning of the project, the establishment of the LEC(PA) was without precedent in Britain. West Glamorgan Health Authorities had no model to follow, no rules to observe. They simply faced the intractable problem of finite, not to say scarce, resources on the one hand, and vast, expanding, and arguably infinite demand on the other. The identification of this problem was nothing new: the willingness to deal with it was.

I examined the possible motivation behind the establishment of the committee in the first chapter. However, it is rare to find an enterprise which offers the promise of success at no risk, and I suggest that the development of the LEC(PA) is not one such golden goose. On the contrary, I suggest that West Glamorgan Health Authorities are to be praised not only for their foresight but also for their practical and moral courage in going beyond the mere identification of the problem and being prepared to address it in a coherent and ethically informed fashion. Although there were possible benefits accruing from the plan, the risks, of the sort that Levin identified, were clearly identifiable as well: the price of being explicit in the rationing of health care resources is to be measured in adverse publicity, in accusations of managerial profiteering taking the place of clinical care, and in decreased public sympathy and confidence in the health service. West Glamorgan undoubtedly took a risk in establishing the LEC(PA).[14]

But if the establishment of the committee was a risk, then how much more so was the decision to allow the committee to be observed in its practice? If mistakes have to be made then better that they be made behind closed doors. Indeed, Goffman (1982: 114-5) argues that the whole of professional and social life is subconsciously but deliberately organised along lines that make it possible to correct mistakes in the "performance" out of the public eye. He calls the regions where such correction is possible "backstage areas".
The West Glamorgan LEC(PA), however, which as a new committee without any predecessor or role model to smooth its way and allow a degree of emulation was almost bound to make mistakes, nonetheless elected to make them - if not in the glare of the publicity that an open meeting brings - at least under the potentially critical gaze of an outsider.

Moreover, I suggest that there are three characteristics common to all the members of the committee which at the same time distinguish them from the paradigm subjects of ethnographic research, and also support my contention that they are, perhaps more than most, people with something to lose.

Firstly, and most obviously, they are named individuals, or rather, since as I observed above, many informants are named but still exceptionally unlikely to be identified by the (geographically distant) readers of the ethnographies in which they figure, their being named is a part of the more general idea that they are easily identifiable by the people who might read the study. It is by no means impossible that one of AM's patients might read this and take exception to something he said. Perhaps greater is the possibility of a journalist reading it and adapting certain passages to his or her own purposes. These risks were not only identifiable in themselves, they were also all the more potent as a result of the identifiability of the subjects of the research, that the subjects were named, traceable individuals.

Similarly, I suggest that the fact that the individuals were all, in different ways, powerful also places them all the more firmly in the category of people with something to lose. One of the effects of the 1991 NHS reforms was to concentrate power in the hands of the health service managers, and it would hardly be to make a controversial point to suggest that this concentration was not universally welcomed. Those involved in health service management, then, were by virtue of the 1991 reforms made both more powerful and at the same time focuses of mistrust and discontent. It was of them, or of people whom the public would perceive as being very like them, that such headlines were run as the *Western Mail*'s "Branded decrepit after the age of seventy: how health service managers play God to balance the books".[15] Unto whom much is given, much is expected: being in a position of perceived power *viz à viz* the allocation of scarce resources for health care, the committee stood to lose at least as much as they stood to gain from the study.

Combining these two themes, of the identifiability and power of the committee members, is the third way in which I suggest they differed from the majority of ethnographic subject groups, making them more liable to be seen, or to see themselves, as people with something to lose: they were accountable. More specifically, they were accountable for what was widely believed to be a service in disarray, and they were accountable to precisely those people who might read the report of their work. Their decisions, and perhaps more importantly the way in which they reached those decisions, would be laid open to scrutiny, for even a thesis is a public document.

Supervenient on all these characteristics, however, is one further observation about the relationship between the committee and the research of which it was the subject, which is singular about the present study: any damage done as a result of the research would be in the nature of a self-inflicted wound.

What I mean by that is this. Unusually in the field of ethnographic research, the access negotiations were neither protracted nor difficult: beyond gaining the trust of the committee *once I was on the inside*, I had little to do in the way of winning their confidence. This is directly related to the fact that, quite contrary to the usual dynamic of a researcher casting around for a suitable group to study, followed by negotiating the right to carry out the research, in this case the opposite was the case: the group itself identified the need for observation, and then it cast around for a suitable observer.

In the same way, I suggest that it makes more sense to think of AW not as a gatekeeper, which is the standard term for the intermediary between observer and group, but more as a host or sponsor. I suggest these latter terms in preference to the traditional one on the grounds that they carry with them a notion more of issuing an invitation to an event rather than having been persuaded to permit access only after suitable pleading and encouragement.

The implications of this are, I hope, clear, at least for the present discussion. I suggest that the Health Authorities must have been only too aware both of the risks that they were taking not only in deliberately setting up a committee to provide ethical review of spending plans, but also of the dangers as well as the possible benefits inherent in establishing a mechanism by which information on the practice and development of the committee could be disseminated. If the experiment went wrong, if the doubters - for doubters there must have been - were vindicated, then they would have only themselves to blame.

That is why such a newly-formed group nonetheless displayed a surprisingly sophisticated rite of passage. As I argued above, the potential risks, as well as the possible benefits, of the initiative demonstrate both the vision and the courage that the West Glamorgan Health Authorities displayed in setting up the LEC(PA).

3. The development of the committee's identity

In this section, I shall attempt to relate the previous discussion of the access negotiations, rites of passage, and the notion of the committee, both jointly and severally, having something to lose from the study, to the dynamic of my developing acceptance by the committee. Of necessity, this section is in part descriptive, in that it is concerned with what actually *happened*, with observation of the behaviour of the members towards the observer. It is also partly speculative, in that I shall argue that certain patterns of behaviour reveal significant developments in the self-identification and coming to be of the committee. In particular, I suggest that the increasing acceptance of an initially threatening outsider is evidential of a developing self-confidence and self-reliance that comes with a fuller sense of identity and self-worth. Before a group admits an outsider, it must be at ease with itself and, at least in its own perception, strong enough - that is to say, sufficiently coherent in itself - to withstand the threats that the outsider may pose.

It is almost a truism of anthropological research that the myths and rituals of a social group are among the most revealing areas of their lives to study. Knowledge of the sacred ideas, the unquestioned beliefs which ground the activities of an institution, sheds much light on the *actual* nature of that group, as opposed to the image that it may wish to foster, what Goffman (1982) calls "impression management".[16] For that reason, one of my concerns has been to chart the development of common myths and reproduced rituals in the life of the committee, in the belief that discovery and discussion of them will reveal something about the nature of both the committee and its enterprise as it is perceived from within.

In this section, I shall trace the development of some of the common myths that have arisen in the early development of the committee, and I shall describe one - I think particularly powerful - symbolic ritual. I shall argue that both the myths and the ritual are evidential of an increasing sense of Self, which is mirrored in a growing acuteness with which the Other is identified. This identification of the Other gives rise to a consideration of "impression management" and "backstage areas" (Goffman: 1982), which in turn brings the argument full circle to a further consideration of the notion of the Outsider, suggesting that there are two distinct audiences to which the LEC(PA) can be thought to be playing.

"Any analysis not based on some translation of the symbols used by people of [a] culture is open to suspicion" (Wilson, 1957: 6): the rituals and myths of a social grouping are among the most revealing areas of study in terms of yielding evidence for the group's perceived identity and construction of Self. There is particular interest in studying the development of the LEC(PA)'s myths and rituals, in that their progression gives a clue to the *developing* sense of Self in the committee. Although it would be an overstatement to suggest that the consciousness of the committee was a *tabula rasa* at its inception, nonetheless it was a group without a clear *modus operandi*, without a role model, and with only a hazy idea of its purpose or goal. As I suggested above, in classic existentialist terms, its existence preceeded its essence: it was before it purposed to be. The extent to which concepts of Self and of purpose have been constructed, at times by reference to perceived opposition from outwith the committee, then, is indicative of the evolution of the committee as a power group in and of itself:

> [myths] teach us a great deal about the societies from which they originate, they help us to lay bare their inner workings and clarify the *raison d'être* of beliefs, customs ... and most importantly, they make it possible to discover operational modes of the human mind ... (Levi-Strauss, 1981: 627)

I want to trace the development of two central myths in the consciousness of the LEC(PA). As regards the knotty problem of the uneasy relationship between the committee and the Health Authorities, it is significant that to the extent that one of these myths is closely linked with a similar belief widespread in the Authorities, it has the function of allying the committee more closely with them; the other serves to distinguish the committee from its masters by identifying a power base within the Authorities that can be regarded as *Unmensch*, as Enemy: Other to the committee's One.

It is significant that both these myths concern the identification of those outside the committee and modes of treatment and relationship appropriate to them. I shall argue, during the course of the discussion of myth, that the identification of the outsider is one of the most powerful forces for the unity and coherence of a group: it is by borders being challenged that they are defined. Lincoln (1989: 22-3) relates the following example:

> In Sienna past-orientated discourse was dominated by the Battle of Montaperti (1260), the last and greatest defeat the Siennese inflicted on their Florentine archrivals. In the decades that followed, Florence eclipsed Sienna permanently and became the dominant military, political artistic and commercial power in Tuscany. Yet in Sienna to this day, any reference to Florence - a mention of the city's soccer team, for instance - is enough to prompt an allusion to the battle or even a richly embroidered account of the cowardice and humiliation of *i cani fiorentini* at Montaperti ...
> ... it is precisely through the repeated *evocation* of such sentiments via the *invocation* of select moments from the past that social histories are continually (re-)established and social formations (re-)constructed. Thus, it is not just that because one *is* Siennese that one feels pride in hearing the story of Montaperti; rather, when one feels pride in this story, in that very moment one *(re-)becomes* Siennese, that is, a person who feels affinity for those others who take pride in Montaperti and estrangement from those who do not.

The example of Sienna and Montaperti shows us that the way to (re-)become Siennese is to refer to an identifiable point (in this case an historical event) in the common consciousness of the interlocutors *which defines a common enemy*. It does not take an experienced anthropologist to see that precisely the same phenomenon is taking place at any sporting encounter between two neighbours: part of what it is to be Scottish is to feel pride at the defeat of "the Auld enemy" in a Calcutta Cup match: a Welshman who is unaffected by his team's defeat at the Arms Park is - in a very clear sense - not fully Welsh: his failure to be touched by the triumph of a commonly identified enemy is associated with a weakened sense of his own national identity.

This identification of a common enemy is crucial to the genesis of a group's sense of Self: without it, individuals are left wondering not just whom they are not, but who exactly they *are*. With it, however, they are able to define themselves as the defenders of X against the hordes of the ungodly Y. It is no surprise, then, that the LEC(PA) developed certain Outsider myths almost immediately. In fact, one of them was not so much developed as arrived fully fledged.

In any community of the powerful and accountable, there is always a fear of the media. Politicians learn quickly that every microphone should be treated as live, and that no comment is ever off the record. I argued above that the members of the LEC(PA), particularly those connected with the Health Authorities, can be seen as people with something to lose. A number of them were no strangers to the dangers posed by the media. It is perhaps not surprising that the first occasion on which I recorded laughter was at the meeting of 20 January 1994 to discuss the Provisional Health Plan 1994-5, at which a tongue in cheek comment was made, designed to reveal the absurdity of rationing health care solely by reference to age, which provoked the comment "You can just imagine what would happen if the *Evening Post* got hold of that!"

The identification of the ever-present threat posed by the local press to the decision-making process, in particular the perceived tendency by story-hungry journalists to portray innocent remarks in a sensationalist light, was enough to provoke laughter. In that moment, the committee members *became* a group: their social identity was established and constructed by reference to an identified outside threat. I shall not dwell on the myth of the threat of the press, mainly because it is an idea that is common to many groups beyond the LEC(PA), among which are many in whose membership the individual members of the committee can be thought to share, and so to that extent it is only in a secondary sense a myth of the committee as distinct from a myth which the committee members bring with them to the group, but I suggest that this example is illustrative of the invocation of an already given myth whose terms of reference require no further explanation to those inside the group.

At this point I should point out that my use of the term "myth" should not be understood to imply that there is anything counterfactual about the belief, in the sense that we speak of the myth of Sisyphus. Rather, I have in mind by the term any belief which is understood implicitly as providing the grounding of the discourse of a group, irrespective of its veracity or otherwise, to which all members of the group have access and whose value they accept. In this sense, myths are not necessarily false - the press, for instance, may well be a constant threat - but nor are they necessarily true. What is important is that they are beliefs that need no further justification when they are referred to within the group. Reference to *The Evening Post* carries with it a bundle of associative and connotative meanings and ideas which require no further examination or elaboration, but which can - between members of the group - be taken as read. In fact, that is part of what *defines* them as members of that group, that they have a certain myth as a common currency of their world-picture.

With this in mind, I want now to go on to look at one of the dominant myths in the committee, which is shared by at least some of the executives of the Health Authorities. It concerns a frequent bone of contention between operatives at or near ground level on the one hand and the forces of central control on the other. In this particular case, it is the battle for freedom to allocate resources between the central Welsh Office and West Glamorgan Health Authorities.

This issue was first raised by KJ at the meeting of 16 December 1993, convened to discuss RL's paper "Methodology of Choice". He remarked that the congruence between the expressed views of the Boards of the Authorities and the public consulted on the relative ranking importance of certain operational parameters for resource allocation decisions was strikingly high: that is, that the Authorities and the public appeared, *prima facie* to be almost of one mind. He noted further, however, that despite this agreement, past funding decisions seemed not to echo these expressed values. In an attempt to explain this apparent contradiction, he suggested that there was significant external pressure - specifically to invest so as to reduce waiting lists - that could be traced to the Welsh Office which meant that the supposedly discretionary funding which was the subject of discussion was not actually allocated at the discretion of the individual Authorities at all, but rather had to be diverted into areas specifically delineated by central governmental directives.

This point was echoed at the next meeting, of 20 January 1994, which discussed the Provisional Health Plan 1994-5. In the first part of the meeting, in which executives from the Authorities were questioned by the committee, AB argued that the Welsh Office expected an increase in the overall number of treatment episodes in any given area, and that this means of measurement - however questionable - was not open to negotiation at the time. Therefore, he continued, since it is the Welsh Office who allocate funds to the Authorities, it is imperative that investment proposals are put forward which accord with their expressed priorities, *even if the proposals so arrived at do not accord with what the individual*

Authorities believe to be the best investments to make. Clearly, this is a pragmatic argument about the payment of pipers and the calling of tunes, and it is one that found much sympathy among both the committee members and their executive guests: TB's answer to AB's comment is instructive. He agreed that there are external constraints on the allocation of resources, and suggested that "they fluctuate almost daily according to which civil servant writes the letter". This renewed reference to the existence of external political constraints on the free allocation of supposedly discretionary funding produced general laughter and a release of the tension that had been building up as a result of sustained questioning of the executive members of the Health Authorities, but it also served to renew the idea that the Authorities, and by extension the LEC(PA) operated to some extent with their hands tied.

By the time of the next meeting, on 24 March 1994, the idea that directives from the Welsh Office are frequently both obstructive and unhelpful had attained the status of a myth: that is it had become a background belief that is neither questioned nor fully elaborated, but rather informed and gave sense and shape to the ensuing discussion. The context was a discussion which centred around an objection to discussing a document detailing scheduled health care investment and disinvestment in West Glamorgan over the ensuing decade at a time when the location of the District General Hospitals (DGHs) in the county was still being debated. AB suggested that the Authorities would in all likelihood welcome comments from the LEC(PA) which suggested that the exercise was something of a sham, and that serious discussion of proposals for long-term investment in health care could not be made in the absence of structured and definite plans about the location of major hospital sites in the county. BS echoed his suggestion, arguing that the public consultation on the ten-year Health Plan in the absence of such information demanded by the Welsh Office was known by the

Authorities to be a profligate use of limited resources on what they (the Authorities) knew to be "an exercise in the ridiculous".

In summarising the discussion from the chair, PW suggested that the committee should comment to the Authorities that the exercise was ridiculous, which they were assumed to know, and that the Authorities themselves could then pass those comments on to the Welsh Office, thus making the point that their Ethics Committee on Purchaser Advice had condemned the central governmental directives as "an absurd and arguably unethical misuse of limited funds".

What is important in all this discussion is the way in which directives from the Welsh Office are *implicitly* identified as misplaced and out of touch with the realities of the quotidian management of the Health Service. In the earlier stages of the committee, for instance at the meetings in December 1993 and January 1994, explicit reference was made to the existence of these external pressures that limited the Authorities in their opportunity to invest as they (in apparent agreement with the public) thought fit. By the time of the March meeting, however, this theme of the obstruction to economically efficient and ethically responsible management of the NHS that centralist directives pose had been internalised and need no longer be expressly articulated for it to give sense and form to the discussion it grounds: it had become a myth.[17]

It is a particularly powerful myth because it is one which serves to bring the LEC(PA) closer to the Health Authorities, and in particular to their senior executives. By identifying a *common* enemy the two bodies, who might in other circumstances be thought to be at least in some measure in tension with one another, develop feelings of communality and attachment - by sharing a myth, they share an identity:

> [t]hus, myth is not just a coding device in which important information is conveyed, on the basis of which actors *can then* construct society. It is also a discursive act through which actors evoke the sentiments out of which society is actively constructed. (Lincoln, 1989: 25)

The second myth whose development I wish to trace has a function, or rather an effect, which is in direct antithesis to this: far from emphasising the common ground (by virtue of a common enemy) between the Health Authorities and the LEC(PA), it draws attention to the gap between the two bodies by the identification of a particular part of the Authorities' hierarchy as itself *Unmensch*. In this way it serves to distinguish the committee from the more powerful Authorities (a distinction which in a world of sub-committees and complicated terms of reference and reporting procedures might otherwise be liable to loss or confusion) by the particularly forceful expedient of labelling part of the dominant party as itself, if not in direct opposition to, at least in potential conflict with, the aims and procedures of the LEC(PA).

If myths reveal something hidden of the character of a society, then jokes reveal something hidden of their myths. Put bluntly, people are off their guard when they are laughing. This much was familiar to Freud in the context of the individual (Freud, 1960). Similarly, "Stephen Leacock said 'Let me hear the jokes of a nation and I will tell you what they are like, how they are getting along, and what is going to happen to them" (Manago, 1962).

In the context of committee discussion, jokes are relatively few and far between. They therefore stand out when they do occur, and can be thought of as significant episodes: they *mean* something. I make no apology for looking in some detail at one particular joke that was made during the meeting of March 1994, since I believe that both its occurrence and its content are revealing.

To begin, then, with the phenomenon of joking. It seems obvious that there are certain preconditions for the successful making of a joke, chief among which for the present purposes is the existence of a shared system of values and referents. Both the teller of the joke and the hearer must - to a certain extent - share views about the place of the subject of the humour in their world.[18] If we observe a joke being told successfully, by which I mean as a minimum that the joke produces laughter and not offence, then we are entitled to conclude that a shared value system is operating between the person making the joke and the hearer of it. Crucially for the present argument, we may conclude that there is a degree of communality between the interlocutors, and this communality is sufficiently clear and established that the teller of the joke may take it as read; s/he may make the joke and confidently expect an appropriate response - laughter, rather than a stony silence. We are all familiar, of course, with situations in which this mutuality of value systems cannot be taken for granted, and in such situations we often find it difficult to know whether a remark, innocuous enough in certain company, would be out of place in another situation. On occasions, the way may be paved for such a remark by one interlocutor expressly acknowledging the difficulty inherent in the process of assessing the harmony of value systems, particularly if one member is new to the group, by saying something along the lines of "It's alright, we're all friends here."

That this was not necessary in the case in point is, I suggest, strongly evidential of an evolving awareness and perception of a shared consciousness among, or rather *of*, the committee. For the member in question to have felt confident enough in the likelihood of an appropriate response to have made the joke, he must have predicted (correctly, as it turned out) that the other members of the committee - or at least a substantial majority of them - would concur with his view of the situation. He must, that is to say, have felt that there was something that the members of the committee all had in common.

In this regard, it is instructive to consider the composition of the committee. The members come from a range of disparate backgrounds, from dentistry to the law, from hospital medicine to general practice, from health service management to the church. There is little, if anything, that they all have in common besides a shared membership of the LEC(PA) and - presumably - an interest in its activities and the subject matter of its discussions. Indeed, given the context of the discussions - a scenario of limited resources in which one part of the health service could only win out at the cost of another's loss - it might have been expected that the members of the committee would tend to polarise into various camps, for instance primary carers ranging themselves against hospital physicians. That this did not happen is, I suggest, instructive. Indeed, not only did it not happen, but quite the reverse can be observed: it was remarkable to notice the increasing amiability with which the meetings were conducted as the committee members grew more familiar one with another, in stark contrast to the initial wariness which characterised the first meetings.[19]

The level of certainty of mutuality and coherence of views required to risk a joke, particularly when the subject of the joke is a professional colleague of at least one of the hearers, then, suggests that a strong and readily identifiable sense of community and Self had arisen. The members' thinking was in significant regard in tune with each other and with the general consciousness of the committee. A coherent social organism had emerged.

The joke in question was made in an aside during the course of discussion of a letter of resignation from the committee from one of the members. The context is significant, since it locates the remark within a framework of both humour (which I have already suggested is particularly liable to reveal significant themes and hidden elements of thinking), and also of reaction to adversity. The letter of resignation, which was copied to all members of the committee, was in some measure critical of both the discussions and reports of the committee to that date. It thus represented the first significant and locatable opposition to the committee's procedures and work. In this sense the reactions of the members to the letter are particularly important. When faced with identifiable opposition for the first time, it is in the nature of human groups either to band the more closely together (the so-called "war spirit" that develops in the teeth of aggression, forming closer bonds of communality in the face of mutual danger), or on the other hand to tend to fall apart in a welter of mutual recriminations. It seems obvious that the stronger groups - that is to say those with a more developed sense of their own Self-identity and a fixed belief in their purpose and objectives - are more likely to fall into the first camp, while the weaker groups will tend to dissolve.

It is therefore reasonable to conclude that a group whose sense of purpose and Self belief are strengthened and more closely defined as a result of a reaction to a challenge, whether from within or outwith the group, is a collective with an already reasonably strong notion of its own identity and worth.

In the interests of the confidentiality of the members (past and present) of the committee, I do not intend to go into the details of the remark. It is sufficient to note that it suggested that one of the reasons for the member's resignation was that he found the work of the committee intellectually beyond him. The remark was not in itself particularly funny, although its timing was near perfection, but it generated considerable and prolonged laughter all around the table. This was the first time that all the committee members had shared a joke to this extent, and certainly the first time that any one of them had been rendered incoherent with laughter. From an ethnographic point of view, then, it is clearly significant. So what was going on?

I suggest that the answer lies once again within the area of the identification of the Outsider. The immediate effect of the resignation was to place a distance between the committee and the member resigning, to create a conceptual boundary around the group. By tendering his resignation, the individual in question removed himself from the corral and placed himself firmly Outside it. With this removal came a difference in relational patterns: by removing himself from the group's deliberations and decisions, he at the same time renounced the (unspoken) agreement of mutual support. It is in the nature of human collectives which are organised with a unified goal to strive in a more or less co-operative fashion, and part of that co-operation involves resisting the instinct to criticise one's colleagues in the interests of group harmony. However, once an individual renounces the group's values, he in the same moment renounces the immunity from criticism that membership conveyed. He becomes an Outsider, and therefore subject to the same rules as the rest of the *Unmensch* world.

In this sense I take it that it is clear that the resignation prompted demonstrations of group Self-consciousness and mutuality. I want also to suggest that it played a significant part in the creation of another foundational myth in the world picture of the committee. The meeting of 24 March 1994 was not the first time that the LEC(PA) had been criticised from this quarter. Following its meeting of December 16 1993, the committee had received from a colleague of the member who later resigned what AW called a "robust" response to its discussion paper LEC(PA), 1993. Informal discussion with several members of the committee suggested that it was felt that the modes of thinking employed by the two parties were irremediably distinct, and that it was likely to be impossible for the two to come to any useful understanding.

It was into this setting that the letter tendering the resignation of the consultant in public health medicine on the committee arrived. Its criticisms were widespread, covering the frequency of the meetings, the size of the committee, the tensions inherent in criticising the Authorities as an employee, the alleged one-sidedness of the input from the Centre for Philosophy and Health Care, and the perceived inadequacy of the reporting process. As I related above, the effect of the criticisms was to unify, rather than to disunite, the committee.

One criticism is of particular interest in the context of the construction of myth: it is suggested that "the two recent papers on the Methodology of Choice and on the Health Plan, do not reflect the mature, fully formed views of the committee. They are nearer to a collage of particular critical viewpoints of utilitarian analysis." The view of the committee at the meeting of 24 March was that the tone of the responses, which it was accepted were in large measure critical of a simplistic utilitarianism, was to a great extent determined by the nature and content of the documents on which the committee were asked to comment. It was noted that one of the functions of the LEC(PA) was to play a questioning role in health care planning,[20] and that this inevitably meant that documents which were broadly utilitarian in character would tend to produce reports that questioned this mode of thinking. It was further suggested by at least one of the members that the output from the department of public health was almost exclusively utilitarian in character, and that it was therefore to be expected that the tenor of remarks would be questioning that approach.

The importance of this discussion for the general theme of the construction of myth is clear. As a result of pre-existing dispositions to see the department of public health medicine as broadly out of step with the conceptual models of the committee, combined with external evidence (in the form of the letter of resignation) which served to confirm this emerging belief in the irreconcilability of the two approaches, the myth of the public health department as significantly Other to the committee arose. The effect of this myth was immediate: the discussion at once moved on to consider whether a replacement from the department was actually necessary.[21] The inference that can be drawn from this is surely that the myth of non-co-operation on the part of the department of public health had taken a firm hold on the imagination of the members in a relatively short space of time. Again, it had become a basic belief that needed no explicit articulation in order to inform and govern the form of the ensuing conversation.

I want to turn now from consideration of myth to an examination of ritual. It is of course self-evident that much of any committee's work is ritualised: the drill of giving apologies for absence, of reading and approving the minutes, of observing rules of order and so on all go to make any committee's structure and *modus operandi* something of a ritual, in the sense of being an observable pattern of behaviour that serves to distinguish a group or collective from the outside world. However, I want to explore one particular ritual which, I suggest, goes beyond this generalised committee behaviour, and which a number of authors have identified as one of the most powerful symbols of sharing and mutuality, that of eating:

> I would simply observe that of all human behaviours, there is none more conducive to the integration of society than the ritual sharing of food. For commensality facilitates of *societas* by establishing bonds of sentiment and obligation among those who share a meal while also drawing a rigid boundary such as that marked by the doors at the hall of Tara or of the Beefsteak Society's grate, between them and those outsiders with whom they do not or emphatically will not eat. (Lincoln, 1989: 87-8)

A short descriptive digression is necessary at this point to set the scene for the discussion. The meetings of the LEC(PA) were timed to start at "6pm for 6.30pm". By this it was intended that while the *official* session of the committee would not begin until 6.30pm, that is, it was at that time that the chairman would call the meeting to order and the agenda items would begin to be discussed, the first half hour of the evening would be a time of arrival, of greeting, and of eating. A buffet table of cold food was placed on one wall of the meeting room. The content of this buffet was almost invariant, and plainly represented standard catering for this level of function as determined by the hospital kitchens. What is important about the food is not what it consisted in, which may readily be imagined, but when and where it was consumed.

I am hardly the first to see the form of eating and drinking employed by a group as powerfully symbolic of that group's sense of identity and cohesion. In his definitive study of rites of passage, Van Gennep (1960: 29) argues that

> [t]he rite of eating and drinking ... is clearly a rite of incorporation, of physical union, and has been called a sacrament of communion.

The effect of a shared meal, the ritual of taking and eating together, is to unite within one conceptual group individuals who might otherwise remain disparate and unconnected. The shared meal is a symbol of trust[22], of reciprocity[23], and of union[24]. In this particular setting, one of its functions is to bring together individuals whose professional backgrounds might otherwise place them at odds one with another in the fight for limited resources.

There is, of course, a very superficial level at which the sharing of a meal "facilitates of *societas*", and particularly so if it is what the catering trade refer to as "a stand-up finger buffet": it is clearly more difficult to stand on one's dignity if one is experiencing difficulty in balancing a slippery *vol-au-vent* and two disintegrating cheese sandwiches on the side of one's saucer. The capacity for the phenomenon of eating and drinking to break down potential social barriers in this trivial sense should not be underestimated.

Similarly, a moment's reflection will reveal that the appearance of food at a meeting provides an almost unrivalled opportunity for displays of status and power. The provision of food at a meeting lays open a rich range of opportunities for such remarks as "You go ahead and get something to eat; I'll just have a look at some of these papers instead" (recorded at the meeting of 20 January 1994). When Michael Douglas uttered the immortal line "Lunch is for whimps" in *Wall Street*, he was merely aphorizing what was already known to be the case: that by implying that s/he has no time to engage in such mundane details as eating, an individual can establish that s/he is simply too busy (and therefore, by association, too important) to be bothered by such trivialities.

But these possibilities do not on their own go to make a *ritual* out of eating; they merely establish that eating has the capacity to become the occasion of integrative behaviour or power displays. To establish that there is a ritual associated with eating and sharing, I need to show more: specifically, I need to demonstrate that there is a replicable pattern of behaviour that serves to delineate or symbolise an important aspect of the Selfhood or mythology of the group. Parkin (1992: 18) suggests the following minimum operational definition of ritual:

> Ritual is formulaic spatiality carried out by groups of people who are conscious of its imperative or compulsory nature and who may or may not further inform this spatiality with spoken words.

Fortunately, I believe I can show exactly that.

Van Gennep (1960: 29) suggests that while the bond of unity established by means of eating and sharing is a powerful one, it is usually transient:

> A union by this means may be permanent, but more often it lasts only during the period of digestion. Captain Lyon [Lyon, 1824: 350] has noted that the Eskimo consider a man their guest only for twenty-four hours.

We could therefore reasonably predict that the building up of a feeling of community and union would need to be renewed at each meeting, and this prediction is borne out exactly by the observations. Each meeting would begin by the members (and, where they were invited, outsiders) picking delicately at the ranks of sandwiches and canapés and chatting - with various degrees of conviviality - among themselves. It is what happened when the meeting was called to order that is, I suggest, so significant.

At this point it is important to keep in mind a distinction between those meetings where there were outsiders present and those attended only by the members of the committee.

General observation of the two types of meeting suggested that the latter are - as might be expected - marginally less formal and distinctly less inclined to be confrontational. The distinction between the *types* of meeting, however, is not absolute, since even at those sessions at which officers of the Health Authorities were invited to appear before the committee, that is to say, at which there were identified Outsiders, such guests were only present for the first part of the meeting: they were questioned for a period of up to an hour and a half, and then left, after which there was a closed session of discussion and reaction.

I noted in a research memo dated 28 January 1994 that:

> It is also interesting to note the difference in the use of food (and the general conduct of the meeting that it mirrors) before and after invited guests have left. In the presence of outsiders, neither food nor drink is consumed at the board table, but rather consumption is exclusively restricted to the period before and the area beyond the formal business of the meeting. Once any outsiders have left, however, a different air descends on the meeting. While not one of relaxed formality (jackets and ties are not removed, for instance), it is nonetheless a noticeably distinct one, most clearly seen in the fact that both food and drink are consumed *at the table* during the discussion ... If it transpires that consumption of food at the table really *is* restricted to those times when the committee is alone, then this begins to look like a very powerful symbol of the exclusive unity of the committee as an organism, where outsiders are treated with the respect due their rank, but not admitted fully into the rites and rituals [of the group].[25]

The phenomenon I suspected echoed that described by Lincoln (1989: 87-8): the group was "establishing bonds of sentiment and obligation among those who share a meal while also drawing a rigid boundary ... between them and those outsiders with whom they do not or emphatically will not eat." It was a paradigmatic case of ritual, in that its effect was to "create a world of relationships and activate and transform it" (Jamous, 1992: 68), to identify, to delineate, and to unite.

At that stage, however, I could not be sure that I had identified the correct reason for the explanandum: the phenomenon could have been explained by reference to nothing more than the fact that the committee members did not feel sufficiently hungry to eat during discussion until later in the evening. Until I had further evidence that it was the presence or absence of those identified as Outsiders that was the determining factor, I could not be sure that I had lighted on the appropriate explanans.

This evidence came at the meeting of 24 March 1994. This was a significant meeting in terms of the present discussion in that it was the first of many that I attended at which there had been no outsiders invited to appear before the committee. It was, in effect, a session of self-appraisal and evaluation, of overt inward self-examination. A research memo written on the following day records that:

> no area emerged as a "backstage" one, particularly with reference to where food could reasonably be consumed. At least five of the members felt able to eat / drink *at the table*, which has never happened in the presence of outsiders. This, I think, goes to show that my original hypothesis was correct, that it is the absence of outsiders that means that individuals can eat during the business part of the meetings, rather than the operative variable being an increasing hunger as the evening wears on.

In fact, the model of the-committee-alone at a meeting, unencumbered by outsiders and guests, came to be the norm, as did spatially undifferentiated consumption. This clear demarcation between the two types of session, respectively those with and without outsiders, is, I suggest, clear evidence of a growing self-definition in the consciousness of the committee, of an awareness of Self defined by juxtaposition with and in opposition to Other.

Baumann (1992: 113) at first sight appears to offer an objection to this account of ritual:

> Narrow readings of Durkheim view rituals as crystallizations of basic values uniformly endorsed by communities that perform them with a view to themselves, ultimately to create and confirm their cohesion as communities. In plural societies, this position is complicated by the presence of 'Others' ...

However, I suggest that the distinction between Baumann's position and my own may be more apparent than real. The central idea in both themes is common: that the purpose and function of rituals is to define a societal grouping and to give it a sense of self-identification. Baumann's objection to the postulated reading of Durkheim is that it is insufficiently flexible to take account of pluralistic societies in which not every member identifies with the ritual or the mythology that it seeks to reinforce. Not only does this objection leave my central theme, of the development of rituals and myths as evidential of the development of a sense of Self in the committee, untouched, it also serves to amplify a point for which I argued earlier, that the multidisciplinary nature of the committee, the diverse and potentially oppositionally related professional backgrounds of its members, means that it is possible that not every member will participate in the rituals, particularly those of exclusion or incorporation, to the same extent. Indeed, given this element of the committee's nature, it would be surprising if its rituals did evoke a unilateral obedience and acquire their own observational imperative: "society is characterised by hierarchy as much as by solidarity." (Lincoln, 1989: 88). Baumann's objection, as I understand it, concerns not the function of ritual, but the mono-dimensionality of ownership of that ritual postulated by narrow readings of the Durkheimian interpretation.

I have suggested, then, that the remarkably swift development of both a mythology and a system of ritual by the LEC(PA) can be taken as evidential of an increasing sense of Self and of Other. This genesis of self-definition, this odyssey of becoming, this purposing to be has two linked but discernible strands within it, which we can characterise as being positive and negative. Within what I term the positive strand can be located such phenomena as remarks and behaviour designed to produce a feeling of social cohesion: what might in another context be referred to as a process of teambuilding. The negative strand, only partly distinguished from this aspect, can be identified as encompassing those aspects of behaviour as have the identification of the Other as their primary purpose, with the teambuilding effect of that identification as a secondary benefit. Within this category we can include such phenomena as jokes made at the expense of "absent friends", and the ritual of eating and delimitation discussed above.

Some aspects of performance, however, resist such inflexible bi-polar classification, as Goffman's discussion of "inside secrets" illustrates:

> These are the ones whose possession marks an individual as being a member of a group and helps the group feel separate and different from those individuals who are not 'in the know'. Inside secrets give objective intellectual content to subjectively felt social distance. Almost all information in a social context has something of this exclusive function and may be seen as none of somebody's business.
> Inside secrets may have little strategic importance and may not be very dark. When this is the case, such secrets may be discovered or accidentally disclosed without radically disrupting the team's performance; the performers need only shift their secret delight to another matter (Goffman, 1982: 142).

The operative idea here is that the myths or sacred themes that bind a group together by what de Beauvoir calls "a kind of immanent complicity" (de Beauvoir, 1988: 556) need not be important *in and of themselves*, in the sense of compromising the effective operation of the group if they are let out of the bag. Their importance lies in the role that they play in the life of the group. We can see this quite clearly in the case of children's gangs. Nothing turns on the discovery of a gang's password by (for instance) a parent, but the sharing of a secret, in this case a password by which the members of a gang (a paradigm case of a self-defined social grouping) identify themselves one to another and exclude outsiders, is of value in and of itself to the extent that it both contributes to the development and preservation of a group identity (a positive function), *and* serves to delineate the boundaries surrounding the gang by defining the Other as those not "in the know"[26] (the negative aspect). This dual function is quite distinct from the (often negligible) strategic value of the secret.

In the preceding discussion, I referred a number of times to Goffman's notion of backstage areas. I want now to look at this notion as it is envisaged by Goffman, and to suggest some applications of it to the present study:

> A back region or backstage may be defined as a place, relative to a given performance, where the impression fostered by the performance is knowingly contradicted as a matter of course, There are, of course, many characteristic functions of such places. It is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated; it is here that illusions and impressions are openly contradicted. Here stage props and items of personal front can be stored in a kind of compact collapsing of whole repertoires of actions and characters ... Here the team can run through its performance, checking for offending expressions when no member of the audience is present to be affronted by them; here members of the team, who are expressively inept, can be schooled or dropped from the performance. Here the character can relax; he can drop his front, forgo speaking his lines, and step out of character." (Goffman, 1982: 114-5)

Goffman's metaphor of the backstage area is a powerful one, and one which is plainly applicable to observations in widely differing situations, from catering or any of the service industries to lavatories in a nightclub. It is also, I suggest, particularly interesting in the context of the present case for two reasons. Firstly, the context of the LEC(PA) sheds light on a revealing ambiguity in Goffman's talk of *a single* audience, and secondly, I shall suggest that the metaphor of the backstage area can in this case be more usefully understood in temporal terms rather than in terms of spatiality.

I have already identified one audience to the performance that is the LEC(PA)'s existence: that is, the Health Authorities on whose initiative the committee was established. The fact that the forgoing discussion of Outsiders revealed an ambivalence between identifying *with* the Authorities and identifying them as Other should alert the reader to the tension that existed in the inter-relations between the two bodies. The committee members were well aware that they formed an advisory committee of the Health Authorities, and were therefore in a sense to be identified with them. Yet at the same time they guarded jealously their (quasi)-autonomy, and resented any suggestion that their discussions should be in any way delimited or shaped by considerations of what the Authorities might find acceptable.[27] In a sense, it is clear that there had to be a considerable degree of co-operation between the LEC(PA) and the Authorities, since the proverbial bottom line was that the committee's expenses and secretarial support were met by the Health Authorities. Indeed, even apart from issues of financial support, the committee was entirely dependent on the co-operation of the Health Authorities in terms of release of and access to confidential documents: had the model of mutual co-operation between the establishing Authorities and the experimental committee broken down, and the committee been denied such access, then it would necessarily have collapsed and the experiment would have been a failure. Total alienation as a result of wantonly outspoken criticism, then, would be in nobody's interests.

Thusfar, then, I have suggested that the LEC(PA) members identified the Health Authority as Other and treated them as such. However, there is also an audience in a much wider sense, to the extent that there is an audience to *all* the work that the Health Authority undertakes: the ever-critical audience of the public.[28] The notion of the public as an audience and as a player in the operation is an interesting one, since it brings with it the possibility that the LEC(PA) might not - in the public perception - be distinguished *at all* from the Health Authorities, an idea which challenges the finely drawn distinctions that I have argued operate *within* the committee.

In this second sense of "audience", the sense by which I mean the public as spectator, it is clear that there is a much broader notion of the boundaries of "the team" at work than in the first. In the first sense, the boundaries are drawn around the officially constituted membership of the committee: those whose names appear on the list are Inside, those who attend its meetings but who are not so listed are Outside. However, in the public imagination (insofar as the public has heard of the LEC(PA)) the two bodies are to be identified one with another as falling under the general rubric of "those involved in health care planning".[29] I shall not say a great deal more about the public as an audience in this second sense, mainly because I have not attempted to gather any data about public perceptions of the Health Authorities with the presence or absence of the LEC(PA) as a variable. That kind of extensive research is the remit of opinion research surveys, not philosophy.

More important is the expanding of Goffman's metaphor that this study suggests by extending the notion of a backstage area to apply in temporal as well as spatial terms. I suggested above (p81ff) that the LEC(PA)'s existence was a matter of not of spatial location but of temporal definition: that is, it *was* only when it was determined that it should be. Unlike its location, which was neither a necessary nor a sufficient condition for its authentic existence, the temporal variable was both necessary and sufficient for the committee to be.

The effect of this in terms of the present discussion is an interesting one. Much of the backstage area of the committee has no *spatial* existence at all, in that the bulk of the work that would in another setting be conducted in a backstage area is in this case done on paper or in correspondence, where the applicability of appropriate attitudes is of less (or at least different) importance. The earlier discussion of AW as a gatekeeper suggested that part of the way in which he was able to win the confidence of both the committee and the Health Authorities was by stressing that all documents which I prepared that would be made public would be pre-checked by him. The effect of this is clear: nothing would be committed to paper - or at least not publicly - that would outrage the public, or indeed the Health Authorities.

The aspect of the nature of the LEC(PA) that is particularly significant in this sense is that - by the very nature of written as opposed to verbal statements - the opportunities for ironing out such embarrassing references are legion in the case of a typescript. We have only to look at the consultative process, that is to say the length of time that drafts of reports and papers are passed around the committee structure for comments and redrafting to see that the "checking for offending expressions when no audience is present to be affronted by them" (Goffman, 1982: 115) is taking place here, on paper, and not in a spatially defined backstage area.[30]

This is, of course, another difference between the present research and the paradigm of social research, in that in the standard case the observer immerses him/herself in the life as it is lived of the group, and this will characteristically include conversation. Even in those situations where conversation has become impossible or has been eliminated for one reason or another, some form of *immediate and spontaneous* communication is essential and is understood by the ethnographer to be revealing.[31] In this research, however, all the public statements of the committee are *written*, and therefore far from spontaneous. They might therefore be thought to be less revealing than their notional spoken correlates. The irony is that these spoken correlates will of necessity remain notional, that is to say that they are never to be actualised: all communication between the committee and the outside world (particularly in the more broadly defined sense of "outside" where it means the general public as opposed to the Health Authorities) is written and not spoken, and therefore by its very nature more polished and less spontaneous.

To some extent, this is linked with the idea that the *whole* of the existence of the LEC(PA) is in a sense a backstage one. The members are the archetypal "faceless men" (and women) who meet in the smoke filled rooms of tabloid mythology. If the audience to whom the committee is thought of as playing is defined as the general public, then in one sense there is *no* public performance for its members to undertake: their impression management is confined to eradicating offending expressions from written reports.

However, if the boundaries around the committee are drawn rather more strictly, so as to include all and only those people who are listed as serving on the committee, then the notion of a stage managed public performance once again becomes a very real one. I hope that the extensive discussion of the ritual of eating and drinking as determined by the presence or absence of outsiders is enough to demonstrate that Goffmanesque impression management is clearly taking place for the benefit of the invited guests. The actions, demeanour, *modus* *operandi* and behaviour of the committee are all modified to take account of the presence of those identified as (in the strict sense) Outsiders.

I have tried, in this chapter, to give some idea of the way in which the research was conducted, to sketch some of the theoretical and methodological obstacles that arose, and to begin to work towards an account of how some of these problems were addressed. To this extent, the chapter has in part been about the nature of the exercise as perceived from within. In the next chapter I want to take instead an *external* perspective, and suggest some moves towards an evaluation of the committee's work.

1. Humphreys (1970: 25) suggests that:

> To wear a button that says 'I am a Watchbird, Watching You' into a tearoom, would instantly eliminate all action except the flushing of toilets and the exiting of all present.

2. Among other things that "taken seriously" might mean, I have in mind the possibility that their remarks might be taken up by the press and quoted extensively and out of context. It is, I believe, no accident that at many meetings there have been references to the press in the guise of an enemy, or at least an adversary of whom the committee must be wary. The normal form for these remarks is along the lines of "You can just imagine what the *Evening Post* would make of that", by which it is implied that certain opinions, although they can be voiced in the controlled atmosphere of a closed committee, cannot expediently be released to the press for wider circulation.

Nor need this be simply a matter of cynical paranoia on the part of the health care planners. There have been occasions when ideas have been canvassed that could easily have given an entirely erroneous impression of health care policy in West Glamorgan had they been reported verbatim in the newspapers. Notable is the use of the *reduction ad absurdum* in argument, where it was for example once suggested that it would be more economically efficient to shut down the casualty ward at weekends, since that is when the bulk of the costs are incurred in its running. Clearly, if quoted out of context, this could cause great alarm.

3. Lest it be thought that this is veiled accusation of hypocrisy, I should point out that there are many things that we say - and indeed, do - behind closed doors that we would not think or would not think of saying - or doing - if the eyes of the world had swivelled our way: but we do not on this account think that we are hypocrites, merely that we have a proper sense of occasion.

4. It is worth remembering that the LEC(PA) members were no strangers to the committee process: unlike many ethnographic subjects, they were - in the context of open committee discussion, at least - not in the slightest bit disturbed by the fact that their every comment was being noted down. Unlike street gangs, committees are used to being minuted, and regard it as an essential tool, rather than a threat.

5. It is important to acknowledge that the records thus compiled formed a valuable tool both for the compilation of reports on behalf of the committee and also for this observational research. However, they remained just that: a research tool. While the internal research records contained references to individuals (identified by initials) any papers derived from these records of the committee's discussion were presented in the name of the whole committee: i.e. the views expressed and arguments advanced were attributed not to the individual with whom they originated in the meeting, but to the LEC(PA) as a whole. This ensured that the confidentiality of individual members was respected.

6. This is not to say that it was not at times a struggle to keep up with the discussion, particularly at such times as the debate involved a large number of participants, each of whom were making only short (sometime one or two word) interjections. But the fact that the recording was draining suggests that I *was* paying exceptionally close attention to the discussion: indeed, in all probability considerably closer than if I had been merely minuting the debate.

7. Similarly, it is one of the overweening strengths of the model of action research that it permits and indeed requires collaborative theorising between the observer and the research subject and that it permits hypotheses and interim theories to be tested against the reactions and views of the research subjects themselves (cf p237ff).

8. Although I hope that - even in if its sphere of influence is thus limited - it is interesting and significant as a history and consideration of a ground-breaking development in the NHS at a time of considerable change and uncertainty, and as a record of the first overt, institutionalised attempt to deal in a consistent, accountable fashion with the moral and conceptual problems surrounding the allocation of limited resources in health planning: problems whose existence, although hitherto recognised, has had little effect on the *actual praxis* of health care planning; see Jarvis (1994).

9. This assimilation of the observer into the process and body of the committee reached its apogee at the meeting of 22 September 1994 when PW, who was in the chair, had to leave the meeting early. AW, who would typically have deputised for him, was unable to attend. The second half of the meeting, following PW's departure, began with an uneasy silence, broken by JD saying "Well, Rupert, hadn't you better get us started?", and my leading the remainder of the discussion. Such a *de facto* election to the chair is not, of course, problem free - my ability to *observe* the meeting could be thought to have been compromised by my incorporation into its process - but it remains true that it is a powerful symbol of my incorporation.

10. Owing to a curious irony, which Humphreys himself points out (1970: 27), the individuals in question were by no means unaware that they were being watched. But they were unaware of the status of their observer: "Any man who remains in a public washroom for more than five minutes is apt to be either a member of the vice squad or someone on the make. As yet, he is not suspected of being a social scientist." (1970: 26)

11. It is important to remember that the business of the committee, although not confidential, was conducted behind closed doors, and with the understanding that opinions could be freely voiced in that setting which individuals might think it less than expedient to own outwith the boundaries of the committee's discussion. It is therefore clear that the presence of an unknown outsider, faithfully recording those same opinions, might be perceived as a threat, particularly in the early stages of the

research when the purpose of the investigation and the constructed role of the researcher are still in the process of becoming, which Chenitz and Swanson (1986: 52) refer to as "the continuing efforts at clarification the investigator [and, they might have added, the investigated] engages in regarding his or her research identity, purpose of research, the rights of others regarding the research, as well as the ongoing process of entrée as the researcher moves throughout the institution."

12. Pandey (1979: 249) offers an almost paradigmatic example of this gatekeeper mechanism in operation:

> This veteran [of the Korean war] could not understand why someone would come so far from another country [India] to study his people. He did not mind being studied by an American, because, as he said, 'we belong to the same country', but he resented an 'outsider' and wanted to take me to the chief of his tribe for interrogation. *When my host* [who was "familiar with the styles and expectations of various social science fieldworkers" and "had known many distinguished Harvard anthropologists" (248)] *told him that I was with him and that there was no need to meet the chief, he left us and disappeared into the crowd* (emphasis added).

In this example, the gatekeeper, who is respected in the group being studied, *literally* says "It's alright, he's with me". This example is unusual, and particularly illustrative of the process under discussion, in that the moment of entry can be temporally pinpointed; the normal function of the gatekeeper is tacitly to vouch for the behaviour of the admitted person.

13. In the early stages of the committee's development, the term "expert in medical ethics" was used not infrequently. I discuss its applicability, and defend one possible sense of usage, in chapter IV.

14. We should be wary of overemphasising this point and giving the impression that the establishment of the LEC(PA) was simply a risk, with no attendant possible benefits. The argument of chapter I was that the establishment and reforms of the NHS had created a tension between demand and supply that could not properly be resolved within the established commissioning framework. To the extent that the LEC(PA) offered to help resolve this tension, then, its establishment can be seen as of considerable potential benefit to the Health Authorities, both in West Glamorgan and elsewhere (cf p227ff).

15. Although a number of the members of the committee were not *by virtue of their professional roles* health service managers, nonetheless they were all, irrespective of professional background, involved even if only peripherally in the management of the health service *by virtue of their membership of the committee*.

16. "ideology tends to be tied up in the rituals of everyday life even more obviously than it is in formal discourse." (Sanchis, 1983: 238)

17. By September 1995 the myth had become so deeply entrenched in the committee's thinking and world picture that their response to the draft health plan for 1996/7 (LEC(PA), 1995e,) argued that:

> Health care commissioning takes place neither in a political nor in a financial vacuum, and the fact and extent of these limitations should be acknowledged ... Commissioning in the County takes place in an environment in part determined by Welsh Office directives (e.g. the Waiting List initiatives).

18. This necessity for a shared *weltanschauung* provides the basis for an explanation of why jokes often do not transmit across cultural boundaries.

19. I discuss this theme of co-operation again in chapter V (p271ff).

20. See LEC(PA) (1994a: 1):

> The committee sees its role as one of questioning the general processes used and the conclusions thus reached in the planning process. It is therefore inevitable that this response and subsequent documents from the committee will be at best wary and at worst sceptical ...

21. It was explained to the members by AW that the constitution of the committee made provision for the membership of a consultant in public health medicine. On these grounds it was decided to seek a new nomination. But it should be noted that no-one on the committee seemed to hold out much hope that such an appointment would be forthcoming, or if it were, that it would be successful. In fact, it would be seventeen months before the vacancy was filled. Such is the immediate power of myth.

22. See Carson (1986).

23. "the acceptance of the [cooked food] gift may signal reciprocity for favours received or jobs well done and the expectation of future services." (Goode *et al.* (1984): 176)

24. See de Coppet's introductory remarks to his collection on the subject of rituals:

> We perceive much better that rituals create and construct, as each society's time unfolds and at varying paces, the social dimension. (de Coppet (1992): 9).
>
> Charsley (1992: 123) argues similarly:
>
> The [newly married] couple were described as 'sharing the richness [of the wedding cake] with friends and family'. This is of course to highlight a distinct aspect of the use of the cake, its distribution, but it is more complex in calling on an acknowledged attribute of the cake, richness, and suggesting - so inexplicably that again it can hardly be challenged - a symbolic dimension to the sharing.

25. Compare Baumann (1992: 98):

> We tend to take it as given, on the whole, [that rituals] are symbolic performances which unite the members of a category of people in a shared pursuit that speaks of, and to, their basic values or that creates or confirms a world of meanings shared by all of them alike ... As Leach puts it with genial clarity, in ritual, in contrast to a musical recital, 'the performers and the listeners are the same people. We engage in rituals in order to transmit collective information to ourselves.' [Leach (1976): 45]

26. cf Riesman's discussion of the "inside dopester" (Riesman (1950): 199-209).

27. It is important to recognise that this quasi-autonomy was by no means unlimited; cf the discussion of the subjective conditions necessary for the identification of a social problem (p50ff above).

28. Although it might be thought that the media form a third audience, for the purposes of this research I have chosen to regard them as contained within the larger group of the public. In this I am open to the objection that there is a hidden (or not so hidden) agenda with which the media - particularly at a local level - operate, which involves vocal criticism of local government and authorities in all forms, an agenda which may not be shared by the public. Although I can imagine that this objection might be made, I do not have the space to explore it. This research is about the nature and task of the LEC(PA), not the local newspapers.

29. Incidentally, it is hardly surprising that the closer one gets to the epicentre, the more finely the distinctions are drawn and perceived by those involved: as Lewis Carroll remarked, "even sheep may look different to other sheep".

30. In this regard, it is interesting to see a sample timetable for the development of official comments on the 1994/5 Health Plans.

October 1993	Initial response to outline Health Plan formulated.
December 1993	LEC(PA)'s original response presented to the Procurement Executive.
20 January 1994	LEC(PA) meets to consider Provisional Health Plan.
21 February	RJ circulates draft of LEC(PA)'s response to AW and PW for comments.
28 February	AW, PW, DG, RJ meet to discuss draft response.
28 February	RJ passes second draft - revised in view of comments at meeting of that day - to AW for circulation to LEC(PA) members for consideration prior to meeting of 24 March.
24 March	Meeting of LEC(PA) considers revised draft and makes further minor alterations.

25 March	RJ sends final version - amended as per meeting of 24 March - to PW and AW.
May 1994	Second Health Plan issued incorporating LEC(PA)'s comments.

31. See e.g. Humphreys (1970): 60-66 for an analysis of the complicated semiotic system of hand and other gestures that has evolved in the silent ritual of homosexual encounters in public lavatories, where the elimination of the spoken word is a reflection of the danger surrounding the encounter.

Chapter III

Evaluating the LEC(PA)

Daring ideas are like chessmen moved forward; they may be taken, but they start a winning game.

Johann Wolfgang von Goethe

1. Problems in evaluation

In previous chapters we have looked at the context of health commissioning into which the committee was introduced, at the way in which it constructed and accomplished its tasks, and at its patterns of operation both at a macro and a micro level. In this chapter I want to work towards an *evaluation* of the work of the committee. Before that, however, I want to explore one or two issues in the field of evaluation generally, and to argue against one - commonly held - view.

It should be mentioned at the outset that there is a possible objection to any evaluative research in this context that such work should be left to social scientists and students of organisational behaviour, rather than being misappropriated by philosophy. To answer that charge, which I happen to think is wrong-headed, it is necessary to look more closely at three problems which are implicit in any evaluative exercise.

The first problem centres on difficulties in ascribing causal relevance to the variable being evaluated. The problem of causal validity is well illustrated by Bernard (1927: 194):

> A physician who tries a remedy and cures his patient is inclined to believe that the cure is due to his treatment. Physicians often pride themselves on curing all their patients with a remedy they use. But the first thing to ask them is whether they have tried doing nothing, that is, not treating other patients; for how can they otherwise know whether the remedy or nature cured him?

As a pioneer in the modern scientific study of experimental medicine, Bernard was arguing for the establishment of something akin to the clinical trial that has now been refined in the form of the double blind randomised controlled trial (RCT) which has become the paradigm of good practice in health research. However, his exasperation with his bombastic, self-deluding colleagues should be a lesson for anyone involved in evaluative research.

There is a clear danger in evaluative research that causal links between two unlinked phenomena may too readily be ascribed by researchers eager to "discover" support for their hypotheses. To take Bernard's warning seriously in the present case is to consider whether health commissioners, in West Glamorgan or elsewhere, "have tried doing nothing"; that is, in the terms of this research, not directly addressing the moral and conceptual issues raised as a result of the process of health commissioning.

I argued in chapter I that the historical approach to rationing decisions in the NHS has been at best minimal; that is to say that *conscious* decisions to deprive one area of funding in order to provide better service in another have simply not been taken. Rather, rationing has been by deterrence and delay (Ruddle, 1991: 17) as advocated by Mechanic (1995). Despite the Royal Commission's findings in 1979, deliberate rationing policies, and attempts within such policies to work out problems regarding the proper scope of health activity, have been the exception rather than the norm in the NHS. Historically, at least, the null option has been thoroughly tested.

Similarly, although West Glamorgan is by no means the only Health Authority in the reformed NHS to become aware of the numbing moral and conceptual difficulties facing them in the commissioning process, it is one of only a very few to have taken an up-front stance in the face of such problems, rather than continue its historical approach to rationing decisions. Almost the committee's only rivals in the field of self-conscious rationing in the UK have been the sporadic and not entirely successful attempts in other Health Authorities, most particularly the Child B case (see below p174ff). These have been remarkable both for the monolithic, condition-based approach to rationing that they have adopted, whereby certain condition/treatment pairings are ruled out of the commissioned canon of health care, and for the lack of success and the excess of media attention that has been attendant on their attempted implementation. The Committee's second response to the 1995/6 Outline Planning Intentions (LEC(PA), 1994d) argued, following Evans (1993) that such condition-based rationing strategies run the risk of riding roughshod over the health needs of suffering individuals.[1] They also attract a very great deal of adverse publicity, partly as a result of this danger. Since the exclusion of specific conditions or treatments from the health care that is to be commissioned gives rise to a situation where *identifiable* individuals are left with conditions that clearly represent a health care need which could be met, it is not hard for a reasonably diligent reporter to locate one such individual and portray him or her as "wronged" by the Health Authority.

In the vast majority of Authorities, however, the fact that one generally acknowledged result of the 1991 NHS reforms has been that rationing decisions that formerly were taken by implication or behind closed doors are now taken in the glare of the public gaze, has had little if any effect on the actual praxis of commissioning. With one or two adjustments at the margins, things carry on much as ever they did. This is, perhaps, not altogether surprising (see Strong & Robinson, 1992: 192). Within the context of difficulties of causal validity surrounding evaluative research, there can be little doubt that substantial control groups exist against which the positive activities of the LEC(PA) can be compared.

The second difficulty for evaluative research centres on what Long and Harrison (1985: 6) call "the issue of attributional validity". They argue that "one must show that other possible (causal) factors are absent ... which might otherwise explain the change". That is, that even once a putative causal link has been established between intervention and outcome, nevertheless, before it can be maintained that the one is an effect of the other, other possible causative factors must be demonstrated not to be in operation.

I suggest that it is impossible to exclude, in a manner sufficient to satisfy these requirements, the possibility that other dynamics were at work that influenced the process of health care commissioning in West Glamorgan over the period studied. Commissioning is not by any means a unidimensional process, and it would be surprising indeed if just *one* initiative could be identified as responsible for any major changes in the direction of the commissioning process. That is to say that it is, I suggest, impossible (in the context of an activity so diverse and with such a multiplicity of causative factors as health commissioning) confidently to ascribe operational effectiveness to *any* single dynamic. It is at best an open question whether a single marginal voice, such as that of the LEC(PA) could itself *ever* be a sufficient condition for a change in health commissioning activity. I suggested in Chapter I that given the investment of hours and resources that almost any activity within commissioning represents, only so much is "up for grabs", that is, open to question by those arguably "fringe" voices that are not themselves directly responsible for commissioning. This understandable example of institutional inertia may mean that there are *no* circumstances under which the LEC(PA)'s recommendations or reservations could be an effective force or brake on the process of commissioning in and of themselves. I should stress that this is not, obviously, a logical point, but rather an empirical one concerning the nature of large scale institutions.[2]

However, this consideration does give rise to an interesting question within the context of the present research, concerning appropriate comparators for the LEC(PA), and I want to suggest two possible models.

CHCs have, since their inception in 1974, had a peripheral and loosely quantified role in the health care planning process (see above p33ff, and Klein & Lewis, 1976: 16). However, one thing about them is clear, that their consent or objections to a proposed policy are in no way determinative.[3] That is to say, that CHCs have a purely *advisory* role to play in the health care planning process. They are one voice among many competing for attention.

Local Research Ethics Committees (LRECs) however, operate on a very different model. Their consent must in practice be obtained before any research on NHS patients or taking place on NHS premises can be undertaken (Department of Health, 1991: 1) In cases where their consent is withheld, the research cannot be undertaken in its present form.[4] Their veto is to all intents and purposes individually sufficient to scotch a proposal: while a CHC's disapproval may remain just that, an LREC's never will.

The question for the present research is whether in this respect the LEC(PA) is more like the CHCs or the LRECs. On one level, the answer is clear: to the extent that the LEC(PA) has no right of veto over any proposals put to it by the Commissioners, it is more like a variant of a CHC. However, I suggest that to the extent that the LEC(PA)'s recommendations and activities can be thought of as having some kind of *direct* effect on health care commissioning in West Glamorgan, this analysis is too simplistic. Although it would be overstating the case to suggest that the LEC(PA)'s role is analogous to that of an LREC, I suggest that the initiative of "Values For Commissioners" (see below p157ff) indicates that the LEC(PA)'s voice can be a significant motivational force.

Long and Harrison (1985: 33) argue that:

> One fundamental problem in assessing the effectiveness of a health care programme is that of knowing whether the programme itself led to the improvement in the health status of the target population, or avoided a deterioration or whether this was partially effected by some other factor ... It is instructive in this connection to consider the range of factors which can cause ill-health ... It also underlines the difficulty in this area because of the multifactorial nature of illness causation and, by implication, health itself, and the relative role of the health services.

Although their remarks were made in the context of evaluating clinical services, they are relevant to the present discussion. I suggest that if physical illness and by implication health have an exceptionally complex and multifactorial etiology, so also a sensitivity to moral and ethical issues will have a similarly multifactorial ancestry *in at least the same measure*. It is therefore to be expected that the activities and responses of the LEC(PA) should form but one dimension of a multidimensional pattern.

The complexity of this picture means that hard evaluation of the LEC(PA) would be at least extremely difficult, and more probably impossible. If clear and concise causal reasons cannot with any confidence be ascribed to changes in physical health, then I suggest that there is no reason whatsoever to suppose that we should be able to do so when it is morality, rather than physical wellbeing, that is in question. Such measurement would require at least the development of more sophisticated and finely calibrated tools of attitudinal quantification than this research permits. Moreover, such estimation is the province of the social sciences. Philosophy has a valuable contribution to make to evaluative exercises, but not in the administration of complicated questionnaires.

The third difficulty for evaluative research underpins both of the first two, and indeed has already been hinted at in the above discussion. There can be no doubt that to the extent that part of the difficulty concerns a need to clarify meanings and concepts, it is the proper province of philosophy. It is the thorny issue of goal identification, the establishment and delineation of those parameters and policy objectives that are thought to be the proper objective of the committee: discussing what the *point* of it is.

It is a commonplace of evaluative research and its critiques that the way in which an exercise is evaluated will depend crucially on a statement of its goals. The success or failure of a screening programme may be estimated very differently depending on whether the objective was defined as the estimation of the prevalence of a condition in the population, the identification of individuals for whom early treatment of the condition could in large measure alleviate it, or the addressing of widespread public anxiety over the condition. Whether or not an exercise can be counted a success will obviously depend on what the purpose of the exercise was held to be.

In terms of the present research, evaluations of the activities of the LEC(PA) will vary with differing accounts of the purpose of the committee. Moreover, there is no reason to suppose that in an institution as broad as a Health Authority there will be any significant degree of unanimity over this central question of the actual *purpose* of the committee. While some may welcome the challenge to traditional solutions that a free-thinking external ethical review can provide, others may see such innovations as dangerous and unsettling. Others may even deny that moral considerations have any part in health care commissioning.

Clearly, then, the way in which the goal or goals of the LEC(PA) initiative are cashed out will govern any assessment of whether or not those goals have been achieved. However, there is one further preliminary point to be made before we immure ourselves in the actual working out of objectives and goals.

It is often held that "objectives should be stated in terms of measurable change in intended directions, and if reasonably identifiable criterion variables are not available, evaluative research is not feasible." (Jones & Borgatta, 1972: 41) That is to say, that unless the goals of an exercise are stated *before* it begins, it makes no sense to talk of evaluation. *Prima facie* this is a persuasive contention: surely the only way to know if a journey has been completed is to have an idea of where it is one is trying to get to? Since this is an important objection, in that it is levelled at the whole task of trying to evaluate the work of the LEC(PA), I want to spend a little time exploring it, to consider why it seems plausible and to sketch a model of the LEC(PA) that it seems to presuppose. I shall then explain why I think it is mistaken.

Holland (1983a: 8) defines evaluation as "the formal determination of the effectiveness, efficiency, and acceptability of a planned intervention in achieving stated objectives." Although Holland is discussing the evaluation of health care interventions, his point may be taken to stand for a general belief that central to the idea of evaluation is the task of comparing outcomes with intentions: simply put, evaluation is about seeing how a plan measures up in practice.

Central to this conception of evaluation is the idea that the intentions behind a particular exercise, in this case the establishment of the LEC(PA), are clear in advance; that is, that it is apparent from the start what it was that the LEC(PA) was supposed to achieve. The supposed difficulty for any credible evaluation of the committee is that it was, at its inception, far from clear what it was that it was supposed to be doing. That is not to say that no thought went into the establishment of the committee, but rather that the tasks with which it was originally charged were so general as to require considerable interpretation:

> The committee will be available to review those ethical matters arising from Purchasing, Provider and Professional Policies as there are, undoubtedly important moral dimensions to health care planning and management. The committee therefore should provide advice with regard to ethical issues arising from the contracting process and the development of an internal market. (LEC(PA), 1992)

The committee, then, had a dual function: "to review ethical matters arising" and to "provide advice". It must be admitted from the outset that these are both extremely general aims. Nowhere in the documents prepared at the inception of the committee is it cashed out what exactly the Authorities had in mind when they required a review of ethical matters arising, nor how much or what sort of advice they anticipated. I have already argued (p36ff) that advice must be realisable if it is to be useful, but even this is not spelled out.

In the interests of making this evaluation of the LEC(PA)'s first years of operation a reasonable and fair one, then, it is necessary to tease out what might have underlain the original intentions. With that done, we should then be able to look at what actually happened and see whether these intentions were translated into action and effect.

Reviewing ethical matters arising from health care planning and management can best be characterised as an exercise in highlighting those policies within health care planning and management that give rise to ethical questions. This function of the committee is essentially about flagging up questions, about drawing the attention of those responsible for planning the provision of health care services in West Glamorgan to the central and often intractable moral questions that underpin their work. As an exercise in ethical review, it carries with it no responsibility to prescribe a putative resolution to the problems thus identified. The scope of the activity could legitimately be restricted to a description of an ethical problem and an identification of the various possible solutions to it.

Since the primary function of the committee was one of review and not of prescription, it had no right of veto over any proposal that was put to it. Any review that it made and advice that it might give remained just that: advice. At no point could its pronouncements become in any way determinative of health policy in the county. It is important to stress this since this lack of a right to block policies had one very important implication for the role of the committee. As the LEC(PA) could in no way be seen as in any respect an ultimate arbiter between two possible (but unattractive) policy options, there was never the opportunity for the Authorities to use the committee as an imprimatur for unpopular decisions which they would otherwise have had to resolve themselves (see Evans, 1994).

The second responsibility of the committee, that of providing advice with regard to the ethical issues identified, goes somewhat beyond the first. It can in essence be thought of as being concerned not merely with raising questions, as the first task is, but with actually suggesting answers to the problems that are identified. In this respect, this task is considerably the more demanding of the two: as the improbable but perceptive Morris Zapp mused, "any damn fool could think of questions; it was *answers* that separated the men from the boys" (Lodge, 1975: 36). If there were nothing more to the LEC(PA)'s task than raising questions, then it would be reasonable to wonder how much of a development in the field of health care planning it really represented; after all, there has been no shortage of journalists and other commentators willing to raise *questions* about the ethical dimensions of health care planning.

This obligation to consider and develop positive responses and constructive criticisms of the proposals and initiatives that reached the committee was clearly stated by the chairman, PW, at a meeting to review Outline Planning Intentions 1995/6 on 20 October 1994:

> ... while some criticism of the document may be helpful, we must be careful to postulate a better version in the end rather than just attacking the existing one.

To the extent that this can be taken as indicative of a growing sense of responsibility and realism on the part of the committee with respect to the quality of its outputs, it can be seen as evidential of an increasing sense if not of identity with then at least of solidarity felt by the committee between it and those directly responsible for health care planning. That is to say that the earlier conceptualisation of the authorities as Other to the committee's One, as if in some way an adversary (cf p93ff), had begun to give way to a more co-operative model of action, at least on the part of the committee, where a duty to work with rather than against the Authorities was felt.

However, it is important to be clear that there is a fundamental difference between giving advice and having a necessary effect. While the advisory function of the committee clearly goes beyond its duty to highlight ethical questions raised by health care planning policies in West Glamorgan, it stops significantly short of a requirement to affect the actual planning in any way. That is to say that we should resist the temptation to evaluate the committee's effectiveness by attempting to compare the moral awareness and responsibility of the Authorities' proposals before and after its inception.

This temptation should be resisted for two reasons. Firstly, it is next to impossible to determine how "moral awareness and responsibility" could be measured, particularly in something so multidimensional as health care planning. If we were seeking to determine the heavy metal content of a sample of sea water, there would be clear procedures that can be followed and the result would be easily quantifiable. But there is no parallel procedure that can be followed in seeking to quantify (if it makes any sense to use such a word) the *moral* dimension of an area of activity.[5] There is nothing analogous to boiling the water off and weighing the residue: "the moral dimension" of something cannot be weighed in anything like that way.

Secondly, and even more importantly, it is important not to evaluate the committee's work in terms of the *effect* that it has had on health policy in West Glamorgan because that was not its task. Its terms of reference extended only so far as giving advice to those responsible for developing and implementing policy, and not as far as actually executing policy decisions itself. To expect the advice in and of itself to have a necessary effect on the dynamic of health care planning is both unreasonable and wrongheaded. Advice differs from direction just to the extent that it leaves the responsibility for any decision taken to the *advised*. An advisor is responsible for the advice given, but not for any actions taken as a result, responsibility for which rests with the instigator of those actions alone. The meaning of the term "advise" is closely connected with its etymology: advice is that which turns one's attention to something - when I advise someone, I show them their behaviour or whatever it might be in a certain way. But nothing follows ineluctably from this; certainly it does not follow that they *have* to see it in the way that I sketch; nor even having seen it thus need they concur with me on an appropriate form of action. The recipient of my advice may or may not agree with my portrayal of the situation: it is for him to decide. Advice, we may say, significantly underdetermines any possible outcome.

As a footnote to this discussion, it is worth recognising that this question is not quite as simple as it may appear. Although it seems reasonable to suggest that a body whose function is to provide advice should not be evaluated simply according to the (confused and over-stringent) criteria of any effect that its advice might have had on practice, nonetheless the question remains an open one of what the purpose of having the LEC(PA) could be if it had *no* effect on health care policy in West Glamorgan at all. If we think of the LEC(PA) in the terms in which Evans (1994) characterised it, as "a health care planner's conscience", then for it to be an *effective* conscience - that is, for it to do with any rigour the kind of thing that consciences typically do - it must surely do more than murmur as a still small voice of calm. For a conscience to be properly so called, it seems intuitive that it must at least *sometimes* act as some kind of a brake on desires (cf Butler, 1897:55).

However, it is important to be precisely clear about what sort of brake on desires a conscience must provide for it properly to be said to be acting. Straughan (1982) suggests that it makes perfect sense to say that someone genuinely wanted to do what s/he believed to be right and yet still *always* did wrong, that is that their conscience was *never* motivationally efficacious. Although this looks initially to be paradoxical, in fact the paradox is only superficial and can be resolved by reference to Butler's distinction between the power and the authority of conscience (see Butler, 1897: 63-4).

Butler argues that while conscience "has manifest authority", it lacks power, and that while it is universally recognised as having right, it does not exhibit strength in the same way. That is to say that we recognise the voice of conscience, and accept that its dictates are right, but, because our physical natures have the strength and power that conscience lacks, it is more or less often overruled:

> Had it strength, as it has right; had it power, as it has manifest authority, it would absolutely govern the world.

What Butler's distinction between the power and authority of conscience makes plain is that while it might be regrettable that our unwilling wrongdoer in the example above fails to live out her moral convictions, nonetheless there is no reason for us to suppose that she has none, nor that her conscience is ineffective. It may certainly be inffective as a brake on action, but that is not its purpose. We might say that while her repeated failure raises a question about her conscience, it does not answer it. In fact, we would be perfectly justified in asserting that she had an effective conscience if it turned out that she was wracked with guilt prior to or after her wrongful actions, if, for instance, it were the case that she habituallly paused before giving into temptation.

This discussion is important for our understanding of the LEC(PA)'s role in moral debate. In evaluating whether or not the committee can be thought of as doing the job of a health care planner's conscience well, we will look not for proposals blocked, but for evidence of increased moral sensitivity in the process of that planning; and on such inspection we find precisely that. While the Health Authorities may not always have gone along with the LEC(PA)'s recomendations (they may not always have been an effective brake on action), nonetheless it is significant that the committee's response to draft versions of the annual Health Plans, which formed part of its allotted workload, was invariably included in the final version of each Plan. In Butler's terms we might say that the right and authority of the committee as conscience had been recognised, even if its strength and power were limited. Although the committee might have moral authority, its not having a veto over policy issues with which it disagreed meant that a wedge was deliberately driven between this moral authority and the executive power that was responsible for the development and implementation of health policy in the county. To expect a complete correlation, then, between the committee's recommendations and actual policy would be to misunderstand the nature of conscience and moral convictions, and to believe - mistakenly - that an habitual wrongdoer would be an individual with no conscience at all. That we know this to be false, indeed, that self-conscious wrongdoing and the attendant pangs of conscience that ensue is all too possible,[6] should be enough to suggest that such a simplistic picture of the relationship between moral belief and action is mistaken.

In this regard it is particularly significant to note that the Health Authorities were in general at some pains to ensure that the committee's reponses *were* included in both the process and documents of planning and *did* inform discussion. Had the establishment of the LEC(PA) been at bottom a cynical exercise in window dressing on the part of the authorities, designed to diffuse potential dissent and concern without in any way having an impact on the practice of planning, then one would have expected the Authorities to have trumpetted the existence of the committee while ignoring its recommendations: that is, to give the impression of taking its moral concerns and responsibilities seriously while in fact doing nothing whatever of the kind. That this is precisely the reverse of what happened suggests that the putative moral concern that led to the establishment of the committee was in fact quite genuine. This in turn explains why the committee's concerns and reservations were taken as seriously as the voice of conscience ever can be.

We have seen that the original goals of the LEC(PA) were notable for their generality: to provide a review of ethical matters arising from the commissioning process and advice concerning those matters. Nothing more was spelt out in detail, and no guidelines for procedure were given. Responsibility for directing the work of the committee and for generating mechanisms by which this work could be effectively undertaken was left entirely in the hands of the committee itself, assisted by the process of action research in which the committee collaborated. As I suggested in chapter II, in its early months of operation, the LEC(PA) found itself in a classic existentialist dilemma: its essence preceded its existence, it was before it purposed to be (see Sartre, 1992: 26-8). Having no blueprint to follow, no pre-existing idea of what course it ought to take, the committee was left to define itself and its tasks.

In this respect, the committee differed significantly from other forms of review of either health care or health policy. That is to say that, although review of health policy was an important part of the committee's work, it was only one part. The LEC(PA)'s task was to look not just at health policy as it was being practised, but to be responsible for the exploration of wholly *new* developments in health policy. It is important to recognise the importance of this novelty, and the correlative fact that neither the Authorities responsible for the setting up of the committee, nor the committee members themselves, had more than a vague idea of what exactly the committee was to achieve, nor - more importantly - how it was to go about achieving it. I argued at the beginning of the project (Jarvis, 1994: 18) that

> West Glamorgan Health Authority is not so unimaginative as to suppose that it has got it right first time ...

suggesting that however carefully the initial work of the committee was undertaken, the task of self-definition made it inevitable that the early work of the committee would form part of a learning process.[7]

Once we have understood this and recognised the importance of the fact that the work of the committee was *completely* without precedent, we can begin to see why we should not be surprised that the active involvement of the (paid) researcher in defining and developing the committee was sought. Given that a substantial part of the committee's work in its first months of operation was to create for itself a *modus operandi*, it is understandable that the help of one paid to support and develop the committee's work should be sought: there is, as we are constantly reminded, not the slightest point in keeping a dog and barking yourself.

So it is clear that part of my responsibilities in the research lay in actually influencing the subject of the research itself: that is, in the jargon of the subject, this was *action research*, which Cope (1981: 7) suggests

> basically consists of first collecting information, feeding this back to the group concerned, deciding and planning what to do on the basis of this data and then initiating some action to follow up the decision.

This, it will readily be appreciated, is far from the fly-on-the-wall model of disinterested ethnographic observation at which some research aims (cf Webb *et al.* 1966). In action research there is no pretence that the presence of the researcher makes no difference to the research subject. Indeed, in some respects it is individual subjects who themselves initiate the sequence by which the difference can be effected. Almost a paradigm of this dynamic in which it is the observed, rather than the observer, who seek to influence the processes as a result of the presence of the researcher was given at the meeting of 22 September 1994 when, owing to a short series of coincidences and over-full diaries, a meeting of the full committee found itself without a chairman. This administrative vacuum was soon filled, indeed without any questions being asked or votes being taken, by my *de facto* appointment to the chair for the remainder of the evening.

Clearly, (assuming that my chairing was non-trivial) it would be ludicrous to suggest that my presence had *no* effect on the conduct of that meeting. Indeed, the effect that it had is particularly obvious in this example since it is the *responsibility* of anyone chairing a meeting to have some kind of effect on the conduct of business, in terms of steering the discussion, facilitating productive debate, and working towards a positive conclusion. Here, then, on a non-interventionist model of observation, would have been a dilemma: to have had any effect on the conduct of the meeting would have been to have betrayed the ideal of detached observation, while not to have influenced the discussion at all would have been to have abdicated the (temporarily imposed) responsibilities of chairmanship. To have refused to have co-operated altogether on the grounds that to have done so would have been to introduce a pernicious influence on the committee's work would not only have been unhelpful from the point of view of getting the committee's work done, but also could have had unfortunate repercussions in terms of my constructed identity as a committee servant.[8]

The model of participant observation and action research, however, questions the benefits of the detached approach, and instead

> aim[s] both to contribute to the resolution of practical problems and to increase understanding of the issues being studied. (Towell & Harries (eds.), 1979: 15)

This is to say that action research is an appropriate model to adopt when the initiative for the research comes from the research subject as much as it does from the researcher, or on other occasions when there is, or could be, agreement between the observer and observed that there are practical problems that could be resolved or at least ameliorated by intervention of outside researchers.[9] Towell and Harries (1979: 15) observe that all the projects described in their volume took place "in collaboration with the people concerned ... [t]hrough close working relationships", but they do not point out that for action research to work, it could not have been otherwise.

Given this, it becomes clear why the invitation to chair the meeting of 22 September 1994 is so significant, in that it represents an initiative taken by the research subjects themselves: an identification of a problem (there being no-one to chair the meeting) and a recognition that one way to solve it was to involve the researcher more closely with the processes. The development of "ground rules" for the meetings which I discuss below (p147) similarly shows an example of a dynamic where the influence (in this case, at a relatively fundamental level) of the researcher was actively sought by the committee. Indeed, we need not even look for particular examples of the influence of the researcher on the research subject: the mere fact that each meeting's discussions were to a greater or lesser extent shaped by the briefing documents that I prepared on each topic is itself evidence of the effect that I had on the committee. As the character of these briefing papers changed, so did the nature of the resulting debate: the research itself became part of the goal definition process that the committee underwent in its early months of operation. As we might expect in a symbiotic relationship where both observer and observed were working out their respective roles, changes in the one both mirrored and helped to produce changes in the other.

One of the benefits of hindsight is that the vision that it affords is 20:20 - when we look back we can see patterns of which we were little enough aware at the time of their creation. The early stages of the committee's work were marked by a somewhat rigid, often negative, criticism of whatever proposal it reviewed: perhaps not surprisingly, having identified the Health Authorities as Other, the committee proceeded to approach documents and initiatives it examined somewhat over-rigorously. This stage, however, in which flaws in Authority proposals were tirelessly highlighted, represented not the end point of the committee's development, but rather its inception. I argued in chapter II that the identification of the Other and the establishment of distinctions and boundaries is an important part of self-identification. It is hardly surprising that a newly formed group such as the LEC(PA) should exhibit precisely these patterns of initial criticism, particularly so, perhaps, as a result of the somewhat nebulous nature of its stated task.

This initial stage, which we might characterise as hostile, can be thought of as giving way to a more realistic acceptance of the Authorities not as an antagonistic force, but rather as an agency with whom some kind of co-operative relationship must be established. This development is grounded in a growing awareness that just as the task of health care commissioning is irreducibly moral, so also is it irrevocably complex, to the extent that it is so unlikely as to be virtually impossible that *any* practical proposal arrived at will measure up to the (unrealistically) high standards set by the ethics committee. Such a recognition of the strict impossibility of the aim of combining moral perfectionism with the requirement to produce workable health care investment protocols could have issued in one of two ways.

Firstly, and less productively, it could have given rise to a kind of nihilistic despair, which questioned what on earth could be the point of serving on such a committee when it could be virtually guaranteed that any of the carefully researched proposals put before the Authorities would be rejected on the grounds of impracticability, or so watered down as to be almost unrecognisable. This would have been an understandable reaction, if an unfortunate one, which would, if it had been representative of the view of the committee as a whole, in all probability have served to wind up the committee with immediate effect.

The second reaction to a recognition of the inevitably limited scope and possibility of the committee is, I suggest, a more positive, although pragmatic, one. It is also one which appears better to represent the feelings of the committee members.[10] The tone of the discussions of "The Waiting List Initiative" and "Outline Planning Intentions" (September & October 1994) evinced this growing acceptance of both the Authorities and the complexity of their task. Although it would be a mistake to suggest that there was any movement towards a positive identification between the Authorities and the committee, it was noticeable that in the September meeting, considerably less time was spent attacking the Authorities, while the tone of the October meeting was in large measure distinctly complimentary of the document "Outline Planning Intentions 1995/6" which was felt to be a considerable improvement on its predecessor, the Provisional Health Plan 1994/5, which the committee had reviewed (in not altogether favourable terms) in January 1994.

Both the September and October meetings were conducted on the basis of a set of "ground rules" drawn up by RJ, PW and AW, which laid down that criticism of the Health Authorities was to be restricted to those areas of planning and implementation for which they were themselves responsible, i.e. that features of health care commissioning that the committee found questionable but which were imposed upon the local scenario from outwith the county (for instance by Welsh Office directives) were not to be commented on. A discussion paper prepared for the September meeting put it thus:

> The committee may not like the waiting list initiative, but the Health Authority has to live with it and make it work. Given the fixed points outlined in the companion paper, what recommendations does the committee have for ethically responsible practice *within* the boundaries imposed ... (italics in original).

I suggest that this dynamic of increasing acceptance of the *practical* scenario within which health care commissioning must necessarily take place is evidential of a growing pragmatism within the committee which can be thought of as replacing its original idealistic notions of the effect it could have on health care policy and consequently on the kind of recommendations that it could make. That is to say that with the benefit of hindsight, we can look back at the first years of the LEC(PA)'s operation, and see it both moving towards its dual goals of reviewing ethical implications of health policy, in which task it was initially uncompromising and unrealistic, and of providing advice, which I have suggested became steadily more realistic as an awareness of the nature of the task for which it was advising became clearer, while at the same time as progress was being made towards these dual goals, the committee can be seen to be defining *itself* as it worked; a self-definition achieved only by trial and error; but then - given the radical incompleteness of its original design - it is hard to see how it could have been otherwise.

If the first years of the LEC(PA), then, are thought of as a journey, then it is clear that the travellers had only the haziest of notions where it was they were trying to get to, and indeed how they were going to get there. It is this openness of objectives that forms the basis of the putative objection that any evaluation of the committee is impossible or meaningless, that "there is no point in evaluating an activity unless there is agreement on its purpose" (Phillips, 1993: 2).

I suggest that, although there must plainly be some agreement as to the purpose of an activity before it can be evaluated, *there is no need for that agreement to precede the activity itself.* That is to say, evaluation after an exercise is perfectly possible even if the people involved in both the planning and execution of the activity did not have a clear and consistent idea of what it was they were attempting to achieve. In the particular case of the LEC(PA), I suggest that since the committee's original terms of reference were extremely loosely phrased, there is any number of ways in which the objectives could have been achieved, and that there need have been no set or fixed idea prior to the committee's establishment as to the *one* path that it was to have taken for it to be pronounced a success. An exercise such as the LEC(PA) initiative, the focus of which was extremely general and ill-defined, can nonetheless turn out to have been a success *post hoc*. In terms of the analogy of the journey that I drew above, it plainly makes sense to say, on the return of a mystery tour that it was a success, even if the passengers in the bus have no idea where they were going before their departure. To put it another way, the question for evaluation should not be "Did the LEC(PA) do a,b,c,...?", but rather, "What did the LEC(PA) do, and was it worth doing?"

Given the thesis that I have been developing, that part of the activity of the LEC(PA) was its own self-definition, it makes sense to say that part of the positive evaluation that we must accord it is derived from the fact that in its early years of operation, the committee can be seen as moving from being a somewhat unfocused (although well-intentioned) initiative to being an important cog in the wheel of health care policy planning in West Glamorgan. That is to say that part of the success of the committee is to be found in the fact that its task and goals are now substantially clearer than they were at the outset of the initiative. To the extent that the committee represented something of a pathfinding exercise, part of its value must be derived from the extent to which a substantive account of its own task and its operational patterns for achieving that task emerge from the activities that it undertakes. I suggest that it is possible to discern an increasingly well defined account of the committee's purpose and subsequent responsibilities emerging from its recommendations and sequences of operation, and that therefore in this respect at least the initiative must be judged a success.

2. Identifiable outcomes

And so we come at length to the question of the facts: what has actually *happened* in the first three years of the LEC(PA)? In what ways, if any, does the health commissioning landscape differ in West Glamorgan as a result of the initiative that the committee represents?

The truth is that after three years of the committee's operation, the differences are, for seekers after the dramatic change and the *volte face*, depressingly slim. Indeed, it would be hard to point to any one proposal's discontinuation for which the LEC(PA) has been either a necessary or a sufficient condition. If the function of the LEC(PA) is to act as a kind of ethical watchdog, turning away those proposals and initiatives that are held to be questionable, then it does not appear to have been much of a success. The biggest single area of work for the committee was the production of comments on the annual Health Plans while they were in draft, consultative, form. As I argued above (p46), the sheer quantum of time and effort that goes into the preparation of such documents as the draft Health Plan itself precludes to a great extent the possibility of radical questioning or thoroughgoing criticism. By the time a Health Plan reaches the draft stage, the number of staff hours that have been invested in it means that any but marginal criticism will in all probability be disregarded. The sense - and indeed the fact - of ownership is simply too great.

Given this, it is perhaps not entirely surprising that the LEC(PA)'s comments on the various provisional Health Plans that it reviewed did not appear to exert any direct and traceable effect on subsequent drafts of the same document. However, it should not be concluded from this observation that the committee's time was wasted, nor that its comments went utterly unheeded. For example, the final version of the 1994/5 Health Plan reproduced in its entirety a paper from the LEC(PA) summarising the committee's reactions to and criticisms of the Provisional Health Plan. Although it would clearly be a mistake to think that inclusion of one of the committee's papers as an appendix to the Final Health Plan represents any great revolution in health planning, nonetheless I shall argue that the significance of the paper's inclusion should not be underestimated, particularly in the light of subsequent developments in the commissioning process.

In the planning round for the year 1995/6, the Provisional Health Plan was replaced, in response to a Welsh Office directive, by a document entitled Outline Planning Intentions. This document was reviewed by the committee at a meeting on 20 October 1994. The output document from that meeting (LEC(PA) 1994c) is instructive in terms of monitoring a change that occurred during the course of the intervening year. Among other remarks, the committee

> was greatly encouraged to note significant differences between the style of Outline Planning Intentions and its predecessor, the Provisional Health Plan.
> In particular, the committee noted that Outline Planning Intentions is a substantially shorter document, the tone of which is more appropriate to a consultation paper ...
> The committee was particularly pleased to note a considerable reduction in the number and purported accuracy of statistics in the paper.
> The committee was also pleased to note that a number of restrictions on Commissioner activity had been identified in the document. The committee recognises that commissioning does not take place in a vacuum, nor without reference to externally imposed criteria of activity. It commends the document to the extent that it expressly identifies such restrictions.

Again, it would be to disregard entirely the problems of attributional validity within the issue of evaluation of the LEC(PA) to suggest that the differences between the Provisional Health Plan and Outline Planning Intentions can be attributed to the criticisms and comments made by the committee in the review of the former paper and in the intervening year.

However, it does not seem grossly improbable to suggest that the outputs of the LEC(PA) had *in some measure* helped to contribute to the changes. As Klein and Lewis (1976: 145) argue in the case of CHCs, there is a danger inherent in too thinly defining one's measures of success:

> Above all, there is a risk of defining the success or failure of CHCs in narrow but measurable terms - so many complaints successfully handled, so many rules successfully changed, so many extra lavatories, etc. - while neglecting what may be more important dimensions. For example, if their existence leads to changes in the style of health service administration - in the way in which administrators and professionals approach and perceive their task - then the introduction of CHCs will have made a major difference to the NHS.

In the case of the LEC(PA), particularly given the nomenclature that it partly shares with the LRECs, there is a temptation to look for patterns of operation in parallel with the LRECs, proposals blocked, unacceptable innovations denied, ethically insecure assumptions exposed. But I have suggested that it does not make sense to think of the LEC(PA) in exclusively these terms: that it would be a mistake to think that by totting up the number of proposals that the committee had managed to sideline in the course of a year one would have said anything very useful about it. Certainly, I suggest, one would be nowhere near coming up with an account of the *value* of the committee in anything like rounded terms.

Underlying this supposition is the belief that there is more to the value of the LEC(PA) than simply the direct effect its recommendations have on a one to one basis: that is, I suggest that there is a value to the committee over and above any easily quantifiable results that may be traced as a result of its recommendations being reproduced in appendices, or quoted in subsequent planning documents. However, before discussing in detail the notion of a more nebulous value of the committee, I want to pursue one further strand that might go some way to persuading the doubtful that in addition to any such indistinct value to the committee, there was a direct and hard-headed value that can be easily traced and located. Far from relying on questionable observations, wish fulfilling interpretations, or dubious attributions of causality and influence, this particular strand of the LEC(PA)'s influence on the actual praxis of health care planning in West Glamorgan is clear, easily quantifiable, and compelling.

One of the central themes running through all the discussions, papers and reports that the committee produced in its first two years of operation highlighted what was held to be a fundamental gap in the commissioning process: a conceptual vacuum at the centre of health care planning. This was identified particularly clearly at the meeting of 14 July 1994 to discuss the Ten Year Strategic Health Plan:

> What's missing is anything that grounds all these individual intentions, any sense of direction, any hint of where the Authorities are trying to go, or how they're going to get there. I hardly like to say it in the present company, but what this Plan needs is a *philosophy*.

Leaving aside the tongue in cheek jibe, this criticism summarises an underlying focus of the committee's first two years: that the documents on which they were asked to comment all lacked any underlying notion of intention or foundational value. That is, the grounding principles on which such documents as the various Health Plans were based were not, from the reading of those plans, clear.

This absence of a grounding philosophy was held to give rise to two quite distinct problems, either of which would have been individually sufficient to require the lack to be addressed. In the first place, certain members of the committee were concerned that there was every reason to suppose that in the absence of a definitive statement of values that were intended to ground health care commissioning in the county, far from the Commissioner representing a stable and directive force in the health care planning process, it might instead be the case that no such stability was achieved, and commissioning decisions were taken in response to individual disconnected factors. A particular example of this type of concern was identified at the meeting of 14 July 1994:

> What I still don't know is whether Health Gain is actually going to be an important factor in investment decisions or not. Up until now, any available money has been going to adept shroudwavers, not those who can demonstrate increased Health Gain. The Authorities are just blowing in an emotional wind.

The point is surely clear enough: the concern is that in the absence of any underlying conception of the direction in which the Authorities wish to steer health care provision, and moreover the absence of any conception of how such objectives might be achieved, the Commissioner's response to conflicting demands for funding and resource allocation cannot be other than *ad hoc* and disjointed. Not having a firm value baseline by reference to which commissioning decisions could be taken, their taking is instead held to lack coherence or any real sense of *policy*: as Smith (1993: ix) argued, no health care delivery system can be regarded as stable unless the fundamental question is first answered of what is and what is not covered.

However, there is a quite distinct problem that arises from the lack of a clear and consistent value base to ground the planning process. Part of the point of any health plans, be they annually produced or covering an entire decade, is to indicate to both purchasers and providers of health care the patterns of provision that are likely to be rewarded with Commissioner funding. That is, those groups and individuals at the coal face of health care provision - professionals who actually meet *patients* - expect to get from the health plan some idea of what is going to be on offer for the period of the plan. Providers need to plan what areas they are going to bid for funding in; purchasers want to know what they are going to be able to offer to their patients. Both these are largely determined by a central consideration: what types and areas of care are going to be commissioned? Or rather, since nobody could be expected to answer that question for a ten-year period, given the possibility of the development of new technologies and diseases, and the passing or eradication of old ones, what *principles* are going to govern commissioning?

It is axiomatic of the market theory that underpins the current NHS structure that qualitatively better patterns of provision can be achieved as a result of the interaction of purchasers and providers of services. The possibility of such an improvement, however, depends necessarily upon systems of communication and information that can adequately convey the purchasing intentions of the buyers to the providers, and the providing intentions and capabilities of the vendors to the purchasers: the whole system depends on the existence of an adequate feedback mechanism and a stable base on which it can be grounded. A market necessarily presupposes effective informational and communication systems.

The root of the committee's concern on this point was that as well as the danger of inconsistent and jointly incoherent commissioning proposals being drawn up as a result of the lack of a foundational vision of the direction and intention of the Commissioner, this absence also gave rise to the problem that neither purchasers nor providers could predict with any degree of certainty what patterns of provision were likely to be rewarded (or were indeed possible) in the future. The LEC(PA) held that a substantial part of the purpose of health plans was to indicate, particularly to providers, what priorities would govern service commissioning: that is to say, any provider should be able to plan his or her patterns of proposed activity in accordance with the priorities of the commissioner from reading a given Health Plan. As a result of this planning, purchasers should then be able to predict what services will be available, and therefore should be better placed to manage their own budgets in accordance with a clear pattern of provision.

The critical comment that I quoted above suggests that the Ten Year Health Plan, at least, did no such thing. The remark was made by a provider of health care services, who suggested that the Plan gave no indication of the kind of patterns of provision that the Commissioner expected from his unit over the next decade: that is, as a document designed to indicate the purchasing intentions of the Commissioner, it failed. The member in question made it quite clear that he understood that it was impossible to predict over a ten year period what care would be purchased in any detail, but he argued that the Plan did not even give any indication of the principles that were going to *ground* commissioning: he did not know what the Commissioner expected of him.

This theme of a lack of foundational vision on the part of the Commissioner ran through almost all of the reports produced by the committee in its first two years of operation. It would hardly be to overstate the case to say that it is the single most important and repeated criticism in that period. It is therefore significant that we can trace its effect directly in terms of a deliberately identified reaction on the part of the Commissioner to exactly that criticism. If we can show that the main thrust of the committee's recommendations was explicitly acted upon by the Commissioner, then we will have gone a long way to establishing a direct and effective link between the committee's recommendations and the actual practice of health care planning in West Glamorgan. That is to say, even on the narrow account of the value of the committee, which I have suggested is inadequate, the demonstration of such a link would establish the effectiveness of the committee, quite apart from any value that it may have as a less focused influence on the commissioning process. I do not suppose for one moment that the doubters will be silenced, but their doubts may be somewhat less vociferous.

Given my remarks about attributional and causal validity above, it might be thought a thankless task to attempt to demonstrate that the impetus behind *any* initiative can be identified as the LEC(PA), or indeed any other single factor. However, in this particular case the task is made distinctly easier by virtue of the fact that the Chief Executive of the Health Authority explicitly identified the LEC(PA)'s advice as the springboard.

In October 1994 the members of the Joint Board received copies of a paper entitled "Values For Commissioners". It had been prepared by the Chief Executive of the Health Authority with a clear and identified purpose:

> The purpose of this paper is to facilitate a discussion by the Joint Board about the Board's values so that these may soon be confirmed, and published, as a means of conveying a set of guiding principles freely available to those with a legitimate interest in them.

This opening statement of purpose was encouraging enough in itself to the members of the LEC(PA), who had been arguing for just such a clarification and declaration for the previous two years. More revealing for the present discussion, however, was the sentence that followed:

This is a sequel to the report of the Ethical Committee (Purchaser Advice) discussed at the July Joint Board.

Here as perhaps nowhere else, we have evidence of a direct causal and attributionally valid link between the work of the LEC(PA) and the practice of health care commissioning in West Glamorgan. Certainly it is worth noting that such response as there was can be traced not to an individual report by the committee, but rather to a cumulative effect of a repeated theme, which reached its apogee in the response to the Ten Year Plan. A picture of the Joint Boards dancing to the LEC(PA)'s tune would be both mistaken and grossly exaggerated: rather we should think of a slow process by which a cumulative effect is achieved by the totality of responses.

"Values For Commissioners" differed from previous documents fundamentally. Where the Ten Year Plan had laid out detailed targets (for instance predicting mortality rates across the county to supposedly exact figures for the next decade), "Values For Commissioners" sought general indications of policy directions. Where the Health Plans had relied on concealed values, the new document argued for an openness in stating foundational values and beliefs. Most significantly of all, where the Ten Year Plan had largely restated the goals of the Welsh Office's Strategic Intent and Direction, "Values For Commissioners" attempted to establish the grounding values for health commissioning in West Glamorgan, and strove to set in motion a process by which it could be elaborated how those values were to be applied in order to achieve aims which had already been agreed upon. Where the various Health Plans produced by the Authorities had done little more than reiterate a description of the targets of the Commissioner, "Values For Commissioners" sought to work towards an account of what lay *behind* those targets.

The radical development represented by "Values For Commissioners" should be plain enough. While specific targets can - and do - change from year to year, frequently in response to externally driven policies and priority sets,[11] foundational values tend of their very nature to be somewhat less ephemeral. That is, while the terms in which a Health Plan is drawn up must of necessity reflect current trends in specific priority setting, a statement of *values* can better reflect the principles on which the whole process of health commissioning is to be founded. It affords an opportunity to explore and clarify the very basic grounding of a complex and multi-layered institutional process.

This institutionality of the process of health care commissioning is important to the extent that it explains how unjust, inefficient, or otherwise negatively valued patterns of provision can come to be replicated: the innate tendency to inertia that characterises any institutional process is plain in this particular field - once a decision has been taken, a very compelling reason has to be advanced before it is reversed. A significant part of the importance of "Values For Commissioners", then, was the opportunity it represented to re-examine actual patterns of provision in the light of explored and enunciated priorities: it was a chance to compare what was hoped for with what was actually happening.

The "Values For Commissioners" initiative, then, represented an attempt on the part of the Health Authorities to take some of the central issues raised by the LEC(PA) head on. As such it can be seen as evidential of a direct link between the work of the committee and the practice of health care planning in West Glamorgan. If the effectiveness of the committee is to be determined by such direct attributable influences, then "Values For Commissioners" makes a good case for a positive evaluation of the committee's work.

But does such an account capture the value of the committee without remainder? Or should we rather think in broader, less clearly defined terms in order to undertake a fully inclusive evaluation of the committee's work? Ham (1993: 66) talks of a "real but less tangible" change in the thinking governing priority setting in six districts studied as a result of the 1991 reforms:

> Managers in these districts refer to a change in the culture of their organisations and a new approach to thinking about priorities without being able to cite specific examples of decisions that have been altered.

This shift is parallel to that which occurred in health planning in West Glamorgan at least partly as a result of the work of the LEC(PA). It is in the nature of such a "trickle-down" process that the effects are neither immediate nor dramatic. However, I shall argue that for all that, the effect of the LEC(PA) is no less fundamental.

One of the concerns running through the committee's discussions of various diverse documents presented to it in 1994 was that of the specificity - or rather the lack of it - of its comments. What do I mean by that?

It is inevitable that the preparation of a planning document such as a Health Plan will entail the production of several drafts, which may vary quite dramatically one from another. It is also the case that these drafts can often follow hard on each others' heels, to the extent that by the time Draft I of the Plan has been circulated to the committee members, a briefing paper prepared to inform a meeting of the committee, the meeting held, a draft output response prepared and circulated to the members, their comments on that draft prepared and sent to the researcher who is responsible for collecting them, collated into a single response and redrafted before submission to the Joint Boards, everybody else is working on Draft XII, which may be substantially different in its detail from draft I, on which all the comments were made in the first place.

Given that it was inevitable that the documents on which the committee were commenting would change in their detail, it was agreed at an early stage that it would be far more productive if the committee were to confine itself to commenting on the *broad outline* of the Plan in question, rather than on any *specific* details which might be altered in or indeed absent from a future version. This principle was clearly stated at the beginning of the meeting held on 14 July 1994 to consider the Ten Year Strategic Health Plan, when the chairman, PW, emphasised

> the need to avoid *specific* criticisms that may not be relevant to future incarnations of the Plan, and to keep in mind the *general* principles that underlie the Plan, criticism of which will outlive this particular draft.

From an early stage, then, the committee was concerned to provide criticism and advice that would be *useful* and *applicable* irrespective of future, unforeseeable, developments in particular Plans.

This is an important principle, since it explains why the committee was less concerned to confront *specific* suggestions to which it objected, and more to provide *general* comments on the overall process of health care planning. Moreover, I shall argue that although this was in part a pragmatic response to a series of delays that was, given the disparate nature of the committee members, unavoidable, nevertheless it gives rise to a mature and responsible approach to the committee's task of self-definition that marked its early months.

Had the committee concentrated its efforts on a series of attempts to alter, change or reverse *individual* proposals made by the Health Authorities, there is every possibility that the experiment that the committee represented would have been short lived. That is to say that if, at an early stage in the committee's development, it had been decided by the then members that their role *viz à viz* the Health Authorities - who were in at least one sense their masters -could best be thought of as an adversarial one, then there is every reason to suppose that the Authorities would have declared the experiment a failure, and discontinued it at the earliest available opportunity.

As it was, however, informal reactions from several of the officers within the Authorities suggest that their perception of the committee was as a useful voice which was, importantly, *unrestrained* with respect to outside influences on the health care planning process such as the Welsh Office. In this respect the LEC(PA) was significantly different from the senior officers of the Health Authorities, who were to an extent limited in any response they might choose to make by a loyalty or subservience to their superiors in the Welsh Office. As far as the senior executives of the Health Authorities were concerned, informal reports suggest that the committee was not viewed so much as an adversary, but as a valuable and unconstrained player in the planning game which was unique in being able to give voice to concerns that were widely identified, but which could not be spoken of by those directly involved in the planning process.

To have identified *specific* proposals, then, and to have attempted to derail them would in practical terms have done the committee no good whatsoever. Moreover, it is important to reflect what would have been the value of such recommendations as had been prepared by the committee at the time of its disbanding had such a particularist and adversarial model of operation been adopted.

The benefit of attempting to reverse individual decisions would have been that the effect of the committee would have been easily traced and immediate - had the attempts been successful. The down side, however, of such a policy would, I suggest, have been rather more significant. Had the committee's recommendations been specific to any one document, or even any one proposal within a particular Health Plan, then it is reasonable to suggest that they would have had very little relevance beyond that particular document or proposal. That is to say that had the experiment been discontinued and the committee not continued to sit, then the corpus of documents and recommendations that it had produced by the time of its demise would very rapidly have passed into the obscurity of irrelevance *if they had been focused on particulars*. However, with the committee's insistence that its recommendations should be drafted in *general* terms that could be more applicable to the health care planning process in the round came a considerably enhanced durability for its recommendations and proposals. Not being restricted to any one draft of any one Plan, nor being limited in their focus to any *specific* initiative, the committee's responses and recommendations were both more positive and more likely to continue to be useful and relevant.

I have suggested, then, that such a generalist approach to criticism and reaction can be thought of as a mature and positive model of operation. But is it, as I have indicated, liable to produce fundamental - if not readily identifiable - changes in the process of health care planning? I suggest that if the effect of the LEC(PA)'s reports and recommendations was in part to change the culture of decision making, the environment in which health care planning decisions were taken, then its effect was, although perhaps far from overt or dramatic, nonetheless deep-seated.

I have already argued that one effect of the committee's concentration on the generalities rather than the minutiae of the planning process was that its recommendations tended not to have the kind of built in obsolescence that would be expected of more detailed, particularly focused, criticisms. I suggest also that as well as being more enduring, such a generalist approach is also more fundamental in its effect. It is perfectly possible to imagine a situation where the committee identified six specific proposals within a particular draft Health Plan to which it objected. Let us suppose that the objections were particularly well articulated, and as a result two of the proposals were dropped in response to the objections. The Plan, however, would in large measure be unchanged: certainly, its foundational basis would be unaltered.

Typically, however, it was precisely that foundational basis on which the committee's objections were actually focused. Although there were specific proposals that were questioned, objections tended more to concern "the general lack of a foundational philosophy or view of commissioning to ground the Plan" (in the case of the Ten Year Health Plan) or "the crudely utilitarian calculus that takes no account of individual need or suffering" (in the case of "Methodology of Choice"). Even had specific objections to these documents been successful in altering their detail, then, the real bone of contention would have remained. The utilitarian character of the latter would not have been in any way affected by a redrafting of any one section; nor would the Ten Year Health Plan have acquired a foundational view of planning by simply tinkering with marginal proposals.

This preoccupation with the generality of health care planning reveals an interesting distinction between the LEC(PA) and both LRECs and CHCs that we used as comparators for the activities of the LEC(PA) above. It is significant that both LRECs and CHCs necessarily have *specific* changes as their goals: LRECs seek to make definite changes to research protocols presented to them. The intention behind this is to effect a better alignment between the protocol presented and a theoretical "gold standard" protocol with which individual research proposals are implicitly compared. To put it another way, members of LRECs have, in the back of their minds as it were, an idea of what a research protocol *ought* to look like, and it is this theoretical construct that they compare to individual protocols that are presented for their approval.

By contrast, the LEC(PA) was not - indeed on some accounts, could not have been - operating with an ideal mental picture to which plans or proposals reviewed ought to conform. Instead of having some notion of an ethical standard, the committee was rather concerned to highlight a *range* of ethical concerns or interests raised by the proposal being reviewed. The important distinction between the range of issues indicated by the LEC(PA) and the specific changes suggested by the LRECs lies in the fact that while the latter require little if any interpretation, the former seek not to suggest a particular conclusion, but rather to suggest the importance of taking the issues so highlighted into account when drawing up investment proposals. To put it another way, the LEC(PA)'s suggestions and comments significantly *under*determined the results of the consultation process.

This openness has a significant implication for the task of evaluating the committee's work. While it would make sense to measure the effectiveness of an LREC in terms of the number of objectionable research protocols that it rejected, that is to say, in terms of its actual effect on the practice[12] of research, a similar evaluational basis would make no sense in the case of the LEC(PA). Rather, it makes perfect sense to say that the LEC(PA) could well have been said to have performed adequately over a particular issue even if the Authorities' actions were quite different from the course recommended by the committee (if, indeed, they recommended a particular course at all) so long as it appears that the proper object of the committee has been fulfilled, that is to say that the Authorities have taken into account and considered the issues raised by the LEC(PA). The aim of the committee was, in part, to ensure a transparency of motive and reasoning in the practice of health care planning. Such transparency is initially achieved by encouraging those responsible for the production of health planning documents to consider the value bases of their work (hence the importance of the development of the "Values For Commissioners" initiative).

Two implications follow clearly from this. Firstly, it is apparent that it would be mistaken to expect the LEC(PA)'s effects to be obvious in the short to medium term: any process that relies on a trickle-down effect is necessarily a longer term measure, but *gutta cavat lapidem*[13]. Secondly, it is clear that the focus of an evaluation of the committee should be not distinct policy changes, but rather the process of health planning itself: since the task of the committee is to influence the *process* rather than the *practice* of planning, an evaluation of its work should take account not just of the finished product of the planning round, but also of the working patterns that went into it. It is for this reason that it is important to look at input and interim planning papers as well as their final incarnations, for it is here in these earlier stages that we shall find evidence of the processes that go into their make-up.

It is hardly to advance a bold thesis to suggest that deep-seated changes tend not to come about overnight. It would, therefore, be surprising if it were the case that any one response or recommendation from the LEC(PA) had had the effect of prompting a fundamental review of the both the vision and the mechanics and health care planning in West Glamorgan. However, I suggest that notwithstanding this putative scepticism, it is the case that the recommendations of the LEC(PA) can be seen to have had a fundamental and important effect on the actual process of health care planning in the county. I suggest that the development of the "Values For Commissioners" initiative can be seen as a direct response to the committee's repeated raising of the issue of a vacuum where the Authorities' basic values and philosophy ought to have been. It was an attempt to take on board the criticisms made by the committee that no coherent picture of values and beliefs grounded the commissioning process, which as a result tended to be directionless and simplisticly reactive, able only to respond to developments over which it had little or no control. The production of "Values For Commissioners" was a concerted and deliberate attempt to address this gap and to establish the values and principles that should ground present *and future* commissioning decisions in West Glamorgan irrespective of the detail of the decisions. It therefore represented a fundamental and long-lasting change in commissioning procedure which was a direct result of the work of the LEC(PA). As such, we can say that although the committee may not have affected specific *proposals*, nonetheless it did have a basic effect on health care planning *policy* as a whole.

Any evaluation exercise runs into trouble at this point. What it seeks is a clear summation of the effectiveness of the LEC(PA): what it gets is a somewhat nebulous assertion that the climate of decision making has changed. But should this be a problem for the evaluator? It was Aristotle who reminded us that we should expect no more precision from a discipline than it was capable of yielding.[14] Indeed, we might go further than that and suggest that we should be distinctly *wary* of any process that claims to yield precise results where we would expect none. Wong (1991: 449) suggests that it should not be thought an objection to sophisticated moral relativism that it yields answers more complex than the questions asked:

> What is left is a moral reality that is quite messy and immune to neat solutions. But why should we have expected anything else?

Mutata mutandis, I suggest just the same applies in this case.

1. I explore in more detail the notion of the individual as the necessary locus of pain and suffering, and the implications of this, in Jarvis (1996: 176ff).

2. This point applies to health policy research beyond our present boundaries. Double blind randomised trials are designed to eliminate (or at least hold constant) variables other than those being studied. While this is feasible in clinical research, it is obviously not so in health policy studies.

3. Questions about whether they are even representative of anything beyond a small group of individuals' views are a matter for further research.

4. Technically an LREC is accountable to the District Health Authority (DHA) that it advises, and with whom ultimate authority to accept or reject a research protocol lies. However, in current practice the correlation between LRECs' advice and DHAs' decisions is total, and it would be remarkable if a DHA took the risk of authorising clinical research in the face of an LREC's refusal to approve it. Quite apart from questions that might be raised about appropriate levels of decision making, such an action would lay the DHA open to possible litigation on the part of research subjects. The effect of this direct and total correlation between LRECs' recommendations and DHAs' decisions is that while CHCs make requests or representations, LRECs give rulings, albeit that they are ratified by the DHA.

5. In fact, I do not think that it makes any sense at all to talk of a "moral dimension" to a discussion, particularly not when that discussion takes place in the context of the inescapably moral activity of health care provision. See Jarvis, 1996: 176.

6. The problem was certainly well known to St Paul; cf Romans 7, 19:

> "For the good that I would I do not: but the evil which I would not, that I do."

7. See for example the change in the committee's perception of the Health Authority from a construction as Other (see p93ff in chap II) to the more co-operative model discussed above (pp140).

8. Wilson (1967: 477-8) chooses to satirise, rather than simply question, the ideal of detachment in his "rather depressing parable ... of the anthropologist [who] is bewitched by his role as an anthropologist"

9. To recall the earlier discussion of Fuller & Myers's (1941) model of social problems (p50ff), action research is appropriate only where there is common ground between the observer and observed as to subjective conditions.

10. It should be noted that this is perhaps not surprising, since it is to be expected that those members who regarded the committee's work as impossible or impracticable would, in all

probability, have resigned. It therefore follows that any members who stayed with the committee following its moral anagnorisis can be thought of as representing a self-selected group.

11. cf LEC(PA), 1995e: 1:

> Health care commissioning takes place neither in a political nor in a financial vacuum, and the fact and extent of these limitations should be acknowledged.

12. Indeed, the Department of Health's guidelines on LRECs lay down that an annual report should be submitted to the District Health Authority containing *inter alia* a list of proposals for research considered by the committee, including whether they were approved, referred, rejected or withdrawn (see Department of Health, 1991).

13. Ovid, *Epistulae Ex Ponto* iv.X.5

14. *Nichomachean Ethics* 1094b19ff.

Chapter IV

Defending the LEC(PA)

Be not too hasty to trust or admire the teachers of morality; they discourse like angels, but they live like men.

Samuel Johnson

It has been suggested to me on a number of occasions during the course of this research that it is confused to talk in terms of ethical review being done by a *committee* at all. These suggestions sprung, I initially suspected, in part from a general distrust of committees, a hangover from Lincoln's scepticism about the value of such bodies when he spoke of a committee being a cul de sac where ideas are lured to and then quietly strangled. A similar point is made by Hallas (1976: 31):

> about a hundred and twenty years ago a myth entered the mind of western man that, if you bring together a large number of people of intellect and professional skill, the result would be efficient organisations. The simple sum of adding together brain+brain+brain ... would ensure that the newly industrialised society would progress to ever greater heights. It took a long time to realise that the result of creating large-scale organisations was best illustrated by the subtraction brain-brain-brain...

However, on reflection it seems to me that there are basically two themes that underpin the more reflective of the objections to my contention that what the LEC(PA) was doing was *ethics*, and I want to consider them in this chapter, which accordingly falls into two parts. I shall call them respectively "the problem of expertise" and "the problem of the professional worrier". The first centres on the objection that there can be no such thing as an ethical *expert*; the second is a less frequently mooted objection, although it is one that our previous discussions have touched on, that conscience is internally linked with action, and therefore that it makes no sense to talk in terms of a prosthetic conscience.

1. The place of expertise in ethics

The first section of this chapter, then, will expound, examine, and - because I think the claim is mistaken - attempt to refute, the suggestion that it makes no sense to talk of an expert in the field of applied ethics. Indeed, some versions of this argument go further than this, as we shall see, suggesting that not only does it make no sense to talk of experts in applied ethics, but that it is in fact objectionable to do so, and even that those who do so are part of an ongoing conspiracy to gain power and prestige for themselves. Accordingly, in this section my main consideration will be to sketch and to examine what I have called the problem of expertise.

As a proviso to this discussion, it would be only fair to the members of the LEC(PA) during the period of this research to record that at no time did any one of them say anything that suggested that they considered that they were themselves to be thought of as experts in ethics. Indeed, quite the reverse was true. PW's suggestion at the meeting of 19 January 1995, that "we're not here to hand out answers from on high: we're just trying to do our best to understand these things and to help the Authorities to do the same" is far more indicative of the self-perception of the committee. A similar refutation of the claim that bodies such as the LEC(PA) tend to presume to speak with authority upon subjects of which they know little or nothing can be found in the reactions of the committee to a suggestion made at the meeting of 11 May 1995.

The meeting had been asked to address, *inter alia*, the question of advice in the case of individual case management, a question which had arisen in the context of the Child B case in Cambridge Health Authority. For the sake of readers for whom this issue is less topical, the brief details of the case were as follows.

Child B was 10 years old and had suffered from chronic leukaemia. Various treatments had been tried, including a bone marrow transplant, none of which had been more than transiently and partly successful. The clinicians treating child B were of the opinion that her chances of surviving intensive chemotherapy and a second bone marrow transplant - which would have been the only possible treatment left - were in the order of two per cent, or to put it another way, that there was a 98 per cent chance that the child would die even if the - painful and traumatic - treatment were carried out. The decision was taken not to purchase the treatment, ostensibly on the grounds that risk/benefit and cost/benefit analyses dictated against it: to put it another way, the chances of the child's surviving were so slim, and her suffering was guaranteed to be so great, that the clinicians in the care team and the commissioning authorities concurred in holding that the treatment was not justified.[1]

So far, the case was - although tragic - by no means unusual; indeed, one Labour politician was quoted as saying "The NHS has always made judgements of this kind, but it has not had to make them on TV" (White, 1995: 20). However, as White went on to argue:

> [w]hat has made it [the case of child B] special was the combination of a tenacious father, yet another unworldly judge, Mr Laws, a market-driven media, and doctors in Harley Street and the US who behave like 'ambulance-chasing' lawyers - happy to work if someone else pays ... (White, 1995: 20).

Cambridge and Huntingdon Health Authority's decision not to fund the treatment was challenged in the courts by the child's parents. In the High Court the challenge was upheld, leading to the possibility that a common law tradition that clinical decisions are not overturned by the courts might be reversed. However, the decision was overturned on appeal, and the Health Authority's decision was upheld.

Owing to a combination of astute management of the media by those sympathetic to the challenge, and the emotional pull of a case that told of tragic rationing decisions involving a sick child, the case generated a phenomenal amount of publicity, leading the *Health Service Journal* to predict that:

> [f]ifty years of muddling through elegantly are now definitely at an end thanks to the latest case of post-reforms explicit rationing to reach the courts. (*HSJ* editorial, 1995: 17)

It was therefore not surprising that the LEC(PA) was asked by the Chief Executive of West Glamorgan Health Authority to comment on the case:

> the Cambridge case raises some interesting ethical issues. It would be useful to test the views of the Ethical Committee in respect of what kind of protocol they would see being acceptable in West Glamorgan ... in respect of the processes which should be gone through when treatment on an individual basis is to be withheld. *I should also be interested to know whether the Committee feels that it should become involved in being a source of reference for such individual cases.* (Memo from the Chief Executive, 13 March 1995, emphasis added).

For our present purposes, it is the committee's reaction to the italicised suggestion that is instructive, that the LEC(PA) might get involved in individual case management in the role of suggesting specific case management options. The reaction of the committee members was unanimous and immediate: they utterly rejected the suggestion that they should, or could, become involved in such procedures. PW's summation again describes the feeling of the meeting well:

> We are here purely as an *advisory* committee. We have no special expertise that could qualify us to pronounce on these issues. It would be unreasonable to expect us to do so, and dishonest of us to pretend that we could.

There is ample evidence, then, that far from attempting to extend its remit into individual case management with the implication of expertise and professional problem-solving status, the committee members were at considerable pains to make clear that they believed that they had *no* special qualifications, no claim to expert status which would enable them to hand out answers as if from on high.

However, we must recognise that, even despite this evidence, there are those who will not be convinced by such remarks, and who will maintain that the committee's ultimate purpose was, notwithstanding its avowed protestations to the contrary, to assume a position of expertise and in so doing to arrogate power and influence to itself. Therefore, although after three years of close observation of the committee's structure, purpose and operations I am in no doubt that its members would stoutly resist the application of the tag of "ethical expert", nonetheless I am aware that the objection is likely to remain unless answered up front. I therefore propose to give it its metaphorical day in court, if only in the hope that it might satisfactorily be dismissed.

Let us begin, then, by considering what it is to be an expert at all. When we have done that, we shall be able to ask whether it makes sense to think of experts in applied philosophy. Bearing in mind that it is as important to be clear about what we do *not* mean as it is to be sure about what we *do*, let us recognise that talking of the possibility of expertise in a subject does not mean two important things.

Firstly, and as I shall go on to suggest later in this discussion when we come to look at the idea of an expert in applied philosophy most importantly, identifying something as a area of expertise makes no demands whatsoever relating to unanimity within the discipline. If that seems a little obscure, perhaps an example will help to illustrate the kind of point I have in mind.

Let us return to the Child B case, not because its relevant features are in any way unique, but simply because the outline of the case is already fresh in our minds. When I noted above that the clinicians on Child B's care team estimated her chances of surviving the treatment proposed at about two per cent, I had not told the whole story. *Mirabile dictu*, medical experts differed in their assessment of Child B's chances: some put them as high as twenty per cent.[2]

This would be surprising only to someone utterly unfamiliar with the substance of the point I am trying to make: that simply because we allow that there may be experts in medicine, we do not need, nor are we entitled, to assume that its practitioners are likely to be in agreement over a diagnosis, or over the chances of a treatment's success, or even over the identity of the most appropriate treatment in the first place. There is nothing in any account of what it is for a discipline to be an area that admits of the possibility of expertise that requires anything more than a reasonable degree of consistency throughout the canon of whatever is taken to constitute the core of a particular profession. Certainly, there would be no reason to suppose that two experts would necessarily agree on any given point, and indeed the Bolam test requires nothing like that degree of unanimity, simply making reference to "a responsible body of medical men".

The important point to understand here is that there is no link between a discipline's status as an area of expertise and a degree of absolute unanimity among its practitioners - within even a very clearly defined discipline such as medicine, and even within a clearly delineated area of expertise within that discipline such as paediatrics or oncology, there is room for substantial disagreement between practitioners without in any way compromising the status of the discipline. Clinicians, even expert clinicians, could - and did - disagree about the Child B case, without calling into question the status either of themselves as practitioners or of their area of expertise as a discipline. The differences of opinion arose not because one party was simply ill-informed, or using unreliable data, or out of touch with current thinking on the subject or in any other way unreliable, but simply because - even in a paradigm case of a discipline that admits of the talk of expertise as is the case with medicine - there is room for substantial disagreement between practitioners. Only the laity imagine that experts will speak with one voice: those more familiar with the subject will not be in the least surprised to discover dissension or doubt within the ranks.

Certainly, we would not be in the least bit surprised to discover that two opposing points of view in an adversarial situation such as a court case were both able to marshall expert witnesses. That this is so should alert us to two facts: firstly, as we have discussed, that there is no reason to suppose that experts in a particular field will speak with one voice, and secondly, *eo ipso*, that it makes no sense so assume that an expert has in some sense a hot-line to the truth of a particular matter. If that were so, then any side able to field an expert witness would be in an unassailable position as having a monopoly on the truth. Since this is self-evidently not the case, we are forced to conclude that to talk of expertise does not itself require us to think that any given expert has privileged access to the truth.

The second thing that does not follow from talking of a discipline as an area of expertise is any clear notion of the *boundaries* of that discipline. I shall suggest that even in the cases of two disciplines that are paradigms for the notion of expertise, medicine and the law, there are clear and live disputes about the boundaries around the disciplines, and about the extent of expertise of their practitioners.

To anyone familiar with contemporary debates within the canon of medicine, this is such a familiar theme as hardly to need pointing out: the debates about the nature of "alternative" medicine, whether therapies such as homeopathy, aromatherapy, and reflexology are to be thought of as *branches of* medicine, or as disciplines *ancillary to* medicine, that is, whether they come within the canon of medicine or not, are widespread. We do not need to go into them here: it is sufficient to note that even in medicine there is no clear agreement as to where the discipline ends, nor as to what exactly constitutes its proper scope.[3]

There are similar debates going on within legal circles: whether or not routine legal searches and conveyancing work should be made open to those not qualified as legal practitioners; within the profession, whether solicitors should have the right of audience in the High Court, or whether that right should - as at present - be restricted to barristers; and, most relevantly for the present case, whether or not the *courts* should play any part in overturning *bona fide* clinical judgements. All these questions about the limits of the law currently exercise the profession's members: but we do not on that account feel moved to cease to think of the law as an area of expertise at all.

What I hope this brief discussion has indicated is that there is no need to assume that simply because we speak of a discipline as being one in which there can be said to be experts, that we hold that its members are going to speak with one voice on any subject, whether it be a particular problem within the discipline or the scope of the discipline itself. What I have tried to do away with in this discussion is the pre-reflective idea of *the infallible expert* who has in some sense a hot-line to the truth of the matter. I hope I have done enough to make it clear that if there is room for such disagreement between experts, even in the case of paradigm expert professions such as law and medicine, this should be no reason to suppose that other experts are any more likely to be unanimous about anything. The point that we have come to, by perhaps a rather roundabout route, is really very simple: experts can disagree. It follows from this that although we may observe even quite radical disagreements within a discipline, we cannot infer, from that observation alone, that it would be unjustified to talk of the discipline's practitioners as experts at all.

What, then, is it that underlies so much of the contemporary writing that seeks to condemn the idea of a moral expert? (See e.g. Maclean (1993), and cf MacNiven (1990: 4) Or to put it another way, what is it about applied philosophy that makes people think that the very nature of the subject precludes the possibility of expertise? To answer this question, I propose to sketch out what I take to be the argument on which such objections are based, and then to examine it to see whether it seems to fit both the facts as observed during the course of this research, and the concepts that we take to be involved.

I take it that the argument goes something like this:

1. All those involved in practical philosophy want to be taken seriously as *experts*, in a way analogous to lawyers and doctors.
2. The nature of the subject in question means that it does not admit of expertise.

⊢3. Therefore the enterprise of practical philosophy is fundamentally mistaken, and its proponents are either fools (for not realising their error) or knaves (for realising it and seeking to enhance their status regardless).

Although I think that this argument is flawed in a number of respects, nonetheless the frequency with which it or something like it is trotted out means that it is important in the present context, and I therefore make no apologies for examining it in some detail.

From what I have already hinted at in an earlier discussion, I think that it is clear that observation of the members of the LEC(PA) wholly contradicts the assertion in the first premise, that those involved in applied philosophy seek to cover themselves with a mantle of expertise and infallibility, and to give their pronouncements on ethical issues the same kind of weight as a clinician's on a clinical matter, or indeed as an expert miner's on a speleological problem. There is little or nothing to be gained from entering a slanging match with the sceptic, who maintains stoutly in the face of all evidence to the contrary that applied philosophy is the refuge of the scoundrel and the charlatan, but there is some merit in recalling the discussion that took place during the meeting of 11 May 1995, when the possibility of the committee's becoming involved on an individual case management basis was raised, not for the first time.

The question occurred in the context of the Child B case, and centred on whether or not a body like the LEC(PA), or indeed the LEC(PA) itself, should have an input into the review of *individual* cases of this sort. In particular, the question resolved into a consideration of whether or not the committee had anything unique to contribute to any review of such cases. A remark by one of the clinicians on the committee is instructive:

> When I see a set of symptoms, I can call on my training and my knowledge and recommend a course of action. But ethics isn't like that: it's not for me or anyone else to dictate terms to a patient or to the Authorities. We can provide a sounding board for them, but it has to be *their* decision in the end. We can't take that away from them. In fact, we mustn't. [general agreement]

We shall come back to some of the issues raised in this comment later in the course of this discussion, as it raises a number of important points for any consideration of the problem of the expert in applied philosophy. For the moment, however, we shall concentrate on the suggestion that "it's not for me or anyone else to dictate terms to a patient or to the Authorities".

I quoted above (p175) PW's summary of the discussion in which this remark was made:

> We are here purely as an *advisory* committee. We have no special expertise that could qualify us to pronounce on these issues. It would be unreasonable to expect us to do so, and dishonest of us to pretend that we could.

I suggest that the theme running through this discussion is one of *modesty*. That is, a modesty in claiming the reasonable scope of the expertise and jurisdiction of the committee: rejecting the labels of particular expertise or authority, and instead sketching a much more mild account of the purpose and remit of the committee.

To anyone whose impressions of those involved in applied philosophy have been formed by those suspicious of the whole enterprise, those who think that its practitioners must be either fools or knaves, these modest disclaimers will perhaps come as something of a surprise. From the picture so often painted by the sceptics, one would have expected the committee members to have leapt at the chance of securing yet another area of influence and purported expertise that allowed them to hand out judgements *ex cathedra*. And yet instead of finding gulled fools or greedy knaves slipping effortlessly down the slope that leads to moral ruin, we discover, if only we take the trouble to *look*, that there is no such pretence to infallibility or mastery, but rather such claims are explicitly laid aside.

It is quite clear that the positions of the two camps over the validity or otherwise of applied philosophy as an area of academic practice are far too entrenched to hope that a brief - or any other - discussion might persuade the disputants to budge even an inch. However, if we cannot hope to convince the extremist, then we may at least contemplate convincing the less entrenched that the devils of the piece are, as so often, not so black as they are painted. What MacNiven (1990:4) calls "the orthodox view ... [that] they assume ... that they can become experts in the same way as doctors and lawyers. They believe that others can turn to them for direct answers to their moral problems, the way that they can to other experts ..." turns out to be not so much mistaken as unknown. Indeed, it turns out to be so grossly at variance with the facts of the matter as revealed by very simple observation, that one might be forgiven for wondering whether those who criticise this "orthodox view" have ever taken the trouble to find out whether it is actually *held* or not. Certainly, the experience of the research into the workings of the LEC(PA) and its members' views, beliefs and values suggests that no such claim to expertise was ever launched, or even suggested.

Now one of two conclusions follows from this. Either it is possible that in a world of charlatans, the West Glamorgan LEC(PA) was particularly blessed in being composed entirely of self-effacing, philosophically modest individuals, while all around them, ethics committees throughout the NHS were taken over by thrusting, ambitious would-be moral preachers; or, on the other hand, the orthodox view, that those involved in applied philosophy are fools and knaves, is simply wrong. I hardly need to state where I believe the balance of probability to lie.

The second premise of the argument for the incoherence of the notion of experts in applied philosophy that I outlined above asserts that the very nature of the subject is such that it does not admit of talking of expertise. I shall suggest that this is, although not flatly mistaken, at least not so simply true as may often be supposed. To do so, however, we shall need to look at the arguments that might be taken to support this assertion: I suggest there are three such buttresses.

The first supportive argument to the supposed incoherence of the notion of moral expertise is derived from an often-made observation, that so-called moral experts disagree widely on almost everything of substance. Accounts about the nature of goodness vary widely, prescriptions about what should be done in any given situation differ enormously, and there are almost as many suggestions as to what a health care professional should do when faced with a conflict of duties, say of confidentiality and honesty, as there are commentators writing in the area.

An exponents of this argument would then infer from this widespread disagreement at all levels among those who might be considered experts in ethics that, since there is no general agreement within the subject, and such lack of agreement precludes the possibility of talking of experts at all, *ergo* there can be no experts in ethics.

It would, perhaps, be easier than might be imagined to cast doubt on the truth of this argument by considering exactly how widespread the supposed disagreement among the practitioners of the subject is: to take an example from close to the concerns of the present research, while there may be differing accounts of the proper response to dilemmas posed by the necessity to ration health care - whether to favour the young over the old, for instance, or the moderately healthy over the chronically sick - nevertheless there are few, if any, who deny that this is a matter of moral concern, and indeed that the choices that have inevitably to be made are tragic ones. There is, it might be thought, a danger in overestimating the extent of disagreement among those who consider such questions.

However, while it would be possible, through extensive description of relatively congruent - or at least parallel - considerations of such problems, this would only be to *undermine* the argument of which the assertion of diversity is a premise. This would be to give room for doubting its conclusion, but still not demand that it be rejected out of hand. More powerful yet than mere undermining would be a *refutation* of one or more of its premises.

A moment's reflection will reveal that the argument that we are considering is more than tangentially related to a familiar, if discredited, one in the study of pure ethics, which goes something like this:

1. People notoriously differ in their accounts of what is right and what is wrong: the Spartans, after all, used to leave babies out on the hill side and think nothing of it, and Eskimos, we are repeatedly told, dispatch their aging grandparents as a matter of course.
2. Anything that is the subject of so much disagreement must be simply a matter of opinion: there can be no facts of the matter in the face of widespread differences of belief.

⊢3. The extent of such disagreements about the goodness or badness of actions is so great that there cannot possibly be thought to be any answers about the rightness or otherwise of any account of morality: such disagreement *must* imply that moral judgements are simply subjective.

The critical premise in this argument is clearly the second one that asserts that the mere fact of disagreement entails the necessary subjectivity of (in this case, moral) judgements. I hope that this premise has in the above sketch of the argument been put sufficiently crudely that it reveals what it is that makes it so clearly mistaken. Notoriously, widespread differences of opinion go no way to establishing the subjectivity of a class of judgements. That is to say that there is no way of moving from the observation "people think different things about the morality of abortion", to the more general claim that "there is no answer to the question of the morality of abortion". The mere fact of *disagreement* in moral judgements cannot be said to impact upon the truth or otherwise of those judgements: the observation of differences does not entail the non-existence of an objective truth.

In just the same way, I suggest, it should be clear that the claim that "the so-called experts in applied ethics disagree between themselves on almost everything of substance within their subject" goes no way towards establishing the truth of the claim that "the opinions of so-called experts in applied ethics are just that: opinions", on the same principle that the simple fact of disagreement does not entail the necessary subjectivity of judgements. To put it another way, while it is undoubtedly true that there is a plurality of views and judgements within the field of applied ethics, nonetheless there is a gap between this observation and the suggestion that forms the substance of the third premise of the argument in question, that asserts that the lack of unanimity between practitioners of applied ethics precludes the possibility of talking of them as experts *simpliciter*.

We should note here, in passing, as it were, that this refutation of the supposed argument in favour of the alleged incoherence of the notion of expertise in applied ethics does not itself commit us to holding that there are right and wrong answers to the sorts of ethical conundra that are typically considered in the subject. I would be reluctant in the extreme to suggest that there is *a* right answer, for instance, to the riddle posed by the Child B case discussed above or to the question of the morality of abortion. However, the refutation outlined above does not, I suggest, commit us to holding this somewhat extreme position. Rather, it shows that the mere fact of disagreement between experts in applied ethics does not in and of itself establish (as it must for the argument to gain a purchase) that there are no such answers, and therefore that there could be no talk of experts in the field in the absence of a corpus of received wisdom.

Moreover, the observation that there is room for substantial disagreement between practitioners in the subject should not tempt us to conclude - fallaciously - that there can on this account alone be no sensible talk of expertise in the subject. Recall that we established above (p176ff) that it makes perfect sense to think of a body of experts who disagree radically either in a particular case or in more general views about their subject or area of work. Once we appreciate that the lay belief, that all experts in a particular field are of one mind and that disagreement between them is unthinkable, is an utter chimera, then we can see why it is that I am quite happy to say that even although applied ethicists may disagree even radically on substantive issues, nonetheless there is no reason, on this account alone, to maintain that it makes no sense to talk of them as experts in their field.

Let us, then, turn to the second buttressing argument for the alleged problem of the ethical expert. In the hope of achieving some kind of clarity, I shall again sketch this argument in relatively formal terms, and then consider it more extensively.

1. Talk of expertise in a subject area requires that the subject is such that it can be said that it is defined by a body of *knowledge* to which experts in the subject have privileged access.
2. On anything other than a strongly cognitivist/objectivist account of the nature of moral judgements, it is generally held that moral judgements are not the sort of thing usually classed as *knowledge*.

⊢3. It makes no sense to talk of experts in any field of morality, least of all applied ethics.

Certainly, the first premise of this argument looks *prima facie* to be true: Fulford (1994: 22) suggests that:

> [m]ost commentators have argued that a professional is identified, *inter alia*, by expertise in relation to a particular knowledge base.

To talk of a professional, on this account, is to assert that the area for which the status of profession is claimed is one which admits of the possibility of talking of *knowledge*, rather than of belief, conviction or opinion. Although there are in some senses important differences between the notions of "expert" and "professional", for our present purposes we can say that the defining characteristic of the expert is facility and familiarity with regard to a certain body of knowledge.

One important point about this claim that we should note at the outset is that it points to an important and in one sense obvious fact about the nature of expertise - that it is "in relation to *a particular* knowledge base". I say that in one sense this is obvious because we surely would not expect an expert in heraldry to be a dab hand at fixing a dripping tap; nor would we have any reason to think that an expert plumber would, by virtue of his expertise with water pipes and so on, be any more proficient than the next man at keeping wicket to fast bowling. In general terms, we might say that expertise is specific to a particular context.

Although in one sense this is an obvious point, it is helpful to get it clear at the outset of the discussion because of the importance of the point to which it gives rise. It makes perfect sense to say of someone that he is an expert in one area of a profession, but not in another. Since at times it seems that almost all philosophy in the English-speaking world makes use of an illustration derived from cricket at some stage or other, and it would be a shame to let such a tradition slip, let us note that we are in no way surprised if an excellent opening bowler turns out to be utterly hopeless with the bat. The point I am trying to make is this: even within the limits - or perhaps, given the cricketing context, we should rather speak of boundaries - of a single profession, we are not in any way surprised to learn that a professional is an expert in one area of the profession and not in another.

We may say with equanimity, then, that a cricketer may be an expert bowler, and yet lamentable with a bat in his hands. However, we do think that there are some expert batsmen; more generally, we might say that we are prepared to admit the possibility of expertise in *every* area of cricket. However, this is not always the case, and, I shall suggest later, it is not the case in applied ethics.

In the case of applied ethics, while we think that there are some areas of the subject in which it would be reasonable to expect a degree of expertise, such as providing accurate information on which decisions could be based, exposing value-laden assumptions in argumentation, and arguing clearly and consistently,[4] there are equally whole areas where we would expect no such expertise. We would not, for instance, think that an expert in applied ethics could tell a worried and confused pregnant teenager whether she ought or ought not to have an abortion. To be sure, he might be able to help her clarify her thinking, and one might hope that he would be able to explore various options with her, and set out their various implications, but one would not expect him to presume to tell her what to do, as if handing down an expert judgement from on high (indeed, one would be right to be outraged if he attempted to do so). The important point here is that while there are areas of the field of applied ethics that admit of expertise, the actual making of moral judgements is not one of them.[5]

Let us be clear, then, that there are limits on the extent of expertise. We noted earlier that it is not global, that an expert in one field will not necessarily be particularly skilled in another. And now we have moved a step further on from that initial position, suggesting that even within a particular area, we cannot expect expertise to be universal, particularly when some areas of the subject are such that it makes no sense to talk of there being any expertise in them.

So granted that we now accept the possibility of expertise in one area and not in another, in which areas does it make sense to talk of a practitioner in applied ethics being an *expert*, and in which does it not? I want to look very briefly at two particular areas in which it has been suggested that it makes sense to talk of expertise in applied ethics, and then to distance this discussion from any suggestion that there might be expertise in a third.

Fulford (1994: 23) suggests that:

> it is the philosopher ... who is the expert at least on the logic of value terms and of related normative concepts such as action.

This notion of the philosopher as an expert on the meaning of value-laden language is related to a function of applied ethics in moral debate to which many have drawn attention and to which we shall return later: that of *clarification*. The caricature of two philosophers arguing along the lines of "But what do you mean by that?", "Ah but what do *you* mean by 'mean'?" *et cetera, ad infinitum* has, like all good caricatures, a grain of truth at its foundation. Very often philosophical wrangles do indeed resolve themselves into disputes about the meaning of a particular word, or, as Fulford puts it, the logic of a value term. Frequently, of course, it is precisely these meanings that turn out to provide the bedrock of the dispute between the two parties: the question is not so much whether animals have rights, as what we mean, properly, when we talk of "rights" at all; whether euthanasia is wrong depends, we are told, on what you mean by "wrong" (and, indeed, "euthanasia").

Just by way of illustration of this point in other than the above, somewhat hackneyed, terms, I should like to turn aside very briefly to consider a particular response made by the LEC(PA), in the early part of 1995, to a request to consider the possibility of disinvestment in commissioning assisted conception services.

There is no merit, for the purposes of the present discussion, in laying out the mass of detail that was accumulated to support the discussion in terms of cross Wales and UK comparators of rationing criteria and service provision. The important point that I want to draw out from the recommendations that were produced (LEC(PA), 1995b: 1) concerns the extent to which the committee was at pains to grapple with the meaning and logic of absolutely central value terms in the debate over the continued commissioning of assisted conception services, with particular emphasis on *in vitro* fertilisation (IVF).

In particular, the committee was concerned to consider two questions: the first was whether infertility represented a *need* for treatment or a *preference*. The committee held that:

> if infertility only represents a preference, then commissioning of infertility services in a scenario of limited resources where needs go unmet would be morally questionable. (LEC(PA), 1995b: 1)

The second central area of debate in the committee's discussions concerned the question of whether infertility represented a *health* or a *social* need. Again, the recommendations held that:

> With the exception of tubal surgery, the procedures do not yield a fertile couple, but an infertile couple with a child. The vast majority of infertility services, therefore, treat the problem of childlessness, not of infertility.
>
> It was held that childlessness is best regarded as a *social* problem.
>
> Infertility, therefore, represents a *social* need (or preference) which is susceptible to a *medical* resolution. (LEC(PA), 1995b: 1, italics in original)

I do not want to labour this illustration, although I think it is a clear and apposite one, because I take it that the point it makes is relatively clear: there was a concern evident in the committee's work to explore and clarify the *meaning* of certain key concepts implicit in the debate of which their work formed a part: in Fulford's terms, the committee strove to explore the logic of these central value terms. Moreover, the committee's efforts did not stop at simple exploration of such terms: as Fulford goes on to suggest, they took account also of the "related normative concepts such as action". The recommendations concluded, in the light of the composite medico-social need quoted above, that:

> an ideal model of infertility provision would encourage joint commissioning by both Health and Social Service agencies. That this model is not the one currently operative was held to be a significant limitation. (LEC(PA), 1995b:1)

(In point of fact, the link between on the one hand the conceptual clarification and exploration of the logic of value terms, and on the other the implications for such "related normative concepts ... as action" was in this case even more clearly extended. Following on from the meeting of 19 January 1995 at which the above recommendations were formulated, the committee was then asked to consider the implications of the composite medico-social model of need for the commissioning of termination services. In this sense, we can begin to see a clear link between consideration of value terms that takes place round a table and the actual provision of services in the health care sector.)

The second area in which it is often suggested that it makes sense to talk of expertise in the field of applied ethics involves what Parker (1994: 38-9) refers to as

> a familiarity with the kinds of questions under discussion and familiarity with a variety of views on those questions.

To put this another way, part of the role of the expert in applied ethics is to ensure that any debate in which he is involved is informed as much as possible by current thinking in the subject, that the terms of reference of the discussion take account of important opinion and research findings in the area, and that a clear distinction is made between issues that are live and important, and that need to be debated further, and those which have become the chestnuts of the subject, in which latter case further attention is unlikely to produce anything either new or profitable.

We come now to the point where, perhaps somewhat confusingly, I must lay out what it is that I am *not* claiming for applied ethics, nor for those involved in the subject who might call themselves experts in applied ethics. I shall do so by stating the position very baldly to begin with, and then exploring it in the hope of understanding it a little better, and of heading off some potential areas of confusion that might arise.

Applied ethics is not in the business of providing answers.

Put as bluntly as that, I suspect that this assertion will seem either blindingly obvious, or frankly mistaken, depending on the reader's point of view and expectations of the discipline. I hope that its meaning will become at once less banal and more clear in discussion. There remains the possibility, however, that preconceived ideas of what it is that applied ethics does will mean that for some this statement must rest either in banality or in obfuscation. In that case, I can only take comfort in reflecting that I am not in the worst of company: Fr John Lafarge remarked of the reports of miracles at Lourdes that "for those who believe in God, no explanation is needed; for those who do not believe, no explanation is possible".

Let us press on, then, and see if we cannot illustrate the kind of thing that I have in mind when I say that applied philosophy is not in the business of providing answers. Before we go any further, we should perhaps qualify the statement's arresting simplicity by saying that of course much of what an expert in applied ethics does may well fall under the description of "providing answers": in the course of compiling a briefing paper to support the committee's discussions that lead to the recommendations concerning the commissioning of assisted conception services (LEC(PA), 1995b), I provided answers to literally dozens of questions: how much was West Glamorgan currently investing in assisted conception services; what criteria were used to ration access to such services; were these criteria employed openly or implicitly; how in these two regards did West Glamorgan compare with other Health Authorities in Wales and the UK, and so on and so forth. The point to notice here is that while the answers to such questions are important to facilitate ethical discussion, they are not themselves the discussion itself. That is to say, such questions as "What is the average wait between first referral and treatment for IVF in West Glamorgan?" are not themselves the subject of applied ethics; rather, their answers enable ethical debate to get going.

I remarked in a paper discussing the implications for patient confidentiality of the new technology for storing patient records (Jarvis, 1996a: 6) that:

> [a]lthough one might have expected a paper of this nature to come up with answers rather than more questions, I suggest that this hope is misplaced. In fact, given the complexity of the question under consideration, we should not be in the least bit surprised that the question is susceptible to no solution entirely free of moral cost,

and it is this sort of thing that I have in mind when I say that applied ethics is not in the business of providing answers. While it remains the case that a certain part of the task of the discipline lies in the area of evaluating - by exposure to the kind of rigorous scrutiny characteristic of philosophical analysis - moral judgements, and thus sifting the deeply grounded from the shallow and the perceptive from the irrelevant, nonetheless the actual *making* of such judgements is no part of the discipline. That is to say that the expert in applied ethics is interested in moral judgements, but he is not interested in making them.

Similarly, I suggest, we can say of the applied ethicist that there are areas of his subject in which we can think of him as an expert, that is, as having some kind of privileged access to a particular knowledge base. I have suggested that two particular areas in which it might make sense to talk of such expertise include exploring and clarifying the meaning and logic of the central terms of the discussion, and setting the discussion in the context of the ongoing debate of which it is a part, describing the state of present scholarship and thinking. Where the applied ethicist's expertise runs out, or rather, where it makes no sense to talk any longer of expertise, is in the field of providing *answers* to questions like "should the Health Authorities continue to commission assisted conception services, and if so, at what levels?".

Because this is an important question, I make no apology for exploring one or two particular illustrations of this principle, that expertise in applied ethics simply gives out when it comes to dictating a particular course of action. To do so, I shall look at the committee's responses in two entirely different areas: the 1995/6 Health Plan, and the already mentioned Child B case in Cambridge and Huntingdon Health Authority.

By the time "Your Good Health", the 1995/6 Health Plan, reached its mature version[6], it had been considered at some length by the committee: we can therefore be sure that the final response to the Plan represents a fully developed account of the committee's extended deliberations and thinking on the issues raised in the Plan.

The central theme of the committee's response to the 1995/6 Plan (LEC(PA), 1995c) was the absolute need for clarity at this level (and indeed at all other levels) of rationing health care services. The opening paragraphs of the Response argued that:

> it is vital that rationing by the Commissioner is as transparent as possible. Purchasers and Providers should be able to plan their activity patterns from the Health Plan, and the criteria by which services are differentially Commissioned should be open to public inspection. (LEC(PA), 1995c: 1)

The important thing to note about the general tone of this Response is that it does not argue for *specific* moves in the rationing process, that is, it does not recommend that (for instance) gender re-assignment procedures be discontinued and the money released be reinvested in cataract operations; rather, the response is about the *process*, not the *outcome* of rationing.

To take this illustration a stage further, it is significant to note that a general recommendation in this Response was that:

> [m]aximal needs satisfaction requires *efficiency* and *effectiveness* in Commissioned services. Services known to be inefficient or not proven to be effective, therefore, should be a low commissioning priority.

This basic principle that the committee recommended should underpin commissioning in the county simply suggests that in a scenario of limited resources, the first priority should be to target those areas of health need where there is evidence that the services *work*: it suggests that if money is to be spent, it should be spent on effective and efficient services, that is on those which actually address the targeted need, and which do so without wasting resources.

Having stated this principle, the Response then suggests one area in which it could be applied. However, and this is the important point, *it stops well short of recommending decommissioning of the service in question*. The committee noted that:

> [t]he Health Plan is at pains to establish that treatment for varicose veins is of questionable effectiveness and value. It then proposes a shift towards day-case procedures for this condition. The committee believes that *if* the treatment is ineffective, the proper response is not to continue to Commission it at a reduced cost, but to disinvest altogether in this treatment. (LEC(PA), 1995c: 4, italics in original).

It might be thought that this example shows precisely the reverse of the point for which I am arguing; that it shows, in fact, that the committee made very specific recommendations about commissioning particular services, and that their responses were in fact extremely directive.

However, I suggest that this should be read not as an argument for disinvesting in varicose veins treatment, but as a plea for clarity and consistency in the rhetoric and rationale of the Health Plan. That is to say, that it is not about a specific treatment, but rather it is about the foundational principles on which the Plan rests. Significantly, the Response goes on to note that:

> [t]he committee accepts that there *may* be good reasons for decommissioning ... [this] service, but did not find them in the Health Plan (LEC(PA), 1995c: 4)

This latter note suggests again that the main concern in the committee's thinking and response was the *process* of rationing, not the fate of particular services as a result of that rationing process. The committee's aim was not to restore certain treatments to the commissioning canon, nor to facilitate the decommissioning of others, but rather to ensure that no matter what the *details* of the rationing decisions taken, the *reasons* grounding such decisions were clear and consistently applied. To use the terms of a traditional distinction, the concern was with the *form* of any commissioning, not with its *content*: it was about *how* it was done, not about *what* was done.

We can see a similar concern with the process of rationing rather than with its detail in the context of the committee's considerations of the implications of the Child B case in Cambridge and Huntingdon Health Authority. In their response, the committee again commended the principle of openness in rationing to the Commissioners, arguing that:

> [w]hatever system of review is adopted, both the mechanism and the means by which its decisions can be challenged should be abundantly clear to purchasers, providers and consumers of care. (LEC(PA) 1995a: 1)

As well as the concern with openness and transparency in rationing policy, we can see that the committee once again focuses not on the particular details of the case, but on the generality: its response is drawn not in terms of particular recommendations for management, but rather of an underlying *philosophy*. The discussion paper does not come up with suggested solutions to the dilemmas posed in the Child B case; rather it focuses on the question of what a proper response to such a tragic situation ought to look like - what form it ought to take, rather than at what answer it ought to arrive.

I do not wish to labour these two examples, and I take it that they show quite clearly the point we were examining earlier: that there is a stage beyond which it makes no sense to talk in terms of expertise in applied ethics. While the committee's recommendations were forthright in their advocacy of a particular *model* of commissioning, they stopped intentionally short of recommending particular policies as a result of an application of that model. In the terms of the present discussion, we might say that the committee's expertise extended only so far as evaluating the reasoning on which a rationing policy was based, and not into pronouncing judgement on the particular results of that policy: that there was a point at which the committee's claim to any expertise was understood to give out.

MacLean (1993) suggests that even this more modest account of the place of reason in moralising represents an over-rationalisation of moral thinking that she alleges has taken place largely as a result of an unreflecting and whole-hearted adoption of crudely utilitarian doctrines in the field of applied ethics. Her concern is that a view has crept in that it is possible to reach a solution to a moral dilemma by reason alone:

> I would contend, then, that opposing moral beliefs, opinions, judgements or attitudes may both - or all - be adequate from the standpoint of reason or rationality; indeed, there need be in such cases *no* standpoint which is *the* standpoint of reason or rationality. Thus it is possible for there to be moral disagreements which cannot be resolved by an appeal to what it is rational to think about the matters at issue; the reason being that there is *more than one* thing it is rational to think about these matters. (MacLean, 1993: 6)

We should be clear that, although this is scarcely an original point (see for example Evans, 1975, Railton, 1984, and Gaita, 1991), there is certainly a good deal to be said for the suggestion that there must come a point in moralising where rationalising has to give out: a stage beyond which reason is silent. However, we should be wary of any moves to distance ourselves from reason altogether, as it is plainly the case the reason giving plays *some* part in moral debate, although (as MacLean accurately notes) it does not exhaust it. MacLean's contention that there is a place beyond which reason alone has nothing to say is taken to be unobjectionable. However, this is very different from maintaining that there is no place for reason in morality. The important point, I think, that we need to take account of is a distinction between moral *debate* and moral *conclusions*. It seems to me that there is plainly a place for reason (and for that matter for expertise) in that part of moralising that leads up to a full-blown moral debate, although we would not, on that account, either wish to say or be justified in inferring that reason alone can yield answers to moral dilemmas: that is, moral conclusions.

I suspect that it is MacLean's (somewhat curious) identification of the term "bioethics" with the rather narrower (and impoverished) "utilitarian bioethics" that drives her to the position she adopts, that there is a danger of reason *foreclosing* moral debate. Certainly, we must recognise that *if* an individual were to adopt strictly utilitarian principles, then he would find that reason alone would claim to provide answers to his moral questions. Indeed, it is precisely this claim of strict utilitarianism that Williams (1980) finds so objectionable, that it leaves no room for anything other than reason to play a part in morality. In the terms of the distinction that I have drawn between moral debate and moral conclusions, we might say that part of what we find objectionable about strict utilitarian doctrines is that they foreclose on the possibility of moral *debate* and instead move directly to a moral conclusion: their conclusion is, in the literal sense, im-mediate, without mediation.

However, if that is MacLean's portrayal of the process of moralising within the field of applied ethics generally, and certainly within the more specific limits of this research, then we must conclude that it is grossly at odds with the observed facts of the matter. At no point in the three years of observation of the committee did I witness any suggestion that reason alone could provide an adequate answer to the difficult, often tragic, questions facing the committee. Rather, the trend observed was one I take to be more mature application of philosophical principles, using reason as a facilitative faculty to lead up to the point where informed moral debate could itself begin. That is to say that the committee saw its role in part as the clarification (by the application of reason) of certain key concepts and normative terms, thus enabling a reasoned (but not reason-determined) moral *debate* to ensue. The presumption was that any debate should take place *informed by* reason, but there was no suggestion that such informing should be taken as determinative. It was held not that reason alone can do one's moral thinking for one, but that if one's moral thinking is uninformed by reason, then it is the worse for it: in traditional terms we might say that the application of reason is a necessary but not sufficient condition for proper moral debate.

We can see, then, that there is a foundational view in the committee's *modus operandi* that underpins this implicit response to the type of criticism exemplified by MacLean, a view that maintains that there is an important place for reason and expertise in moralising *up to the point at which moral debate begins and no further*. Beyond this point, that is, in the course of the moral debate and the construction of a moral conclusion, the gloves are, so to speak off. It is this position, that once the substantive process of moral debate has begun the voice of the expert speaks no more loudly than any other voice, that leads Parker (1994: 35-6) to talk of philosophy as

> an inherently democratic model of influence, assuming as it does that the correspondent is of equal status.

Throughout this discussion of what I have called the second argument in favour of the alleged problem of the expert we can see that the LEC(PA) can be thought of as operating within a dynamic developing right through the NHS throughout the period of research: the idea of "evidence-based" health care commissioning. This took the form of an understandable concern to ensure that the decisions taken *viz à viz* commissioning health care were taken on the best evidence available. It was this concern that ensured the recognition and success of the *Effective Health Care* bulletins produced jointly by the universities of Leeds and York, as well as Anglia and Oxford Regional Health Authority's *The Bandolier*, which sought to provide facts and figures about the levels of effectiveness of various rival interventions within thematically defined areas of health care provision.

It should be noted that the talk throughout this period was of *evidence*-based, not *knowledge*-based commissioning. There was a clear acceptance that for vast areas of health care provision, it was fair to say that we do not *know* which of two or more treatments is the more efficient or efficient one available. However, there was through the period of this research a growing tendency to begin to accumulate *evidence* that pointed towards certain conclusions of this nature, for instance highlighting the fact that effectiveness rates in IVF were massively lower in cases where the patient was over forty. This discovery led to a general position where IVF was not offered to women over forty on the grounds of clinical ineffectiveness. It would be wrong to speak of this sort of selective commissioning as knowledge-based, as it rests solely on a body of evidence, and not on a clear understanding of the mechanisms by which these results are obtained. However, we should not underestimate the importance of such evidence, and indeed the LEC(PA), as I suggested earlier, argued repeatedly for selective commissioning to be based on clinical evidence, and not on hearsay or prejudice.

In this sense we can see that the work of the LEC(PA) can be thought of as standing firmly within the broader dynamic of evidence-based commissioning. This view is one which does not commit the mistake of confusing the committee's recommendations with *knowledge*, that is, it labours under no illusions about their epistemic status, but equally it recognises them as more than mere *opinion*, on the grounds that they have been worked out and tested by reason and debate: that is to say, that they have stood up to the examination of intellectual scrutiny, reflection and questioning. It is this that demonstrates most clearly the place of expertise in applied ethics, and of philosophy in public policy. As Parker (1994: 35) puts it:

> [p]hilosophy overall asserts the value of reflection, whether reflection on first principles or reflection on the significance of certain kinds of action. I suggest that a philosopher who did not assert the value of reflection would be a contradiction in terms.

And so we come, at length, to the third buttressing argument for the supposed problem of the expert. Again, let us begin by sketching the argument out:

1. The *scope* of morality is such that everybody is necessarily involved.
2. Talk of expertise has the effect of excluding some, and elevating others to a position not properly theirs.

⊢3. Talk of expertise in ethics is wicked.

The first thing to note about this argument is that it goes somewhat beyond the other two; or rather, it asserts more than simply a mistake. While the first two buttressing arguments concluded that talk of expertise in the field of morality was mistaken, this third suggests that it is in itself morally questionable. While the first two arguments were content to notice a failure of reasoning, the third purports to draw our attention to an alleged moral error. This error is illustrated by what MacNiven (1990: 4) calls "the orthodox view" of applied ethics, according to which:

> [t]he moral philosopher is in a position to tell other people, including doctors and lawyers, what they ought to do. As a result they become involved in a kind of false paternalism which springs from moral conceit and denies the autonomy of the people they would have as clients. The mistake has bad consequences both for ethical theory and ethical practice.

Notice that the error to which the orthodox view gives rise is in direct tension with the model of philosophical reflection as inherently democratic that Parker (1994: 35) proposed. So is there something wrong with Parker's model, or is the orthodox view of the moral conceit of those who engage in applied ethics itself mistaken?

Since this research is irredeemably grounded in the observations and experiences of three years involvement with a particular experiment in applied ethics, it is only appropriate to record that my experience of those who do so engage in applied ethics, far from wishing to dictate terms and morality to others, if anything shirk too readily the responsibility to suggest specific actions as a result of their discussions. If I were to criticise the LEC(PA), I suggest that far from being over directive of policy, their recommendations were insufficiently determinative, and tended at times to leave off just where substantive moral debate could have begun. This is to recall our earlier discussion (p173ff) of the committee's reluctance to become involved in management of individual cases: I suggest that this reluctance is evidential of a caution in discussion and a modesty in objective that is entirely at odds with the caricature of the applied ethicist as a "moral busybody" (MacNiven, 1990: 9).

The second point we should note about this argument is that its first premise, that morality is a game which we all must play, is undoubtedly true. However, while true, it is also potentially misleading. While it is true to say of the process of moral *debate* that it is fundamentally a democratic exercise, and one in which, to employ a well-worn principle, each should count for one and none for more than one, the same cannot be said of the process of clarification and conceptual analysis that goes on before the stage of debate is even reached, that part of the process of what I have called "moralising" in which I suggested above it *does* make sense to talk of expertise. If the effect of talking of professionalisation in practical ethics were to disenfranchise the majority and leave the responsibility for moral debate in the hands of the philosopher kings, then I would have no hesitation in agreeing with the claim that such talk was wicked. However, I suggest that to think this is to fail to appreciate the different parts of the process of moralising, and the different functions of these parts. I have argued that the part of the process that we call moral debate represents neither the beginning nor the end of the process. Before this stage comes a period of clarification, analysis and gathering, in which it is entirely appropriate to expect the help of experts, and after it comes the substantive outcome of the debate, the moral conclusion. And while it is true that the middle stage, the moral debate itself, is a necessarily democratic and universal process, the same is not necessarily true of the first stage. I therefore conclude that there is no tension between suggesting that there is room for experts in applied ethics and at the same time maintaining that there is a foundational need for universal involvement in moral debate.

If we look at the LEC(PA)'s recommendations, we can see that a central theme running throughout them is that of opening up discussion rather than closing it down. By this I do not simply mean the repeated emphasis on the need for public involvement in determining rationing parameters, nor the steady weft of calls for transparency in rationing, but rather the more general dynamic of seeking to expand discussion, rather than foreclose it; looking to explore other pathways, rather than to conclude a discussion as soon as possible. I take it that it is this sort of function that MacNiven has in mind when he suggests that:

> [t]he idea of the moral expert which emerges from an organic casuistry is not that of the moral busybody who goes around telling other people what to do (even if they want to be told). It is that of the moral educator working in an interdisciplinary fashion, both theoretically and practically, with other professionals to try to reach creative solutions to the moral problems of autonomous moral agents (MacNiven, 1990: 9-10).

In passing, we should note the importance of what is almost a throw-away remark in the above context, the suggestion that health care professionals might not actually *want* to be told what to do by applied ethicists. After three years of research and observation, I cannot stress this highly enough: every claim that health care professionals want to be told what to do, that they want applied ethicists to do their moral thinking for them, is simply wrong. And more than wrong, it is highly patronising, and reveals the makers of the claim to be utterly out of touch with the subject on which they seek to comment. Suggestions that the consulting professions such as medicine and the law fall easily into a paradigm of mistaking the philosopher for an expert who can tell them what to do are simply mistaken.

An archetypical example of this model of exploring and opening up where sceptics would have predicted foreclosing can be found in the committee's discussion of the provision of termination services in West Glamorgan (LEC(PA), 1995d). The grounding theme of this response was to *open up* the options available to women who experienced an unplanned pregnancy. The feeling in the meeting to discuss this issue, held on 16 March 1995, was that there was a tendency to constrain women's choices by creating a climate of termination. The concern, therefore, was to explore alternative models of response and in so doing to help women to reinterpret the problem they faced. As MacNiven (1990: 9) puts it:

> [w]e need to engage in creative moral thought. We need to look at situations from different perspectives to see how we might restructure them in richer ways.

Accordingly, in the section of the paper entitled "Parallel alternative responses", the committee argued:

> [u]nderpinning any restructuring of termination services should be a commitment to *enabling*, not restricting, women's choices, by exploring the suggestion that termination is neither the only nor necessarily the most appropriate way for a woman to control her life. Such exploration should avoid the imposition of a monolithic response (termination *simpliciter*) to a frequently complex problem (unwanted pregnancy) (LEC(PA), 1995d: 2-3).

This clearly illustrates the principle that far from seeking to foreclose on any discussion, the purpose and objective of the committee was actually to *open out* the terms of the debate. This is so clearly the antithesis of the paradigm of the expert, who gives answers rather than raising more questions, that it may at first seem to be out of place in a discussion of the alleged problem of expertise. However, I suggest that what it shows is that the suggestion that talk of expertise in applied ethics has the tendency to exclude rather than to include is simply mistaken. Indeed, quite the reverse is true.

And so at last we come to the end of this analysis of the supporting arguments for the problem of the expert. I have suggested that the argument from disagreement applies no more to expertise in ethics than it does to any other profession; that it makes perfect sense to talk of expertise in applied ethics so long as one is careful to restrict such talk to such areas of the subject as properly call for it; and that an appreciation of the three stages of moralising - namely clarification, debate and conclusion - allows us to see why it is that talk of expertise in ethics is not only not mistaken, but not vicious either. With all that behind us, then, I propose now to look at a slightly more positive question: what is the proper role of the philosopher in moral discussion?

Almost inevitably, I suppose, the foregoing discussion has already hinted at an answer to this question. While I argued that once the moral debate proper has got under way, philosophy has no particular contribution to make, nonetheless I suggested that in the preliminary discussions, as it were, there is significant room for a discipline that deals in examination, reflection and clarification. An exploration of the meaning and logic of the central terms of discourse, as for instance we discussed earlier in the case of the committee's discussion of commissioning assisted conception services, is one which can properly be undertaken by a specialist in philosophy. In fact, so clearly is this sort of exercise one which falls within the canon of the subject, that one might be forgiven for wondering what it is that is added by talking of this sort of reflection as "applied" philosophy at all. However, the voice of fashion is a strident one, and we will gain little by attempting to challenge it.

The role of the philosopher, then, in moral discourse, boils down to a facilitative one: he must seek to clarify often obscure concepts, to unpack dense material to demonstrate the value assumptions on which premises rest, and to set a discussion within an ongoing context of philosophical debate and reflection. In all this, we can see that the task of philosophy is not to do one's moral thinking for one (indeed, as we saw MacLean pointing out, such a hope would be misguided) but to bring the debate to a point where real moral thinking can get under way; with the exploratory part of the discussion, the "but what do you mean by deserving?" type questions behind us, then the substantive moral debate can get going in earnest. The application of philosophy does not bring us to the end of the debate, but rather to the point at which the debate itself can get underway. Parker (1994: 35) suggests a similar role for philosophy, talking of

> a return to the earliest conception of philosophy, involving, not a claim to ethical expertise, but a commitment to the canons of clear argument and open debate (Almond & Hill, 1991). *This duty implies the role of enabling not directing public debate* [emphasis added].

Enabling, not directing; allowing the discussion to go forward, not seeking to curtail it with *ex cathedra* statements: that is the proper role of philosophy in moral debate.

Of course, it would be disingenuous to pretend that this standard of disinterested commitment to reflection and discourse has always been maintained. The most obvious, and most easily yielded-to danger is the temptation to preach. There is no doubt that some so-called experts in applied philosophy have succumbed to this temptation when the opportunity arose. Perhaps, deceived by vanity, they were the "philosophers ... in danger of misplaced recognition as experts because of the normative expert paradigm of other professions" (Parker, 1994: 37). Certainly, some have not even attempted to hide the fact that they were preaching. Lord Longford, in the preface to his committee's report on pornography (Longford *et al.*, 1972) tells us, with a hint of pride, of a bus conductor who encouraged him saying

> if a man ... sets himself to improve the morals of a nation then he must expect to be called a humbug. But I say him let him stick to his guns (Longford, *et al.* (1972: 7).

Others in his position have been less open about their didactic purposes. Mary Warnock, in her committee's report on reform of the abortion and embryology legislation, notoriously used her position of influence as the Chairman of the committee to ensure that the tone of the final report reflected her own intuitionist position on the moral issues discussed (see e.g. Stone, 1990: 72). There is every reason to deplore such abuse of position, not because Warnock's views count for nothing, nor because they do not deserve to be heard, but because they count for no more than yours or mine: they should not be heard any more loudly or clearly than those of Lord Longford's friendly bus conductor. There are two mistakes that can be made here, and both of them involve extremes. It would be a mistake to suppose that a training in academic philosophy entitles one to have one's opinion taken more seriously than that of the next (wo)man, but equally it would be a mistake to think that because the philosopher has no *special* role to play in the process of moral debate, that *qua* citizen he has no right to be heard at all. Certainly, he has a right to be heard, but no more right than anyone else. In just the same way, the professor of political theory is as entitled to a vote at the next general election as you or I, but he is entitled to only *one* vote.

So now that we have an idea of the sort of thing that *ought* to be going on when people engage in applied ethics, we can begin to look at what we mean when we ask of a particular example of it whether it represents its being done well or being done badly.

The first thing that we need to note is that the nature of the subject matter of all ethics, whether applied or otherwise, is such that we need to eliminate a possible confusion in our discussion between two senses of the word "good" and its compounds such as "well", and "better": and, of course, their antonyms - "bad", "badly", "worse" and so on and so forth. We can capture the distinction between these two senses by talking of them as the *practical* and the *moral* sense of evaluation. It is perhaps easiest to see what we mean by this distinction by means of an illustration.

We might say of an advertiser who consistently comes up with dull jingles, uninspiring by-lines, and insipid illustrations that he is a bad advertiser. By this we do not mean that his morals are in question (we do not, for instance, adduce evidence of an extra-marital affair) but rather that as an advertiser, he is simply hopeless: hopeless, that is, as doing the kind of thing advertisers are supposed to do. We mean that he is bad in a purely practical sense: bad *at* advertising, that is.

Consider by contrast his competitor whose concepts are brilliant, who wins huge contracts from multi-national companies, devises witty, appealing campaigns, and so on, and is in every way an excellent advertiser (in the practical sense). Of course, no one but a saint is *all* good, and saints are curiously thin on the ground in advertising, and this latter, call him Morris, is - in the evaluative sense - a bad advertiser: he lies, he puffs up the products he is promoting, on occasions he even goes so far as to suggest that drinking a particular brand of alcohol is good for you. His campaigns may work: that is, they may sell the goods, but although he advertises well (in the practical sense), Morris is a bad (morally bad, that is) advertiser.

We need at this point to be clear that there is in no sense a necessary link between the two senses of the word. In fact, we might even go so far as to say that they are entirely different words that merely happen to sound alike. The important point is that the (practically) good advertiser need not be (morally) good, and *vice versa*. Indeed, the cynic might suggest that being good in one sense is a positive *handicap* (within advertising) to being good in the other.

I suggest that what we can say of advertising (in this particular sense) we can say also of applied ethics. We can imagine the practically good but morally dreadful philosopher, who is as evil as they come in his actions, seducing his students, accepting bribes for inflated essay marks, offering positive reviews for his friends' publications, and so on; and on the other hand we can imagine his charitable colleague, scrupulously honest and fair, never missing a deadline, but who is really rather lamentable when it actually comes to doing any *philosophy*. And we can distinguish relatively easily between them. We will not be surprised if they do not turn out to be the same person. We are not surprised to find young historians, agoraphobic geographers, or impoverished economists, so why should we expect ethicists to be morally perfect?

More importantly, we can distinguish between those who are good philosophers (good in either the practically or morally evaluative sense) from those who are doing the activity (philosophising) badly, that is, from the charlatans and the moral bullies; that is, those who simply *masquerade* as philosophers (and who are therefore poor in the practical sense), or who abuse their position to gain prominence for their particular viewpoint (who are morally bad).

We might say of someone that he is a good (of practical description) philosopher in the same way that I might say that this is a good pencil. Now plainly in the comparator case I do not mean that it is good by reference to any *moral* properties that it has (it would, for instance, be simply silly to say that it is a just pencil because it writes equally well for all irrespective of class, age or creed). I can say that it is a good pencil by virtue of its performing certain tasks well. We could, if we had nothing better to do, list these tasks, but I take it that in the case of a pencil they are fairly obvious. Let us just say, then, that there is a bundle of tasks called "pencil-tasks" that a good pencil must do well.

Now what I want to suggest is that philosophy itself is a task, or an activity. To use Platonic jargon, we might say that it is a craft: *techne*. And like any other craft, I suggest, it can be done well or badly. Because we have an idea of what it is that a translator ought to do - render a foreign language with which we are not familiar into clearly understandable English that accurately reflects the meaning of the original utterance, for instance - we can say of a particular translator that he does his task well or badly. Clearly, this is to make reference to the sense of the word in which we make a practical, not a moral evaluation.

Similarly, I have suggested that we have an idea of what it is to do the task of philosophy well. In a passage I quoted earlier, Parker suggested (1994: 35) that it must necessarily assert the value of reflection. We went beyond that point to suggest that it must also involve clarification of the central terms of the discourse, and an explication of the present state of thinking in the subject. I conclude, then, that we do not have the slightest difficulty in distinguishing philosophy done well from philosophy done badly. Add to this our analysis of the supporting arguments for the so-called problem of the expert, and I believe that we have shown that it makes perfect sense to talk of expertise in applied ethics.

And so we come at length to the second strand that I suggested runs through the general reservations about the notion of doing ethics by committee, what I called at the beginning of this chapter "the problem of the professional worrier". The second part of this chapter will examine the alleged problem and attempt to explain why it is perhaps less of a difficulty than might at first sight be proposed.

2. The professional worrier

In Chapter I (p38ff) we looked briefly at Evans's (1994) model of the LEC(PA) as "a health care planner's conscience", and I suggested that although the model that Evans's discussion implies is startlingly dualistic, nonetheless it is not immediately self-contradictory. I want now to turn to the objection that could be made to this model that focuses on the notion of "the professional worrier". Not for the first time, I believe that the best way into a discussion of this problem is through an analogy.

There has recently been a move in the caring professions[7] ancillary to social work to consider what exactly is the status of the carer known as a "befriender". This person may work with any one of a variety of clients of the social services, from those with housing problems to informal users of mental health services or drop-in day care centres. One of their distinguishing features is that they are as a rule unqualified, or at least not operating in a role for which they are specifically qualified. That is to say that while a particular befriender may have a postgraduate diploma in social work, she will not be operating in the role for which this qualifies her. The befriender is essentially a lay role.

The notion of a befriender came about when it was realised that the official care and contact provided did not meet all the needs of the service users: to take a simple illustration, many of the homeless people using a certain drop-in centre needed someone to talk to and to listen to them just as much as (if not more than) they needed a roof over their heads. While social care professionals could *identify* this need, the extent of the demand for their professional services by other clients prevented them from meeting that need themselves: and so the befriender's role was conceived.

While it is generally accepted that the befriending scheme can do a great deal of good in certain cases, nevertheless there remains a significant degree of uneasiness in the minds both of professional social workers and of the befrienders themselves about the validity of the model used to describe their work (cf Phillips, 1982). What these difficulties typically boil down to is a concern that *friendship* is not the sort of thing that can be provided on a professional basis: it cannot be commanded, nor is a friend the sort of thing you can get by mail order. Underpinning these suspicions is an idea that it simply makes no sense to talk of a professional friend at all, that there is something about the *meaning* of the word "friend" that precludes the idea of employing someone as one.

We can make this concern slightly clearer if we compare the professional friend with the paid companion so beloved of Victorian novelists. It makes sense to talk of employing someone as a *companion* (although the idea may now strike us as odd), but not, it might be argued, as a *friend*: the words just play different roles in the language.[8]

I hope that we can now see what it is that might be meant if someone were to object that it makes no sense to talk of a prosthetic conscience, of employing someone to do one's moral thinking for one: what I have referred to as the problem of the professional worrier. The suggestion is that it is in the nature of moral thinking that it cannot simply be delegated to another: no-one could say "I'll do the operating and you worry about the value of the life that I'm trying to save" without incoherence.

This putative objection obviously derives from a particularly persuasive picture of the scope of morality and moral debate. It suggests that the *range* of moral debate and activity is such that everyone is necessarily involved in it, that it makes no sense to talk of standing outside the realm of morality and just *acting*. If this is so, then is it not the case that it is conceptually confused to seek to abdicate moral responsibility and to pass the duty to engage in moral debate to another?

It seems to me that the answer to this question is "yes", but that is not what was going on in the LEC(PA) experiment. To justify this response, we shall have to look a little further at the objection and see if it stands up to questioning.

The claim is that there is an inescapably moral dimension, a moral *flavour*, that pervades all aspects of health care delivery from macro-level resource allocation to the performance of actual procedures. Any area of human activity that deals, as health care delivery does, with human goods, harms and suffering is inescapably tinged with precisely this moral flavour: as I argued in Jarvis (1996b: 176):

> The inescapable fact of health care provision is that it necessarily involves, at all levels, a complex interplay of human costs, benefits and harms. Lest we forget, people hurt and die in hospitals.

The suggestion here is that morality is not an added dimension of health care that can be bolted on if and when it suits the professional. Rather, like the yeast in the dough, to use St Matthew's analogy, it is a feature that permeates every aspect of health care delivery.

Now I imagine that the claim would be that if we accept that anyone engaged in providing health care services at whatever level is necessarily engaged in an inescapably moral activity, then we must accept also that it is absurd to talk of a prosthetic conscience, as if those who worry and review could be thought of as in any way distinct form those who act. It would, the claim seems, be a denial of moral responsibility - the Socratic imperative continually to examine one's practice and actions - to devolve the duty to engage in creative moral thinking to another party.

This claim looks to be a powerful one in the present context because it relies on such a plausible picture of the moral task, as a game in which we all have a part to play, indeed as one in which we all *must* play our part. Do we not then have a problem, given the clear distinction that existed between the LEC(PA) and the Health Authority Boards, that is to say, between the conscience that reviewed and worried and the impetus that took decisions and acted? Is there not a clear conceptual confusion between those who advised and those who acted?

I suggested in chapter I (p36ff) that a necessary feature of advice, whether about morality or otherwise, was that it necessarily be *practicable*: that is, that any advice must be so realistic as to be capable of being carried out by the advised. I want now to suggest another necessary feature of advising that distinguishes it from being overbearing, or from indoctrinating, or from taking the matter out of someone's hands, or from any one of a number of related concepts. Advice necessarily *underdetermines* any possible outcome.

What I mean by that is really quite simple, and can be illustrated by reference to a purely practical piece of advice that might be given. If you ask me the best way to drive from Swansea to Edinburgh, I would, if I were being helpful, advise you to take the M6 motorway as far as Carlisle, and so on. However, note that this falls a good way short of programming the cruise control in your car to take this particular route irrespective of anything. It might be, in the real world, that you have a particular fear of motorway driving, perhaps it bores you and you are afraid of falling asleep at the wheel. Perhaps you simply prefer to take a slower route and see more of the glorious scenery than would be possible from the fast lane. My (purely practical) advice to you does not impinge on any of this. You asked me a practical question, and I gave you an answer in the same terms. What you choose to do with that answer is your business.

And it is this latter feature that is such an important characteristic of advice properly so-called. I can advise you till I am blue in the face, but so long as my advice is just that and nothing more, the decision to do A or B (or X or Y or Z) is yours *and remains yours irrespective of the fact of my having offered advice*. (If this does not seem conclusive, consider how weak an exculpating account it would be if little Johnnie were to suggest that he should not be punished for breaking the window since Natasha suggested he should throw the ball against it. Johnnie is the culprit and Johnnie gets the blame - as many of us know to our cost. We would only be looking to blame Natasha if she actually *forced* Johnnie to throw the ball).[9]

If this account of advice as necessarily *under*determining any possible outcome (moral or otherwise) is correct, then it is clear that there is no conceptual confusion implicit in talking of a body (or individual) distinct from the agent responsible for *advising* that agent about his moral (or other) position. Schematically, X can give Y moral advice (for instance, an understanding aunt may talk about abortion and adoption to a worried, confused, pregnant teenage girl), but what makes it Y's moral choice is that *she* takes the final decision. X's advice may (or may not) have an effect on Y's choice, but note that we still talk of it as *Y*'s choice. It is no more absurd to talk of taking advice about a moral matter than it is about any other concern: to use a colloquial term, it is a question about where the buck stops, about who bears responsibility for the decision in the end.

With this reasoning in place, then, we can see why it is that it *does* make sense to talk of the LEC(PA) as the conscience of the West Glamorgan Health Authorities. Albeit that the committee might offer *advice* about a particular issue, any decision remains the responsibility of the Boards or the unit referring the question to the committee: irrespective of the advice offered by the LEC(PA), it remains the referrer's moral choice. Incidentally, this also explains, in conceptual terms, to add to the practical ones explored earlier, why it is that the committee could not have had a veto over any items of policy. Cooper's (1971: 225) discussion of the necessary "gappiness" between desire and action, or in the terms of our present discussion between moral belief and policy, demonstrates the chasm that lies between thinking that X is the right thing to do and actually getting around to doing X - the phenomenon referred to as weakness of will. Although Cooper's remarks are made in the context of the individual's conscience, the same holds true of an organisation: the faculty of conscience *never* has a veto.

1. I say "ostensibly", because there is reason to suppose that this was not an exhaustive account of the reason not to purchase the treatment. Part of the reason for the publicity and controversy that flared up surrounding the Child B case was Cambridge and Huntingdon Health Authority's invocation of limited resources as a factor in the rationing decision. Although plainly no purchasing decision can be taken in abstract, distinct from an overall picture of the resources available, nevertheless to suggest that the - or even a - reason for the non purchase of a treatment is its budgetary cost is indefensible, both morally and as a piece of public relations. Indeed, in its paper on the subject (LEC(PA), 1995a: 1), the committee

> urge[d] the Authorities in the strongest possible terms to restrict rationing criteria to *clinical* variables. The committee is of the opinion that much of the trouble centring on Cambridge HA's decision is related to their inclusion of *financial* concerns in the rhetoric of their rationing. Had they restricted themselves to the (entirely adequate) clinical reasons for refusing treatment to Child B, the committee believes that the decision would have been both fairer and more generally accepted.

2. In fact, these latter clinicians may have been nearer the truth of the matter. At the time of writing, Child B (or Jaymee Bowen as she is now known to the world) is in remission and leading a relatively normal life.

3. Similarly the debate, itself reviewed and contributed to by the LEC(PA), concerning the status of fertilisation services and assisted conception therapies, and whether it makes sense to think of such services as falling within the description of *health* care, or whether they can better be thought of under the description of *social* care, demonstrates how such boundary disputes are live issues of the first importance for issues within the area of resource allocation.

4. I explore the question of which areas of the subject admit of talk of expertise in greater detail below.

5. Note that while the making of moral judgements is not a possible area of expertise in the field of applied ethics, the *supporting* or investigation of them is. That is to say that while the applied philosopher should not have any interest in handing out his own moral judgements, nonetheless he should properly be interested in judgements that others have made: he will seek to discuss their supporting reasons with the intention of examining them from the standpoint of those areas of the subject in which he can be presumed to have a degree of expertise. So for instance if he discovers a value-laden judgement masquerading as an objective (say, clinical) one then he will quite properly draw upon his expertise to point this out.

Interestingly, the committee performed precisely this function in the debate over the commissioning of infertility services in West Glamorgan, where it noted that the grounds given by one Health Authority for not commissioning such services, that the people suffering from infertility were not actually *ill* (see

Klein & Redmayne, 1993) were not, as was suggested, clinical grounds at all, but rather the position was a moral one, and therefore one which required a moral, not a clinical, defence. This identification of the argument as a moral, rather than a clinical, one had the effect of opening up the debate (an effect which I argue below - see p208ff - was fundamental to the committee's operations) in that *qua* moral disagreement it was a matter on which all could have an opinion.

6. The 1995/6 Plan was notable for the number of widely differing incarnations in which it appeared, ranging from comparatively short drafts of thirty or so pages to a full two volume account including reams of technical data.

7. I use the term loosely here to include quasi-professions and lay disciplines. The status of such quasi-professions is, for many, precisely the question. Happily, this is not a question we need to grapple with for our present purposes.

8. cf Thackeray (1986: 176):

> Nor have you, O poor parasite and humble hanger-on, much reason to complain! Your friendship for Dives is about as sincere as the return which it usually gets. It is money you love, and not the man; and were Croesus and his footman to change places, you know, you poor rogue, who would have the benefit of your allegiance.

9. Note that this assumes that Johnnie and Natasha are of equal status: if Natasha were a teacher, for instance, or had some kind of control over Johnnie, then he might (to a greater or lesser extent, depending on the nature of the influence or control) be exculpated from the blame that would otherwise accrue. Similarly, if my financial advisor gives me poor advice about shares in which I am thinking of speculating, I might similarly be partly exculpated from blame (say, the blame of wasting my children's inheritance) on the grounds that while I am not expected to be conversant with the movements of shares, my financial advisor is.

Superficially, this argument might look as if it offers to exonerate the Health Authorities from blame and focus responsibility for unpopular decisions on the LEC(PA), as expert advisors of the Authorities. However, there is an important difference between the status of the financial advisor and the giver of moral advice. Recall that we sought earlier to distinguish the notion of expert in applied ethics from that of moral expert. I suggest that we are inclined to find the notion of "a moral expert" questionable or even repugnant on account of conceptions of the enterprise of morality that we share: as moral agents, inescapably caught up in the moral realm, we consider that we are all equally well qualified to make moral judgements, and that moralising (as opposed to conceptual analysis or formal argument) is simply not the sort of thing that admits of talk of expertise.

By contrast, we do not think anything of the kind in the case of financial advice: I expect a financial expert to make qualitatively better judgements than I about investments: he is an expert, I am a layman. But there are no moral laymen, any more than there are any moral experts.

Chapter V

Retrospective and prospective perceptions of the LEC(PA)

Moderation is the silken string running through the pearl string of all virtues.

Joseph Hall, Bishop of Norwich

I want in this final chapter to try to pull together some of the themes that have run through the discussion of the early years of operation of the LEC(PA): to try to connect what may at times have seemed a disparate and only loosely connected treatment of some of the issues that this research has raised and attempted to deal with. There is of course a sense in which there is a certain artifice about this: the committee will, thankfully, outlive the confines of this particular project, and while the discussion has reached its final chapter, the committee is only just beginning to work to its full capacity. Any conclusions, therefore, that are adduced in the course of this chapter should be read with a *caveat*: they are interim conclusions, and must be open to re-evaluation in the light of future events. However, I am convinced that there is enough evidence as a result of close observation of the committee's first years of operation to suggest that certain patterns have indeed emerged, and certain ways of constructing and envisaging both the committee's task and its strategies for dealing with that task have developed sufficiently strongly to force themselves onto the attention of an observer. This is not to suggest that these constructed models to help to explain the task and performance of the committee are the only ones possible, nor that they are set in stone and not open to re-interpretation. But it is to suggest certain, I hope helpful, ways in which we can seek to construct the experiment that is the West Glamorgan LEC(PA).

Another part of the task of this final chapter will be to argue that the experiment should be taken seriously beyond the boundaries of the county, that it has implications for other Health Authorities. I have already hinted that neither the situation that was the occasion of the need to ration health care services, nor the problems that inevitably arose as a result of such rationing (notably in public disenchantment with the way that the service was being run, and in clinicians' and other service personnels' becoming dispirited) was unique to the present case: by way of example, West Glamorgan was certainly not the only Health Authority to consider disinvesting in fertility services and to receive forceful representations from various interested groups purporting to explain why such a step would be unthinkable.

It is interesting to note that much of the history of the NHS following the 1991 reforms has been the (re)issuing of the claim that overt rationing had arrived, that there was no longer any possibility of pretending that health services were available for all, limited only by clinical need. In fact, this theme of attempting to acknowledge publicly the inevitability of rationing predated (as we saw in chapter I) by some twelve years the 1991 reforms of the service[1], but there is no doubt that it re-emerged forcefully as a *leitmotif* in discussion and criticism of the service following 1991.

It would, of course, be to advance no very radical a thesis to suggest that the achievement of such transparency of both the necessity and procedures of rationing in health care provision was a fundamental part of the aims of the reforms, and it is in this light that some commentators (see e.g. Ranade, 1994, and cf Ruddle, 1991: 13) have suggested that 1991 marked a turning point in the history and self-conception of the NHS, from a service that hid from its necessarily limited and finite nature to one which faced up to its finitude and resolved its limitations as best it could. However, as I have already suggested, this recognition seems more often to be made than fully acted upon: four years after the reforms the *Health Service Journal* was arguing that the Child B case in Cambridge and Huntingdon Health Authority (see p174ff) itself represented a turning point in the history of the service, proclaiming that "[f]ifty years of muddling through elegantly are now definitely at an end" (*HSJ* editorial, 1995: 17).

I suggest, however, that it is too simplistic to think in terms of such synchronic turning points in the history of the NHS. It is perhaps a tendency of the historian to seek to identify a particular event, a single point in time which encapsulates and apparently denotes a change that was in reality much more gradual. I would argue that there was no more a single point in time at which rationing in the health service was openly acknowledged for the first time than there was a day of the week on which the Renaissance began. Rather, it would make more sense to say that with the benefit of hindsight we can discern that there was a general move towards the more widespread acknowledgement of the truth of the necessity and inevitability of rationing, despite the promises of the NHS's foundational vision. We should talk not in terms of a watershed, seeking to establish spurious causal links between an isolated event and a very general change in the service's *weltanschauung*, but rather in terms of a gradual dynamic, along which certain points can be identified, as if as milestones that point and measure the way.

The LEC(PA) experiment represented a deliberate attempt to come to terms with the multifarious, confusing, and sometimes disenchanting implications of the 1991 reforms of the NHS; an experiment that at the time of its inception was without precedent. It was, in the truest sense of the phrase, a trail blazer. Given that the problems that it sought to address, and the resources with which it could work, were common to all Health Authorities in the UK after 1991, there is a direct and immediate value in its process, successes and failures being widely debated and examined. History, Viscount Bolingbroke declared, is philosophy teaching by examples (Bolingbroke, 1972: 9). As I have argued in the course of this examination of the LEC(PA), the committee's workings were by no means free from error. If progress consists at least in part in learning from mistakes, then there is an obvious benefit in learning from the mistakes of others, rather than having to repeat them for oneself before one can learn the lesson: as Santayana remarked, "Those who cannot remember the past are condemned to repeat it".

Throughout this research I have tried to keep two very general aims in mind: unfortunately, they are in some sense in tension, and no doubt the means by which I have sought to resolve that tension will not strike every reader as satisfactory. My intention was to ensure that the research was firmly grounded in the workings of the LEC(PA), and it was with this intention that I have endeavoured to give a flavour of its meetings and its reports. My aim in this was always to guarantee that the research reflected the actual workings of the committee, workings which I believe, although perhaps inevitably flawed, are nonetheless vitally important as an example of how one health authority attempted to implement the 1991 reforms and to fulfil the moral obligations felt by its members as individual moral agents in some sense responsible for and implicated in the decisions of the Health Authority concerned not only to manage the service as best they could, but also to air, discuss and seek to address the moral dilemmas and tensions to which such management gave rise.

At the same time, I have been at some pains to ensure that the research should be both applicable and of interest beyond the boundaries of the immediate experiment. I have attempted to provide a linkage with the experiences and situations of Health Authorities beyond West Glamorgan not only by considering the reactions of the committee to specific problems, such as the Child B case in Cambridge and Huntingdon, but also by seeking to ground the research in a service-wide vision of the context of health planning.

These twin dynamics of research grounded in the specific experience of identifiable individuals, which is intended to be of interest to and value for a much wider audience, have not always pulled in the same direction. Indeed, at times my efforts to achieve one aim have placed the other in jeopardy. In particular, there has been a constant tension between the imperative to preserve the anonymity of individuals and the confidentiality of the committee's deliberations, while at the same time providing enough information to enable a wider audience to interpret the data that I have collected.

I hope that this - very brief - explication of the twin aims and methods of this research, to seek to shed light on general problems by means of examining one particular solution, goes some way to explaining the shape of this discussion. The four chapters can be seen as attempting to answer four different yet linked questions. Chapter I examined the question of what job the committee was required to do, and what factors in the prevailing landscape of health planning - particularly as reformed in 1991 - dictated that such a job was necessary; chapter II discussed how the committee, faced with an existentialist dilemma of being called into existence before it had a clear idea or account of its essence or purpose, set about the accomplishment of its task, and both the definition and redefinition of both its Self and its goals; Chapter III then asked two further linked questions following on from the previous accounts, seeking to ask if we could determine at all whether or not the task had been fulfilled, and if we could so determine an answer to that question, how we could set about doing so; and finally chapter IV addressed the fundamental question of whether the task that was envisaged and (re)constructed was a possible one in the first place.

Running through the introductory sketch of this discussion which attempted to set the activities of the LEC(PA) into some kind of context, was a brief examination of the history of the NHS in terms of various attempts to come to terms with the apparently inescapable shortfall of resources relative to expressed demand in the population. I argued that we can see the whole history of the service in terms of continual attempts to review and reform the process of service provision in order to increase efficiency: from the establishment of the NHS itself in 1948 to the 1991 reforms, I suggested that we can observe a single dynamic uniting each subsequent effort to reform the service. Rather than vastly increasing the resources available for health care (although costs continued to rise), each set of reforms sought to bring demand more closely into line with supply by facilitating a more efficient delivery of service provision.

Underlying these continued attempts to reform the service lay the belief that the problem with the NHS was simply that it was not operating efficiently enough: that too much was being wasted in terms of over-prescribing, duplication of tests, inadequate record keeping, and so on and so forth. While the methods by which such presumed inefficiency was to have been eliminated may have varied from the establishment of a single service in 1948, to the introduction and strengthening of general management in 1974, 1982 and 1984, to the deployment of the unseen hand of the market in 1991, the root problem at which all these so-called solutions aimed was the same: inefficiency. I suggested in chapter I that such solutions were necessarily inadequate owing to the nature of the very concepts of health and demand for health care. As I argued in Jarvis (1996: 183), the various reforms:

> may have been useful attempts to push back the point at which the need to ration treatment bit, that is, they may have allowed more to be squeezed out of the same lemon, but they could not - logically could not - have eliminated the need to ration ... What no reforms could escape was the logical point that we discussed earlier: that no health care activity saves money - it necessarily generates further demand for existing resources ...

Similarly, no reforms addressed the central question of what was meant by "health", and therefore what could reasonably be demanded in the name of health care. As Lefever (1990: 75) argues, the lack of definition around and within the NHS is more of a problem for the service than is its underfunding.

Part of the problem of trying to discuss in quasi-historical terms a process which is still in the process of developing is that conclusions and arguments can at best be *pro tem*, that is, nothing that is said can be anything more than provisional. During the course of this research, a new dynamic has arisen both in commentaries on the NHS from outside the service, and in discussions originating within the institution itself.[2] It does not refute our earlier analysis of the NHS in terms of the pursuit of ever more efficient modes of service delivery, but it does bring in another theme. In the same way that it was believed that greater efficiency would resolve the tension between demand and supply, thus rendering rationing unnecessary by the freeing up of resources previously squandered, the interest in the notion of evidence based medicine[3] that was widely manifested in 1994 was founded on the idea that the need to ration health care services could be eliminated simply by dispensing with those therapies and interventions that did not measure up in terms of effectiveness.[4] Where the first forty years of the NHS had concerned themselves with trying to increase the efficiency of the service (how much was achieved for a given input), the hope of evidence based medicine was that the effectiveness of individual interventions could be measured and assessed, and those therapies that were insufficiently effective, that is roughly that did not produce the required results often enough, would no longer be purchased. In the same way that greater efficiency measures were intended to release resources previously hidden, thus doing away with the need to ration services at all, so also the promise of evidence based medicine was that the resources released as a result of the decommissioning of services known or found to be ineffective would themselves be sufficient to treat the backlog of ill health in the community, that is, to meet unmet demand.

The astute reader will notice that talk of a notionally objective and finite "backlog of ill health in the community" recalls the simplistic vision of the foundation of the NHS, which acted as if there was simply a finite quantity of illness that needed to be mopped up, and which, once disposed, of, would leave the service simply to tick over meeting a few new needs as they arose. To the extent that this utopian vision is at odds with the experience of the NHS as it is lived both by its employees and by the public who rely upon it, so also should we be wary uncritically of embracing an analysis of its problems that represents a return to such mistaken idealism.

Let us be quite clear about one thing: I am not looking to conflate the notions of efficiency and effectiveness one with another. On the contrary, it is important, from the point of view of the economist and the manager, that they are kept quite distinct. The reason that I have linked them together is rather that they represent two linked beliefs about the service, that the problem with the NHS (that is, the problem of the mismatch between the supply of health care services that the NHS was able to provide and the demand for those services) was that resources were being used ill-advisedly. In the case of the drive towards greater efficiency, the belief was predicated on a view that simply streamlining the methods of delivery (by any one of a number of methods) would be enough to ensure that all that was needed could be done, while in the later case of evidence based medicine the belief was rather that the decommissioning of ineffective services would release sufficient resources to enable all needs for effective therapies to be met. In neither case was an increase in overall resources proposed, nor was much thought given to the idea that either hope might be mistaken.

I argued in chapter I (pp18ff) that the great white hope of efficiency was to an extent a mistaken one: while there was room, undoubtedly, for taking up the slack in the NHS, it would simply be mistaken to suppose that the eradication of inefficient practices would in and of itself be sufficient to restore equilibrium between resources and demand for health care. This is not to say that no savings could be made, but rather to point out that there is a world of difference between making savings and eliminating altogether the need to ration.

In the same way, there is now little doubt, following the work of the pioneers of the evidence based medicine initiatives, that the treatments offered as a matter of course by the NHS in the 1990s included a considerable number that were to a greater or lesser degree ineffective: that did not do the job. In the scenario of limited resources in which health care planning necessarily operates, it is, so the evidence based medicine argument runs, indefensible to commit resources to areas of health care where they are not achieving their proper and stated goals. If resources are tight, then it is only right that they should be targeted to where they can do most good.

The argument looks to be a plausible one, and it surely cannot be doubted that, *ceteris paribus*, of two treatments, only a fool would prefer the less effective. Whatever may be said about health care managers, most of them are not fools, and they are, quite properly, concerned with extracting the maximum amount of health care from each health care pound. However, what the proponents of evidence based medicine as the way forward sometimes run the risk of ignoring, or failing to notice in the first place, is a simple truth that we discussed in the context of the drive for efficiency in the NHS: that simply streamlining the provision of care, or re-targeting the areas into which care is channelled, will not - cannot - in and of itself be enough to remove the need to ration services. What both approaches fail to recognise is that the reason there is a tension between supply and demand or need in the NHS is not that the service is short of capital or resources, but that it is far from clear about what it proposes to offer; as Lefever put it, the problem with the NHS is not that it is underfunded, but that it is undefined (Lefever, 1990: 75). The source of the tension for the NHS is not funding, but logic - not money, but meaning.

Debate about such meaning certainly appeared to be getting under way in South Wales beyond the boundaries of West Glamorgan. While within the county the LEC(PA) was the arena in which ethical evaluation of and recommendations relating to health care planning could be undertaken, it would be incorrect to suggest that the rest of the country "counselled ignoble ease, and peaceful sloth".[5] Notably for the present research, in September 1995 the LEC(PA)'s discussion papers and recommendations on the subject of the future funding of infertility services formed the basis of a day's discussions organised by the health commissioners in East Dyfed, an adjoining health authority. The details of the day need not detain us here, and the outcome of the discussions - whether IVF was purchased in East Dyfed in 1996/7 - is irrelevant. What is important is that the *process* of rationing was self consciously and deliberately undertaken in a reflective fashion: that health authority members, GPs, gynaecologists, managers and a philosopher came together in order to discuss the questions that would underpin any purchasing rationale. The East Dyfed meeting is an important sign to the extent that it reflects both a growing acceptance of the need to ration both rationally and reflectively, and also a role for the work of the LEC(PA) beyond the boundaries of West Glamorgan.

In the sense that the acceptance of the necessity of rationing, then, was still in 1995 in, if not in its infancy, at least in the early stages, we can see that there was a continuing place for the LEC(PA) in the process of health care planning in West Glamorgan. The service and management context into which it had been introduced had by no means remained unaltered over its first three years of operation, but the need to perform a deliberate and deliberative task of ethical review and recommendation had not gone away.

I have argued that "West Glamorgan is not so unimaginative as to suppose that it has got it right first time" (Jarvis, 1994: 18), suggesting that the LEC(PA) experiment did not represent the only way by which the problems implicit in the resource shortfall in the NHS could be addressed. East Dyfed looked to address the problems not with a formal committee, but with a stand alone study day: no doubt other health authorities have considered other techniques. But the important thing about the LEC(PA) is that it represented an attempt to face up to and take on board the task of rationing as an integral part of the overall process of health commissioning and planning. Although the immediate context of commissioning may have changed from the one into which the LEC(PA) was introduced, nonetheless such developments as the evidence based medicine initiative, with its attendant suggestions that the tensions can be resolved simply by reforming or re-targeting the service, give rise to the suspicion that the task that the committee was created to perform has not gone away, and that there is still very much a place for the questioning voice that seeks to expose the value bases on which proposals rest, and looks to explore and if possible help to resolve conceptual unclarities in the process of health care planning. Similarly, in November 1995 the committee met to discuss the implications of the Health Authorities' proposals for review of in-patient mental health services in the county.

If the first chapter of this discussion concerned itself with the context of the LEC(PA)'s operations, seeking to take something of a broad view of the committee's operational circumstances, then the second can be thought of as something more akin to an in depth examination of its actual methodological processes and patterns. I hoped that by initially describing the practice of the committee as it was constructed and performed by the members we could gain a greater understanding of the committee's task as defined and envisioned by those who undertook it. This second chapter, although it had in part a descriptive character, goes beyond the mere reiteration of events to examine how it was that the purpose of the LEC(PA) came to be defined, and how its members looked to set about achieving that purpose.

This chapter also looked at certain issues that can be thought of as falling broadly within the area of philosophy of the social sciences, and in particular at the question of the extent to which it is proper for the fact of observation to feed into and influence the behaviour observed. This question of the validity of so-called action research was raised in particular in the context of my feeding back my hypotheses about the committee to the committee members themselves, and seeking to sharpen my theories and constructions of their behaviour patterns and activities by comparing my observations with theirs. It would be idle to pretend that it was any part of my brief as a committee servant to ensure that I had no effect on the operation of the committee: as a paid assistant, whose duty it was to inform, direct and report the deliberations of the committee, it was plainly fundamental to my role to ensure that I precisely did have some sort of effect on the process and outcome of the meetings. To have failed to have done so in any particular whatsoever would have been to invite the charge that my involvement in the preliminaries to and conduct of the committee's meetings was superfluous.

Plainly, then, it was part of the role constructed for me by the establishers of the LEC(PA) to affect the conduct of the committee. I was there in part to co-operate with those individuals whose behaviour and discussions I observed in order to facilitate the achievement of the committee's goals. We noted in chapter III that these goals of the committee were broadly - very broadly - drawn at the time of its inception, and that in the initial stages of its operation there was no very concrete idea, either of what it was that it was supposed to be doing, or of how it was supposed to be doing it. This ambiguity of purpose and method in an institutional arrangement is almost a paradigm case for the intervention of action research, which offers not only to (re)describe patterns of operation and goals, but also to help (re)construct these goals and patterns in order to facilitate their achievement and proper function. In this sense it can be seen that the activity of action research is an intrinsically co-operative endeavour, in which both observer and observed strive together in order both to identify and then once identified to achieve certain (partially shared) ends.[6]

The essentially co-operative nature of action research is hinted at by Cope (1981: 7):

> Action research basically consists of first collecting information, feeding this back to the group concerned, deciding and planning what to do on the basis of this [*sic*] data and then initiating some action to follow up the decision.

What Cope could perhaps have emphasised more is that the feeding back, the deciding and planning and the initiation of any subsequent action are all fundamentally *shared* functions between the researcher and the research subject: the agreement between and a sense of shared and mutual ownership among both parties is, we might say, a necessary condition for action research to progress properly. Without such agreement the co-operation (literally, labouring together) that is basic to action research cannot be achieved: there can be no action, and the research will remain static and ultimately sterile. We must not lose sight of the grounding truth of this type of research, that it aims to make a difference to the subject studied. This is not the same as suggesting that the point of action research is to make the researcher indispensable to the research subjects: on the contrary, the involvement of an external observer may be extremely short lived. Rather, the purpose of the research is to enable the subject to identify, by the assistance of the observer, such patterns of activity and areas of practice which could profitably be changed in order to facilitate the achievement of the goals of the organisation studied.

It is particularly interesting in the context of the present study to note that the essentially co-operative nature of this piece of action research is represented in powerfully symbolic form in the fundamentally symbiotic relationship between myself and the committee.

I suggested above that the observer-observed relationship was a powerfully mutualistic one of considerable reciprocity, and that a degree of interdependence is likely in any piece of extended research of this type. However, I would argue that in the present case we can go even further than that by recalling the discussion in chapter II (p76ff) of the symbiotic relationship between myself and this particular committee, where I suggested that there was a sense in which all parties to the research stood to gain something from its being undertaken. To this extent we can take the present research as a particularly powerful symbol of the symbiotically interactive nature of the relationship between observer and observed that is almost the hallmark of action research.

In life as it is lived, and therefore inevitably in life as it is observed, things are rarely so straightforward that they can easily be characterised in simple terms, and slotted into neat pigeonholes. To talk of action research as emblematic of an initiative of constructive co-operative endeavour, and to suggest that the parties in the research stood only to gain from its taking place, would be simplistic and to an extent misleading. It is therefore important to recall at this point the discussion (p86ff) of the potential risks that West Glamorgan Health Authority ran when setting up the LEC(PA). We need not repeat that discussion here: what is important to note is that the establishment of the committee represented neither an uncomplicated risk nor a clear potential benefit to the Authorities; the same, stated perhaps even more strongly, is true of the decision to invite an outsider to observe the committee's activities. While there was undoubtedly a potential for considerable benefit in both the establishment and observation of the committee, neither activity was free from risk, and it would be idle to pretend otherwise.

To an extent, we can see many human interactions as attempts to deal with and place limits upon potential risks, as strategies for disaster limitation, or for coping with untoward events or developments. So it was that certain rules of engagement were drawn up by the Authorities for my involvement with the committee, notably in the field of what we might think of in Goffman's (1982) terms as external impression management: in particular, any breaching of the boundaries that surrounded the Authorities' activities (for instance in the event of my publishing any papers, or attending conferences or the like in my role as committee servant) required prior clearance by one or more of the Authorities' personnel.

We can see evidence, then, of attempts to control the social environment and impose (albeit possibly constructive and certainly entirely understandable) limits and restrictions on the activity of the committee's observer by the Health Authorities. Similarly, I suggested in chapter II that we can construct much of the committee's early behaviour and *modus operandi* in terms of a similar attempt to control the environment in which it found itself. In the particular case of a newly created body like the LEC(PA), I argued that its early months were marked by a pattern of seeking to construct for itself an identity, by reference to which its task could itself be defined. I argued that one prominent feature of this process of Self-construction was the identification of the Other, and that it is by defining what it was *not* that the committee came to decide for itself what (more positively) it was, and suggested that one significant obstacle that stood in the way of the LEC(PA) achieving its task, at least initially, was that its task was very far from clear: that it had no particularly clear areas of responsibility, nor parameters within which to operate, but that on the contrary it had at one and the same time to define its task and also to carry that task out. In a sense, perhaps, we should not be surprised at this: as Aristotle reminds us, it is by playing the lyre that we learn to play the lyre[7] - a skill or activity is mastered by its performance.

One of the features of this process of Self-definition that makes it surprisingly difficult to analyse, or at least, to break into for analytical purposes, is that it is an essentially cyclical process, rather than a single teleological dynamic from a starting point to a *terminus ad quem*. I suggested in chapter II that in the development of a conception of Self, among the most important dynamics were the construction of myth and the identification of the Outsider (the latter is, of course, in certain senses a subset of the former category). Were it the case that the task of Self-construction and definition took place along a uni-dimensional vector, then the development of myth and the identification of the outsider would feed into a construct of Self, which would then be fixed and influence other matters little. However, I suggest that this is a mistaken conceptualisation of what is going on, and that the process, far from driving in a single direction, is dramatically cyclical, so that the construction of Self that is derived from the development of certain myths and the identification of individuals or groups as significantly Other itself (re)feeds back into the ongoing development of myths (including those of the Outsider). In this way we can see that the (re)development of myth is not a single dynamic, but rather a diachronic development over time where the output feeds back into the original construction from which it was derived.

It would be wrong to leave this re-examination of the development of the Self-conception of the LEC(PA) without discussing one further particular example. I suggested above that the committee came to construct and envision what it was at first by identifying and delimiting what it was *not*. If such negative identification is in a sense the first step on the road of Self-construction, then we might say that in the process's end is its beginning, and

I shall suggest that a clear refusal to adopt one particular role that might have been foisted upon it can be seen as representing if not the fulfilment then at least the maturation of the committee's Self-conception: the process of Self-definition and construction both has its origins and reaches its fullest expression in a negative assertion. In the identification of the Other or the refusal to adopt a particular role strong boundaries are formed that are the positive correlate of the negative identification from which they are derived.

It is important to remember in the course of this discussion that the early years of the committee were a period of uncertainty, both about the present (in the form of wondering what tasks the committee was to perform and how it was to go about them) and about the future (in the sense of wondering whether the experiment that the committee represented would continue, or whether it would founder at an early stage). In the context of such uncertainty, it would be easy to understand if it had been the case that the committee had shown itself keen to take up any issues that might have been raised in an attempt to broaden its base of experience and activity, almost as if to seek to make itself indispensable. That it did not do so is both a reflection on the integrity of the members of the committee and at the same time an important symbol in the development of the committee's Self-definition.

At the time of the establishment of the committee it was envisaged that in addition to its dual function of providing advice and ethical review for consideration by the Health Authorities, it would also

> be expected to provide advice on an individual basis serving as a resource to Practitioners worried by particular cases or policies.
> It would not be the role of the LEC(PA) to adjudicate on particular management decisions. (LEC(PA), 1992: 1)

It is immediately apparent that there is what Hart (1993) calls a "penumbra of uncertainty" surrounding the question of the extent to which the committee can legitimately be involved in particular decisions: on the one hand, it was charged to provide advice on the back of individual practitioners' concerns about specific cases as well as specific policies, and yet in the very next sentence it was expressly stated that there was no question that the committee should have any right to become involved in individual management decisions. We have already seen (p173ff) that the committee was extremely reluctant to put itself in a position where it could become involved in the management of such individual cases. It is clear, then, that the possible tension that could have arisen as a result of variant readings of the Outline Terms of Reference was resolved in the direction of non-intervention in individual case management. Indeed, it would be no great exaggeration to say that this became almost a touchstone of the committee's Self-definition and operation in its first three years of operation, and it certainly had an important influence on the way in which the series of requests that I shall discuss was treated.

In January 1995 the committee met to discuss the continuing commissioning of fertility services in the county. West Glamorgan was by no means the only Health Authority to examine the grounds on which it commissioned and governed access to fertility services, and there was a general awareness both in the Health Authority and within the committee itself that there was every chance that the committee's discussions and findings might be taken notice of beyond the boundaries of the county. It was therefore thought particularly important to ensure that extensive research was undertaken in order to support the committee's discussions.

Initial investigations revealed that there was a feeling both within the Health

Authorities and among clinicians involved in the provision of fertility services that neither party had a complete picture of the other's view. It was therefore proposed that I should interview the clinicians involved as well as individuals within the Health Authority in order to provide a clear picture of contemporary patterns of service provision in the county, and compare them with those in other Health Authorities. To this end I arranged meetings with various individuals concerned, notably (for the present discussion) the consultant responsible for fertility services in the county.

The meeting was a constructive one, and a much clearer picture of the somewhat arbitrary service patterns was built up. Importantly, however, for this discussion, the consultant in question revealed that he had been concerned that the Purchasing Ethics Committee might have turned out to be little more than a vehicle for enabling disinvestment. In a climate of cost-cutting, and particularly at a time when the provision of fertility services was coming under heavy scrutiny nationally, such concern is entirely understandable and wholly legitimate. It is therefore significant that the initial meeting should, as well as helping to build up an accurate picture of fertility service provision, have had the added effect of creating a climate of mutual trust and respect between the LEC(PA) and the Department of Obstetrics and Gynaecology: what Barbera-Stein (1979) calls the "access negotiations" that I was in effect undertaking on behalf of the committee were brief and complete.

So complete were they, in fact, that by the time of the next meeting in March the committee had received a request from the Department of Obstetrics and Gynaecology to investigate the question of routine ante-natal testing for hepatitis-B. Although in one sense this question might have been thought to touch more on issues of the rights of the patient than on questions with which the LEC(PA) might legitimately have been concerned, nonetheless the committee accepted that there was a purchasing dimension to the question occasioned by the need to examine the basis on which tests were purchased and (expensive) barrier precautions employed in cases of high risk. The important thing for the present discussion to note is that in the committee's eyes, consideration of this question fell under the rubric of providing a resource for practitioners concerned by individual policies, and that therefore it was a legitimate area for consideration by the committee.

By May 1995 the lines of communication and a history of co-operation and support between the obstetricians and the committee had been sufficiently clearly established that the committee received a further request, this time to report on and give advice in relation to the management of a particular case that concerned a potential surrogacy arrangement that the department had been asked to arrange. The consultation had been carried out on a private basis, and there was therefore no involvement in the case whatsoever of any Health Authority funds. The committee learnt (as a result of partial overlap in membership with other Health Authority bodies) that the question had already been put forward to the LREC, who had declined to discuss it on the grounds that as surrogacy arrangements had been arranged elsewhere, there was no research element to the proposal, and that therefore discussion by the LREC would be inappropriate.

The committee's response to the request to discuss the issue is interesting, in that it represents the first occasion on which a request to report on an issue of direct ethical interest had been declined. The committee accepted that the case raised interesting and complex ethical issues, but found that not only did its terms of reference preclude involvement on an individual basis in case management, but also that since the case was being considered within the context of a private arrangement, no purchasing issues were raised that could be considered by the committee.

In so doing it implicitly rejected a picture of itself and its role that would have seen it as in some sense a sink tank for the discussion of ethical problems that arose in clinical practice that could not be discussed elsewhere in (more clearly established and delimited) fora such as the LREC. The committee was, in effect, asserting a belief that it had a unique role to perform, and that this role required it to look only at those cases and policies that gave rise to ethical issues concerning purchasing and commissioning health care. In particular, this was to deny that the LEC(PA) could be treated as "just another ethics committee" that could serve some kind of a mopping up function, addressing issues that other bodies could not or would not examine.

In this way the LEC(PA) can be seen as asserting a belief in its own unique value and role: a belief that was plainly stronger than its desire to dance to the tune of external bodies. By refusing to adopt a role that had been offered it, it evinced a clearer picture of what it could and could not usefully do: in the terms of this discussion it showed itself to be strong enough in its own Self-identity that it felt able to turn down referrals inappropriate to its own model of its purpose and operation. In the sense that the committee's refusal to engage in generalised moral debate and recommendation independent of its specific terms of reference involving purchasing advice marked the emergence of a more clearly delineated picture of its Self-construct, then, I suggest that this episode marked a defining point in its process of becoming.

The Lord giveth and the Lord taketh away, we are told; so also is it the case with philosophical analysis. Where the outline of the discussion in chapter II might give the impression that clear patterns can be discerned from the observations made, the discussion of the vagaries and limitations of research of this kind in chapter III should to some extent offset this perhaps slightly optimistic view. The discussion in the third chapter, which was intended to work towards a basis on which the early work of the committee might be evaluated, suggested that given the scale on which institutions such as the NHS or individual Health Authorities within it are organised, it would simply be mistaken to expect to find clear lines of influence and patterns within such a setting.

I suggested also in chapter III that to expect to be able to discover clear lines of influence and effect running between the discussions and recommendations of the LEC(PA) and the practice of health care planning in West Glamorgan would be wrongheaded for the reason that the actual practice of planning in the county was not the proper area of concern for the committee: rather it was concerned, as a provider of *advice*, with the *process* of planning.

This distinction makes hard-edged evaluation of the work of the committee in a sense much more difficult (although this is principally a worry not for the philosopher but for the sociologist), in that the multi-strandedness and poly-dimensionality of the culture of health care planning mean that discerning lines of influence is difficult or impossible: there are simply too many dynamics at work and too many variables that would need to be eliminated before this type of evaluation is possible. Notwithstanding these difficulties that are implicit in any form of evaluative research that is located in an institution, I suggested in chapter III that we could discern a number of threads that suggest links between the recommendations of the LEC(PA) with the process of health care planning in West Glamorgan.

I also suggested in chapter III that a further difficulty with any evaluation of the committee's work lay in the fact that its task was far from clearly outlined at the time of its inception. On the face of it, this might be taken to pose an insurmountable difficulty for any putative evaluation of the committee's work, in that it might be held that evaluation is impossible unless clear goals are stated from the first (see e.g. Phillips, 1993). However, I argued that this was not necessarily the case, and that it made perfect sense to suggest that evaluation can take place *post hoc*, so that the goals emerge by an organic process from the action that is itself the subject of the evaluation.

Given this openness and incompleteness of goals that characterised the establishment of the LEC(PA), it is clear that the model of action research was a particularly appropriate one for the project to adopt. A fundamental part of the project was the pursuit of an account of what - if anything - a body like the LEC(PA) could reasonably be expected to achieve. If, as I suggested (Jarvis 1994: 18) it was unlikely that the West Glamorgan experiment had hit upon the solution to the apparently intractable problems raised by health policy, then there is every reason to suggest that a process in which an external observer/facilitator could work with the experimental body in such a way as to enable a clearer understanding of its goals to be developed and a more realistic method of achieving those goals outlined would have much to recommend it. The feeding back of provisional hypotheses into the research itself is a basic element of action research. The model therefore is uniquely well adapted to permit facilitative observational and evaluative research where part of the objective is to explore and outline in clearer terms the purpose and aim of the research subject.

Given the complex intertwining that inevitably exists between the aims and purposes of the observer and those of the research subject, it should perhaps be no surprise that during the course of this research project an increasingly co-operative model emerged in terms of relations between myself and the committee. What was perhaps more surprising, particularly given the somewhat adversarial nature of the relationship that arose between the committee and the Health Authorities in the early stages of the committee's work, was the extent to which a similar degree of co-operation arose between the LEC(PA) and the Health Authorities as well. We can discern a dynamic running through the first three years of the LEC(PA)'s operation whereby the committee moved from construing the Health Authorities as Other to their One and as in some sense an adversary, to a construction of relationships that placed more emphasis on creative co-operation and constructive interaction. This, I suggest, may be taken as an encouraging sign both for the future of the LEC(PA) and as an indicator for any similar experiments that might be undertaken elsewhere. It shows, if nothing else, that there is a very real possibility of establishing positive working relationships between different bodies involved in the health care planning process in a way that offers to transcend institutionally derived differences and the divisions within the service that are partly a result of the purchaser/provider split created by the 1991 reforms.

If the emerging co-operative model between the LEC(PA) and the Health Authorities was a pleasant surprise, the co-operation that evolved between myself and the committee was, although no less pleasant, perhaps less of a surprise. I hope I have already argued sufficiently that the *modus operandi* of action research as a methodological exercise necessarily presupposes a considerable degree of co-operation between observer and observed. This mutuality of purpose and shared vision goes beyond a mere openness to question and consider, and encompasses a positive desire to construct goals in collaboration with another. To the extent, then, that action research is an inherently co-operative effort, we should be pleased but not surprised when such co-operation is evinced in the course of such research.

The picture of the commissioning landscape that I sketched in chapter I suggested that a twin dynamic of a growing acceptance of the inevitability of rationing in health care provision, coupled with an increasing awareness of the necessarily moral flavour that permeates health care delivery (see Jarvis, 1996) resulted in an uneasy tension whereby both the objective and subjective conditions for a social problem existed (i.e. the tension between finite resources and infinite demand, and the recognition of this tension), and yet no attempts had been made to address the problem thus identified. This lack of precedent for the work of a body such as the LEC(PA) meant that a significant part of the initial purpose of the committee was in fact a task of self-definition, taking the form of an exploration of the purpose and methods of such a committee. As I argued earlier (p71ff), the LEC(PA) was without form and void at its inception: only after it was did it purpose to be.

If, as I have suggested, it makes sense to see an experiment like this as an exercise in part in clarifying what it is that a body like the LEC(PA) can be expected to achieve, and it makes sense to think of the LEC(PA) - at least in part - as something of a pathfinder for future similar bodies, then it follows that if it can be shown that over the period of the first few years of its operation a clearer conception of the purposes of the committee and the methods and patterns of operation by which it might set out to achieve these purposes can be seen to have emerged, then on this count alone the work of the committee can be shown to have been a success. This is to suggest that the self-definitional imperative, the dynamic of which we examined in chapter II, can be understood to have a value for similar bodies above and beyond the experiences of an individual institution's local experiences.

Just as the early years of the committee were shot through with a theme of a quest for a self-definition, so also were they dominated by the continual re-iteration of the need for policy documents to be grounded in a clear and consistent vision of commissioning and provision. The increase in the clarity, acknowledged value assumptions and transparent philosophical foundations of Health Authority documents that came about during the period of this research, I have suggested, can be in some measure traced directly to the influence of the LEC(PA). However, I argued that the fact that the changes that the committee aimed at effecting were extremely general meant that inevitably any effect that the committee might have on the climate and culture of commissioning in the county would be correspondingly slow. By virtue of aiming at generalities in the planning process rather than specifics in particular plans, the committee aimed to have a fundamental effect on the commissioning landscape, which effect, being fundamental, must necessarily be slow. If Smith (1993: ix) and Lefever (1990: 75) are correct, and the tension between resources and demand for health care springs from the fact that insufficient attention has been paid to the question of the nature of the health service, and indeed the nature of health itself, then it is unreasonable to expect these problems to be solved in the twinkling of an eye. Certainly three years of committee discussion are unlikely to provide a resolution. However, the LEC(PA) initiative represented an important development in the attempt to grapple and come to terms with the implications of these types of diagnosis of the NHS's problems, and in this sense the committee, although its terms of reference were necessarily limited by geographical area, can be seen as important beyond mere county boundaries, by indicating one possible means by which a resolution, or moves towards such a resolution, might be pursued.

One of the central themes of the whole of this research has been the committee's developing Self-awareness, and with it a growing confidence in itself. Although chapter II particularly examined the details that revealed such Self growth, nonetheless it is clear that this theme has underpinned much of the research, so that we might say that the research has been, *inter alia*, the story of the development from the committee's inception through its first moves towards a Self-construction to a more mature understanding of both its tasks and its own nature.

Given that the period of the research has been marked by an almost unbroken dynamic of such burgeoning self-confidence, it might have been expected that there would have been moves towards some kind of assertion of expertise on the part of the committee. It is hardly to advance a very bold thesis to suggest that once settled in a role, individuals or corporate institutions tend to assume and portray a level of confidence in their abilities that frequently gives rise to an assertion of some kind of special competence or expertise in their chosen field.

I argued in chapter IV at some length for the view that for the committee to have assumed such a role would have been mistaken, not so much in virtue of the fact that it would have been politically inopportune (although that may well be the case) but because I argued that it is in the nature of ethics that it does not, unlike clinical aspects of health care, admit of talk of expertise. We can, however, see that there was before the committee a very real temptation to assume the mantle of the ethical expert, handing down answers to problems as if from on high. This temptation was all the more real by virtue of the fact that not only would it have served to gratify entirely understandable (if not very laudable) desires for reward and status on the part of the individuals serving on the committee, but it would also have given the illusion of providing *answers* to problems that had only recently been publicly acknowledged (although they had, as I argued in chapter I, been implicit in health care delivery since the foundation of the NHS in 1948). Such an expert consultative paradigm would also have dovetailed neatly with a parallel model of clinical expertise and consultation under which many of the committee members operated in their everyday working lives.

For the committee to have assumed the role of ethics consultant, in the sense of providing consultations leading to diagnoses and solutions then, might have served the personal ends of individuals, and would certainly have given the impression that West Glamorgan Health Authority had not only faced up to and grappled with the implications of a necessarily under-funded health service, but had also actually come up with some determinate answers to the problems facing Health Authorities countrywide. To the extent that this would have been a quite extraordinarily gratifying impression to have given, we can see that the temptation that the claim of expertise represented was both a real and a potent one.

It is therefore all the more surprising, not to say encouraging both in terms of an evaluation of the specific situation of the LEC(PA) and of the hope that the committee's experiment might hold out for similar initiatives elsewhere, that far from the committee's increasingly clear Self-definition and concomitant self-confidence being mirrored by moves towards a claiming of expertise, in fact precisely the reverse proved to be the case. Where the style of the early documents produced by the LEC(PA) (see e.g. LEC(PA): 1993) was notably declamatory and inclined to criticise in a tone that suggested that the committee did indeed have if not all the answers then at least quite enough of them to make a better fist of the preparation of the documents than their original authors, as the committee developed and its responses became more measured and mature, so also did their tone alter to a more constructive one that was decidedly more open to the acceptance of views that ran counter to those advanced in their responses. So for instance where the committee's response to the discussion paper "Methodology of Choice" (LEC(PA), 1993) reported the committee's views that:

> The underlying concern is that the whole exercise rests on a naive belief in the possibility of a regular "scientific" system which ignores the inherently open-textured subjective nature of the process. Investment prioritisation is inescapably value-laden, and the richness and diversity of the values which inform such a process cannot adequately be captured by the kind of statistical analysis on which the methodology rests (LEC(PA), 1993: 6)

the recommendations on the future funding of infertility services in the county more modestly admitted that:

> The committee does not believe that this issue is capable of being resolved simply. More particularly, it is thought likely that there will be some hostility to the outcome whatever decision is taken about the commissioning of infertility services [and that] ... some of these hostile reactions will be implacable... (LEC(PA), 1995b: 3).

This willingness to accept that answers were not always going to be there for the giving, and that it is in the nature of moral debate that it cannot readily be concluded to the satisfaction of all involved, is indicative at one and the same time of a growing maturity in the committee's responses both to individual Health Authority documents and to the tasks and problems facing it, and also of an important feature in the scope and role of philosophical inquiry in applied ethics that I indicated in chapter IV: that the role of philosophy in moral debate, apart from ensuring such formal requirements as the internal consistency of arguments advanced, is by engaging in conceptual analysis of the terms in which a debate is couched simultaneously to clarify and to open up the range and scope of both the discussion and any putative solutions that may emerge as a result of it. In the sense that philosophy's role in moral debate is a facilitative one, the task of a body such as the LEC(PA) is not to provide determinate answers and in this way foreclose on further discussion, but rather to facilitate and thus open up the debate in a way that allows views and solutions other than the obvious ones to be canvassed and investigated, "to engage in creative moral thought ... to look at situations from different perspectives to see how we might restructure them in richer ways" as MacNiven (1990: 9) puts it.

The growing modesty of both the tone and remit of the committee's responses described above is therefore significant. As the discussion papers produced became less directive in content and less directive and intolerant in style, so they more nearly approached the ideal of the involvement of philosophical inquiry in practical moral debate: we might say that they became more philosophical. Where the paper on "Methodology of Choice" (LEC(PA), 1993) looked in large measure to dismiss the document on which it commented, later responses sought to engage in creative reflection on issues raised and to expose new ways of constructing the problems thus identified, not so much with a view to prescribing action, but rather in the hope that this creative reconstruction of apparently intractable moral difficulties might shed some new light on the issues in a way that could allow a generally acceptable working solution to be reached. As I suggested in chapter IV, this movement towards a facilitative rather than a prescriptive role is perhaps best symbolised in the discussion paper on the issues posed by responses to unwanted pregnancies (LEC(PA), 1995d), that sought to (re)open discussion of responses other than termination.

But in the present context it is important to note that the committee did not prescribe a definite reduction in the number of terminations (which would have been radically prescriptive) but rather it suggested that women presenting with an unwanted pregnancy should be given the opportunity to explore options that had perhaps not occurred to them, or about which they had, and could obtain, precious little information. The intention was not to reduce the number of terminations performed in absolute terms, but simply to enable discussion: not to direct and conclude the debate in any one particular direction, but to enable it to take place in a richer, fuller context.

Implicit in all these suggestions, that the recommendations of the committee became both more limited and more co-operative as its Self-construction grew more vivid and consistent, is a profoundly modest construction of the committee's nature and purpose, that sees it not so much as an answer to the problems of the NHS but more as another strand of the evidence that might properly be taken into account when commissioning services. This is to see ethical concerns as properly having some weight in the process of commissioning, a view that would seem to make sense given the inescapably moral nature of the task. Although I suggested in chapter I that the committee was established in order to address and examine the sorts of problems thrown up by a recognition of the inescapable tension between finite resources and infinite demand for health care, this stops well short of claiming that the purpose of the committee was to provide answers to these problems. Indeed, it should be quite clear from the discussion of moves towards an evaluation of the committee in chapter III and from the forgoing discussion of the need for philosophy to open up rather than close down moral debate that it was far from being the purpose of the committee to eliminate the very real moral concerns that arose in the context of health care practice or planning.

In much the same way, it would be both immodest and wrongheaded to have supposed at the outset of the committee's work that the tendency of individuals, units or other collectives within the service to be anxious, whether about specific or very general concerns posed by the activity and process of health policy, should have vanished simply because the Health Authority had established a committee to examine these concerns. When I suggested in chapter IV that it made sense to think of the committee as in some sense a professional worrier, I meant to argue that it makes conceptual sense to effect some kind of distinction between a forum in which moral concerns are discussed and the agency responsible for the actions that give rise to these concerns. This discussion should not be taken to imply that the establishment of an arena in which ethical concerns can openly be addressed might in any way lead to the responsibility to engage in such ethical reflection being passed off to the committee by individuals. To the extent that all players in the health policy game are intrinsically moral agents, with their own intuitions and reactions, it is inevitable (and quite proper) that they should engage in critical reflection on the ethical implications of their work at whatever level.

The LEC(PA) was not established in order to, and did not in its operation, attempt to supplant the entirely reasonable moral concerns that individuals may have felt in relation to certain policies for which they were responsible, or with which they might in the course of their work come into contact. Rather, the committee's task was to supplement these individuals' moral concerns in a way more amenable to formal documentation and report. In a sense, there was little (save in the procedural sense of reporting formally and directly to the Health Authorities) that the LEC(PA) did that individuals working within the health service in the county could not have done. Indeed, in all probability the kinds of discussions that the LEC(PA) undertook in the period covered by this research were taking place at greater or lesser degrees of informality across the county.

What the LEC(PA) sought to do was to attempt to formalise such individual moral reflection in a way that could look to address issues of quite general concern in a rigorous and sustained fashion, both supported by at times extensive research in order to ensure that the committee's discussions were grounded in the actuality of health care policy, and undertaken with strict regard to the canons of clear and consistent argument. The intended upshot of this was that the perfectly legitimate moral sensitivities and concerns of individuals could be tested by comparison with the committee's responses. In a sense the committee can be seen as having a value in terms of focusing attention on the need to engage in constructive and sustained moral and philosophical reflection not just on the part of individuals appointed to an ethical review committee, but by all those involved in an area of life whose moral flavour is inescapable.

The picture that should perhaps emerge here of the LEC(PA) is not one of an organisation seeking to eliminate the need to think about, to look for and to debate areas of moral concern in health policy, but rather of one looking to undertake these very tasks (that themselves form a substantial part of any proper moral response to such problems both on the part of an individual and an institution) in a more formalised fashion; a fashion both more formal in the sense of academic philosophy, in that the discussion was more clearly grounded in fact and logical argument rather than in prejudice and assertion, and also more formal in the sense that clearly established pathways of communication and reporting from the committee to Health Authority were laid down in the establishment of the LEC(PA).

In this way the committee can be seen as an organisation that sought to give added weight in the process and practice of health care planning to the concerns that individuals may well have felt prior to its establishment, in a climate of market economics and pressures in which it is sometimes argued (see e.g. Friedman, 1962) that such moral concerns have no place. As an inescapably moral activity, however, I suggest that the provision of health care is quite properly informed by the airing, discussion and addressing of moral concerns. The LEC(PA) could not have taken, and did not take the place of the moral concerns of individual moral agents: rather, it gave them a clearer voice, "a local habitation and a name".[8] As both partially involved in and yet at the same time removed from the process of health care planning, the committee was at one and the same time less influential (in the sense of having an effect) than the Health Authorities, but also, by virtue of its greater freedom as being less constrained by external institutional factors, potentially more powerful than the Authorities in the sense of being able to raise and examine issues that the Authorities might themselves be unable (politically unable, that is) to discuss.

Consideration of this possible function of the committee, as an agenda setter rather than a reactive discussion forum, recalls our earlier discussion of the subjective and objective conditions for the identification of a social problem (see p50ff). It was argued, following

Fuller and Myers (1941: 320), that in addition to the presence of the objective conditions for a problem, that is the external factors of circumstance that created the climate of the difficulty, before a problem can be identified there must also be in place the subjective conditions, that is the identification and recognition of these external factors by key individuals or groups within an institution. That is to say that two sets of similar circumstances may be identified as a problem in one grouping but not in another. In the context of our present discussion, we might say that there were in the course of this research, and there will no doubt continue to be, areas of opinion where there was substantial disagreement between the LEC(PA) and certain key opinion formers within the Health Authorities: that is to say, that there were areas where there was no appreciable degree of intersubjectivity between the two groups.

Interestingly, one very clear example of such a difference of view can be found in the context of the discussion of an issue not originally identified by the LEC(PA) but rather referred to it from an external source, a clinical director who was keen to seek the committee's recommendations on an issue that touched on both purchasing strategies and on the safety of both his staff and their patients. The paper detailing recommendations for practice as a result of the committee's discussion was copied to a senior employee of the Health Authorities who declared that it was "nonsense", and that there was no need to discuss this kind of issue. This radical difference of view illustrates not only Fuller and Myers's point, that while the external facts (the objective conditions) may remain constant, the interpretation of and reaction to them (subjective conditions) may nonetheless vary, but also the ever-present need for the committee to effect some kind of a balancing act between seeking to address new problems, or old problems in new ways, while still at the same time remaining sufficiently grounded in the practice of health care provision as it was then established and perceived. To put this point very generally, reformers must always ensure that they carry the institution that they seek to reform with them if they are not to be sidelined as fanatics out of touch with the real world.

This is not to say that the committee need be so at the beck and call of the Health Authorities that all it does is to respond within a remit exclusively dictated to it, but rather that it must avoid echoing the Bishop of Norwich's rather pathetic inquiry to the rebels at Mousehold in 1549: "Tell me which way you are going, that I may lead you the better". In just the same way that I argued that part of the value of the LEC(PA) was that it broke new ground in terms of providing an explicit and identifiable forum within which ethical concerns posed by questions arising within health care provision could be examined and discussed, so also it is the case that within the framework of health care planning in West Glamorgan, a substantial part of the value of the committee lay in the fact that by virtue of the greater freedom that it enjoyed, it could ask questions that could not be asked within existing frameworks.

It should be clear, then, what I have in mind when I speak of the committee's continuing task as something of a balancing act. There must always be an awareness of two contradictory demands if the committee is to continue to function usefully: the need not to depart too radically from the context within which health care provision is currently grounded; and at the same time the need to challenge and prompt the examination of the basic presuppositions that underpin it. Furthermore, there must continue to be an awareness of the inevitable tension between these two: between the need to ask new questions, and the need not to ask questions that are too threatening. Failure to recognise and successfully resolve this tension will result in the committee's either being reduced to mouthing old platitudes, in which case its advice will become bland and irrelevant, or on the other hand giving unrealistic advice, in which case it will suffer the fate of many radical voices and simply be ignored or silenced.

One particular way in which the questions posed and the issues raised by the committee could run the risk of being too threatening, that is, of striking too deeply at the heart of a conventional understanding of the task of health care provision, is by looking at issues that go well beyond the detail of any particular instance or decision, and to look instead at very much broader issues in the field of health care provision. A theme that recurred several times during the committee's discussions in 1995 was the question of the blurred boundary between health and social care. It was first raised in the context of the discussion of the provision of infertility services, where it was held that the character of the need for such services was mixed socio-medical; it re-emerged in the next meeting where responses to unwanted pregnancies were discussed, where it was also held that a joint health-social care model of service commissioning might be helpfully explored, and it was discussed in a further meeting to discuss the 1996/7 draft Health Plan, where DG expressly indicated that there were concerns about the boundary distinctions between health and social care, and that this had important implications for resource allocation and other issues within health policy.

It is in the nature of the area of discussion, that in the distinction, if any, between medical and social care at their shared boundary, the questions to which it gives rise cannot readily be resolved, and certainly they are too complex to be fruitfully addressed within the confines of this present discussion. However, it is important to note that by examining such issues which are both very much broader and similarly more fundamental than more detailed questions within the field of health policy, the committee can be seen not only to have embraced an overtly philosophical model of operation that subscribed to Socrates's opinions as to the value of the unexamined life, but also to have raised questions that were potentially much more threatening to the practice of health care provision as it was currently organised. As I argued above (see p160ff), had the committee restricted its criticisms of planning documents to details, then it is possible that the responses so produced might have become redundant following minor redrafting of the original document. By concentrating on much more general trends, however, the committee ensured that its criticisms and observations outlived any particular draft of a planning document, and in so doing raised questions that concerned not the specific implications of a policy, but rather the values and beliefs that grounded the policy in the first place.

In just the same way, by turning its attention from specific issues within the field of health policy to the question of the field of health policy itself, the committee raised deeper and more fundamental questions about the whole enterprise of health care, its scope and methods. While to do so was both important and potentially valuable, it also ran the risk of alienating influential opinion within the Health Authorities. Although by examining such broader issues as the interface between health and social care the committee could productively capitalise on its freedom to raise questions that perhaps could not be raised elsewhere in the commissioning process, nonetheless at the same time there was, and remains, an ever-present need to maintain a careful balance between seeking to raise unasked questions while at the same time not creating a threatening climate between the Authorities and the committee. This need to maintain good working relationships between the two bodies was not simply a question of ensuring that the committee's funding was not cut off at source, but rather of preserving a potentially fragile equilibrium that relied on criticism and advice being constructive and grounded in the reality of health care planning.

It was encouraging to note the development of this theme of questioning more broadly the scope as well as the methodology of health policy towards the end of this research period as there had at times been a danger during the course of the research that the committee was tending to be influenced by external factors in its ability to dictate its own agenda. While I suggested in chapter III that the committee itself identified areas for discussion as well as responding to questions raised for it, nonetheless is was true that in its first two years at least of operation the committee's discussion remit was significantly limited by pre-existing discussions that had at the time been taking place in the Health Authorities. So for example while the LEC(PA) resolved of its own accord to examine the issues surrounding the provision of infertility services, nonetheless it was no coincidence that this examination coincided with the DMC's own discussions of the questions. To put it in terms of the earlier analysis, the LEC(PA) tended to wait for conformation of intersubjectivity of identification of conditions before launching out into a new area of discussion.

In a sense this is only a very mild criticism of the LEC(PA): to expect the committee to have operated entirely independently of its environment would not only have been unreasonable, it would also have been to confuse liberty with licence. While the committee was free in respect of setting its agenda (with the exception of the annual Health Plan on initial ability to question unconditionally was lost. In a sense this should not be surprising; as I suggested, the phenomenon is well known in anthropological circles where an outsider observing an institution or grouping comes to be at least partly incorporated into it, and so it is perhaps not so remarkable that the committee came over time to lose the unique viewpoint of the outsider that is characterised both by its naivety and at the same time its uncanny insight (cf Schutz, 1964).

It is important to note that this criticism of the committee is internally linked with another point made earlier (see p254ff) where I suggested that the committee's development was characterised by a growing maturity that came with an increased sense of realism and an acknowledgement of the problems that faced the Health Authorities in their tasks. These points are corollaries one of another to the extent that without the growing familiarity with the currency and landscape of commissioning decisions, the committee would not have been able to produce the mature and reasonable documents that helped feed back into the planning process in a constructive fashion. However, with that growing familiarity came also a loss of the privileged insight of the outsider, that meant that at least to some extent the possibility of unique external review that the committee originally offered at its inception came to be lost as it was assimilated more and more into the process of health care planning that it was formed to review.

Having looked back at the discussion in an attempt to draw together some of the strands of the argument in a way that perhaps more clearly highlights the inter-connectedness of the concerns, it is appropriate to end on a note of very general overview. It is also particularly encouraging and gratifying to be able to conclude this research on a positive note.

I suggest that if there is one single theme that unites all the various aspects of this research, from an historical examination of the foundation and reform of the NHS, through a sociological and anthropological study of the workings of one of its committees and philosophical examinations of questions ranging from the nature of the concept of health to the purposes and prerequisites of evaluation, then that theme is one of resolution of tensions and an approach towards models that, while perhaps far from being perfect, are at least capable of implementation.

As supporting evidence for this claim I shall advance three areas of development. The first is a move spread right across the whole NHS network, and therefore one that ought to give observers of the service considerable cause for hope. It is the move away from the single minded near-obsession with increasing the efficiency of the NHS and towards a recognition of the importance of effectiveness in health care delivery. There is, of course, an attendant danger that this drive to evidence based medicine will itself prove to be a blinding intoxication that leads it to being supposed that eradicating ineffective services will free up enough resources to allow the health service to be adequately funded. For obvious reasons, I hope that this is not the case, but I also am inclined to believe that it will not be. While the rhetoric of evidence based medicine is impressive, I believe that the idea of the inescapability of rationing in the field of health care provision has, in the wake of stories such as the Child B case, gained a hold both on the public imagination and on political perceptions.

This twin dynamic, of a growing acceptance of the inescapability of the need to ration health care delivery, and of a move away from a single-minded belief in the power of increased efficiency to solve the problems of the NHS is, I suggest, a move towards a model of health care provision that can be made to work.[9] The details may be far from clear, and there remains much to be worked out in terms of the extent of coverage by the service. However, the all important first step has been taken: the problem has been recognised.

We should be wary of overstressing this optimism, however. While the move from a single-minded preoccupation with the development of more efficient methods of service delivery, through the embracing of evidence based medicine as a tool for identifying and facilitating more effective services, and the growing acceptance of the need explicitly to allocate resources is a positive one, nonetheless it would be dangerous to suppose that we had arrived anywhere of final significance by virtue of this development. The amalgamation of concerns of efficiency, effectiveness and resource allocation does not represent the end of the NHS's problems, but rather the beginning of a means by which they might usefully be resolved.

However, although I suggest that this positive linking of the three themes of efficiency, effectiveness, and resource allocation represents a critical development in thinking in and about the NHS, nonetheless it would be rash to conclude from this that it is anything but fragile. While it may be the case that this recognition prompts fundamental and vital re-evaluation of the tasks, remit and methods of a national service for health care delivery, there is still room for a concern that such re-evaluation may not represent so much an attempt to identify those elements of the health service that are fundamental to its proper activity, so much as those more peripheral elements that can be safely discarded if resource pressures demand that something give. The sort of concern I have in mind here is one that notices that it is characteristic of philosophical interventions in health policy to examine certain so-called fringe areas of health care (fertility services, cosmetic surgery, gender re-alignment, and so on) and often to declare that they do not represent *health needs* at all, either on the grounds that they do not represent a need so much as a preference, or that the need (or preference) that they represent is not a need (or preference) for health care: that people seeking fertility services are not really *ill.*

Although I would resist any argument that attempted to show that it is a necessary function of the involvement of philosophy in health care planning that it facilitates the decommissioning of such services, as if in some way lending their decommissioning a spurious intellectual credibility, nonetheless I can see that the objection could be made, and I accept that it is not without a certain practical validity. Although I would not accept that there is any necessary link between on the one hand a philosophical examination of the nature of health and of health care, and on the other the conclusion that health care is a much narrower canon than previously supposed (in fact, I would suggest that philosophical analysis could suggest quite the reverse), nonetheless I would acknowledge that there is a practical danger that such analysis *could* lend weight to decisions to decommission services. Certainly, it would be to advance no very radical a view to suggest that given sufficient time and incentive, a less than scrupulous philosopher of reasonable talent could produce a justificatory case for almost any decision in health policy: *nihil tam absurde dici potest quod non dicatur ab aliquo philosphorum.*[10]

In the light of this acknowledged danger, coupled with my general commendation of the principle of philosophical involvement in health policy decision making, I would stress that it is as much the task of philosophy in this area to locate and identify those areas of health care that are indispensable as it is to advance reasons for certain services being seen as peripheral or fringe: that is, philosophy should seek to affirm as much as it does to reject or to deny.[11] This may mean that the discipline is not as useful to health service managers as might perhaps at one time have been thought to have been the case: useful, that is, in the sense of resolving complex problems. However, I suggest that it is no part of the philosophical enterprise to allow difficult decisions to be side-stepped, nor to provide quick fixes to difficult or intractable moral dilemmas.

This discussion should lead us to two conclusions about the place of philosophy in moral debate of the kind found in decisions in the field of health policy. Firstly, its role is an exploratory one that seeks to open up rather than to foreclose the discussion, suggesting further reconstructions rather than looking to impose a particular solution. Secondly, as one of the discipline's strengths is the reconstruction of problems in richer and hopefully more constructive ways, it is clear that the involvement of philosophy in health policy is not a once and for all affair, as if a finite backlog of questions existed that needed to be cleared up and once resolved would leave the service clearly defined and with no ragged ontological edges. Rather, as I have suggested already, the internality of moral and philosophical problems to the enterprise of health care provision means that there must be a continuing place for philosophical analysis in the practicalities of health care provision. There would be almost as great a danger in assuming that philosophy had "done its bit" for health policy and could leave the arena as there would in denying that the disciplines had anything to say to one another in the first place.

The second note of optimism and resolution of tension that I would wish to sound in summarising the results of this research concerns the nature of relations between the LEC(PA) and the Health Authorities responsible for its inception and continued work. To the extent that the history of these relations is a history of a move away from a negative conception and towards a more constructive, collaborative model of working, I would argue that the research shows a resolution of such tension in favour of positive models of working that gives hope for the possibility of success of similar projects that might be undertaken elsewhere.

The third and final aspect of this theme of themes is one which I have already argued is implicit in the process and methodology of action research itself: a move towards the construction of a positive working model between the committee and myself as the observer. I argued in chapter II that just as Humphreys (1970) was not trying to become a homosexual, but merely to be accepted by a particular homosexual community, so also my task was not to become a member of the committee, but rather to gain full acceptance by the legitimate members as a useful tool to facilitate and enable their work to be done better. It is my lasting hope that I have been able in some measure to do this; the task, perhaps by virtue of its very open-endedness, has not always been the easiest, but it has been continually challenging and fascinating. If it has been useful as well, then there is little more that I could have hoped for.

1. See Royal Commission on the National Health Service, 1979: 51.

2. It is significant that Ham's (1994) discussion of the NHS contains five references to more or less extended discussions of the notion of efficiency, but not a single one to effectiveness. By 1995, however, a journal of evidence based medicine had been established, and the Oxford Centre for Evidence Based Medicine (which opened on 22 March 1995) was conducting research in the area. In addition to these developments within the academic world, 1995 also saw the publication of Anglia and Oxford Health Authority's *The Bandolier*, a monthly review of evidence based health care, and of "a review of clinical effectiveness, sources of information, dissemination and implementation" (see Appelby *et al.*, 1995). This growing interest is significant to the extent that it represents a move to institutionalise - and thus give legitimacy to - ideas that were far from new (see Cochrane, 1972), a process that led to renewed interest in the idea of evidence based medicine.

3. The term "evidence based medicine" has achieved prominence, despite the fact that it actually encompasses a much broader spectrum of health care than medicine alone. I therefore follow the customary usage, and intend the term to include, for instance, evidence based nursing as well.

4. It would be wrong to suggest that there had been no thought given to the idea of effectiveness prior to 1995. Indeed, much of the thinking can be traced back to Cochrane's work (see for example Cochrane, 1972). However, the very fact of the coining of the term "evidence-based medicine", the establishment of the international Collaboration that bears his name (see Sackett, 1994), and the other developments already referred to all support the view that the idea of effectiveness was experiencing a renaissance in health service thinking at this time.

5. *Paradise Lost* Book II, 227.

6. The ends of the observed are shared by the observer obviously only in a partial sense, to the extent that a certain degree of reciprocity and mutual respect and dependency is built up in the course of any observational research between the parties. In this sense it is easy to see how it can come to be the case that there is the *sense* even if not the actuality of mutual identification and involvement between the parties, so that the goals of one come to an extent to be shared by the other.

7. *Nichomachean Ethics* 1103b.

8. *A Midsummer Night's Dream*, V,i.

9. While the question of what health amounts to, and therefore of what can legitimately be demanded in the name of health care, has yet to be answered, it has at least been recognised as a fundamental one for the NHS.

10. Cicero, *De Divinitatione*, ii. 58

11. In this regard it is interesting to note that the Dunning report (Government Committee on Choices in Health Care, 1992) can be thought of as falling into precisely this trap, in that the model of consideration that it proposes, characterised by the image of four sieves, is exactly one that facilitates the removal of services from the canon of state provided health care. While it may not have been a fundamental part of Professor Dunning's intention to lend support to a move to decommission state funded health care services, nonetheless the model that underpins the thinking of his committee's report does precisely that. By defining the question in terms of what can be excluded (what is caught in the sieves) the report contributes to an intellectual climate where philosophy's task is constructed as the identification of reasons and arguments not for *in*cluding services in the line-up of commissioned health care but rather for *ex*cluding them.

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APPENDIXES

APPENDIX 1

Outline terms of reference and membership of the West Glamorgan Local Ethics Committee (Purchaser Advice)

1.0 Function

1.1 The committee will be available to review those ethical matters arising from Purchasing, Provider and Professional Policies as there are, undoubtedly important moral dimensions to health care planning and management. The committee should therefore provide advice with regard to ethical issues arising from the contracting process and the development of an internal market. Consideration should also be given to the ethical issues arising from the Professional / Management interface. In addition, the committee would be expected to provide advice on an individual basis serving as a resource to Practitioners worried by particular cases or policies.

It would not be the role of the LEC(PA) to adjudicate on particular management decisions.

2.0 Work programme

2.1 Health Plan

2.2 Local Strategies for Health

2.3 At a minimum the LEC(PA) would:

- review the Health Plan of West Glamorgan Health Authority in March of each year;
- review Local Strategies for Health when produced and amended.

3.0 Membership

3.1 Membership should be opened to a wide variety of individuals with expertise in ethical matters. Each member should be appointed as individuals in their own right. A small overlap of membership with the LEC(CR) would ensure continuity in Ethical Review in the Authority. Suggested membership is outlined Annexe E.

4.0 Chairman

4.1 The Chairman should be appointed by the committee on an annual basis.

5.0 Term of office

5.1 members of the committee should hold office for three to five years (to coincide with the LEC(CR) membership.)

6.0 Meeting of the committee

6.1 Meetings will take place at least twice a year at the end of which an Annual Report should be produced.

7.0 Secretarial support

7.1 To be provided by the Chief Administrative Pharmaceutical Officer as convenor of the LEC(PA).

Annexe E

Membership of the Local Ethics Committee (Purchaser Advice)

- Single professional ethicist (nominated by Director of Centre for Philosophy and Health Care, Swansea University)
- Member of the Health Authority (nominated by the Health Authority)
- A Public Health Doctor
- 2 medically qualified practitioners, one of whom shall be a general practitioner.
- A nurse
- A dentist
- A lawyer / solicitor
- The Chairman or Vice-Chairman of the DMC
- A chaplain
- 2 members of a patient interest group
- A health professional (other than a medically qualified practitioner)
- A health service manager (nominated by Chief Executive Director)
- Chief Administrative Pharmaceutical Officer (Convener)

APPENDIX 2

Methodology of Choice

A response by the LEC(PA)

1.0 Background

1.1 The Welsh Office has directed that each commissioning Authority should have an explicit methodology for prioritising investment decisions. In West Glamorgan, "it was decided that the methodology would reflect the values of both the local population and the commissioning Authorities" (p1), and accordingly a model was constructed "incorporating what were felt to be the most important parameters when prioritising investments (p1) and "the local population were consulted in how important overall and relative to each other, these were" (p1). Dr Ronan Lyons's paper lays out the details of the approach adopted in West Glamorgan.

The Health Authorities requested that the discussion of Dr Lyons's paper should be informed by a commentary from the LEC(PA). This paper summarises the discussion in a meeting of the committee held on 16 December 1993.

2.0 The committee's reservations

2.1 The committee felt that there were concerns governing both the methodology and the potential use of the findings in addition to Dr Lyons's reservation that the prices of being explicit is that it is time consuming.

2.2 Several members voiced concerns about how representative the responses actually were. There were particular concerns that certain socio-economic groups were under-represented.

2.3 It was suggested that the values being compared and added are incommensurable, and not open to being manipulated in this way.

2.4 It was felt that despite the open-textured and subjective nature of the replies, apparently precise index figures were being produced. The committee felt that this is a simplistic approach to a complex area, and one which might produce an illusion of scientific precision where none exists.

3.0 Recommendations

3.1 The committee noted the encouraging congruity between the views of the Boards and those of the public. It also noted that *actual* spending patterns do not always reflect these expressed values. The committee accepts that given Welsh Office directives, there is a need to adopt an explicit methodology of allocation, but notes that this democratic model is not the only option. It suggests that the results of the research are compared with actual spending patterns and significant discrepancies investigated. It suspects that such a comparison will reveal that there are external (e.g. political) influences on resource allocation decisions. Given this, it asks how much discretion the Boards actually have in allocating this money.

3.2 The committee would not wish to discount the research completely, but believes that in the light of its reservations, it is not to recommended as a tool for planning future expenditure. However, it recommends that the research is used as a retrospective tool to measure *actual* funding decisions against expressed values. On the original issue - the need for the rationale behind funding decisions to be made explicit - the committee recommends that it be affirmed that the explicit methodology of choice employed in West Glamorgan is that funding decisions are taken by the Boards, although there is a considerable congruity between the expressed values of the Boards and those of the public.

APPENDIX 3

The West Glamorgan Health Plan 1994/5

A response from the LEC(PA)

This paper follows an earlier response to the Health Plan, dated October 1993. It summarises the LEC(PA)'s discussion of the Provisional Health Plan at a meeting attended by representatives from the commissioning authorities on 20 January 1994. It does not attempt to set out specific proposals for amending the Provisional Health Plan. The committee sees its role as one of questioning the general process used and the conclusions thus reached in the planning process. It is therefore inevitable that this response - and subsequent documents from the committee - will be at best wary and at the worst sceptical. The committee is concerned to point out that this should not be interpreted as a direct criticism either of any individuals responsible for the Health Plan, nor of the authorities themselves. The reservations felt and expressed are directed at the *process* of health planning, not those responsible for it.

1.0 Introduction

1.1 The task of planning health care expenditure, which the committee believes has an inescapably moral dimension, is complex and the issues such planning raises are not subject to resolution by applying a single model. The committee commends the Authorities' efforts to achieve as wide an audience as possible for the consultation exercise. However, the committee feels that both the development and the content of the Provisional Health Plan were still open to comments.

2.0 Consultation process

2.1 Although the goal of the consultation process is to derive opinions from the widest audience possible, the committee felt that this had been thwarted by the style of the document, which one member described as "opaque". It is accepted that the Health Plan must contain a great deal of information, but the committee was concerned that it had been made insufficiently approachable for a lay audience. The response that a summarised version of the Health Plan had been circulated to lay audiences did not reassure the committee. In what sense is a process consultative if those concerned do not understand (or lack access to) central facts?

2.2 There was also concern that information additional to that contained in the Health Plan was not readily available. The committee accepted that appropriate levels of information would differ with the consultative forum in question, but believes that the provision of adequate information is central to any effective consultation exercise.

2.3 There is a conceptual question about the nature of the response generated. Given that each group consulted necessarily speaks from a partial perspective, the committee is unconvinced that an amalgamation of such perspectives will produce an objective viewpoint. It is appreciated that the Provisional Health Plan attempts to display tensions in a broader framework. Nonetheless, it was felt that the necessarily subjective and partial character of the judgements made in the Plan should be indicated.

2.4 The committee reiterated its concern expressed in its discussion of Dr Lyons's paper "Methodology of Choice", that widespread consultation exercises may be counter-productive if their effect is perceived to be minimal.[1] Given that the Provisional Health Plan concerns approximately 1% of the Authorities' budget, it is felt that there is a danger of over-consultation, and subsequent disillusionment. In general, the committee remains unclear as to the actual effect that consultation of this nature has on health planning.

3.0 External pressures

3.1 Allied to this is a concern that external - especially governmental - pressures may be more felt than recognised. The committee accepts that investment decisions are frequently made under external political pressure, and that decisions taken thus may not accord with judgements based on other (e.g. clinical) criteria. It was felt that the range of pressures under which investment decisions are made should be more clearly identified. In particular, the values and assumptions relied on in arriving at the Authorities' priorities should be made explicit, and the Health Plan should acknowledge that funding decisions are not made solely with reference to clinical criteria.

3.2 For example, it was clear from discussion that the decision to continue to invest in renal dialysis services is not made solely with reference to health gain. The committee is happy to accept that this should be so, and that some investment options suggested by a purely rational calculus should be discounted on non-rational grounds. However, this should be acknowledged.

4.0 Scope

4.1 The committee also felt that the frame of reference for the consultation exercise could be more widely drawn. The Provisional Health Plan sets out some of the assumptions and pressures under which funding decisions are taken which cover 1% of the Authorities' expenditure. There is an immediate need to discuss investment prioritisation decisions in existing services, as well as in new service provision. Commitment to such publicly informed debate and open service provision must involve expanding such consultation and giving serious weight to public opinion.

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[1] See also Pollock and Pfeffer, *Health Service Journal*, 2 September 1993.

5.0 Health gain

5.1 The committee is particularly concerned about using the concept of health gain as a currency for decision making. While there is a clear benefit in assessing an intervention's benefits, it is unclear how, for instance, the achievement of well-being can be compared directly with pain relief. The so-called objectivity of health gain is questionable, all the more so as it is unclear whose definition of gain is to be accepted.

5.2 Ranking scales, such as the QALY and the Rosser-Kind Valuation Matrix, which purport to offer an ordering for investment, notoriously produce counter-intuitive results,[2] such as bias against the management of incurable diseases in which there is little or no expected health gain, and against interventions in elderly patient. Strict adherence to the health gain values apportioned to various interventions seems at best a questionable way forward for investment.

5.3 If, however, health gain is not the only currency of investment and disinvestment decision making, then the committee is concerned about possible contradictions between the implications of considering health gain and those of weighing up other factors, such as the desirability of reducing waiting lists. A clear anomaly might be a long waiting list for a low health gain intervention, or *vice versa*.

5.4 In the light of these concerns, the committee recommends that the concept of health gain is used with caution, and the tensions between it and other values in decision making, for instance the need to comply with external, political, pressures, the desirability of reducing waiting lists, and a need to take publicly accountable decisions, are made explicit.

6.0 Issues in management culture

6.1 The committee is also concerned that the use of macro-level planning tools such as health gain and the QALY might contribute to a culture in which the *individual* focus of care is replaced by a statistical construct of norms and means. While it accepts that macro-level tools have their place in macro-level health planning, it is concerned that if planning focuses too much on this level, it is easy to lose sight of the needs of the individual.

6.2 The committee shares the concerns of many that an approach to health planning that seeks to produce greater efficiency of service by increasing the number of interventions contributes to a "quicker and sicker" culture. It appreciates that the Authorities are required (in the jargon) to "increase productivity", by which is understood providing more health care for the same investment, or the same quantity of care at a reduced cost.

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[2] See Harris, J., "QALYfying the value of life", *Journal of Medical Ethics*, 13 (1987) p117-23

7.0 Primary care

7.1 However, it is concerned that a strategy for reducing hospital costs by earlier discharge into the community might be derived from a focus on cost-saving rather than patient care. In particular, the committee belies that a policy of earlier discharge from hospital places an increased burden on primary and lay carers in the community. While this may have the effect of reducing the Authorities' *financial* burden, the emotional and other costs on community carers are not so easily quantified.

7.2 Moreover, it is possible that earlier discharge leads to significantly higher re-admission rates. If this is the case, then even in narrowly construed financial terms for the hospital, the savings made are questionable.

7.3 The committee recommends that resources freed up by disinvestment in hospital services should form part of a parallel re-investment in primary care services. It is also concerned that there is no mention in the Provisional Health Plan of the provision of controls and additional support to back up any such changes, and would expect outlines of such procedures to be included in the final Plan.

7.4 It particularly recommends that disinvestment should be made only on proven clinical grounds, and that any such disinvestment should be automatically followed up by *specific* audit, over and above the general consultation and audit process.

8.0 Appropriate focus of care

8.1 The committee again expressed its concern that the focus of attention in health planning is moving from the individual to the statistical norm. Specifically, it is worried that pressure may be brought to bear on *individual* consultants to manage *individual* patients in accordance with accepted mean figures. For example, a patient who requires an 8-day stay for what is defined as a 5-day intervention will on a mean-cost analysis transgress the defined norm, and will therefore represent an extra cost to the unit.

8.2 There is great anxiety that while the overall (mean) standard of care may not be affected, the care of individuals may be compromised. While the committee accepts the importance of overall standards, it believes that there should be a firm commitment to upholding standards of care of the individual, and means of safeguarding these standards.

8.3 The Health Plan must guard against, not encourage, the subsuming of the individual's interests to those of the overall pattern of care. In particular, it needs to make explicit how it can be ensured that cost-saving pressures lead neither to inequitable nor to bad clinical practice.

9.0 The need for transparency

9.1 The committee also recommends that in the interests of providing adequate information regarding health planning, the consequences of proposed disinvestment are more conspicuously identified in the Plan. If the consultation process is to be a valuable rather than a paper exercise, it is imperative that adequate and transparent information about the effects of proposed disinvestment decisions is provided. This recommendation is felt to be particularly apposite in the light of the possibility of future disinvestments. It is felt that continued disinvestments may contribute to the creation of "Cinderella services" which are dramatically underfunded. This is a particularly keen danger if the previously questioned concept of health gain is used as the main factor in planning investments.

APPENDIX 4

The drive to reduce waiting lists
LEC(PA) briefing paper

1. Background

John Redwood has been quoted as saying "Reducing hospital waiting times is my top priority for the health service in Wales." This commitment has been demonstrated by the earmarking of funds aimed at ensuring a maximum waiting time of two years[1] for any specialist treatment from the time of referral by a GP.

This paper proposes a vision of waiting lists and the problems raised by the current drive to eliminate them. It will be followed by a discussion document for consideration by the LEC(PA) sketching headers for discussion of some of the ethical issues that arise.

2. Elasticity of demand for health care

The traditional view that:

> "rationing is inevitable, and if we want a service that uses the public's money in an efficient and equitable way we should not just sit back and accept it as a necessary evil".[2]

has recently been questioned by the Royal College of Nursing:

> "whilst it is true that demographic changes will influence demand, it cannot be assumed that demand will continue to expand indefinitely".[3]

However, conceptual analysis of the relationship between provision of and demand for health care suggests that demand is potentially infinite. The open-textured nature of the notion of health, coupled with the burden of rising demand carried by increasingly effective health care delivery, means that rationing is an inescapable part of planning health care.

3. An historical parallel

> "One of the assumptions made in the Beveridge Report was that expenditure on health services would decline once the backlog of ill-health which was thought to exist in the community had been eradicated ... This assumption turned out to be false ... expenditure increased steadily ... it is now recognised that the demand for health care

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[1] 18 months for cataracts and hip and knee replacement operations.

[2] Sheldon, T., and Maynard, A., (1993) "Is rationing inevitable?" in Smith, R., (ed.) (1993) *Rationing in Action* (London, BMJ Publishing Group) p12.

[3] RCN (1994), *Memorandum to the Health Select Committee*, "Inquiry into priority setting: purchasing", p3.

> is potentially limitless."[4]

If the Beveridge Report was mistaken, then it looks as if the present drive to eliminate waiting lists is under a similar misapprehension. Even massive investment in eliminating current waiting lists will not eradicate the backlog of ill-health. Rather, it will yield its own increased demand for existing or new services. It is interesting to wonder what will happen at the end of the three year period for which the Secretary of State for Wales has earmarked £24m: does he suppose that this investment will have eliminated unmet demand for health care, or does he recognise that this is inevitably recurring investment that is destined to rise exponentially as demand - logically - increases?

4. The hidden cost of health care activity

The effect of recent increased health care activity both within and outwith West Glamorgan has been *de minimis*. Estimates differ according to the interpretation of complex statistics as to whether the increased activity has had no effect or has actually exacerbated the problem, but it is clear that the legacy of need that is created by successful health care delivery means that investment leading to increased activity *necessarily* results in the creation of new demand. Contrary to *prima facie* ideas, investing in waiting lists will expand, not eliminate, unmet demand for health care.

In this sense, it can be seen that the NHS is an imperfect market, where demand is partly determined by supply, and not the other way around: GPs' referral patterns follow waiting list criteria, and only those patients who stand a chance of being seen are added to a waiting list: "To exaggerate only a little, demand for health care is what the medical profession chooses to make it"[5]. Klein's point concerns the introduction of new technologies and procedures, but it holds equally for the targeting of resources by health service planners. Increased activity necessarily results in greater demand.

5. A clash of priorities?

The Secretary of State for Wales has announced unequivocally that reduction in waiting lists is the top investment priority in Wales. However, *Strategic Intent and Direction (SID)* declared that **health gain** was to be "the guiding criterion for judging not only new investment but also the existing pattern of health care" (para 15). It is clear, as the LEC(PA) has argued elsewhere, that there is a tension here:

> "If, however, Health gain is not the only currency of investment and disinvestment decision making, then the committee is concerned about possible contradictions between the implications of considering health gain and those of weighing up other factors, such as the desirability of reducing waiting lists. *A clear anomaly might be*

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[4] Ham, C., (1992) *Health Policy in Britain: the politics and organisation of the National Health Service* (Third edition, Basingstoke, Macmillan) p38.

[5] Klein, R., (1993) Dimensions of rationing: who should do what?", in Smith (ed.) *op.cit.* p97.

> *a long waiting list for a low health gain intervention, or vice versa."*[6]

Nor does health gain represent the only possible contradictory currency:

> "Nationally set priorities, such as waiting list targets under the Patient's Charter, may distort purchaser's ability to prioritise service efficiently ... this judgement [to admit to a waiting list] is affected by waiting list targets which take account of waiting time rather than clinical need. The RCN believes that patients should be referred for treatment in accordance with their clinical need and not according to waiting time targets..."[7]

There is a clear need to address this basic tension between two fundamental Welsh Office dynamics.

6. Problems with information and statistics

The simple totalling of time waited for a service tells the health care planner nothing about the quality of or the need for care:

> "The explanation for a long waiting time can be that quality of care is good. general practitioners may perceive this to be the case and refer more people. Alternatively, a long waiting time can result because outmoded care ... is being practised ... Thus, long or short waiting times can occur for good or bad reasons."[8]

Unreflective funnelling of resources into reducing waiting lists appears to mistake time elapsed in a queue for evidence of inefficiency: the mere fact of a long waiting time for a service reveals nothing whatever about the quality of the service, nor about the quantum of the need represented by the waiting list; and if it can reveal neither of these, then equally it cannot alone provide information about the service's desert as a bidder for limited funds.

7. The role of the public in decision making

There is considerable uncertainty over the proper role of the public in the setting of priorities in health care. Despite pilot schemes such as the Oregon experiment and the City and Hackney survey, there has been no serious attempt to turn health care planning into an exclusively democratic process. Even in Oregon, where considerable effort was expended in designing and executing a survey of public opinion, the results gleaned were adjusted by health professionals.[9]

There is currently an uneasy balance between two competing dynamics. On the one hand there are calls fora wider public debate of the issues of priority setting and rationing:

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[6] LEC(PA), (1994), "Response to the West Glamorgan Health Plan 1994/5".

[7] RCN *op.cit.* p4.

[8] Donaldson, C., (1993) "Economics of priority setting: let's ration rationally!" in Smith, R., (ed.) *op.cit.* p80.

[9] See Honigsbaum, F., (1992) *Who shall live? Who shall die? Oregon's health financing proposals* (London, King's Fund College).

> "it is important to get involved in rationing to ensure that it occurs in a responsible and just fashion rather than the current process, which is largely unchartered".[10]

Opposed to this, however, is an awareness that turning the process over to a plebiscite would not necessarily be even in the public's interests:

> "Should the public be involved in priority setting and what account should be taken of its wishes? If the public is consulted, how should it be done, and what attempt, if any, should be made to influence its choices?"[11]

This balance needs to be examined, and means for resolving potential disagreements (eg high public priority for clinically ineffective interventions) proposed.

8. Leaving a managerial vacuum?

"Healthcare rationing in the form of waiting lists has existed since the NHS began."[12] Since 1948, waiting lists have been used implicitly to manage demand for services that exceed supply capacity. Since 1990, this use of waiting lists as a tool for managing demand has been exposed and - in Wales at least - it now looks set to disappear altogether. Any attempt to eradicate waiting lists - however conceptually confused - must answer one critical question: if waiting lists may no longer be used to manage demand, then what is to replace them?

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[10] Sheldon and Maynard, *op.cit.* p12.

[11] NAHAT, (1994) "Rationing of health care", NAHAT UPDATE.

[12] NAHAT, *op.cit.*

APPENDIX 5

Outline Planning Intentions 1995/6

A response by the LEC(PA)

1.0 Introduction

1.1 The LEC(PA) met on 20 October to consider Outline Planning Intentions 1995/6. As a result of that meeting, two papers have been produced. The present paper is a reaction to the draft document presented at that meeting. A companion paper has been produced, which examines the purpose of Outline Planning Intentions.

2.0 Style of the document

2.1 The committee was greatly encouraged to note significant differences between the style of Outline Planning Intentions and its predecessor, the Provisional Health Plan.

2.2 In particular, the committee noted that Outline Planning Intentions is a substantially shorter document, the tone of which is more appropriate to a consultation paper. To the extent that its language is clearer, and its presentation of intentions undertaken in broader terms, it was held to be a more "user-friendly" document. The committee was particularly pleased to note a considerable reduction in the number and purported accuracy of statistics in the paper.

2.3 The committee was also pleased to note that a number of restrictions on commissioner activity had been identified in the document. The committee recognises that commissioning does not take place in a vacuum, nor without reference to externally imposed criteria. It commends the document to the extent that it expressly identifies such criteria.

2.4 Underlying these commendations is the belief that Outline Planning Intentions is both more *honest* and more *modest* than the Provisional Health Plan 1994/5.

3.0 Particular concerns arising

3.1 Concern was expressed about the extent to which standards of quality could be maintained if nursing care were to be devolved to the private sector. The committee believes that this is a particular example of a general concern: the extent to which standards can be guaranteed in a competitive private sector. The committee accepts that monitoring is possible, but stresses the tension between the imperative to care on the one hand and the profit motive on the other.

3.2 The committee is also concerned that the disputes concerning the boundaries between health and social care identified at 7.1 may not easily be resolved. It is of the opinion that the guiding principle of any agency in the field should be the welfare of the individual, not the identity of the purchaser. Co-operative moves towards a definition of these boundaries should be made a priority.

4.0 The requirements of realism

4.1 The committee notes that a number of proposals for investment are considered in Outline Planning Intentions. Furthermore, it notes that commissioning for the coming year takes place at a period of zero resource growth.

4.2 It therefore questions whether *any* developments should be considered that are other than resource neutral, that is, that can be supported by the release of resources implicit in their implementation. If Outline Planning Intentions is to be more than a statement of *desires*, if, that is, it is to be a realistic planning document, then it must be realistic in its proposals.

4.3 The committee recognises that proposals can be made *at a consultative stage* that, while individually possible, cannot jointly be fulfilled. If the objective is to canvas the extent of support for various development proposals with a view to implementing only those which are generally supported, then the approach is justified. However, any Health Plan arising from this document should avoid promising, or appearing to promise, that which cannot be delivered.

4.4 Linked to this, the Final Health Plan should make it clear what safeguards are to be put in place which will address the problems of ECRs and EMAs. The committee believes that such unforeseen expenditure imperatives posed a major barrier to the achievement of the targets set in the 1994/5 Health Plan.

APPENDIX 6

Outline Planning Intentions 1995/6

A proposal by the LEC(PA)

1.0 The task of commissioning

1.1 In West Glamorgan, as elsewhere, health care resources are finite and inadequate to meet the potentially infinite demands and needs of the population.

1.2 The task of commissioning is, within a framework of limited resources, to align supply, demand, and need to the benefit of the whole population: that is, to ration.

2.0 Problems with the current model

2.1 *The fundamental task of health care commissioning in West Glamorgan should be to ensure that health care needs in the county are met as far as possible.* Any model of commissioning that does not lead to the precise reflection of *need* is inadequate. In the present model, patients and referral patterns follow available resources: supply determines demand, and needs are unaddressed.

2.2 Where supply and activity determine demand, existing resource patterns will tend to be reproduced in future plans. A supply led model therefore leads to inertia in resource allocation, perpetuating inefficient and unjust provision patterns.

2.3 Where demand is determined by supply, with patients following money, lack of available resources in a specialty (scarcity of supply) leads to a drop off in referral rates (demand). This reduced demand is *artificially* engineered, and does not represent a reduction in *need*. Similarly, non-treatment of other than clinical grounds reduces demand, but has no effect on need.

2.4 Demand can outstrip need where health services are requested that would not meet a genuine need. Some requests for health care do not represent needs at all (as opposed to preferences); some represent a need for other services (eg social care).

3.0 Approaches in Outline Planning Intentions

3.1 In its discussions, the LEC(PA) identified several different approaches to the resolution of this conflict underlying the proposals indicated in Outline Planning Intentions.

(a) Ruling out specific interventions from the health care that is to be commissioned, such as vasectomy reversal and female sterilisation. Such a model has been proposed in Oregon, and has - at the margins - been suggested in certain Regions in the UK.

(b) Increasing resources for certain areas of health care provision.

(c) Rationing should be knowledge-based. Exercises such as the oncology review in the county which attempt to evaluate major areas of service provision and expenditure are therefore to be commended.

(d) GPs have an important role to play in identifying *need* and translating it into *demand.* Need is an elastic concept, and is assessed in different ways by different practitioners.[1] This gives rise to significant variations in referral rates across the county, which is held to be at odds with the principle of equity of access on which the NHS is founded.

4.0 Analysis of approaches

4.1 All of the options outlined in section 4 are proposed in Outline Planning Intentions. This eclecticism could be seen as a strength, but the committee believes that such a "pick and mix" approach to rationing is neither consistent nor helpful. The purpose of Outline Planning Intentions is to give providers of care in West Glamorgan an indication of the parameters that will govern health care commissioning in the county in the period 1995/6. In its current form, it fails to do this.

4.2 Concern has been expressed that condition based rationing is inflexible and cannot take account of individual need and suffering.[2] Exclusion of specific treatments or conditions (eg in N.E. Thames and Sheffield) has also been unpopular.

4.3 Overall funding levels are set outwith the Authorities. Therefore overall resources can only be increased by bidding for earmarked funding, eg that reserved for waiting list activity.

4.4 Although greater knowledge of effectiveness and efficiency is necessary, it will not alone resolve the Commissioner's rationing dilemmas.[3]

4.5 The committee strongly recommends the development of knowledge based assessments of need and the alignment of this with expressions of demand. It believes that this can only be achieved with the help of GPs as purchasers of care and front-line assessors of need.

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[1] See Cummins, H., *et al.* "Do general practitioners have unique 'referral thresholds'?" *BMJ* 282 (1981) p1037-9.

[2] See Evans, D., "Limits to Care" in Szarwaski, Z., and Evans, E., (eds.) *Solidarity, Justice and Health Care Priorities* (Linköping, Linköping Collaboration Centre), 1993.

[3] See *Choices in Health Care, a report by the Government Committee on Choices in Health Care (The Dunning Report)* (1992), p14.

5.0 The committee's alternative model

5.1 The committee considers that health care commissioning should concern itself with identifying and meeting health care *needs*. This crucial task is hindered by the current model of commissioning, in which demand is determined by supply. In an ideal model, supply of services would follow need for such activity.[4]

5.2 Although the committee believes that need should be the most important factor in establishing commissioning patterns, it recognises that it is most clearly expressed - and therefore most easily measured - as demand.

5.3 It therefore follows that while provision can be based on validated demands, it cannot be based *directly* on needs without the expression of demand. Given the asymmetry between demands and needs, it is imperative that all and only those demands which are expressions of needs are met.

5.4 Therefore, the primary task of health care commissioning should be the establishment of mechanisms by which demand can be more precisely aligned with need for health care services. This model corresponds closely with the ideal of a needs based service sketched at 5.1.

5.6 By reference to such a model, GPs would be enabled to exclude those demands for health care which do not reflect actual health care needs. Instead of driving the commissioning process, supply would be led by need as expressed in validated demand.

5.7 *Therefore, the committee recommends that the Joint Authorities should, in collaboration with GPs in the county, construct a model of health care need to facilitate its distinction at an individual level from preference or demand, or need for non health care services.*

5.8 The LEC(PA) would welcome such an initiative, and would value the chance to comment on any such model at an early stage.

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[4] See Evans, J., "Evaluation of geriatric services" in Holland, W., (ed.) *Evaluation of Health Care* (Oxford, OUP, 1983) p124.

APPENDIX 7

Learning the lessons from Cambridge

An LEC(PA) discussion paper

1.0 Introduction

1.1 The recent case of Child B, the leukaemia victim whose treatment was not funded by Cambridge Health Authority, has re-established the issue of rationing treatment at the forefront of public and media-led debate.

1.2 West Glamorgan's LEC(PA) is a nationwide leader in the attempt to make rationing decisions fairly, rationally and openly (see *Health Service Journal: Health Management Guide* number 5, p6-7). It is therefore entirely appropriate that the Chief Executive should have asked the committee to comment on issues surrounding the case.

2.0 Preamble

2.1 The committee believes that the Child B case is highly unlikely to be the last such challenge to an Authority's decision mounted in the courts.

2.2 The LEC(PA) initiative represents a significant advance in the Ethical Review of Purchasing. It is therefore important to capitalise on that development so as to maintain its momentum *before* any challenge to the Authority is mounted.

2.3 In particular, the committee recommends that action to establish protocols appropriate to such circumstances should be established pro-actively, not re-actively. That is, they should be clarified *now*, rather than waiting and having to cook something up in a hurry when an actual challenge is mounted.

3.0 General principles

3.1 Whatever system of review is adopted, both the mechanism and the means by which its decisions can be challenged should be abundantly transparent to purchasers, providers and consumers of care.

3.2 Whatever the details of the decision making mechanism, the committee would urge the Authorities in the strongest possible terms to restrict rationing criteria to *clinical* variables. The committee is of the opinion that much of the trouble centring on Cambridge HA's decision is related to their inclusion of *financial* concerns in the rhetoric of their rationing. Had they restricted themselves to the (entirely adequate) clinical reasons for refusing treatment for Child B, the committee believes that the decision would have been both fairer and more generally accepted.

4.0 The status quo in the County

4.1 In discussion, the Director of Public Health sketched the model under which any decision relating to extraordinary expenditure would be taken.

4.2 In theory, all ECRs are considered within the contracting mechanism of the HA; they are vetted by the department of public health medicine, and discussed, if appropriate, with the referring clinician. If the referral is turned down at this stage then the clinician could appeal to either the SET or to the Boards.

4.3 However, a memo from the Chief Executive suggests that this mechanism may not be as clear in practice as in theory, indicating a need to clarify existing procedures.

4.4 The committee was encouraged to learn that steps were being taken to make explicit decision making pathways, and that there was at least some idea of a mechanism by which such decisions can be made.

4.5 However, the committee was less convinced that the mechanism by which such decisions can be *challenged* was clear to consumers of care (patients and their families). In particular, reservations were expressed that the mechanism of the second opinion may not be sufficient (and may not be *seen* to be sufficient) to provide patients with a way of challenging a clinician's decision. The committee would urge the Authorities to consider examining second opinions prior to refusing treatment in order to establish the independence of the system.

4.6 Moreover, the committee also expressed its concern that the mechanism was not sufficiently *transparent*, either to those involved in it or to the subjects of its decisions.

5.0 Recommendations

5.1 The committee urges the Authority to investigate the current mechanisms by which extraordinary funding decisions are taken.

5.2 Once an accurate picture of the present mechanisms has been established, the Authorities should then review current practice with reference to the parameters of clarity, fairness and consistency.

5.3 The model of the revised decision making procedure, *together with a clarified schema by which its decisions can be challenged*, should then be made available to interested parties in the interests of open service provision, and followed rigorously in the future. Although such a schema will not prevent future challenges, it will provide a framework for them that can be *shown* to be fair and consistent.

5.4 It should be remembered that Cambridge HA's unfortunate publicity arose from a challenge mounted not by Child B's care team, but by her parents. The committee is anxious that the model devised should clarify the mechanism not just for challenges by clinicians, but also by patients and their families.

5.5 The committee believes that this issue is as much about being *seen* to be fair as about the actual rationing itself. It is imperative that West Glamorgan Health Authorities establish clear procedures *now* that they can point to as having been followed when a challenge arises.

5.6 The LEC(PA) would welcome the opportunity to be involved in the review of the clarified procedures when they have been clearly established.

5.7 Only cases referred for ECR will come to the notice of any such review mechanism. The LEC(PA) is concerned that there is no way to monitor similar problems arising *within* contracts, and urges the Authorities to discuss this issue with individual contractors.

APPENDIX 8

Commissioning fertility services
Recommendations of the LEC(PA)

1.0 Background

1.1 The LEC(PA) met on 19 January to discuss the commissioning of fertility services. This paper summarises the Committee's discussions and makes some recommendations.

1.2 The Committee believed that institutional limitations on fertility service provision prevent an ideal solution from being reached (see 4.4).

2.0 Openness in service provision

2.1 Current levels of funding for infertility services are inadequate to provide a service capable of meeting demand. Some rationing of services is therefore unavoidable.

2.2 The Committee held that this inevitability of rationing should be explained to patients at their first point of contact with the service. Failure to explain to a couple their chance of progressing through all available treatments was held to be dishonest.

3.0 Does infertility represent a need or a preference?

3.1 If infertility only represents a preference, then commissioning of infertility services in a scenario of limited resources where needs go unmet would be morally questionable.

3.2 The Committee could not agree whether infertility represents a need or a preference. It is therefore unable to recommend disinvestment on these grounds.

4.0 Does infertility represent a health or a social need?

4.1 With the exception of tubal surgery, the procedures do not yield a fertile couple, but an infertile couple with a child. The vast majority of infertility services, therefore, treat the problem of childlessness, not of infertility.

4.2 It was held that childlessness is best regarded as a *social* problem.

4.3 Infertility, therefore, represents a *social* need (or preference) which is susceptible to a *medical* resolution.

4.4 The Committee therefore held that an ideal model of infertility provision would encourage joint commissioning by both Health and Social Services agencies. That this model in not the one currently operative was held to be a significant limitation.

5.0 Recommendations for commissioning

5.1 The Committee recognised that the situation is a fluid one: resource levels are likely to change, demand for fertility services may rise, as may reported effectiveness rates of the various procedures. These recommendations, therefore, relate only to the current planning year.

5.2 Current levels of funding for IVF were held to be inadequate to constitute a proper service. Moreover, the Committee understood that there was no widespread support for a significant increase in funding for IVF services.

5.3 In the circumstances, the Committee anticipates that commissioning of IVF services will be discontinued as is understood to be the case in two neighbouring Authorities. Given the fluidity of the situation, the Committee considers that it is important that the Commissioner is expressly clear about the *reasons* for such a disinvestment.

5.4 The Committee recognised that costs and demand for IUI could both rise, leading to a possible replication of the current dramatic IVF shortfall in IUI services. If supply of IUI cannot adequately compare with demand in the future, then future commissioning plans may have to reconsider continued investment in IUI in the light of any decision about IVF taken this year.

5.5 **For the moment, however, the Committee recommends that IUI continue to be commissioned.**

6.0 Prioritising applicants for fertility services

6.1 The Committee held that equity, rather than effectiveness, should govern access to fertility services.

6.2 **The Committee therefore recommends that as far as possible, only clinical exclusions should be made in admitting patients to waiting lists for fertility services.**

6.3 However, the goal of total equity of provision is probably unachievable within the framework of a fixed budget. It is likely that demand for IUI services will outstrip the resources available to meet that demand.

6.4 There is therefore a need to address the problem of excess demand for limited services. The Committee held that rationing by exclusion of *categories* of patient, as is the practice in many Health Authorities,[1] can often yield grossly unfair decisions and would therefore be inappropriate.

6.5 **Therefore the Committee recommends that applicants for fertility services should be prioritised by individual clinicians in line with considerations of effectiveness and individual need, rather than by reference to centrally defined criteria.**

7.0 Resolving the tension

7.1 The Committee does not believe that this issue is capable of being resolved simply. More particularly, it is thought likely that there will be some hostility to the outcome whatever decision is taken about the commissioning of infertility services.

7.2 Although some of these hostile reactions will be implacable, a proportion are likely to accept the eventual decision if it is carefully explained.

7.3 **The Committee therefore recommends in the strongest terms that the *reasons* for any decision reached are given in addition to the decision itself.**

7.4 The Committee anticipates that questions over future funding of fertility services are likely to re-emerge. **It therefore recommends that the Commissioner work with Social Services in the county to address the commissioning of measures to combat childlessness ahead of future health plan priority decisions.**

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[1] See the attached papers for a list of exclusion criteria employed by various Health Authorities across the UK attached, together with a breakdown of service provision patterns in Wales, and an analysis of an article examining the reasons given by six Health Authorities for the commissioning, or otherwise, of fertility services.

Annexe 1
Arguments for and against purchasing fertility services advanced by six Authorities:[2]
with some comments on them

THOSE IN FAVOUR:

- **There is already a provider of assisted conception services in place, and he is well respected and an able advocate for his services.**
    - This is a weak argument, as it risks perpetuating patterns of resource allocation that are unjust, inefficient, or ineffective.

- **The family is an important unit and should be encouraged.**
    - There are many ways of encouraging the development / maintenance of the nuclear family (even ignoring the prejudices thus invoked) that are quite clearly not part of health care: the Commissioners should obviously not be looking to Relate to purchase their services. Nor should it (on these grounds alone) be refusing to provide contraception services to couples with no children in the interests of creating *more* nuclear families.

- **Infertility can give rise to psychological harms.**
    - All sorts of things give rise to psychological harms, but are quite plainly none of the business of a health commissioner: living in a damp and depressing flat, for instance; or not having a roof over one's head at all. But these are obviously the concern of social services, and not within the remit of *health* care.

- **Any authority that purchases abortion and contraception services has a moral obligation to purchase fertility services.**
    - It is difficult to see where this "moral obligation" arises from: it appears to be something to do with maintaining a balance (of numbers?) between those destroyed and those created, but this looks like a very crude and unappealing type of calculation.

- **Since fertility services are available in other areas, it would be against the ethos of equality of access that grounds the NHS not to provide them.**
    - Two problems follow this. Firstly, equality of access could be guaranteed by *not* providing any services *anywhere* just as easily as it could be by providing services in all areas. Secondly, and more importantly, it seems to fly in the face of the general principle that health funding decisions should, wherever possible, be taken at as local a level as possible. This is in line both with the

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[2] Extracted from Redmayne, S., and Klein R., (1993) "Rationing in practice: the case of in vitro fertilisation" (*BMJ* 306, 1521-4).

Secretary of State's expressed beliefs, and the idea that needs / demands can best be assessed *where they occur*, rather than by a central monolithic institution.

* **Sub-fertility is actually a *health care problem*.**
  * This is the best of the reasons offered so far, but unfortunately it is not supported by any argument: just asserting it won't do.

THOSE AGAINST

* **The cost of assisted conception services is too high.**
  * Presumably by cost is meant budgetary, rather than opportunity cost. On this account, no matter how effective or efficient assisted conception services might be, their purchase could not be justified because of the actual price of each cycle. Importantly, this argument can only be applied to services such as IVF (@ £2000/cycle) rather than DI (@ £70/cycle), which are relatively cheap. Moreover, several forms of treatment currently commissioned are extremely expensive, but continue to be purchased because they are thought to be important. Budgetary cost alone should not provide an over-riding objection to a treatment.

* **Those demanding assisted conception services are not really "ill".**
  * Again, no account of what "real illness" amounts to is offered, only that infertility is not an example of it. We would need to know a lot more about the specific account of illness before we could acquiesce to it. Certainly, those demanding it are biologically dysfunctional and in considerable distress.

* **In an affluent area, those who demand fertility services can afford to pay for them themselves.**
  * A particularly gross argument, which seems to depend on a suppressed premise that assisted conception services are not *really* health care, or at least are so marginal that their not being purchased could not be a real problem. Moreover, it is hard to imagine any Health Authority for which it is true that *anyone* in its area demanding assisted conception services could afford to pay for them. It also flies in the face of the ethos of the NHS which purports to offer treatment to all irrespective of income: ability to pay should not necessarily be a barrier to access to services free at point of delivery.

Annexe 2

Patterns of service provision in Wales

	Clwyd	E Dyfed	Gwent	M Glam	Powys	W Glam	S Glam	Gwynedd
AIH	BC	?	SC	?	ECR	BC	?	?
DI	BC	?	SC	SC	ECR	BC	?	?
IVF	ECR	?	SC	SC	ECR	SC	?	?
GIFT	BC	?	SC	?	?	SC	?	?
Tubal surgery	?	?	BC	SC	BC	BC	?	?

Key: BC - purchased within block contract for gynaecology services
SC - purchased as part of a specific contract for fertility services
? - no information provided by the authority
ECR - treatment only purchased by extra contractual referrals

* Clwyd, M Glam, and W Glam have no exclusion criteria in place.
* E Dyfed are to develop criteria, and Gwent have "none at present".
* Powys has proposed the following criteria: women aged < 40, in a stable relationship, both partners living in Powys for > 3 years. A maximum of two cycles will be funded.

NB: This breakdown is drawn from figures in the College of Health's Provision of Funding for Infertility Treatment in the United Kingdom (August 1994). All figures refer to the year 1994/5.

Annexe 3

Health Authorities known *not* to purchase infertility services[3]

AIH 9 Authorities:
Bucks, N Essex, W Kent, Cornwall & Scilly, Southamton & S W Hants, Leics, Solihull, S Birmingham, Worcester.

DI 12 Authorities
Bucks, Huntingdon, N Essex, Chester, Croyden, W Kent, Cornwall & Scilly, Southampton & S W Hants, Leics, Solihull, S Birmingham, Worcester.

IVF 21 Authorities
Bucks, Cambridge, E Norfolk, Northamptonshire, Camden & Islington, N Essex, Croyden, Cornwall & Scilly, Exeter & N Devon, N & Mid Hants, Portsmouth & S E Hants, Somerset, Southampton & S W Hants, Lincs, Solihull, Warwks, Worcester, Grampian, Orkney, Southern HSSB (N Ireland), Western HSSB (N Ireland).

GIFT 28 Authorities
Bucks, E Norfolk, Northamptonshire, Camden & Islington, N Essex, Bromley, Croyden, E Sussex, Kingston & Richmond, W Kent, Cornwall & Scilly, Exeter & North Devon, IOW, N & Mid Hants, Portsmouth & S E Hants, Somerset, Leics, Southampton & S W Hants, Lincs, Solihull, Walsall, Warwks, Worcester, Ayreshire & Arran, Grampian, Orkney, Southern HSSB (N Ireland), Western HSSB (N Ireland).

Tubal surgery 3 Authorities
Northumberland, N Essex, Worcester.

* The more expensive IVF and GIFT services are much less likely to be purchased by those authorities inclined to disinvest in infertility services.

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[3] All figures come from *The Provision of Funding for Infertility Treatment in the United Kingdom*, prepared by the College of Health, and commissioned by the National Infertility Awareness Council (August 1994).

Health Authorities known to provide infertility service *only* by ECR

AIH 13 Authorities
E Norfolk, Barnet, Morecombe Bay, N W Lancs, E Sussex, Merton Sutton & Wandsworth, N W Surrey, Dorset, IOW, Somerset, Warwks, Powys, Western Isles.

DI 14 Authorities
E Norfolk, Barnet, Morecombe Bay, N W Lancs, E Sussex, Merton Sutton & Wandsworth, N W Surrey, Dorset, IOW, Somerset, Lincs, N Worcs, Warwks, Powys.

IVF 18 Authorities
Berks, Barnet, Hillingdon, Redbridge & Waltham Forest, N W Lancs, Merton Sutton & Wandsworth, N W Surrey, W Kent, IOW, Lincs, N Notts, Rotherham, N Worcs, S Birmingham, Wolverhampton, Clwyd, Powys, Western Isles.

GIFT 15 Authorities
Berks, Wakefield, Barnet, Hillingdon, Redbridge & Waltham Forest, E Lancs, Morecombe Bay, N W Lancs, Merton Sutton & Wandsworth, N W Surrey, Dorset, N Worcs, S Birmingham, Wolverhampton, Western Isles.

Tubal Surgery 4 Authorities
South Tyne, Barnet, N W Lancs, N W Surrey.

* Tubal surgery, the only listed treatment that *cures* infertility, is only exluded altogether in three authorities, and confined to ECRs in only four; it is therefore available in 86% of responding health authorities. Despite this, tubal surgery is held to be one of the most expensive and least effective of all assisted conception services.[4]

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[4] See Lower, A., & Setchell, M., (1993) "Should the NHS fund infertility services?", *BJHM*, 50, 509-512.

Selection criteria used

Criterion	Number of Authorities using this criterion
Age	2
Woman aged 25-36	1
Woman aged 25-37	1
Woman aged 25-38	1
Woman aged 27-40	1[5]
Woman < 35	8
Woman aged < 38	5
Woman aged 25-43	1
Woman < 40	12
Both partners under 45	1
Male partner < 45	2
Male partner under 50	3
Male partner aged < 55	1
Couples in stable relationship	15
Heterosexual couple in stable relationship	2
Maximum 3 cycles	11
Maximum 2 cycles	5
Maximum 2 cycles per financial year	1
Only one cycle offered	4
No previous IVF treatment	6
Maximum one child between both partners	2

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[5] priority given to women > 38

Woman should have no surviving children	2
No living children from current relationship	6[6]
No children from this or any other relationship	15
Potential to benefit	1
> 3 years unexplained female infertility	4
> 2 years infertility	3
No history of violence or abuse	1
Woman not overweight or underweight	1
Resident in Area	7

* Over 50% of responding health authorities use overt selection criteria of some kind.

* The selection criteria mentioned are divided equally between clinical (eg age of female partner) and non-clinical (eg being in a stable relationship).

* We cannot tell what the reasons were in those authorities where fertility services were either not purchased or were only funded as ECRs.

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[6] sometimes includes *adopted* children

APPENDIX 9

The 1995/6 Health Plan

A response by the LEC(PA)

1.0 Introduction

1.1 This response from the LEC(PA) to the Health Plan 1995/6 follows responses to Outline Planning Intentions 1995/6 dated September 1994.

1.2 The Committee recognises that the draft received is an early one, and notes that there are a number of errors requiring editorial changes (sample list attached), which it is assumed will be corrected in the final version.

2.0 Transparency in rationing

2.1 As the LEC(PA) has argued elsewhere, it is vital that rationing by the Commissioner is as transparent as possible. Purchasers and providers should be able to plan their activity patterns from the Health Plan, and the criteria by which services are differentially Commissioned should be open to public inspection.

2.2 The Committee therefore applauds the attempts at openness in the 1995/6 Health Plan. In particular, it is encouraged by the statement of values in section 2.1.4.1 of the draft received.

3.0 The task of Commissioning

3.1 Health care delivery must be grounded in *need*. The task of Commissioning, therefore, is to identify health care needs and to facilitate the maximal meeting of these needs.

3.2 Maximal needs satisfaction requires *efficiency* and *effectiveness* in Commissioned services. Services known to be inefficient or not proven to be effective, therefore, should be a low Commissioning priority.

3.3 Therefore the Commissioners should concentrate on assessing need and directing resources appropriately. This may require substantial realignment of current investment patterns. Changes suggested in the 1995/6 Health Plan, however, are restricted to the decommissioning of a few marginal services. The Plan, therefore, does not address potentially significant areas of inequity, inefficiency, ineffectiveness or activity not grounded in need.

4.0 A coherent approach to rationing

4.1 Notwithstanding the comments in 2.2 the Committee noted that the statement of values was in large measure *not* applied to the disinvestments considered in the body of the Plan. For example, the suggestion that "Priority is given to areas of greatest health need" has been ignored in relation to Commissioning circumcisions (section 4.7.2), where it is admitted that consultants in the county held that there *is* a need for such services. Similarly, although no statistics are given for effectiveness rates for reversal of female sterilisation, the impression is given that the technique is comparatively *effective* on certain patients. And yet disinvestment is proposed in both these cases.

4.2 Therefore, although the Plan is to be commended for attempting to reveal the values that ground Commissioning in West Glamorgan, *such values must actually be applied* to avoid a mere paper exercise.

5.0 Approaches in the 1995/6 Health Plan

5.1 In its discussions, the LEC(PA) identified several different approaches to the resolution of this conflict underlying the proposals indicated in the 1995/6 Health Plan.

(a) Ruling out specific interventions from the health care that is to be Commissioned, such as vasectomy reversal and female sterilisation. Such a model has been proposed in Oregon, and has - at the margins - been suggested in certain Regions in the UK.

(b) Increasing resources for certain areas of health care provision.

(c) Reviewing patterns of service provision by exercises such as the recent cancer services review.

(d) Working with GPs (who have an important role to play in identifying *need* and translating it into *demand*) with a view particularly to eradicating the significant variations in referral rates across the county, which is held to be at odds with the principle of equity of access on which the NHS is founded.

6.0 Analysis of the approaches

6.1 All of the options outlined in section 5.1 are proposed in the 1995/6 Health Plan. This eclecticism could be seen as a strength, but the Committee believes that such a "pick and mix" approach to rationing is neither consistent nor helpful.

6.2 Concern has been expressed that condition based rationing is inflexible and cannot take account of individual need and suffering.[1] Exclusion of specific treatments or conditions (eg in N.E. Thames and Sheffield) has also been unpopular.[2]

6.2.1 The Committee notes that all the examples of disinvestment proposed are held to be of questionable effectiveness.

6.2.2 However, the Committee also notes that all the examples are at the margins of health care. The Committee is concerned that disinvestment should be proposed on the grounds of clinical ineffectiveness, and not because of the character of the service or the demand for it.

6.2.3 Moreover, the Committee believes that rigorous application of the principle of Commissioning only services of proven effectiveness would require disinvestment on a vastly wider scale than proposed in the Plan.

6.3 Overall funding levels are set outwith the Authorities. Therefore overall resources can only be increased by bidding for earmarked funding, eg that reserved for waiting list activity.

6.4 Although greater knowledge of effectiveness and efficiency is necessary and can highlight and help address problems, it will not *resolve* the Commissioner's rationing dilemmas.[3]

6.4.1 The Committee particularly commends the model of whole service evaluation, as exemplified by the recent cancer services review in the County. It believes that such root and branch evaluation leads to knowledge-based health care delivery, and is preferable to a piecemeal approach of marginal condition-based disinvestment. The Committee would greatly prefer a Health Plan modelled on such evaluative research rather than on marginal disinvestments.

6.5 The Committee strongly recommends the development of knowledge based assessments of need and the alignment of this with expressions of demand. It believes that this can only be achieved with the help of GPs as purchasers of care and front-line assessors of need.

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[1] See Evans, D., "Limits to Care" in Szarwaski, Z., and Evans, E., (eds.) *Solidarity, Justice and Health Care Priorities* (Linköping, Linköping Collaboration Centre), 1993.

[2] It may be more than simply unpopular. See the remarks of the Health Committee, First Report, *Priority Setting in the NHS: Purchasing* Vol 1, London, HMSO, 1995, pxxxv.

[3] See *Choices in Health Care, a report by the Government Committee on Choices in Health Care (The Dunning Report)* (1992), p14.

7.0 Particular criticisms

7.1 As noted above (section 2.2), the Committee was encouraged by the Plan's transparency. Such transparency ensures that rationing proposals are clear, and allows the possibility of discussion of such proposals.

7.2 However, the Committee was concerned that the focus of the Plan was on marginal disinvestments, rather than the need to evaluate areas of service provision. The Committee does not believe that such tinkering at the margins represents the way forward in Commissioning, and commends the model of root and branch service review to the Commissioners. Such reviews identify health needs and the means by which these needs can best (that is, most efficiently, effectively, and equally) be met.

7.3 The Committee was concerned about the following particular examples of disinvestment:

7.3.1 An assessment of need and effectiveness by clinicians in the case of circumcision has been ignored by the Commissioners, in clear contravention of their expressed priorities and values.

7.3.2 Patients already on a waiting list for treatment (as in the case of gender re-assignment) should not simply be abandoned as a result of that service being decommissioned. Rationing decisions should not, the Committee believes, be retrospective.

7.3.3 Although gender re-assignment procedures "do not *necessarily* abolish gender dysphoria", this is not to say that they do not work *simpliciter*. Moreover, that "clients are exposed to physical dangers of hormonal and surgical procedures" is hardly a reason for disinvestment, nor are the dangers unique to this therapy.

7.3.4 The Health Plan is at pains to establish that treatment for varicose veins is of questionable effectiveness and value. It then proposes a shift towards day-case procedures for this condition. The Committee believes that *if* the treatment is ineffective, the proper response is not to continue to Commission it at a reduced cost, but to disinvest altogether in this treatment.

7.3.5 The reasoning behind the proposed disinvestment in fertility services is brief and unclear. A copy of the Committee's recommendations for future investment patterns in fertility services is attached.

7.4 The Committee accepts that there *may* be good reasons for decommissioning all or any of these services, but did not find them in the Health Plan.

8.0 Conclusion

8.1 The Committee believes that the 1995/6 Health Plan is to be commended for attempting to be open in priority setting.

8.2 However, the Committee also believes that it is a flawed and not wholly consistent approach to Commissioning. More work remains to be done on the construction (in collaboration with primary carers) of a model of health care need, as well as further research, locally and nationally, to establish effectiveness rates for core treatments as well as those at the margins.

APPENDIX 10

Responses to the problem of unwanted pregnancy
An LEC(PA) discussion paper

1.0 Introduction

1.1 Following recommendations in the committee's consideration of commissioning issues in the provision of infertility services about the desirability of a linked medical-social model of response to the problem of childlessness, this paper looks at responses to the problem of unwanted pregnancies and children.

1.2 The committee is grateful to Mr John Calvert, Clinical Director of the Department of Obstetrics and Gynaecology at Singleton Hospital, and to Mrs Ann Laker, Principal Adoptions Officer for the County for their help in preparing briefing papers.

2.0 Levels of activity

2.1 According to the Welsh Public Health Common Data Set (1992), West Glamorgan has, with Gwynedd, the highest termination rate in Wales (11.1 per 1000 women aged 15-44). 14.3% of all Welsh terminations are performed in West Glamorgan, while 12.7% of women aged 15-44 are resident in the county.

2.2 It is understood that approximately 25% of terminations undertaken in the County are performed on patients from Bridgend or Carmarthen. The committee believes that this is a reflection of a relatively liberal service in the county. Although the committee is happy that this should be so, it expressed some concern at the prospect of West Glamorgan becoming the abortion capital of West Wales.

3.0 Interpreting the figures

3.1 In a cash-limited service, it is axiomatic that investment must be knowledge based.

3.2 It is therefore vital to know *why* women present for terminations in order to ensure maximally effective targeting of resources. The committee was concerned to find no evidence of any such knowledge.

3.3 The committee believes that the problem of unwanted pregnancy is a complex issue, and that women present for terminations for a number of diverse reasons.

3.4 It follows that a woman's unwanted pregnancy is susceptible to a number of responses. The committee believes that there has historically been an over-reliance on termination as a uniform solution to a multi-facetted problem. The heterogeneity of the presenting group re-emphasises the need for a composite response.

4.0 Parallel alternative responses

4.1 The committee was at pains to emphasise that the various responses to the problem of unwanted pregnancies should be seen as working in harmony, and not as mutually exclusive options.

4.2 The committee is generally of the opinion that it would be beneficial to effect a reduction in the overall number of terminations performed. Of the possible responses to unwanted children - effective contraception at the time of intercourse, effective post coital contraception (PCP), termination, and adoption - termination cannot be considered the preferable response on economic, medical or moral grounds.

4.3 However, the committee would strongly discourage simple capping of resources available to meet the present demand for termination services. Although it believes that alternative strategies should be available, the committee could not condone an immediate reduction in provision of termination services. Women who currently expect to be able to rely on such services should not simply be abandoned.

4.4 The committee believes that by exploring the alternatives to termination both in educational initiatives and with individual patients, the choices open to women would be increased rather than the reverse. Such exploration of alternatives would, it is believed, bring about a long term reduction in the number of women presenting for termination.

4.5 Subject to results obtained from the research recommended in **3.2**, the committee recommends investigating the possibility of increased effective contraceptive advice, particularly to those groups most heavily represented in the termination figures. The committee also welcomes the present move to reclassify the status of emergency contraception, and would recommend investment in a targeted educational initiative to accompany such a development.

4.6 The committee would strongly recommend the purchasing of routine pre-termination adoption counselling, undertaken by an independent counsellor to discuss the advantages and disadvantages of adoption with women presenting for a termination. In 1994, West Glamorgan Social Services made 2 traditional placements. Nearly 1000 women have terminations annually in the County. Even *one* of these 1000 converting from termination to adoption as a resolution to her problem could increase adoption activity levels by 50%.

4.7 The committee would also encourage the purchasing of routine follow-up counselling both at the time of the termination and by the referring GP. The committee was unable to discover any data concerning repeat referrals for terminations except in the case of case of the teenagers studied by Dr Su Vui Lo in 1993, of whom 18% had been pregnant before. Even this limited data, however, demonstrates a clear need for such follow-up counselling.

4.8 Underpinning any restructuring of termination services should be a commitment to *enabling*, not restricting, women's choices, by exploring the suggestion that termination is neither the only nor necessarily the most appropriate way for a woman to control her life. Such exploration should avoid the imposition of a monolithic response (termination *simpliciter*) to a frequently complex problem (unwanted pregnancy).

4.9 Initial discussions with the County's Adoption Officer supported the principle of exploring a broader model of response in collaboration with the County's Social Services. The committee would welcome such an initiative.

APPENDIX 11

Outline Planning Intentions 1996/7
A response by the LEC(PA)

1.0 Introduction

1.1 The LEC(PA) met on 21 September 1995 to review *Outline Planning Intentions 1996/7.* This response reports the committee's recommendations for the progress of this particular document and for versions of *Outline Planning Intentions* in future years.

1.2 The committee found elements in the document to commend: it was particularly pleased to note a drive to evidence-based health care, the inclusion in the document of national priorities (p48ff), and an attempt to state the purpose of the document (p5). However, the committee also believed that the document was still deficient in a number of respects.

2.0 Evidence-based health care

2.1 The committee commends the efforts in *Outline Planning Intentions 1996/7* to take account of current research into evidence-based health care. The committee re-iterated its view (expressed in its report on *Outline Planning Intentions 1995/6*) that services should be commissioned in line with knowledge-based responses to clinical need.

2.2 However, the committee believes that further progress could be made in respect of evidence-based commissioning. In particular, it urges the authorities to:

2.2.1 Include some means of evaluating past versions of *Outline Planning Intentions* with respect to actual performance. A simple comparison between the intended/hoped for investments identified in *Outline Planning Intentions 1995/6* and actual patterns of spending would provide a valuable opportunity to measure the accuracy of such plans.

2.2.2 Make explicit comparisons between the Director of Public Health's annual report on the state of the health of the County and the immediately prior version of *Outline Planning Intentions*. This would facilitate evaluation of the effectiveness of such planning documents by demonstrating the extent to which spending on health care correlates with increased health in the community.

3.0 Inclusion of national priorities

3.1 The committee was encouraged to note that nationally determined priority areas are identified in the document, and that *Outline Planning Intentions* is seen as "an opportunity ... to share ... objectives and constraints with ... providers" (p5).

2.2 However, the committee hoped for greater and clearer identification of the limits on the commissioners. Health care commissioning takes place neither in a political nor in a financial vacuum, and the fact and extent of these limitations should be acknowledged.

2.3 In particular, the committee believes that *Outline Planning Intentions 1996/7* should expressly have identified three categories of constraint on commissioner activity:

2.3.1 Resources: the committee accepts that accurate figures cannot necessarily be given for every planned investment. However, unless some idea of the quantum of the figures involved is given, the value of the document as a serious indication of intentions is questionable.

2.3.2 External constraints: commissioning in the County takes place in an environment in part determined by Welsh Office directives (eg the Waiting List initiatives).

2.3.3 Situational fluidity: *Outline Planning Intentions 1996/7* notes that its key message is one of consolidation and that "once again, Health Authorities are in the midst of organisational and cultural change" (p5). One potential change in the committee's view not sufficiently clearly identified is the implications of the development of a new hospital at Baglan, which could drastically affect any investment proposals contained in the document.

3.0 The purpose of *Outline Planning Intentions*

3.1 The committee was encouraged to note the statement of purpose @ p5.

3.2 However, the committee believed that part of the document's problems sprang from its being expected to perform two quite distinct tasks, namely being both a **consultative** and an **indicative** document.

3.3. If *Outline Planing Intentions* is purely a consultative document, then the inclusion of areas that may not in the end be funded may be appropriate. However, if the document is designed to convey commissioning **intentions**, then a greater degree of realism is necessary. In particular, the document should avoid appearing to promise more than can be delivered.

3.4 Confusion of the consultative and indicative functions creates an unfortunate climate of expectancy among providers and possibly patients, by suggesting that more services will be commissioned than can in fact be the case. The committee urges the Health Authorities to ensure that *Outline Planning Intentions* is grounded as firmly as possible in the reality of commissioning, to avoid the creation of a credulity gap between what appears to be promised and what can be delivered.

4.0 Conclusion

4.1 To the extent that *Outline Planning Intentions 1996/7* is an attempt to ground health care commissioning in evidence about services and restrictions on commissioning activity, the committee commends it. However, it believes that more can be done to ensure that the objectives of and constraints on commissioner activity are made clear to providers and patients, and that clearer mechanisms for evaluating the performance of all parties in health care provision are available and should be provided.