Patient and public engagement in UK medical education

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Declaration

I, Anita Berlin, confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

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Acknowledgements

A thesis, is by definition, a solitary enterprise. Nonetheless there have been many good people working backstage to ensure this work saw the light of day who I am now delighted to thank. Foremost are my supervisors: the truly inspiring yet ever-practical Professor Kathryn Riley - who has kept me going, and drawn me into some of her own exciting work along the way; and the very wise Professor David Eddy Spicer - who opened my mind to new ways of understanding the world. Both have been exemplars of the *epistemically just* - generously sharing their knowledge and time, while encouraging me to use my own experience and intuition.

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Finally, I dedicate this thesis to my late mother, Carmen, - who knew how to engage with everyone- , and to my loving father, Ludwig, who would have written a superb thesis[1] but was denied the chances he was able to give me.

[1] Provisionally entitled: *The teaching of 20th century history in French, German and English schools: a comparison*.

Abstract

This practitioner research is the story of what happens when we take an important, but heterogeneous idea, and turn it into a mandatory standard. It explores how public engagement and patient involvement are framed and enacted in UK medical education, in the context of evolving regulatory requirements and diversity of medical schools. Four case studies are presented - three medical schools with different missions, and the regulator (the General Medical Council, GMC). Interview transcripts with school leaders and GMC officers were analysed applying two approaches, informed by symbolic interactionism and social epistemology: boundary object theory and frame analysis.

The study shows that public engagement is a diffuse, plastic concept acting at organisational and individual levels with many features of a boundary object. This conclusion is further supported by its institutionalisation as a regulatory standard (in *Tomorrow's Doctors 2009*). The study sheds light on ideas of professional and organisational identity formation and on boundary agents - those working across intra, and extra organisational boundaries. Through frame analysis, the case studies provide an insight into the socio-political, moral and pedagogical dimensions of involving patients and the public in medical education as viewed by educators and regulators, and how these ideas are affected by the use of knowledge, values and authority on one hand, and regulation on the other. Medical school leaders frame public engagement and patient involvement with reference to their local higher education and healthcare context, and their knowledge community. Variations in framing encompass individual, person-centred, and collective, socially-oriented dimensions.

New regulatory standards for medical education and training were published in January 2016 - a reframing of professional and regulatory priorities. This study helps us understand how such standards in professional education evolve and provides a framework for investigating and analyzing their intended and untoward effects at individual, organisational and institutional levels.

Contents

Glossary of Abbreviations

Abbreviation	Term
AHSC	Academic Health Science Centre
AMEE	Association for Medical Education in Europe
BMA	British Medical Association
CBE/ CBME	Community based (medical) education
CBPR	Community based participatory research
CEME	Community engaged medical education
CeMENT	Community based medical education North Thames
COME	Community oriented medical education
DAPs	Degree awarding powers
GMC	General Medical Council
GP	General Practitioner
GCSA	Global Consensus on Social Accountability of Medical Schools
NCCPE	National Coordinating Centre for Public Engagement in Universities
MSC	Medical Schools Council
NHS	National Health Service
PE	Public engagement
PERC	Patients as Educators Research Collaboration
PMQ	Primary Medical Qualification
PSA	Professional Standards Authority (formerly CHRE - Council for Healthcare Regulatory Excellence)
PPI	Patient and public involvement
QA / QE/ QM	Quality Assurance/ Quality enhancement/ Quality Management
QABME/QIF	GMC Quality Assurance of Basic Medical Education/Quality improvement framework
REF	Research Excellence Framework
RAPPORT	ReseArch with Patient and Public invOlvement: a RealisT evaluation
TD09	*Tomorrow's Doctors 2009* (GMC outcomes & standards)
THEnet	Training for Health Equity Network
TUFH	Towards Unity For Health Network
WFME	World Federation for Medical Education
WHO	World Health Organisation
WONCA	World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians

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REFLECTIVE STATEMENT - THROUGH THE UNKNOWN, UNREMEMBERED GATE[2]

Caminante, no hay camino,
se hace camino al andar.
Al andar se hace camino,
y al volver la vista atrás
se ve la senda que nunca
se ha de volver a pisar.

Wanderer, there is no path,
the path is made by walking.
Your footsteps create the trail,
and on glancing back
you see the path
that will never need be trod again.[3]

Antonio Machado (1912)

The purpose of this statement is to show how the elements of the programme have linked together and contributed to my professional understanding and knowledge. I start with a brief reflexive summary; I then consider each component of the programme and make links between the elements, and I conclude with a synthesis of my learning through the programme as a whole.

Over my time as a GP I have probably seen a couple of dozen doctoral students at different stages of their own journeys in various forms of crisis. Some had fallen out of love with their topics, others had simply fallen out with their supervisors, and a further group were derailed by personal or family illness. Reflecting on these professional encounters I note I have avoided the first two. I have had excellent support and advice from knowledgeable supervisors and I have remained engaged with my various topics - no doubt the composite programme structure has helped maintain interest. There have, however, been periods where it has been hard to find the protected time needed to stay focused and make good progress . Nonetheless I find, as I come to the end, it seems appropriate to consider where I started.

Despite the sentiments expressed in my original application - an avowed desire for professional and personal improvement - the honest truth is that my motivations for starting the doctorate were largely extrinsic and instrumental: in my regular academic appraisals my line manager, over a number of years, reminded me that a research degree was an expected

[2] Eliot, T.S. (1922)-- "Little Gidding" (the last of his *Four Quartets*)
http://world.std.com/~raparker/exploring/thewasteland/explore.html

[3] Machado,A (1912). Campos de Castilla English, adapted by me from *Translation by Stanley Appelbaum, Dover Publications, 2007,* ISBN 978-0486461779.

part of my portfolio and the only route to career progression. I had resisted. The EdD offered me structure but I told myself if it was too hard I'd just give up, at least I'd tried. The motivation then shifted - the contents of the modules was interesting and relevant; the interdisciplinary debates, stimulating and fun – a sort of legitimised truancy within a learning community of other official truants. The enjoyment of the taught course drove me on – but I could only continue if I submitted an assignment! To my surprise I got through the materials and produced a 5000 word draft for the first module (Foundations of Professionalism, see below). The initial feedback was better than good. No corrections needed. I could write! Now the intrinsic desire to get more positive feedback replaced the external drivers. And I began to see the connections with the other dimensions of my life and work.

Re-reading my reflective statements from different stages of the doctorate I see slightly exaggerated references to my life *as "poly-contextual" or " super-complex"*. Made up of four overlapping spheres and identities these were: my academic work as a medical educator; my clinical work in general practice; home and family; and the doctorate itself. From the outset, I began to see a constant synergy and interplay between them. This operated both via the enhancement of practice through a greater understanding of theory, as well as familiarity with a range of lenses through which to refract and interpret different identities - mine and those of my patients and my students.

As an educator, becoming a *student* again is a salutary experience. Being reminded of the complex interaction between intrinsic and extrinsic motivators, the effect of what we put in the curriculum and the unpredictable intrusions of the learner's social world has been some of the most valuable learning of the entire doctoral process. I have re-considered the importance of the human aspects of teaching, especially feedback, and can relate this to the impact of assessment and deadlines on my students' own learning.

The thinking, reading and writing related to how we research the way to develop the doctor-patient relationship led me to use critical and feminist perspectives, and consider in greater depth the idea of individual subjectivity, notions of competency, and the possibilities of transformative pedagogy. These all have theoretical and practical dimensions which I have been able to apply in devising learning and teaching around the consultation, population perspectives, and social determinants of health. Moreover, they have equipped me with a framework for analysing the potential contribution of a medical school to society. The link between this concept and public engagement has driven much of the thesis that follows. I

briefly consider the individual elements of the doctoral programme before returning to these in the summary.

The programme involves a number of elements: four taught modules (each examined with a 5,000 word assignment), and institutional focused study (original research in the home institution of 20,000 words) and finally the 45,000 word thesis that follows.

Summary of assignments		
Module / study	**Assignment Title**	**Content focus**
Foundations of Professionalism (FoP)	The rise of professional standards in higher education: implications for clinical teachers in a UK medical school	Medical teachers/QA
Methods of Enquiry 1 (MoE1)	Patient-centredness and hospital outpatient clinics – the student perspective	Patients
Leadership and learning (L&L)	Leadership paradigms and conceptions of learning - implications for a medical school	Leaders
Methods of Enquiry 2 (MoE2)	Medical students' conceptions of their learning – a qualitative study	Students
Institutional Focussed Study (IFS)	Conceptions of leadership, learning, and the institutional ecology: A qualitative study of senior faculty in a research-intensive university (Institutional Focused Study)	Leaders, learning, institutions
Thesis	Patient involvement and public engagement in UK medical education	Public engagement and regulation

The Foundations of Professionalism module was excellent for placing the field in a socio-political context. Reflecting on the changing notion of the professional provoked lively discussions introducing the gamut of academic lenses. In the assignment I was able to develop analytical perspectives with reference to my own work in educational quality. I considered the notions of performativity and the over (lapping) regulation of basic medical education (following *Tomorrow's Doctors* 2003). I discussed how this was preceded by decades of *laissez-faire* approach to standards for clinical teachers and considered the benefits and critiques of standards. This led me to Clark's Triangle[4] and Etzkowitz's triple helix[5] and to revisiting the work of Carr (which I used in my Masters) and the ideas of *techne* and *praxis*. I summed up my learning thus:

> *This essay has exposed me to a rich seam of ideas which has given me new insights to help me make sense of my work in quality assurance. The negative discourse of perfomativity, couched in the language of masculine aggression*

[4] Clark BR.(2004) Delineating the Character of the Entrepreneurial. University Higher Education Policy,17,(355–70)
[5] Etzkowitz's, H. Leydesdorff L. (Eds), 1997, *Universities in the Global Economy: A Triple Helix of University-Industry-Government Relations*.

made me feel guilty, like an academic Ms Whiplash, building a career on flagellating the boys in white. I am more convinced that conscious "feminisation" will contribute positively to the standards debate. Perhaps a nurturing Earth Mother is too mumsy. A Good Witch as described by Kerman[6] (1997) is a better image.

MoE1 involved an in-depth review of ontology, epistemology and methodology and, through the assignment, demonstration of a coherent understanding of the relationship between these. I enjoyed wading through the reading; critical theory (Habermas, Freire), post-structuralism (Foucualt, Zizek) and feminism (Cixous, Irrigaray). I also benefited by returning to the literature on communication, the doctor-patient relationship, and humanism, and considering how research in medical education is often parochial and under-theorised. Together these modules eventually resulted in a co-authored book chapter using Foucauldian discourse analysis to examine the professional identity of women clinical academics (Park, Berlin and Griffin, 2014). The L&L module with a focus on compulsory education meant I had to work to extrapolate to my own context, exploring discourses of learning in medicine and implications for leaders. This led directly onto the IFS work. Finally MoE2 was a helpful way to synthesise the course thus far, but the shift into the practical side of "doing" research was perhaps not as well emphasised as all the ethical and analytical aspects.

The institutional focused study IFS included a comprehensive literature review with a novel organising framework relating the multitude of leadership styles and theories to learning. I believe it also provided some new insights into university leadership and proposed a model of the research-intensive environment as a delicate ecology where teaching struggles for oxygen. The philosophical notion of the Guattari's tri-ecology[7] (human subjectivity (psychological and intellectual); social relations; and the environment - political, physical and emotional), which was the conceptual outcome of the study, formed the basis of further scholarship and has expanded to a more holistic understanding of medical education in a globalised world, which I applied to developing materials on global health and health equity. The work resulted in conference and seminar presentations and the commission for a book chapter in an interdisciplinary compendium of philosophical essays (Berlin, 2013).

[6] Kerman, L. (1997) "Good Witch: Advice to women in management" Chapt 9 p131 in Morley, L, Walsh V [eds] Feminist Academics: Creative Agents for Change Taylor Walsh, London

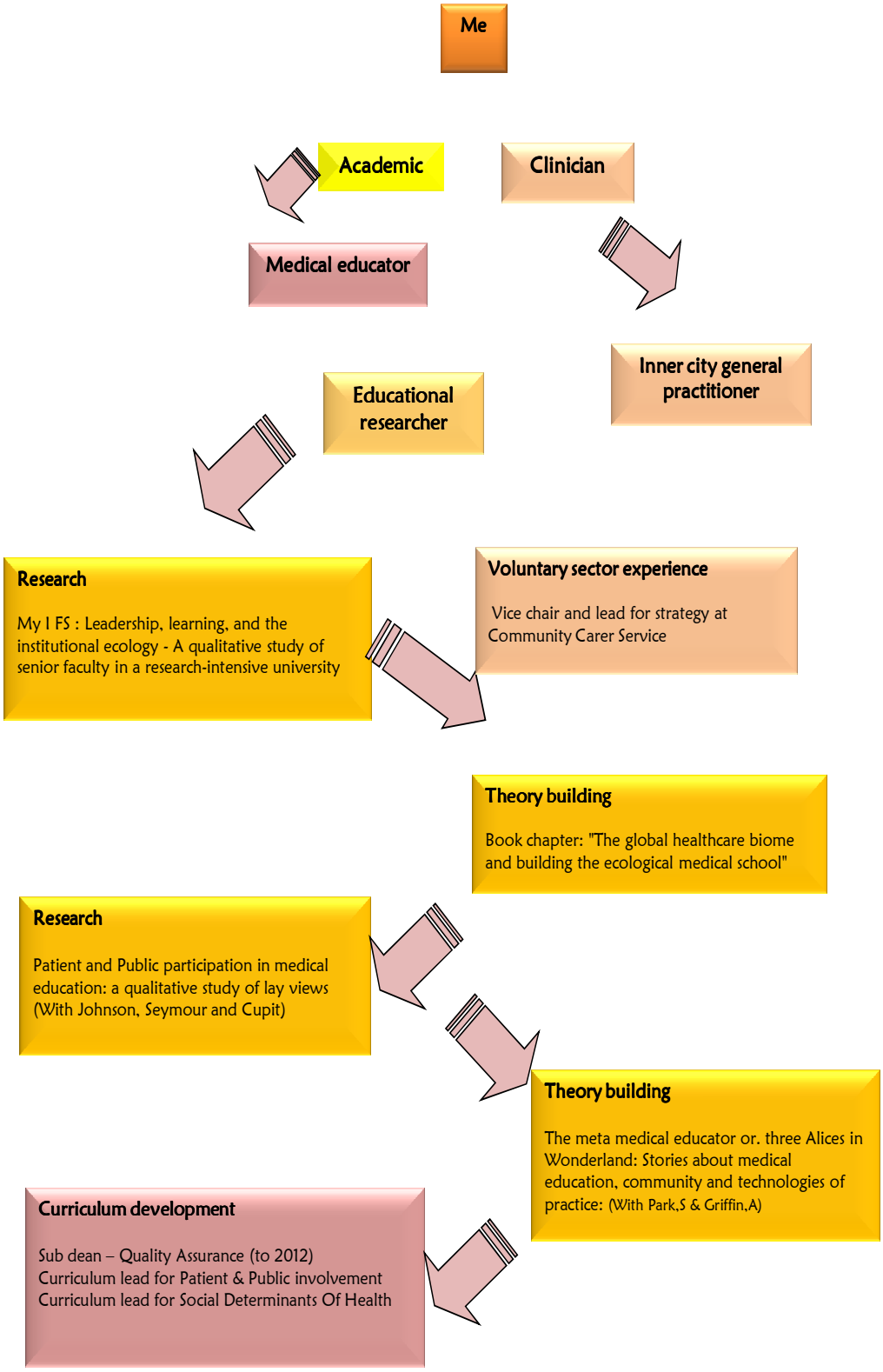
[7] Guattari (1989) The three ecologies. (Translated by Pindar & Sutton) London Contiuum

Finally, through the work in this thesis, I have been able to build bridges and make links across my various fields of work. This includes drawing together public engagement, curriculum leadership, governance and design, while considering tensions between different epistemological and moral frameworks. I have incorporated the idea of the "boundary object" as a way of exploring shared endeavours. I have gained a very broad understating of the institutionalisation and enactment of public engagement. Furthermore, the use of framing to approach the methodological challenge of interpretation across structural levels, is distinctive and innovative.

I have acquired valuable practical and academic skills; searching literature, using NVivo and Endnote. Two particular "thinking tools" standout - the notion of the tri-ecology and frame analysis. It would, I suggest, be impossible to read or think about frame analysis without regarding the entire social and political world in an altered light. Coupled with the notion of epistemic justice applied to individual and institutional relationships the way I think about and approach both my clinical and my academic endeavours is now very different and enriched in comparison to when I first came through the doctoral gate .

In summary, there is no doubt that undertaking this doctorate has – as it says on the tin - changed my analysis, and understanding of my professional field - to *techne* and *praxis* I have added *phronesis*. It is inevitable that a statement such as this will include metaphors of transformation, circular journeys, or scaling immense heights. It has been hard work - which could easily have been abandoned due to those unexpected challenges that life sometimes throws at us. I recognize that to have been able to complete a thesis is a personal achievement. It is also a remarkable privilege to have had the opportunity to do so, when so many are deprived of even a basic education. In recent weeks, as I finally saw my work come together, into something coherent, looking up in search of the right word or phrase - to see the magpies and jays fighting in the trees or the blue tits building their nest in the drainpipe, I have realised how engrossed I have been in my work and felt a sense of gratitude and satisfaction. Nonetheless, I am very glad to be able to glance back and see a path that I will never need to tread again. Time to go back through that gate again, spend time with my neglected family, and take what I have learned, to improve my practice - for students, patients and colleagues - wherever the onward path now takes me.

Overview of academic portfolio informing this thesis



CHAPTER 1 POINT OF DEPARTURE - RESEARCH & PRACTITIONER CONTEXT

> In the UK, perhaps to a greater extent than in any other country ,... public engagement activities are undergoing a process of institutionalisation. *Burchell (2013: p1)*

1.1 Introduction to the study & research context

Through the practitioner-research presented in this thesis I seek to understand the relationship between medical schools, their regulatory body and the public. I explore how medical school leaders and officers of the regulator, the General Medical Council (GMC[8]), frame their policies and practices in response to a growing perception that the public should be more actively engaged in health, healthcare, and higher education. The story unfolds in the context of increased pluralism in the academy and public services, alongside tighter regulation. This chapter sets the scene with an overview of the research context, current issues facing medical education, and challenges in the governance of public institutions; followed by a statement of my interest in public engagement; and finally, a summary of research gaps and my research questions.

In brief, the cases in this thesis - three medical schools and the GMC - provide a rich, focussed insight into the interpretation, enactment and institutionalisation of public engagement and patient involvement in UK medical education. I use a novel combination of analytical and methodological approaches to deepen understanding of the dynamic educational, social, and governance landscape. The study reveals the effects of knowledge and authority on the one hand, and regulation on the other, at the level of the individual, the organisation and medical education as a whole. The findings will be of interest to curriculum and engagement leaders, practitioners and researchers, as well as health professional regulators. This is particularly so in the light of recent events in the NHS, new educational standards (GMC, 2016), and proposed changes in the higher education quality framework (Secretary of State for Business Innovation and Skills, 2015) and professional regulation (PSA, 2015).

[8] GMC General Medical Council is the UK medical licensing and regulatory body of medical education and individual professionals. It strives to maintain the trust of both doctors and the public, and to keep up with socio-political trends by regularly revising policies and reframing regulatory requirements. Lay participation is now central to the GMC's approach to its own governance. According to Wright (2011) the GMC has a reputation internationally for providing a model of regulatory excellence.

1.2 Public institutions, policy dynamics and the "struggle for guardianship"[9]

In a comprehensive international review Frenk, Chen et al (2010) identify *relevance* as the key systemic challenge for health professional education: that is the mismatch between professional knowledge and values, and patient, public and community needs. Their solution is a transformed curriculum, that integrates individual and collective needs through engagement, promoted by good leadership, strong governance and social accountability. Such reorientation will shape, and be shaped by, the expectations of students, the culture of the host university, the state of health services, and the regulatory environment. Increasing relevance to patients and the public, presents medical school leaders with a number of options and constraints.

Medical education sits at the intersection of two major UK institutions, higher education and healthcare, where public engagement has become "*de rigueur*" (Parry *et al.*, 2012). The range of terminology and practices under the engagement banner reflects a set of contested agendas which struggle to balance expertise, control and cost, with relevance, openness, and social justice (McIlrath and Mac Labhrainn, 2007; Ocloo and Fulop, 2011; Scott, 2013; Scott and Engwall, 2013; Tritter and McCallum, 2006; Watson, 2008b; Watson *et al.*, 2011). Such public institutions in the UK are operating in a new setting characterised by a shift from big public provision to a small, but firm, state regulating services in quasi-markets consistent with neoliberalism (Ball, 2012). The current situation in both health and higher education sectors represents a conceptual hybrid of public services for 'the public good', (Scott, 2015) co-existing with commodities provided to clients as captured in Table 1.1.

The trends toward multiple priorities and foci take different forms across, and within, healthcare and higher education, associated with a different lexicon - discussed in detail in Chapter 2. In both cases there are tensions between the individual, the collective, and the institutional. In higher education there are issues of student voice, student centredness and student satisfaction[10]. There are initiatives related to research funding and impact, and

[9] Taken from Strain et al (2009)

[10] Educating the professions is of particular interest to UK higher education. Student-paid fees are increasing and what public funding remains for undergraduate programmes is stratified by subject. As of 2012-13 home students pay a flat fee. All universities with medical schools set the fee at the maximum (£9,000). The state component of funding paid directly to the HEI by HEFCE per student in high-cost subjects, group A (medicine and dentistry), is £9,804 and £1,483 for group B (science, engineering and technology). HEFCE does not allocate funding for other subjects. HEFCE (2012) Overseas students - (paying up to £250,000 by graduation) - are both discerning, and attractive to medical schools.

institutional reputation. Competition has led to heterogeneity of university missions in the pursuit of local, social and international goals.

Table 1.1: Policy dynamic in higher education and healthcare

	Guiding principle			Dominant contemporary policy/governance mechanisms
	Right /public good (via government)		Commodity (via governance)	
Higher Education policy	Academic freedom State funding Civic commitment Improved access / Massification	**Social governance through public engagement**	Student experience + Student fees Research enterprise Diversity of academic work (i.e. academic consultancy)	Inter/national ranking. Institutional accountability Marketisation & Competition (instrumental drivers) Choice and voice (student)
Health-care policy	Universal state healthcare provision based on risk sharing and risk pooling. Relies on clinical expertise		Patient choice + diversity of providers (social enterprise & for-profit providers) Relies on competition Patient as client	Commissioning & payment by results (instrumental drivers) Regulation & compliance (normative driver) Choice and voice (patient) Moral & instrumental drivers

In healthcare, expectations of patient centredness (Department of Health, 2006) coexist with demands for collective accountability, each bolstering different professional, political and social agendas. The professions, especially medicine, have had to make strenuous efforts to maintain public trust. Fallout from a number of scandals (Dixon-Woods, Yeung and Bosk, 2011; Francis, 2013b) has been key (as is supported by my findings). The profession has been forced to get its training and regulatory houses in order (O'Neill, 2002).

Social governance, through public engagement, in many forms, has been actively promoted although its roles in these sectors, and potential purposes remain unclear (Anheier, 2004; Sørensen and Torfing, 2011). Much hinges on different concepts of public, civil society and the social sphere, and the principles and discourses shaping policy, as well as the assumed mechanisms and benefits of engagement and involvement - at individual, organisational and

institutional level. This dynamic is shown in Table 1.1 (above) and addressed in detail in Chapter 2 and Appendix 3.

As Sørensen and Torfing (2008: p.2) suggest:

> *In the last decade, the heated ideological debate about whether to base social governance on either state or market has been challenged by new developments in societal governance. Hence, in order to compensate for the limits and failures of both state regulation and market regulation new forms of negotiated governance through the formation of public–private partnerships, strategic alliances, dialogue groups, consultative committees and inter-organizational networks have mushroomed.*

1.3 UK Medical education: addressing relevance and quality through regulation and engagement

In the UK, formal governance of medical schools is shared between higher education quality arrangements and the GMC. The latter has the dominant role, licensing the 31 UK schools and registering 7,000 graduates annually. Licensing is against published standards and outcomes. Starting in 1947, initially framed as decennial recommendations, they became legally binding *requirements*, with revisions to the Medical Act, 2004 (Hasman, Coulter and Askham, 2006). The standards, entitled *Tomorrow's Doctors*[11] from 1993, were reviewed every five years or so[12] and modified to reflect both new trends and evidence of effective implementation(Wright and Associates, 2012) (see page 44).

This research is concerned with the period governed by the 2009 edition (GMC 2009). *Tomorrow's Doctors* covers syllabus (as learning outcomes) and *standards* for selection, teaching, assessment, and governance. The Quality Improvement Framework, QIF (GMC, 2012) structures implementation combining annual self-assessment by schools with periodic inspection visits[13]. In 2009 the GMC added new standards to *Tomorrow's Doctors* (2009) which require medical schools to provide evidence of patient and public involvement in

[11] *Tomorrow's Doctors 2009* is discussed in Chapter 3

[12] Revised standards, *Promoting excellence* came into force in January 2016. The *Outcomes for graduates section of Tomorrow's Doctors and* Supplementary advice remains, for now, extant.

[13] The QIF, incorporating QABME (Quality Assurance of Basic Medical Education), the nature of visits and the composition of teams is discussed in Chapter 5 and summarised in Appendix 2.

teaching, assessment and governance. Relevant paragraphs are included in Box 1.1[14]. This thesis is a response to the inclusion of these standards.

Box 1.1: Extracts from standards for medical education, *Tomorrow's Doctors* (GMC 2009), related to public engagement and patient involvement. (My emphasis and paragraph numbers in **bold**)

Domain 2 – Quality assurance, review and evaluation

43 Quality data will include:
(a) evaluations by students and data from medical school teachers and other education providers about placements, resources and assessment outcomes
(b) feedback from patients
(c) feedback from employers about the preparedness of graduates.

Detailed requirement
48 Apart from the medical school officers and committees, all education providers of clinical placements, and all clinical tutors and supervisors, students, employers and ***patients should be involved in quality management and control processes***. Their roles must be defined and information made available to them about this.

51 There must be procedures in place to check the quality of teaching, learning and assessment, including that in clinical/vocational placements, and to ensure that standards are being maintained. These must be monitored through a number of different systems, including student and ***patient feedback***, and reviews of teaching by peers.

Domain 5 - Design and delivery of the curriculum, including assessment

111 Students must receive regular information about their development and progress. ...All doctors, other health and social care workers, ***patients and carers*** **who come into contact with the student** should have an opportunity to provide constructive feedback about their performance. Feedback about performance in assessments helps to identify strengths and weaknesses, both in students and in the curriculum, and this allows changes to be made

The contested nature of such involvement, and the way in which the standards were phrased, initially caused confusion, as revealed in low levels of compliance in the first round of self assessment in 2010. The publication of *Supplementary Advice* (GMC, 2011a), after a brief consultation, provided an eclectic review of the literature and "good practice" leaving medical schools to interpret the standards. The GMC's expectations were summarised in its introduction (GMC, 2011;p2):

[14] Included in Appendix 1 for ease of reference later.

Tomorrow's Doctors (2009) fosters a culture which enables patients and the public to contribute actively to the educational processes. It calls for systems which give patients an opportunity to feed back on the quality of teaching, learning and assessment as well as individual students' performance.

1.4 Practitioner context

I have two professional motivations for this research. First, my leadership roles at a UK medical school: formerly sub-dean for educational quality, and currently lead for patient and public involvement, and social determinants of health. In 2010 I was responsible for interpreting the new regulatory standards in *Tomorrow's Doctors* (GMC, 2009), and providing evidence of compliance for the annual self assessment. I very much welcome the inclusion of patient involvement and public engagement in *Tomorrow's Doctors 2009* but I discovered that, like me, colleagues all over the UK had declared their medical schools "non compliant" for these requirements. Secondly, as a GP teacher for over 20 years, I have struggled to reconcile the needs of individual patients and students, alongside community perspectives. I have been unsure how to align myself (and my organisation) in these important processes, and I wished to know how others have grappled with these challenges.

This work builds on my academic portfolio, adding to explorations of leadership and learning in higher education (Institutional Focused Study, part of this doctorate, Berlin 2011), the place of the medical school in society (Berlin, 2013; Rudolf *et al.*, 2014), and the role of lay representatives in the curriculum (Berlin *et al.*, 2011). Personal factors also underpin my interest. In addition to my academic roles, my work as a GP, and work at home attending to the needs of teenagers and husband, I also have become a carer (both my parents were diagnosed with Alzheimer's disease) and, as an indirect consequence, I am now the Vice-Chair of my local Carers Centre.

Taken together, these professional, academic, and personal motivations have led me to consider the challenges of individual and collective agency, and accountability at the boundaries between civil society, public services, and the institutions of governance from multiple perspectives.

1.5 The research: knowledge gaps, design and research questions

Having considered the background and context I turn to the research itself. The essence of medical education is student contact with patients. Over the past two decades schools have expanded the range of settings for, and modes of involvement of patients and public in learning. These arrangements have moved from the opportunistic and voluntary, to the strategic and institutional. It was understood by medical schools that in *Tomorrow's Doctors* (2009) the GMC sought to promote patient involvement and public engagement in the curriculum and its governance through standardisation. My literature review (see Chapter 2) reveals few studies examining stakeholder perspectives of public engagement at the organisational level in medical education (for example O'Keefe and Jones, 2007; and Reddy *et al.*, 2013); none from the UK. Furthermore there is an acknowledged gap in understanding the effect of professional regulation (Quick, 2011). This is the first study to investigate public engagement in UK medical education and its institutionalisation through the GMC standards.

While curricula are now converging through more explicit external definition, medical school contexts vary and their leaders retain some autonomy to diversify [15] (described in Chapters 2 and 5, p77). Embedded in the mission and pedagogic practices of each school are tacit statements about the nature of professional knowledge, expertise, values, status, power, and social justice. The main interest of the study, the framing of public engagement, plays out in three medical schools selected to **maximise diversity** due to their different histories, orientations and regulatory experience (applying a rubric described in Chapter 5 and Appendix 11), alongside a case study of the regulatory perspective based on interviews with GMC officers.

I apply two approaches, informed by symbolic interactionism: boundary object theory and frame analysis, explained in detail in Chapters 3 and 4. Through the notion of the 'boundary object' (Star and Griesemer, 1989), I explore accounts of public engagement across organisational boundaries. Boundary objects are ill-defined but shared concepts that link otherwise separate social worlds, and communities of practice/knowledge at intra- and inter-organizational boundaries. I test the idea that public engagement in medical education acts as a boundary object and I consider educational leaders as "boundary agents" - organizational actors with a capacity to adapt and move (or impede) objects. Star (2010)

[15] Broadly (1) the established, (2) hybrid - those involved in sponsoring /mergers/demergers ; and (3). the new. See Appendix 11 for full list.

describes the tendency for published standards (such as those in *Tomorrow's Doctors*) to arise from boundary objects through a transition from negotiated endeavours to control devices. To explore this idea I use the notion of the *frame*: a set of concepts and perspectives that organize experiences and guide the actions of individuals, groups and societies. Frame analysis is the study of these socially derived concepts. It seeks to understand the multiple frames used by individuals and collectives to define a problem, diagnose causes, attribute responsibility, make professional, academic, and moral judgments, and suggest remedies. Frame analysis goes beyond thematic interpretation of individual perspectives. It allows me to test the idea that public engagement functions as a boundary object and curriculum leaders as boundary agents, as well as analyse public engagement across the entire educational and institutional field. The study design, data collection and analysis are located within the broad tradition of *interpretive* research (Crotty, 2003). Thus the aims are exploratory and theory-testing, not to make comparisons between cases. It is an investigation into *interpretations* of public engagement as a regulatory standard, not an account of its implementation (as for example in May (2009)). Through the application of boundary object theory and frame analysis, I can, at least, deepen our understanding of public engagement and draw plausible lessons[16]. of relevance to medical education and its regulators.

Research Questions

With the above in mind, I have developed the following principal research question:

> How is public engagement policy framed and enacted in UK medical education in the context of evolving regulatory requirements and organisational *diversity* of medical schools, and what are the implications for leadership?

Having considered the literature, my professional interests, and the most fruitful theoretical and methodological approaches, the thesis is further shaped by these six supplementary research questions:

i. To what extent does the notion of the boundary object enhance our understanding of public engagement and its institutionalisation in medical education in the UK?

[16] Within the interpretive tradition it is NOT appropriate to make claims of generalisability, however frame analysis allows bridging across cases. Such issues of design and rigour are addressed in more detail in Chapters 5 and 7 , and in Appendices 12 and 13.

ii. Who are the boundary agents with regard to public engagement in the cases studied, and how do these agents frame public engagement?

iii. What appears to be happening in the contested boundary spaces between professional, academic and public sphere?

iv. What can we learn about how knowledge is framed and constructed between different knowledge communities or fields studied?

v. Is public engagement framed to support individual, professional priorities or socially-oriented change in curriculum practice ?

vi. How does regulation appear to affect framing of public engagement ?

The next two chapters map out and synthesises the existing research and policy literature that informs this thesis and to which I aim to make a contribution.

CHAPTER 2 MAPPING THE TERRITORY - THE SCHOLARSHIP OF ENGAGEMENT

2.1 Approach to the literature

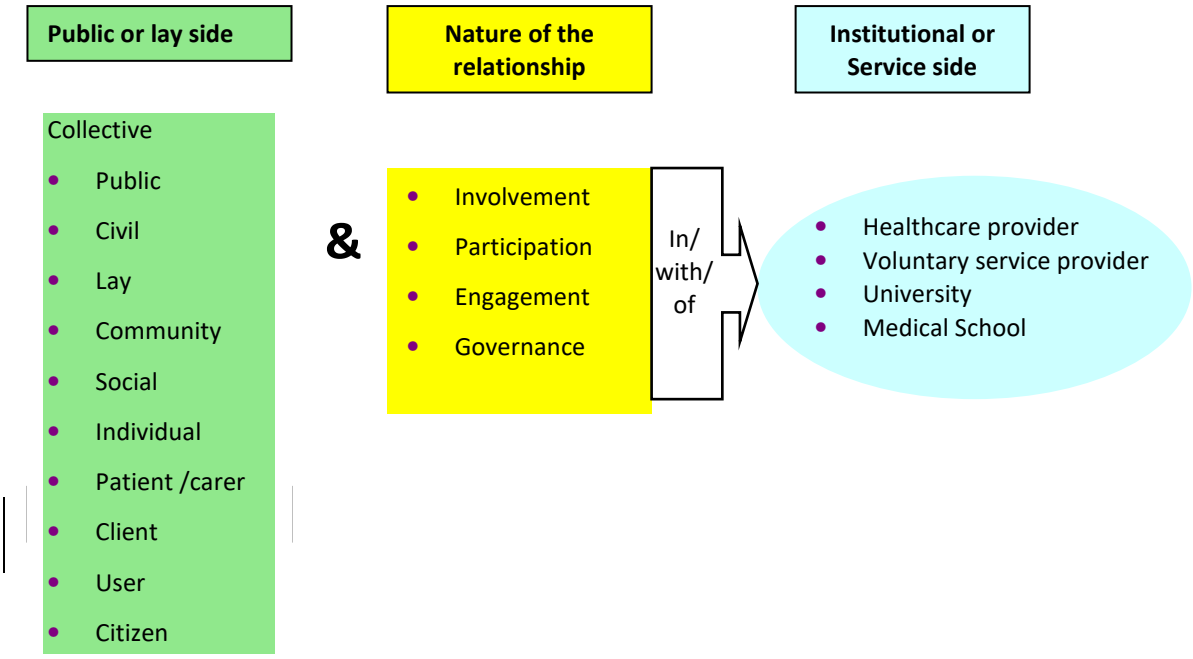
The literature is handled in two chapters. In this chapter I place my research within the existing body of scholarship of engagement and involvement. My purpose is to map out the field, position my work within established intellectual traditions and analyse knowledge gaps. In Chapter 3, I address the separate body of work describing the evolution of public engagement as a regulatory standard. Public engagement is an exceptionally broad field and these chapters are supplements by a detailed review in Appendix 3.

The first part of this chapter is a summary of my search strategy and a discussion of the terminology related to public engagement and its etymology. I consider the origins of public engagement and its political and historical relationship with social governance. The second part is an analysis of engagement literature in healthcare, and in the university; this is included to further contextualise this study and overcome the tendency to refer to work in one's own immediate area, ignoring relevant work in adjacent fields. The third and final part of this chapter considers the literature at the intersection between these two areas, my field of interest, the medical school.

2.1.1 Terminological couplings: Search strategy, etymology & a working definition

As Benhabib (1992), and Towle (2010) suggest, the literature forms a web of overlapping terms and concepts which cannot realistically be fully unravelled. I am aware, nonetheless, that choice of terms (mine included) aligns with particular traditions and communicates certain standpoints. Ideas of what (and where) *the public* are or what a *patient is* in medical education are central to this study, as are notions of how, and with what, they may be involved or engaged. Core to understanding the field, is the recognition that public engagement and allied terms refer to a “relationship". The literature logically and largely assumes a two-sided relationship generally perceived from the institutional side (see Figure 2.1)

Figure 2.1: A generic model of public-institutional relationships



Two initial issues arise from this collection of near-synonyms (in Figure 2.1). First, the challenges of undertaking, and then sustaining, an up-to-date literature review. Dealing with the multiple, overlapping terminological couplings requires repeated, systematic searches - explained fully in Appendix 3. Secondly, the need, for ease of reading, to settle on a limited set of terms. The most common terms in the settings of interest are ***public engagement*** (which I will use in full) and ***patient and public involvement***, which I will use where directly appropriate, with the abbreviation ***PPI***.

The way in which terms have come to coexist, provides the base on which my review and synthesis of the literature sits. Facer, Manners and Agusita (2012, p. 3), in their literature review of public engagement in research, state that the question of terminology 'bedevils the field'. Research orthodoxy suggests it is incumbent upon me to provide a clear definition of the terms I am using (public engagement and PPI). However I resist this. It is precisely this imprecision that is of interest to me. As Parry *et al.* (2012) observe, writing about their work with the public on stem cell research:

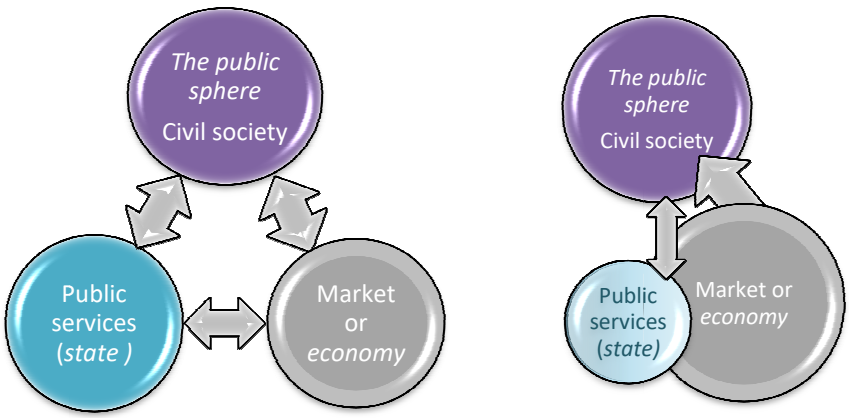
> *...these weakly structured heterogeneous visions enable public engagement to operate at a site where diverse actors with diverse interests and agendas can come together and achieve something which all find meaningful, albeit in diverse ways. p72.*

It is important that the term remains "weakly structured" (a so-called boundary object (Star and Griesemer, 1989)) to encompass all theoretical perspectives and accommodate their diverse, coexistent manifestations in my field of interest. Exploring this pluralism is a key *object* of my study, incorporated in the interview topic guide and pursued in the data analysis.

2.2 Spheres of influences: the social, the civil, and the public[17]

The shifting social settlement or relationship between state, market and society (Wildemeersch, Biesta and De Bie, 2014), introduced in Chapter 1, is a central preoccupation of social, political and economic theory of the last 150 years and underpins public engagement practice and research. Two terms for the public or societal component of this trinity dominate the literature: the public sphere and civil society. They have different origins (associated with the ideas of Habermas and Gramsci (Keane, 1988)) but have become intertwined, often used as synonyms. Anheier (2004) and Edwards (2014) describe how the blurring between state and market has important implications for the role of civil society and conceptions of state-sponsored institutions. The market is becoming more dominant leading to an increasingly unidirectional dynamic with civil society (right side Figure 2.2). This is of major significance for both higher education and healthcare in the UK, and therefore their relationships with the public.

Figure 2.2: Changing relationships in the components of the social settlement for civic relationships (former on left, revised on right)



[17] A longer version is included as Appendix 4

In this reading of arrangements higher education and healthcare assume more complex roles and responsibilities with regard to civil society (Facer, Manners and Agusita, 2012; Watson *et al.*, 2011). As Hauser (1998) and May (2007) argue, there is often no single public - but many publics that are recruited by institutions or emerge and coalesce for a time, at different levels around specific concerns.

Civil society, can thus serve widely differing purposes. It provides support for the political processes that shape and sustain the state provision of public services, primarily by expecting greater relevance, responsiveness to public needs. At the same time, through consumer choice, it facilitates the reduction of state provision (and responsibility) to allow expansion of the market. Anheier describes civil society as a *"sphere located between state and market--a buffer zone strong enough to keep both state and market in check* (2004, p1). It is largely through the processes of participation and engagement that this buffering and accountability is expected to be enacted (Gibson, Britten and Lynch, 2012). By far the most cited framework for public engagement or "citizen participation" is Sherry Arnstein's (Arnstein, 1969; Conklin, Morris and Nolte, 2015; Innes and Booher, 2004; May, 2007; Rowe and Frewer, 2005)(reproduced in Appendix 4). This uses a ladder metaphor - to display the steps to citizen empowerment (See Appendix 4). Arnstein foregrounds the inherent issues of power and control - the overt and covert ways in which *the deal* between the public and institutional sides is brokered (Landzelius, 2006).

2.2.1 The engagement relationship: to share, to consult, to serve, or to transform

Having considered the public-side of the engagement equation, I turn to the *nature* of the relationship. In the literature and in practice, involvement, participation and engagement convey similar ideas (Charles and DeMaio, 1993). Although often used interchangeably, they may highlight dynamics and power gradients (Gibson, Britten and Lynch, 2012). In Box 2.1 I provide a synthesis of three distinct (if overlapping) traditions of thought and practice.

Box 2.1: Three traditions of thought and practice in public engagement.

1. Institutional needs - Pull in/Push out

- Fields: healthcare (Tritter, 2011, Landzelius,2006, Ocloo & Fulop;2005); science and technology (Datta,2011; Parry,2012;); development (UNDP, 2012) and planning (Innes, 2004)
- Rooted in idea that public sphere is needed to fill institutional deficit (Datta, 2011; Rowe and Frewer, 2005; Stirling, 2007) and thus to address the "crisis of legitimation" - improve trust and relevance ; also fill public knowledge deficit.
- Frames public engagement as dialogues that seek to shape actively individual healthcare and research decisions, and endorse institutional policy - often around areas of efficiency, services development and research (Wilson *et al.*, 2015)
- *" A dualist approach, combining ideologies of democratic participative public engagement with an economically motivated 'consumerism'.* (Stirling, 2007)
- In healthcare PPI incorporates both individualized patient-centeredness and collective purposes
- Literature is relatively de-politicised - issues of power are not generally addressed.

2. Institution as public good

- Field: appears frequently in higher education sector (Scott, 2015; Watson, 2011; Goddard, 2009)
- Rooted in the notions of civil society, civic virtue and sustaining democracy (Hart, Northmore and Gerhardt, 2009; Munck, Lyons and McIlrath, 2012; Watson *et al.*, 2011)
- Engagement viewed from public perspective with broad goal of the pursuit of public good to build social capital (Innes and Booher, 2004), & individual ends by increasing identity capital (Cote, 2002)
- Frames public engagement as community service with intentions of local and regional socio-economic and cultural/creative enhancement (Scott, 2015)
- Sponsoring institutions seen as part of community, and local resources, their staff and especially their students, enact engagement within, and as a service to, the host community

3. Co-construction - transformative

- Arises from critiques of public engagement, and evidence regarding limitations of (1) & (2) above
- Goal of social change through process of co-construction of the agenda and goals, and co-production of the outcomes
- Frames public engagement as bidirectional underpinned by explicit concern for justice and equality.
- Intention is transformative, even emancipatory (Gibson, Britten and Lynch, 2012; UNDP, 2013) to benefit the institution, its relevant publics (individually and collectively) and the relationship between the two (UNDP, 2013)
- Centrally concerned with the relationship between structures and agency

Critics from all the sectors have written despairingly about the perennial challenges of public engagement and these are summarised in Appendix 4. The next sections review public engagement, thought and practice within the distinct literatures relating to healthcare, higher education, and the education of doctors, before considering the role of regulation in Chapter 3.

2.3 Engagement in adjacent sectors: healthcare & higher education

> *'Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.'*
>
> *Sontag (1978, p3)*

A full version of this section is included in Appendix 6 but a brief overview of PPI in healthcare is included here, followed by a summary of public engagement in higher education. PPI in healthcare focuses on issues of trust in professionals and the accountability of services they provide; as well as the individual's role as part of both a humanistic patient-centred project and as a consumer in a commodified health economy. The field has attracted numerous policies and legislation which I display chronologically, interleaved with the consultations and public inquiries that have shaped them in Appendix 5. Key among these are inquiries into Bristol paediatric surgery (Kennedy *et al.*, 2001), the Shipman murders (Smith, 2004); and the care provided at Mid Staffordshire NHS Trust (Francis, 2013a & b).

Much of the literature is concerned with concepts of patienthood, legitimacy and representativeness, leading to complex pluralism of the patient personae (Landzelius, 2006). Tritter (2011) makes a distinction between approaches based on *individual* rights that promote "wants" over needs, and those based on *collective* rights (concerned with social equity and population priorities[18]). Public involvement was given as an essential collective voice to feed into local healthcare policy through statutory bodies (originally Community Health Councils, and then LINKs). Recent legislation explicitly restricts the advocacy role of local HealthWatch groups, undermining the collective voice *within* the NHS and shifting emphasis to individualised feedback.

[18] Such as legislation creating smoking free environments, and the fiscal controls of the cost of alcohol.

Following the Francis Inquiry (2013b) the current trends are complex and somewhat incoherent. Berwick (2013) advocates PPI at every level as the route to a zero-risk culture. Coulter argues that collective PPI involvement in strategy and policy is a fallacious attempt '*to tackle the "democratic deficit" '* (in Andersson *et al.*, 2007, p. 32) in the NHS -and a worthy distraction from the main goal of making individual doctor-patient relationships more patient-centred. She claims that since the inception of the NHS, patients have adopted a passive role, sustained by a resistant, paternalistic professional culture. Others take the individualist view of PPI as essentially collaborative, patient-centred interactions (Barr, Ogden and Rooney, 2014; Gibson, Britten and Lynch, 2012; Hogg, 2004 ; Mead and Bower, 2000). The emphasis on the individual follows wider trends, both in the framing of disease causation and intervention. As Brown (2013) points out, this exculpates policy makers from addressing wider factors such as environment, ethnicity, and economic inequity – placing responsibility for many, often complex, problems on individual patients and their doctor.

Empirical studies of effectiveness are important as they frame PPI in a way that aligns with dominant concepts of evidence and its relationship to policy and practice. Improved clinical outcomes and satisfaction can be demonstrated, in a number of areas particularly for people with long term conditions (Tritter & McCallum, 2009)[19]. Qualitative, participative methodologies focusing on soft outcomes (Hawley, 2015) related to empowerment, advocacy, safety and trust (Brett *et al.*, 2014; Calnan and Rowe, 2008; Ocloo and Fulop, 2011) may provide valuable insights.

Turning to the literature related to the university sector, this reveals different conceptualisations of engagement to those identified in healthcare due to the sector's varied roles and stakeholders. We see reference to all three traditions identified above in Box 2.1 *pull in/push out* to address legitimacy and a perceived democratic deficit; *a public good* for civic and community enhancement; and *co-production/transformative* approaches to achieve social change (See Box 2.1, above).

Many authors refer to the economic and political value or capital ascribed to knowledge as well as its potential for moral and social good (Fernandez-Pena *et al.*, 2008; Goddard, 2009; Jacoby, 2009; Olson and Worsham, 2012; Peters, 2010; Schuetze, 2012; Scott, 2010; Scott, 2015; Strain, Barnett and Jarvis, 2009; Watson, 2008a). Different types of universities are

[19] Which now includes participation through the web and social media.

associated with different ideas of public engagement, raising questions about how knowledge is created, legitimized and used across varied knowledge and social communities (Barnett and Di Napoli, 2008). Engagement is, therefore about both social and knowledge relationships, and about individuals and the organisations, within a local, national and even global political and economic dynamic (Watson *et al.*, 2011).

The scholarship of engagement in higher education is further predicated on two different understandings of the university itself. The first - arising largely from north America – assigns the university three roles: the so-called three legged stool or three ringed circus (Toews and Yazedijian, 2007) of research, teaching and service. The second understanding, used in the UK, is largely limited to dual roles of teaching and research. These differences have a significant impact on understanding public engagement in medical education, addressed later.

The "engaged campus" is promoted as an holistic project joining learning with research and service through critical enquiry and service (Boland, 2012; Boyer, 1990; Boyer, 1996; Calleson, Jordan and Seifer, 2005; Healey, 2010; Hofmeyer, Newton and Scott, 2007). Both volunteering and service learning (credit-bearing educational experiences) are associated with conceptions of curriculum, informed by transformative pedagogy (Rubin *et al.*, 2012) aimed at advancing collective social justice, while shaping individual social identity and encouraging agency, with evidence that participation increases civic engagement in graduates (Tansey, 2012) (See Box A6.1 in Appendix 6). At the same time, there may be considerable personal and institutional self-interest at play in the 'engaged campus' (Avalos in Tansey, 2012) - in that students can augment their CVs, and institutions can fulfil regulatory and funder requirements (summarised in Appendix 6.)

With regard to the UK, the literature reveals, a tendency to consider engagement in higher education as synonymous with *research* engagement, to the exclusion of education, and broader community development. This reflects the focus of the modern UK university on *extractive* activities (Barnett in McIlrath and Mac Labhrainn, 2007), *World Class*[20] aspiration, and global ranking - particularly in the research-intensive universities (Dyer-Witheford, 2005 ; Holmwood, 2011; Watson 2012).

[20] *World-Class* ranking criteria does not include any element of community engagement or social accountability.

The general effect of current research policy and funding is that UK academics (as with my own participants) tend to equate public engagement with lay participation in individual research projects. As the late David Watson (2012, p. 6) succinctly states:

> *'Despite Herculean efforts everything reduces to peer-reviewed research.'*

There is some evidence of a rekindling of traditional civic missions in the sector (Goddard, 2009; NCCPE, 2016). This is framed as a predominantly push out/pull in process, an offsetting strategy (Boland, 2012; Gourley, 2012) to remediate claims of irrelevance, commercialisation, and elitism. However, there is also a genuine will to connect with the community (Barnett, 2012) by individual students, academics and institutions, for the public good.

> *'The—intriguing—implication is that the university of the 21st century should re-engage with its urban and regional environment rather than float off into a virtualised globalisation'. Scott (2013, p. 230)'*

2.4 Engagement and involvement in medical education

The distinct but parallel processes and framings of engagement in higher education and healthcare, (as elaborated in Appendix 6), come together, not always comfortably, in medical education. The medical school's primary task is to educate its students. Medical students, in turn, have both their own interests and those of their future patients to consider[21]. The centrality of contact with individual patients in the preparation of doctors-to-be, dominates the literature. Probably because of their location between education and an increasingly scrutinised health service, medical programmes are the most tightly regulated in the university sector. As described in Chapter 1, new regulatory standards for patient and public involvement were introduced in 2009 (GMC, 2009). Curriculum leaders have to balance competing priorities: the needs of students for ample clinical contact, the rights of patients, and the indirect expectations of the public for competent, caring graduates, a wider social agenda, and now those of the GMC .[22]

[21] Medical schools in the UK are all located in universities and - currently, unlike counterparts in many part of the world - have no direct health service role. With the advent of the UK Academic Health Science Centres , this distinction is already blurring.

[22] Medical programmes must, at the very least, remain mindful of current and future health needs, and are dependent on health services to provide appropriate settings for clinical learning.

This review has been helped by Towle and Godolphin's bibliography (PERC, 2009), and Spencer et al's summary (2011). Howe (2003) and Jha et al (2009a) provide UK overviews, and GMC's *Supplementary Advice* to *Tomorrow's Doctors* (GMC, 2011a) is a compendium of good practice. A number of models have been produced to marshal the literature or support policies. The three most cited (Spencer *et al.*, 2000; Tew, Gell and Foster, 2004; Towle *et al.*, 2010) are all based on a ladder structure with varying numbers of rungs implying a hierarchy reminiscent of Arnstein (1969) - broadly speaking, real patient contact is at the bottom and committee membership is at the top. It is not my intention here to reproduce these save for a brief synthesis. My interest is to consider how PPI is framed and to connect this with the wider context of higher education and healthcare.

Scholarship of engagement in medical education for individualistic (student / patient focussed) and collective (organisational/public) purposes are associated with fundamentally different underlying concepts of the medical curriculum itself. The former is broadly aligned with competency-based approaches, the latter with notions of transformative pedagogy. In brief, the transformative curriculum takes the needs of its host community as its starting point (Frenk, Chen and al, 2010; Mezirow, 2000) - rather than the competency of the individual student (Box A6.1 in detail in Appendix 6). Therefore there is a clear social purpose based on partnership that assumes agency and advocacy on the part of the school and those within (staff and students).[23] I focus on the literature regarding patient involvement in student learning now and later consider PPI in medical curricula at an organisational level.

A considerable literature addresses the role of patients in learning, assessment, and course design, consisting of mostly small, descriptive studies, proposals, and aspirational guides, covering a wide range of topics such as: clinical and communication skills (PERC, 2009); patients with chronic conditions (such as HIV; mental health, or the disabled) (Karnieli-Miller *et al.*, 2014; Towle *et al.*, 2010); different clinical and community settings and faculty, lay, and student perspectives (Anderson, Lennox and Petersen, 2003; Cooper, Gibbs and Brown, 2001; Dornan *et al.*, 2006; Forster *et al.*, 1992; Frankford and Konrad, 1998; Hastings, Fraser and McKinley, 2000; Howe, Billingham and Walters, 2002; Lee *et al.*, 2014; Murray *et al.*, 2001; Nicholson *et al.*, 2001; Thistlethwaite and Jordan, 1999). There are many examples of patients contributing to course design at module level. Short term benefits to students,

[23] Transformative education does not eschew disciplinary knowledge and competence but embraces and enhances it so that individuals and institutions act as agents for change rather than guardians of a status quo.

patients/public, and occasionally faculty, are described, and theoretical risks identified (summarised in PERC, 2009).

The medical education literature reiterates the known challenges to public engagement (see Appendix 4, Box A4.1). Solutions in the UK draw on experience of PPI in healthcare. Thus public engagement in health professional education reflects "motifs" from the health sector (Tritter, 2011) rather than higher education, framing PPI as a "pull in" process - essential to improving the experience of, and outcomes for *individuals*. No published accounts describing *curriculum-wide* lay engagement with design, evaluation or governance in the UK were identified, although recent developments suggest they are expanding (see for example, thanks to a large donation, the new PPI centre at Manchester (2014). Published examples of school-wide lay involvement exist from Canada (e.g. Farrell, Towle and Godolphin, 2006) and Australia (e.g.O'Keefe and Jones, 2007).

2.4.1 Community as locus, focus and active participant

The literature on the wider collective purposes of public engagement in medical education draws on two parallel bodies of scholarship: the engaged university, already discussed above, and community related medical education (*community based education*, CBE; *community oriented medical education*, COME, and *community engaged medical education*, CEME). A combination of the Alma Ata declaration calling for primary health care for all (WHO, 1978), demographic, and service changes, led to a significant increase in CBE in UK medical schools, mainly through general practice (GP) placements from the 1990s onwards (Howe, 2001; Howe, 2011; Shamroth, Haines and Gallivan, 1990). General practice, as locus and focus of medical education in the UK, was *not* founded on community partnerships but on the ability of general practice to (1) provide appropriate spaces for learning outside the teaching hospital, and (2) to promote holistic, patient-centered practice (see for example Grant and Robling, 2006; Howe, 2001; Thistlethwaite and Jordan, 1999). This shift to CBE has been sustained (Lee *et al.*, 2014; Turkeshi *et al.*, 2015) but often translated into vehicles for teaching technical skills servicing the dominant competency-based curriculum paradigm (Bryant *et al.*, 2003; Hastings, Fraser and McKinley, 2000; Murray *et al.*, 2001; Nicholson *et al.*, 2001; Wallace *et al.*, 2001).

In parallel, community (as opposed to GP) placements have also been described in the UK (Dornan *et al.*, 2006; Hopayian, Howe and Dagley, 2007) involving students visiting a wide range of health and social care settings usually to observe, interview individuals, or occasionally contribute to CBPR[24] (Mullen, Nicolson and Cotton, 2010). Some continue for many decades (Anderson, Lennox and Petersen, 2003; Forster *et al.*, 1992; Lee *et al.*, 2014) but face challenges of sustainability such as exhaustion of community providers and perceived redundancy in a narrowed curriculum targeting competencies (Waddington, 2003). Innovative optional learning and volunteering activities have been described (Jones, Lloyd and Meakin, 2001), but the notion of credit-bearing service learning (Stewart and Wubbena, 2015) has barely evolved in the UK. This is effectively proscribed by concerns for safety and legal indemnity (see the vignette from Casterbridge Medical School in Chapter 6). Overall, the community, in particular general practice, is now an indisputably legitimate, institutionalised locus of education[25].

Studies of COME emanate from outside the UK but are of direct relevance to my own findings in this thesis. COME has been widely promoted and evaluated since the 1970s (Fulop, 1974), framed as a challenge to the dominance of biomedicine, the rigidity of the Flexnerian model (Engel, 1977; Richards and Fulop, 1987), and a strategy to increase relevance (Boelen, 1995) and social accountability (Boelen, 1999). The underlying principle is a medical school curriculum orientated to local and regional need, that includes, but goes beyond, GP and community-based placements.[26]

2.4.2 The engaged medical school, the socially accountable curriculum & the limits of competency

There is a recent reframing from community oriented to community *engaged* medical education (Ellaway, 2015; Strasser *et al.*, 2015). Building on the notion of the engaged

[24] CBPR : community-based participatory research

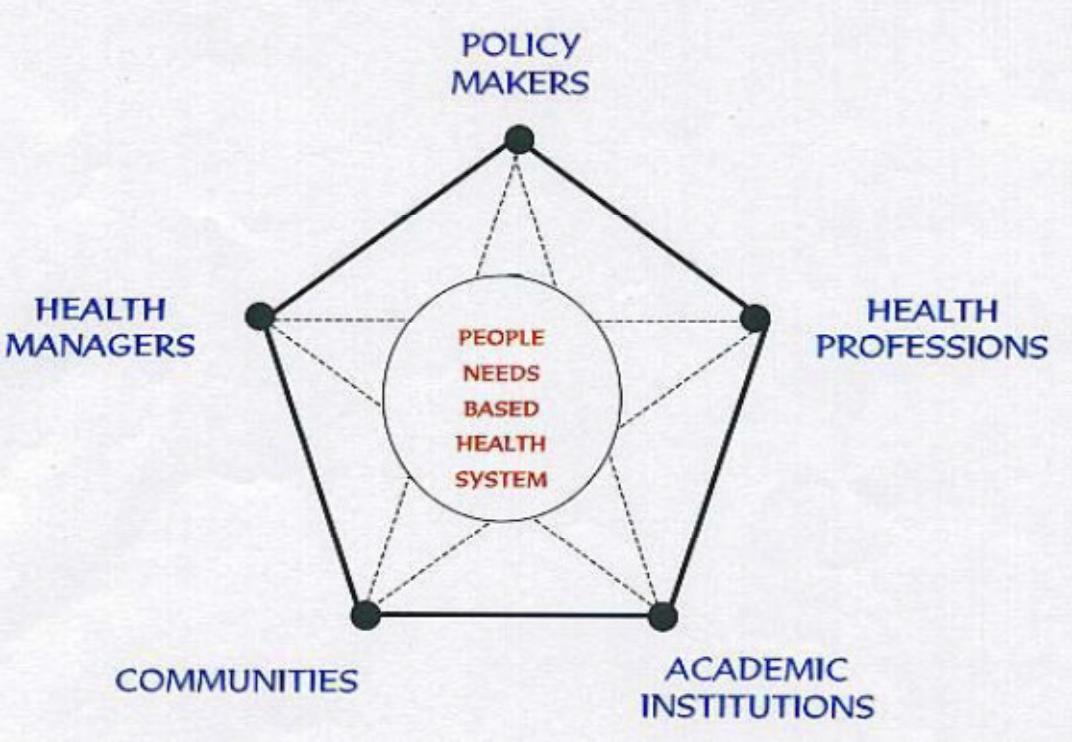
[25] In fact there are a number of previously unthinkable examples of GPs becoming "custodians" of the medical academy - as directors or deans of education in UK schools - as in my own sample.

[26] Worldwide COME schools have been supported for 30 years by a community of practice (TheNET (2015)) and an academic network (Towards Unity For Health, TUFH (2015)). Neither has had, to date, a UK medical school as a member.

university, the engaged medical school addresses wider on-going concerns (Calleson, Jordan and Seifer, 2005; Farnsworth, Frantz and McCune, 2012; Frenk, Chen and al, 2010; Goldstein and Bearman, 2011; Strasser *et al.*, 2015; Valsangkar *et al.*, 2014). An essentially transformative project, the key motif is collective benefit, in which the school itself serves the public good, actively recruiting from, and training for, underserved communities and specialties (Barr, Ogden and Rooney, 2014; Frenk, Chen and al, 2010; Larkins *et al.*, 2015; Rubin *et al.*, 2012; Whitehead, 2013) while reducing the reliance on overseas trained professionals (Crisp and Chen, 2014; Epstein and Epstein, 2012). The covenant underpinning the engaged school is to work closely with, or directly provide, community-oriented health services. In settings that lack universal health coverage *pro bono* care may be provided by staff *and* students (Bitton *et al.*, 2014; Brulin, 2002; Calleson, Jordan and Seifer, 2005; Dempsey, 2009), and Martinez *et al.* (2014) argue that such service learning, as opposed to ordinary clinical placements, develops attributes such as advocacy, agency and awareness of health inequity.

Part of this reframing incorporates the notion of the *socially accountable medical school,* a progression of the social movement that demanded medical school reforms in the late 20th century (Boelen, 1995; THEnet, 2015; TUFH, 2015). Integrating with the health system (across the five domains suggested in Figure 2.3) medical schools should have overt social purposes as engaged organisations, dedicated to equity (local and global), accountable to a community, and graduating altruistic doctors, committed to social change as a strong part of their professional identities (Ambrose *et al.*, 2014; Bleakley, Brice and Bligh, 2008; Christobal, Engel and Talati, 2009; Cooper, Gibbs and Brown, 2001; Farnsworth, Frantz and McCune, 2012; Moss and Golden, 2014; Rubin *et al.*, 2012; Rudolf *et al.*, 2014).

Figure 2.3: Social accountability "pentagram" framework (Boelen *et al.*, 2007)



Although much of this new discourse continues to use the language of competence, the spirit of the desired reforms can be understood through a critical lens, aligned to emancipatory curriculum orientation, and transformative pedagogical traditions (Eaton, Redmond and Bax, 2011; Frenk, Chen and al, 2010; Kickbusch, 2013; Rudolf *et al.*, 2014; WHO, 2015). It could be argued that the engaged, socially accountable medical school is less relevant in the UK, partly due to the provision of universal health coverage, and partly due the narrower role of the university - two legs rather than three on the stool (see page 35). A number of drivers appear to be changing this assumption: growing health inequalities (Marmot *et al.*, 2012), complex epidemiology and demography, shrinking health services, and problems with recruitment and retention in general practice (Roland and Everington, 2016; Rosenthal and Chana, 2011).

One reading of the situation, and an argument for transformative reform, is a response to *hyperprofessionalisation* arising from a narrow preoccupation with competency, accreditation, and risk aversion (Calnan and Rowe, 2008; Dickson, 2010; Gill and Griffin, 2010; GMC, 2003; GMC, 2009; Rovere, McCartney and Thornton, 2006). These trends are linked to the public inquiries (Baker, 2004; Kennedy *et al.*, 2001) alluded to above (section 2.2 and in

Appendix 5). We see a paradox: despite the benefits of person-centredness and community-based learning we have fearful, passive students (Berwick, 2013; Brightwell and Grant, 2013) who rely on contact with scripted or simulated patients in sanitised spaces to the detriment of their identity formation, humanity and eventual performance (Park, 2011). Great clarity has been afforded by the competency based orthodoxy (Albanese, Mejicano and Gruppen, 2008; Albanese *et al.*, 2008; GMC, 2003; GMC, 2009; Holmboe, 2015) and the promise of a critically-thinking, patient-centred workforce (Barr, Ogden and Rooney, 2014; Gill and Griffin, 2010; Howe, 2001; Towle *et al.*, 2010) but the one does not - de facto - lead to the other (Bleakley and Bligh, 2007; Bleakley and Bligh, 2008; Brightwell and Grant, 2013). Nor - as Francis noted - does it lead to caring, compassionate, personally and socially responsible health professionals (Agnew, 2015; Francis, 2013b). Boelen and colleagues (GCSA, 2010) demand a rethink of the entire project focussed on engagement and social change. As O'Keefe and Britten wisely observe:

> *'Challenges lie ahead for both the lay community and medical schools around reconciling the heterogeneity of community needs and the lack of pre-existing pathways for lay participation.' O'Keefe and Britten (2005: p32)*

2.5 Reprise of the scholarship of engagement

In summary, as in healthcare and higher education, there are multiple framings of public engagement and patient involvement in the medical education literature. Some of this is due to specific and different historical and political pathways in the UK and elsewhere. The literature is shaped by waves of universal concerns regarding the preparation of future doctors, followed by corresponding waves of interventions. My review demonstrates that the medical undergraduate curriculum in the UK, and internationally, has embraced patient involvement and developed "*the community*" as a locus and focus of learning within a tightly defined competency-based framework.

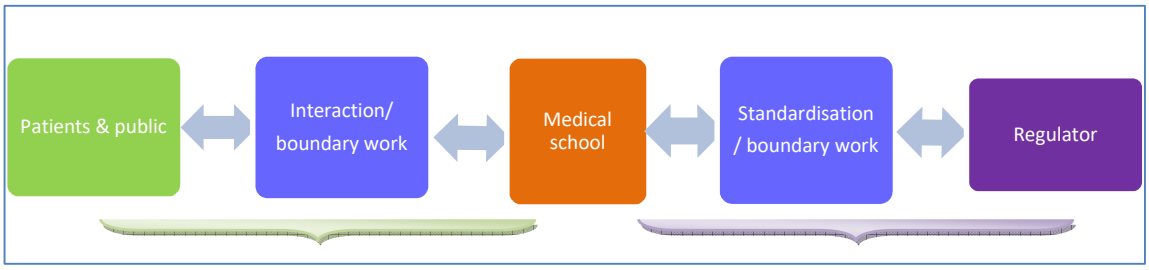
The literature review indicates that a new set of concerns has emerged - with the suggestion of a causal relationship between the epistemological, practical and moral *constraints* of an individually-focused curriculum, on crucial softer, social outcomes for both patient and student. Stressing a wider role for medical schools as organisations committed to a *collective* concern for community, social justice and accountability, appears to be part of a revised

framing of public engagement which is reflected in this study. There is an established tradition in medical education - regardless of the desired change - to seek implantation through institutionalisation, using policy, governance, voluntary accreditation and regulatory standards. The separate body of work that addresses this phenomenon is the subject of the next chapter.

CHAPTER 3 INSTITUTIONALIZING ENGAGEMENT: REGULATION & STANDARDS

This chapter turns away from the literature on engagement between medical school and the public (Figure 3.1, left hand side) and concludes the review by looking at the scholarship relating to medical school governance and its relationship with standards for public engagement (Figure 3.1, right hand side).

Figure 3.1: Overview of medical school relationships considered in this study



I examine medical education regulation in the UK and place this in a wider context. I provide a schematic overview of these processes (Figure 3.2, later in this chapter) which I use to classify relevant documents containing standards for public engagement (Appendix 7). This is followed by a brief review of research into standards and how they evolve, across boundaries, from shared idea or concern, into mandatory, regulatory instruments. The chapter concludes with a consideration of the gap in the literature regarding the effect of standardisation on medical school leadership, and how this has informed my own research.

3.1 Governance of medical education - context and trends

The relationship between governance and regulation (Levi-Faur, 2011) is complex and beyond the scope of this review. Suffice to say that institutional governance may combine formal top-down regulation, and informal processes based on voluntary codes and guidelines (Madara and Burkhart, 2015); and may be more or less socially oriented. These processes are enacted through a range of relationships (intra, inter and supra organisational), and scales (individual,

collective, institutional) presenting a challenge for those responsible to align coexisting expectations (Boland, 2012; McDermott *et al.*, 2015). Leaders need to interpret what is proposed and make choices regarding which level or scale to prioritise (Freshwater, Fisher and Walsh, 2015). The governance of medical schools, like other professional programmes located in universities, must attend to the missions and requirements of their host institutions and the expectations that graduates are fit to practise their profession (Strain, Barnett and Jarvis, 2009).

The many frames emanating from different spheres (civil society, the profession, the academy, and the state) become manifest in conceptions of curriculum and quality (Freshwater, Fisher and Walsh, 2015; Watson *et al.*, 2011). Watson (2008a) and Strain, Barnett and Jarvis (2009) note that, as universities assumed responsibility for educating the professions, they adopted more instrumental (outcomes-focussed) governance processes than those associated with less applied disciplines. They argue that, while professional education is open to commodification,[27] this is tempered (generally in a positive way) by explicit entry standards and regulatory bodies. Apple (2006) and Park (2011) observe that standardising curricula is also a process of insinuating ideologies into educational programmes to achieve broader aims. Berwick (2015) argues that medical education and its regulation must be governed by the principles used in healthcare. Dixon-Woods, Yeung and Bosk (2011), and Marcovitch (2015) argue approaches to regulation and quality improvement in UK healthcare have been driven by responses to NHS scandals, with significant implications for the regulation of individual doctors by the GMC. [28]

As healthcare has become hyper-regulated (Yeung and Dixon-Woods, 2010) in the UK, Nordquist and Grigsby (2011) describe how the same preoccupations with safety, risk, and managerialism are at work in medical school governance. The regulatory standards applicable during this study (GMC, 2009) are part of a process that has raised quality in, and harmonised UK medical education identifying important risks and areas for improvement (for example in high stakes assessments, student conduct procedures, and supporting inclusion of disabled students (GMC, 2013). At the same time they emphasise instrumental control through a

[27] Note this commodification is demonstrated by the exponential growth of proprietary (for profit) medical schools in the emerging economies and business consultancies and full-fee paying overseas students in the UK)

[28] In the USA the focus is on safeguarding patients from commercial exploitation (Bauchner, Fontanarosa and Thompson, 2015; DuBois *et al.*, 2013), and globally, concern focuses on managing the market in healthcare professionals (Boulet and Van Zanten, 2010; Crisp and Chen, 2014; Epstein and Epstein, 2012; Nair and Webster, 2010).

competency-based curriculum, and quality management through assessment and surveillance of individuals which Park (2011) sees as fundamentally neoconservative. The involvement of patients and the public translates into a narrow patient-centredness, and recruitment of individual lay representatives with no expectation of collective institutional-community engagement. This parallels Tritter's (2014) critique of the dominance of individualised, client-oriented neoliberal public engagement in healthcare. Recent publications from the USA suggest formal medical school governance is widening there to incorporate standards for institutional social and public accountability (Kirch, Nivet and Berlin, 2012; Liaison Committee on Medical Education, 2015) a trend not seen in the UK.

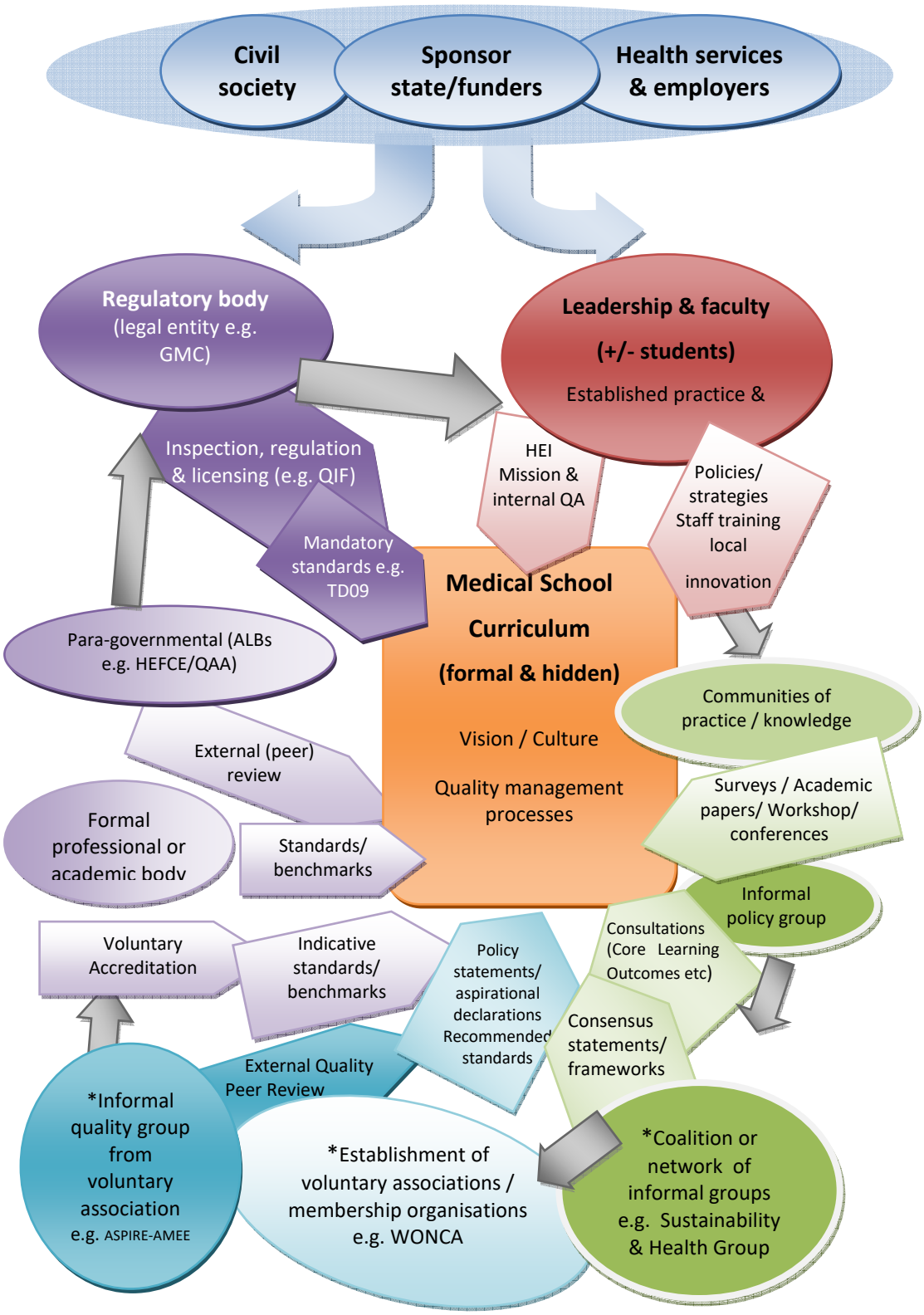
Frenk, Chen and al (2010), reviewing stewardship and governance of medical schools globally, identified the need for strong interdependence between health systems and health profession education at an institutional and community level. They found numerous local, national and international groups articulating policies, suggesting standards, and advocating on behalf of special interests through more or less formal networks and alliances. Nordquist and Grigsby (2011) note that global demands to increase the quantity of doctors trained, go hand-in-hand with expectations of improved quality. They identify a paradox whereby the most exigent keep raising the bar, while the less regulated are left behind. In many countries, medical schools seek better educational oversight and governance to ensure their graduates are more employable (Crisp, Swerissen and Duckett, 2000; Epstein and Epstein, 2012) and/or to accredit their unique characteristics (Bauchner, Fontanarosa and Thompson, 2015; Hosny, Ghaly and Boelen, 2015; Mullan *et al.*, 2011). This results in the growth of a *globalised substructure* of transnational bodies (Strain, Barnett and Jarvis, 2009) (p18) offering voluntary quality assurance and accreditation. (e.g.WHO-WFME, 2005; see Appendix 7) and the ASPIRE (AMEE 2013) .

3.2 The dynamics of medical school governance - the case of standards for public engagement

Figure 3.2 (p.47) is my way of displaying the interaction between governance bodies and a medical school. In this schematic diagram I provide an overview of bodies / agents involved in informal and formal governance, and the types of instruments (standards etc) they employ. The diagram also serves, therefore, to illustrate the well-observed trend towards the

institutionalisation of informal codes and guidelines into measurable standards (Lampland and Star, 2009). Appendix 8 lists the some of these bodies/organisation with the instruments identified in my search concerned with public engagement in the governance of medical education. Space does not permit a discussion of each item but the figure in Appendix 8 and table aim to set the scene for the discussion of *Tomorrow's Doctors* (2009) that follows. Taken together, this figure and the table underscore two observations: (1) the multilayered and contested interests - individual, collective, institutional, and socio-political - involved in articulating standards (such as for public engagement) ; and (2) the dynamics of the standard-setting process itself.

Figure 3.2: Generic schema for dynamics of governance: Standardising and regulating medical schools and their curricula (Key and notes for this figure appear on following



Notes on Figure 3.2: Generic schema for dynamics of governance: Standardising and regulating medical schools and their curricula (Instruments are listed in Appendix 8)

Key:
Coloured circles = bodies interested in standards; Coloured arrows = governance instruments and processes;
Green = informal; Turquoise = voluntary membership; Purple = formal; Blue = wider influences;
Trends towards mandatory standards = grey arrows
* = Transnational groups/bodies (see (5) below)

This diagram includes some of the myriad *bodies* (coloured circles) - that may create *instruments* (coloured arrows) aimed at institutionalising curricular standards. Medical school leaders may be more or less open to these attempts at shaping their endeavours, and responsive to wider organisational and policy actors (funders, health services and civil society). This follows the process described by Lampland and Star (2009). See Appendix 8 for list of instruments aimed at promoting and standardising public engagement**.**

1. There is a trend moving from informal, to aspirational, to voluntary, to mandatory standards (grey arrows), although the process is more iterative than can be drawn

2. All the informal and voluntary groups tend to lobby both the medical schools ***and*** the regulator to use their instruments. Note: some have been successfully incorporated as learning outcomes for the new "Generic Professional Capabilities" (GMC, 2015).

3. In many settings in the world there is no single legal entity regulating medical schools - therefore voluntary review and accreditation may be an important process.

4. Instruments may be framed (Benford and Snow, 2000) as progressive to "raise standards" and transformative, to change practice, or regressive - to protect interests of specific academic (*knowledge/discipline*) or professional (*practice*) communities.

5. The evolution and up-scaling of communities of practice into established professional bodies loosely follows that seen in social movements (Thiele, 1993). In medical education we see a growth in transnational groups (*) interested in quality and governance

6. Members of knowledge/practice communities may join or align with a *number* of larger networks or associations simultaneously.

7. Medical schools are part of higher education and subject to specific university governance and increasingly diverse higher education institution missions.

3.3 Tomorrow's Doctors: patient involvement & public engagement standards for UK medical schools

We can see the cycle in Figure 3.2 (described in the notes above), applies to the evolution of the GMC's QIF (see Chapter 1). Standards, such as *Tomorrow's Doctors,* aims to clarify expectations, permit coherent, defensible judgements, and ensure - or at least to explicate - accountability to students, employers and the public. The manifest regulatory responses to wider trends and the aforementioned inquiries (Dixon-Woods, Yeung and Bosk, 2011; Marcovitch, 2015 see Appendix 5). They are both normative (to adhere to current good practice norms) and instrumental (to achieve useful outcomes). Various iterations of GMC professional codes of conduct represent an important linguistic shift from "*should*" to "*must*" comply (Gill and Griffin, 2010), reflected in the normative reframing of *Tomorrow's Doctors* between 2003 and 2009. The document is divided into two: (1) a list of nearly 100 competency-based outcomes; and (2) standards for the delivery of teaching, learning, assessment and quality in nine domains. Importantly, the stress on the needs of *students*, and the validity of their voice, in the 2003 edition of *Tomorrow's Dcotors* was largely replaced by a focus on the patient, with the added standards for patient involvement and public engagement (Appendix 1). Spencer et al (2011) noted that they were at once mandatory and vague. For example, it is hard to see how the following standard (para 48) - starting with the words *'apart from'*, fulfils the need for a standard to be specific and measurable. How therefore should schools, and GMC visitors make a relevant judgement?

> ***Para 48*** *Apart from the medical school officers and committees, all education providers of clinical placements, and all clinical tutors and supervisors, students, employers and patients should be involved in quality management and control processes. Their roles must be defined and information made available to them about this. GMC (2009, p38).*

Supplementary advice followed (GMC, 2011a), which reframed the standards as more flexible constructs and provided a summary of evidence, largely composed of short, small scale evaluations. They acknowledged:

> ***Para 63*** *Patient and public involvement in quality and governance arrangements is a broad and challenging area, with the greatest potential for effective, constructive input which could influence strategic and long-term decisions, and at the same time the greatest threat of tokenism. It is therefore not surprising that involvement at this level is not as widespread as it is in teaching and assessment. GMC (2011a p11).*

The GMC's review of the impact of *Tomorrow's Doctors* (GMC, 2013) found on-going poor compliance with patient and public involvement, and, in particular, "feedback from patients" (level not specified) against a background of compliance in most areas[29].

A small literature explores the drivers for public engagement *standards* in medical education. They can be seen as benchmarking compensatory mechanisms for professional self-interest (Hasman, Coulter and Askham, 2006); remedies for making a narrower curriculum more relevant (Boland, 2012; Boulet and van Zanten, 2014); and offsetting the insular nature of medical schools, especially in research intensive institutions (DuBois *et al.*, 2013). For some it is part of a bigger, long-term project to ensure *social governance* and thus transform the medical curriculum, starting with voluntary accreditation (Boelen, 1990; Boelen, 2008; Boelen, Dharamsi and Gibbs, 2012; GCSA, 2010; Woollard and Boelen, 2012):

> *'The medical school can and should enhance its potential to influence the planning, production and use of the health workforce. Quality improvement in medical education and evaluation standards to address social accountability must be revisited and national accreditation mechanisms established accordingly.'* Boelen and Woollard (2011 p614)

Some doubt whether regulatory standards - formal and informal - are capable of dealing with the fundamental moral issues at stake (Madara and Burkhart, 2015), others claim they are the only option (Yeung and Dixon-Woods, 2010). As Baker observed on the eve of publication of the Medical Act 2004[30] -

> *'The key issue is how doctors think about themselves in relation to their patients, both at the level of the individual doctor and patient and at the level of the professional bodies. The key task for the profession and its organizations is a process of renewal whereby the interests of patients genuinely come first.' Baker (2004: p169)*

3.4 Moving standards across boundaries - the process of institutionalisation

It is impossible to do justice to the literature from the field of regulatory studies and research into standards, however, a brief review of the process, whereby shared concepts are institutionalised through standardisation, is relevant. My review highlights the plasticity of public engagement . As such it matches the characteristics of a boundary object (BO) (see Table 3.1).

[29] The GMC published a new set of standards for medical education and training, *Promoting Excellence*, in 2016. These are considered in Chapter 8 .

[30] A response to the Shipman Inquiry, of which he was a member.

Table 3.1: Definitions and characteristics of boundary objects[31]

Feature	Boundary object
Definition	• An object or concept shared by several different communities but viewed or used differently by each of them (Star 1988) that satisfies the information and coordination requirements of each party by providing a common language for each stakeholder to represent and negotiate their interests (Kirby, 2006)
Characteristics	Boundary objects : • Act in common ground -"liminal spaces" - interfaces between communities/ organisations ; bridge perceptual and practical differences (Star, 1989) • Have interpretive flexibility: has different meanings in different fields, and meanings may be negotiated over time (Banner 2012, Hulten 2013) • Maintain the integrity of the interests of each party within the object to secure his or her ongoing participation. Since interests will change over time, continual negotiation of the boundary object is necessary (Emad and Roth, 2008) • are useful to each party in his or her own social world and not just when collaborating with actors in other social worlds. Star 1989 (in Kirby) • Dynamic between ill-structured and more tailored uses • Result in standardization of methods and measures develop as the object moves between groups and across scales - individual /collective/institutional (Star 2010)

The tendency of BOs to undergo dynamic transmogrification into standards has been described in a range of fields - from software design (Chongthammakun and Jackson, 2012) to sustainable ecology (Baggio, Brown and Hellebrandt, 2015; Cohen, 2012) and education (Banner, Donnelly and Ryder, 2012), as well as public engagement in biomedicine (Parry *et al.*, 2012). Those involved in "boundary work" across and within an organisation have been referred to as boundary agents; those working across a number of structures or organisations, as boundary *spanners*[32] (Williams, 2010). Boundary objects operate at structural levels, in an obligate relationship with boundary *agents*, defined as human

[31] Adapted from (Baggio, Brown and Hellebrandt, 2015)

[32] Spanner as in the span of a bridge rather than a wrench in a toolbox

"*marginals*" who interpret and use object, and facilitate or control collaborative work at the boundary (Chongthammakun and Jackson, 2012; Merali, 2002; Park, Berlin and Griffin, 2014). Boundary spanners (or boundary *brokers* (Kimble, Grenier and Goglio-Primard, 2010)) are organizational actors with a capacity to move and adapt objects between intersecting or structural levels worlds, and facilitate (or block) others who use those boundary objects. (Chongthammakun & Jackson 2012). These agents are usually formally appointed leaders, and those with leadership capacity in more peripheral or inter-organisation positions. The boundary *work* they undertake is informed by their position, and professional and disciplinary factors. They discursively frame boundary claims, such as public engagement policy, in ways that might support existing hierarchies and practices (Bucher *et al.*, 2016), lead to transformation or facilitate the evolution of formal standards.

Lampland and Star (2009) identify five common characteristics of standards (see Box 3.2, below) and their evolution, institutionalisation and eventual abandonment. It can be seen from the discussion above (and the list of documents in Appendix 5) that all these five characteristics apply - to a greater or lesser extent - to the process a standardising public engagement in medical education.

Box 3.2: Characteristics of standards (from Lampland and Star, 2009, p. 5)

Standards are

1. nested inside one another
2. distributed unevenly across the sociocultural landscape
3. relative to communities of practice (well-fitting in one, an impossible nightmare in another)
4. increasingly linked to, and integrated with others across organisations, nations and systems

Standards

5. codify, embody, or prescribe ethics and values often with great consequence for individuals (most notably in relation to education - that is, they express an implicit moral position)

Lampland and Star (2009) highlight potential effects of standards in education - a phenomenon studied extensively in the school sector (see for example Mons (2009) and Tomei (2015)). Research has looked at power, agency and notions knowledge.

There is little equivalent work in health professional education. Wright and Associates (2012, p. 6) (in a report commissioned by the GMC) summarised feedback from education providers

and other , suggesting that the GMC is at the forefront of regulatory practice, described as providing a "*still, calm, centre"* to medical education and importantly, driving enhancement and change. They concluded that the GMC is increasingly aligned with principles such as those outlined in *"Right touch regulation"*[33] i.e. proportionate to risk, outcome-focussed and enhancement-led. Quick, however, in his review commissioned by the Professionals Standards Authority (Quick, 2011), concluded that there is a striking lack of systematic knowledge regarding the effect of professional regulation. Heimer (cited in Quick, 2011: p17) concluded:

> *...rules, regulations, guidelines, ...do in fact have some effect, but it is neither exactly the instrumental effect their writers intended nor the symbolic or political effect that we might expect.*

Boundary object theory has been used to understand the way in which exogenous norms are absorbed, negotiated, diffused or even ignored by school leaders and teaching teams (Banner, Donnelly and Ryder, 2012; Hulten, 2013) inviting similar approaches in medical education.

3.5 Reprise and gaps in the literature

To sum up, this review shows that public engagement is a widely researched phenomenon, increasingly so, reflecting scholarly interest in changes in the settlement between society, the public sector, and the state. I have focused, not on the evidence of its effectiveness, but on the way in which public engagement is manifest and the multiple, contested ways it can be understood. Maintaining an up-to-date review has been like killing the hydra - with new relevant publications arriving on a daily basis. There are some common observations. Public engagement is a dynamic process in itself, and over time. It happens at the boundaries between individuals, groups and organisations, and its study is informed by the scholarship of social movements. This, in turn, includes the idea of framing - how desired social or organisational change is shaped and articulated (Snow, 2004). Study of public engagement reveals common challenges across sectors with implications for structures (formal and informal), actors, and power (Anheier, 2004). Facer et al's (2012) excellent review showed a

[33] Now updated as *PSA (2015)*

wide range of ideologies, discourses and conceptual frameworks employed which provides a rich, but inchoate, knowledge base. Much of the literature reiterates the ladder model first proposed by Arnstein (1969) – often aspirational in form. More recent work divides engagement into broadly individual or collective focused endeavours, inviting consideration of the roles of individual, organisational and institutional identity, authority, and agency - which are addressed in the next chapter.

This review reveals extensive small-scale engagement practices in UK medical education focused on an individualistic framing (GMC, 2011a; Spencer *et al.*, 2011). This reflects dominant concerns and prevailing ideologies affecting healthcare and the profession. This is in contrast to publications from north America and transnational bodies where public engagement is concerned with the collective: an engaged medical school with socially oriented curriculum and governance - in response to the lack of universal health coverage. The UK situation is likely to be explained, in part, by increasingly neoliberal policies, but also by the different socio-historical contexts: UK universities were established with a double, rather than triple, mission, and UK healthcare for the last 70 years has been provided by our universal NHS. This of course is subject to change!

There are strong academic (Rowe and Frewer, 2005), practical (Boulet and van Zanten, 2014), and moral (Boelen, 2008) arguments for including evidence of engagement in the regulation of medical schools. However, the process of institutionalisation, as seen in other sectors, has significant implications for educational leaders, their faculty, and their organisations as a whole. What happens when a heterogeneous concept, that needs a degree of plasticity to work across boundaries, is codified?

Two key interlinked gaps have emerged: (1) understanding public engagement at the organisational and institutional level[34]; and (2) exploring the impact of regulatory change on medical school leaders. While medical schools are subject to numerous influences shaping everyday practice and overall missions - of which regulation and licensing carries the greatest weight - I have *not* found a single study that explores this dynamic. The welcome inclusion of public engagement in *Tomorrow's Doctors* 2009 and the subsequent confusion, coupled with the reverberations from the Francis Report on the medical profession, its training, and regulation, provided a fertile and timely research opportunity.

[34] This work had been done for universities by Watson *et al.* (2011) but not for medical schools.

The Francis Inquiry (2013a) levels specific criticism at undergraduate medical education and its regulation. How, Francis asks, given the extent of the problems in mid Staffordshire, was it possible that the students on placement, the medical school, and the GMC quality assurance team (who were inspecting the school annually) all failed to report concerns regarding patient care? His tone is scathing. His recommendations include facilitating the raising of concerns and improving the GMC's processes through better inspections and increased lay participation. As we will see in my data, and with the publication of Promoting Excellence (GMC 2016), the Francis Inquiry has had significant, but as yet not fully understood, effects on public and patient involvement, in the NHS, medical education and its regulation.

The in-depth study that follows fills a small but novel niche in our understanding of the relationship between medical schools and society[35]. In conducting reviews in Chapter 2 and 3 I have tried to go beyond stacking up papers, instead marshalling the literature in a way that locates my research within its own empirical field and leads logically to the next chapter, in which I lay out my theoretical and methodological approach.

[35] The study also extends my own research (Berlin, 1998; Berlin, 2011; Berlin, 2013; Berlin, 2014; Berlin *et al.*, 2011)

CHAPTER 4 THEORY & METHODOLOGY:

CONCEPTUALISING ENGAGEMENT REGULATION

4.1 Knowledge construction & social epistemology

The task of this chapter is to locate the research in its theoretical field: to consider how we might understand and investigate public engagement. As we can see from the literature review, public engagement has been explored, described and implemented in numerous ways. Furthermore, these myriad manifestations vary according to setting, influenced by the dynamics between different disciplines and spheres. As Facer, Manners and Agusita (2012, p. 3) say, writing about public engagement in higher education:

> *'...different modes of university-public engagement are products not merely of competing languages and disciplinary traditions, but different epistemological traditions, with competing understandings of truth, value and reason. Philosophical and epistemological studies, and arguably religious studies would provide a powerful resource for inquiry in this area.'*

They go on to identify five interlocking foci for interrogating public engagement practices: how knowledge develops; how people make meaning; how change happens; how democracy works and publics are constituted; how knowledge-based institutions develop. Each of these has been associated with a cluster of often overlapping theoretical traditions. There is, therefore, a precedent to just about any approach to research. My initial options are wide. In similar vein to Facer, Manners and Agusita (2012) my review revealed a set of key public engagement challenges and themes (in square brackets below) arising from medical education literature and therefore potential foci for enquiry:

- How do we define public(s); [concepts of public(s)]
- How is engagement understood and enacted by academic leaders and their organisations [orientation of academics & organisation]
- What is the dynamic of public engagement practices, across various boundaries; [dynamics of public engagement practices]
- What/who are the drivers and agents; and [political and professional drivers]
- How are ideas and roles of governance (social and regulatory) conceptualised? [ideas & roles of governance]

From these issues I have been able to narrow my gaze to derive the following questions (with the theoretical concept in italics) in Box 4.1.

Box 4.1: Research Questions

Principal Research Question:

How is public engagement policy framed and enacted in UK medical education in the context of evolving regulatory requirements and organisational diversity of medical schools, and what are the implications for leadership?

Supplementary research questions

i. To what extent does the notion of the *boundary object* enhance our understanding of public engagement and its institutionalisation in medical education in the UK?

ii. Who are the boundary agents with regard to public engagement in the cases studied and how do these agents frame public engagement? (*boundary agents*)

iii. What appears to be happening in the contested boundary spaces between professional, academic and public sphere? (*boundary work*)

iv. What can we learn about how knowledge is framed and constructed between different knowledge communities or fields studied (*social epistemology*)

v. Is public engagement framed to support individual, professional priorities or socially-oriented change in curriculum practice? (*epistemic justice*)

vi. How does regulation appear to affect framing of public engagement? (*institutionalisation*)

This chapter is divided into four sections elucidating my approach to these questions. First, my stance regarding the nature of knowledge and how we understand the world and the topics in question (epistemology); section 4.2, the philosophical underpinnings regarding what is being researched, and how it can be investigated (my theoretical perspective); section 4.3, my framework for undertaking the investigation, and the conceptual assumptions; and finally section 4.4, the rationale for choosing my particular plan (methodology), and how this

has informed data gathering and analysis. This will lead into the next chapter in which I describe the methods employed.

Stressing the plasticity of boundary objects may suggest that this is essentially an ontological project. The social reality in question here draws attention to ontological issues. Boundary objects have "process ontology" - in this case encompassing public engagement as both a polymorphous, dynamic concept *and* fixed regulatory standards. They depend on structure and agency (or conditions and actions), and their relational interaction.

In this project I am fundamentally interested in the epistemological dimensions, rather than the ontological (Seibt, 2016), that is - *ways of thinking* about public engagement, and therefore the nature of knowledge used to *explain* public engagement practice, drivers and the problems it seeks to address. That is - how public engagement, in its various guises, is framed.

Therefore this research is informed by social constructionism; a broad epistemological stance that proposes human understanding is constructed through social processes (Crotty, 2003). The knowledge held by individuals (personal, experiential, scientific and professional) and – it can be argued – that of groups, communities and organisations, are forms of constructed knowledge serving particular purposes. Social epistemology is a field of constructionism associated with the nature of scientific knowledge as a *collective* endeavour, differing from classical epistemology, which focuses on how individuals engage with knowledge and ideas of truth. Social epistemology has been concerned with identifying the social forces and influences involved in knowledge production in scientific fields. Knowledge is what is held true in a given community, culture or context. This is not to deny an existence of a tangible real world - but to stress that facts and events have a *social reality* constructed through discursive cultural-cognitive processes of interaction, interpretation and shared values about *why* things exist or happen.

The idea that scientific fact, in particular, is socially constructed is, in part, attributed to Kuhn (1977) although his absolutist view - that facts are contingent on specific scientific paradigms - is not held by all social constructionist thinkers (a position I share). Fleck (1979/1935), a predecessor of Kuhn[36], takes a more versatile view of social epistemology and the process of

[36] Kuhn's focus is the physical and biological sciences, and excludes the social sciences, the professions or other possible knowledge communities.

knowledge construction through communicative interaction. Fleck, a medical microbiologist writing in the 1930-50s[37], was interested in knowledge production in a wider range of communities, allied to science that included the professions and nonprofessional groups (Brorson and Andersen, 2001). The collective knowledge of such groups generates a “thought style”. With particular reference to the professions, Fleck talks of knowledge held in the *esoteric* circle and the *exoteric* (lay) circle (different "thought collectives"). Both Kuhn and Fleck share the concept of "incommensurability" to describe the challenges of interaction and communication across different, even close, knowledge groups (Fleck, 1979/1935; Kuhn, 1977; Mößner, 2011).

My starting point for this thesis is the way in which an organisation, the medical school, which deals in scientific and professional knowledge, constructs engagement – a process of working across different knowledge groups – and the way this is governed. As I will show, this includes social agency at the level of the individual leader, the organisation and the wider institution of medical education. As Stirling (2007) says of trends in public engagement in science (citing Jasanoff 2005).

> *...apparent moves toward enhanced social agency and accountability reflect epistemic as much as cultural and political developments. Stirling (2007 p265)*

It has been seen in the literature review that public engagement can be; a process of sharing and disseminating knowledge, and a way of legitimating knowledge, as well as a mode of knowledge construction itself. These concerns resonate with the ideas of knowledge in the tradition of social epistemology. Social epistemology is, however, evolving and contested. In some contemporary forms its concern extends beyond the social construction of knowledge to the process by which knowledge is institutionalised (Goldman, 2001). Goldman does not reject the idea of a rational or objective basis of understanding, but sees the social factors "external" to knowledge production, and its use, as paramount. These factors include any form of relational influence - between individuals, collectives or institutions - that affect epistemic worth (Goldman and Blanchard, 2015). Goldman and Blanchard's interest here is the relationship between scientific evidence on the one hand, and moral values and beliefs

[37] On the ontology of syphilis and subsequently work on typhus in the Lwów Ghetto and Auschwitz-Buchenwald where he was imprisoned (Sady, 2012).

on the other; which have been called the evidential and the doxastic[38]. These are not oppositional - social epistemology is increasingly concerned with how these interact at the level of structures and agents. Fricker (2007) has used this approach to understanding doxastic attitudes in the knowledge practices applied to doctor-patient relationships and others, e.g. Anderson (2012), have taken this to an institutional level. The purpose of social epistemology – as a form of analytical philosophy (Fuller, 2000) - is to improve understanding of epistemic projects (those concerned with the development and sharing of knowledge). It can facilitate the assessment of social practices and knowledge-institutions (i.e. medicine or the academy) at these different levels: (a) individual uses and doxastic attitudes to social evidence (that is the testimony of others); (b) collective group epistemic and doxastic attitudes; and (c) epistemic consequences of institutional arrangements (for example, social governance).

Public engagement is not, of itself, a form of knowledge, but it is a knowledge practice concerning, in my case, a knowledge-based institution – and in Fleck's sense – processes across/between different circles/ knowledge collectives. I argue that attempts to articulate my research questions are well served and aligned to social epistemology in particular (II) and (III) above (Box 4.): assessment of epistemic quality of group doxastic attitudes (of medical school leaders to public engagement) in the context of the social and professional evidence they use; and the epistemic consequences of institutional arrangements (for governance - social and regulatory). How can this assessment be tackled?

4.2 Symbolic interactionism & the nature of public engagement

Symbolic interactionism is an approach to interpreting and explaining society and the human world[39]. It is one of a number of theoretical perspectives associated with constructionism, and links well with social epistemology through its emphasis on human interaction. It provides the grounds for selecting an appropriate methodological approach to this research. Central to symbolic interactionism is its affordance of multiple interpretations of an

[38] "Doxastic attitudes are a sub-species of propositional attitudes, ones that make categorical or graded judgments concerning the truth or falsity of their propositional contents." Goldman and Blanchard (2015) incorporate the idea that evidence-based knowledge as derived from a number of sources - including the social - give rise to evaluations of justification, rationality and virtue.

[39] Limitations of symbolic interactionism are explored in depth in Appendix 12.

apparently singular concept - here, public engagement. It deals with the study of interactions - communication, relationships, authority - that shape cognition, values and attitudes – and in turn - form communities. At its heart is the notion that these processes can be apprehended by a researcher (Crotty, 2003). Social interactionism has a number of putative parents. It is strongly associated with Bateson (1972/1955) work on the ecology of the mind, and with the work of pragmatist social philosopher, Mead, whose ideas were popularised by his student Blumer (a sociologist)(Blumer, 1969). Mead analyzed society by addressing the primacy of subjective meanings, arguing that people's observed behaviour is based on what they believe and not just on what appears objectively true.

> *The authentic meaning of ideas and values is linked to their outcomes and therefore to the practices in which they are embedded.* Crotty (2003: p73)

Meaning making is a process of constant renegotiation and can be modified through interaction over time. As a theoretical underpinning to research it has been applied in a wide range of settings and levels (from body image to gang membership (Charmaz, 1991; Reynolds and Herman-Kinney, 2003) and is associated with many methodologies[40]. It has (as would be expected given the very essence of social interactionism itself) evolved, reshaped by its ongoing use. Notable contributors to this process have been Goffman (1974), and Schön (1994). Snow (2004) expanded on the original concept identifying a set of broad orienting principles for example (Robson, 2002), exploring the link between what we hold as evidence, values and practices, and their intended goals, summarised in Box 4.2.

Box 4.2: Symbolic interactionism defined

Symbolic Interactionism: Synthesised from Blumer (1969); Crotty (2003); Reynolds and Herman-Kinney (2003)

The central idea is that no action happens in a vacuum: it occurs in the context of interactions with others, with the social environment (family, community, work), and social structures. Exact definitions vary as symbolic interactionism has been subject to the very social interaction it seeks to interpret.

Organising principles often cited include:

- Human agency is shaped by the meaning we assign objects in the world;
- Meaning is derived from our social interactions (interactive determination);
- Symbols are any culturally derived objects (including speech, traditions, codes and texts) which have more or less shared meaning (symbolization);
- Meaning is determined and modified through negotiation and accommodation during social interaction (emergence).

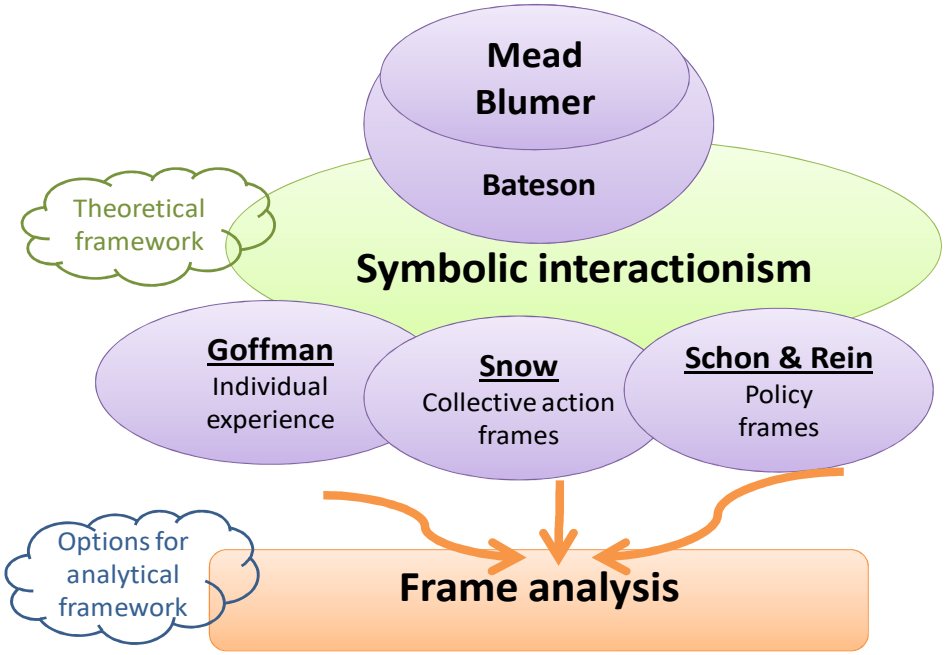
[40] Two of the most widely cited works in medical education (Becker's *Boys in White* and Hafferty's work on the hidden curriculum) applied methods informed by symbolic interactionism. (Becker *et al.*, 1961; Hafferty, 1998).

4.2.1 Frames

> *'The framing perspective is rooted in the symbolic interactionist and constructionist principle that meanings do not automatically or naturally attach themselves to the objects, events, or experiences we encounter, but often arise, instead, through interactively based interpretive processes.' Snow (2004 p384)*

It is through the growing use of frames in fields associated with my own (public engagement in healthcare and education (Borum, 2004; Nisbet, 2009; Nordquist and Grigsby, 2011; O'Keefe and Jones, 2007)), that I can find a valuable empirical precedent. Frames are associated with three distinct, but increasingly overlapping, schools. All rooted, as Snow says, in symbolic interactionism (Figure 4.1).

Figure 4.1: Linking symbolic interactionism with frame analysis - key thinkers



Goffman (1974), and researchers aligned to his notions of frames, focus on individual subjective identity formation and inter-subjective construction of meaning (eg Charmaz, 1991). Snow's work (Benford and Snow, 2000; Snow, 2004), advances the idea of collective action frames in the examination of social movements, and the ways groups make meaning

that shapes their action. Schön and Rein (1994) apply frames to public policy processes. In a detailed and intricate paper van Hulst and Yanow (2014) advance the proposition that these three approaches can be usefully and legitimately braided together - from their common origins in the work of Bateson (1972/1955) and Mead (Blumer, 1969)[41]. Frames have been applied in numerous academic fields from communication and media studies (Entman, 1993; Hervik and Boisen, 2013); political science (Lakoff and et al, 2004); policy studies (Borum, 2004; Schön and Rein, 1994); gender studies (Dombos *et al.*, 2012); science and technology (Minsky, 1975); environmental science (Nisbet, 2009); and, notably, the sociology of social movements (Benford and Snow, 2000). As a result, there is no single definition of a frame - but a very strong consensus emerges.

Frames are:

> *'...the organizing principles that are socially shared and persistent over time, that work symbolically to meaningfully structure the social world.' Reese, Gandy and Grant (2001, p. 17)*

> *'...the mental structures that allow human beings to understand reality,.. they shape how we reason and how we perceive the impact of our actions.' Lakoff and et al (2004, p. 25)*

> *'both mental structures that order our ideas; and communicative tools that evoke these structures and shape our perception.' Darnton and Kirk (2011, p. 67)*

Frames - a synthesis

A frame is a set of concepts and theoretical perspectives used to organize experiences and guide actions (Goffman, 1974). Frames are used by individuals, groups and organisations in all aspects of daily life to make sense of the world, to integrate knowledge with experience (Entman, 1993). We use frames to make sense of what we read and we observe, and to facilitate social interaction (Snow, 2004). All authors agree (using slightly different terminology) that frames manifest in these key human processes: problem definition; cause identification (diagnostics); making moral judgements; and suggesting remedies. Goffman (1974) offers the picture frame analogy - as a structure to hold and shape our view of the world. As can be imagined there is much debate regarding the distinction between frames,

[41] A separate school of frame analysis has grown from Goffman's work, in the field of linguistics, somewhat divorced from symbolic interactionism.

mindsets, discourses, ideologies, *weltanshauung*[42], and fads (Snow, 2004) - and I will address relevant aspects in the discussion of my findings.

Communities (in the broadest sense) share primary frames (analogous to Fleck's epistemic thought styles). In the original construction they are not created or merely held by the individual but arise through the inter-subjective and the social. Frames are manifest through narratives and categorization of specific issues and events. Between groups, different degrees of incommensurability are tolerated and metaframes may emerge. As van Hulst and Yanow (2014 p5) state :

> *'[To frame] an issue is a condition for being able to do one's work. Selecting, naming, and categorizing are ways not only of shaping the world that one has made, but of knowing it...'*

In the empirical field, frames offer a way of evaluating social epistemic process, the combining of evidential and doxastic knowledge - both beliefs and disbeliefs. It is possible to access these phenomena through first and third party "testimony" - data gleaned from direct observation, interviews, and texts (Goldman and Blanchard, 2015; Mößner, 2011) such as policies and standards (Borum, 2004; Schön and Rein, 1994; van Hulst and Yanow, 2014). By including leaders and policy makers it may also be possible to grasp the epistemic consequences of certain institutional arrangements. For example, the idea of commensurability and how the presence of experts (from the esoteric circle) or perceived non-experts (from an exoteric circle - the outsider) may affect problem framing and solutions. Other dimensions add to understanding frames depending on the perspective and purpose of researchers (van Hulst and Yanow, 2014); such as the notion of reflection when dealing with intractable policy controversies (Schön and Rein, 1994), strategic action orientation (Benford and Snow, 2000), and critical awareness (Dombos *et al.*, 2012). The procedural options involved in frame analysis are discussed in the following chapter.

Frame analysis has a number of limitations - some of these are general to its application (and are common to many forms of qualitative research), while others are particular to the type of quasi-insider research undertake herein, compounded by the obligatory solitary nature of a

[42] Roughly translated as philosophical world view of an individual or group

doctorate. These limitations and their mitigation are discussed in detail in Appendix 12 . A brief summary is included in section 5.6.

The next section describes how I apply these ideas to my own conceptual framework for the study of public engagement. Before doing so I need to touch on two further considerations: first, the concept of the boundary object as an additional theoretical perspective, and second, the issue of scale that delimits the structures and agents in my empirical field, and the articulation between them.

4.2.2 Boundary object theory - a supplementary perspective

One opportunity offered by symbolic interactionism and the application of frames in this study is to focus on the framings of public engagement in the context of a standardisation initiative - in this case the new standards in *Tomorrow's Doctors* (GMC, 2009). I described in Chapter 3 (Box 3.4, p50-1) Star's theory (1989) of *ill structured* boundary objects - and their associated tendency to become institutionalised. Boundary objects have their roots in symbolic interactionism, being concerned with social construction and interaction between groups. As Huvila (2014) observes the application of boundary object theory to the conceptual frameworks in contemporary research is expanding rapidly, moving from explorations of sociomaterial phenomena in technology (Doolin and McLeod, 2012) to embrace more abstract, immaterial and epistemic developments - such as policy and curriculum (Emad and Roth, 2008; Huvila, 2011; Koskinen and Mäkinen, 2009). Added to a methodology based on framing, it allows additional purchase on particular aspects of public engagement and the regulatory policy process. These are: (1) the narratives in the primary framing by different groups; (2) the areas of incommensurability, and (3) the dynamics of translation (negotiation and restructuring) associated with the GMC standard and how this shapes new frames and metaframes from the residues lost or left behind during standardisation.

With particular relevance to this thesis Parry (2012) and Polman (2014) have applied boundary object theory to the study of public engagement, and Nisbet (2009) applied frame analysis to public engagement. Wenger (2000) used the idea of the boundary objects in her work on communities of practice. Public and healthcare policy researchers have connected boundary objects with framing (Borum, 2004; Kirby, 2006; Parry *et al.*, 2012; van Hulst and

Yanow, 2014; Williams, 2010 for example). As Gal, Yoo and Boland (2004) note, focusing on boundary objects during times of change provides insights into the *social infrastructures* within which they are embedded and into the *social identities* of the groups that share them. When considering boundary object theory I am mindful of the crucial role of associated "conceptual progeny" (Trompette, 2009): boundary agents, brokers and spanners (as described in Chapter 2) and how their *boundary work* shapes, and is shaped by, framing (Bucher *et al.*, 2016). These ideas are highly relevant to the role and agency of educational leaders and I will return to these concepts in the analysis and discussion. The way boundary object theory informs methodology is evolving to include inter-and intra-group dynamics (Huvila, 2011; Kimble, Grenier and Goglio-Primard, 2010). It can be used to highlight issues in my conceptual framework, in the context of medical education and public engagement: the relationship between actors (school leaders), structures (medical school/GMC), and regulatory standards. I turn briefly to these relationships next.

4.2.3 A note on fields, structure and agency (and what I cannot research)

> *'Developing collective understanding is fundamental to successful organizational activity and requires attention to the discursive activities and structures that enables the process' Macpherson, Jones and Oakes (2006)*

The final step in putting together my conceptual framework is to define the empirical field. This is essentially a process of applying a theory based rationale for the practical task of identifying where to go and what information I need to answer my research questions.

Within classical sociology the fundamental components of the social world are structure and agency. This dualism invites questions about the nature of the two, and about the relationship between them i.e: the degree to which (1) social structures shape individual actions and ideas or (2) individual actors are able (have agency) to influence structures. Developing a position regarding this dynamic in medical education, and the framing of public engagement in relation to it, is central to the theoretical underpinning of the proposed study. This might imply a process with opposing "directionality". For example, with regard to the institutionalisation of public engagement in medical schools, the processes may be either or both of the following, i.e. an iterative process or feedback loops:

(i) GMC->medical schools-> collectives/individual actors

(ii) GMC<- medical schools <- collectives/ individual actors

The central concern of this study is, therefore, the relationship between structures and agents. There are a number of theoretical options and detailed analysis of each is not possible. Some scholars emphasise the complexity (Bourdieu 1984; Giddens 1991) but are said to conflate, rather than resolve the structure/agency dualism. Archer (2001) considers the relationship between structure and agent as dynamic and obligate (one depends on the other) but stresses that they should be considered separate - that humans have individual and collective agency that is shaped by, but also can shape, structure. Humans retain this potential - even in a hyper-connected world - through their capacity for reflection, self awareness and social connections.

It has been argued that boundary objects themselves lack the capacity to act or evolve (Star, 2010). Their translational capacity is rarely a *natural* affordance of the "object" but relies on individuals or collectives acting as boundary agents (Merali 2002). Thus, for purposes of articulating my framework, I assume there is a degree of separation between agents and structure. Agency, both individual and collective, may act at different structural levels and within different spheres. Without defining these we cannot identify the boundaries and the liminal spaces in which public engagement is negotiated and practised, on the one hand, and regulated, on the other. I draw on work in organisational and institutional theory to conceptualise these overlapping spaces - the key final step in making a feasible research plan. The choice is important given that it needs to align with the constructions of public engagement (elaborated in Chapter 2), afford insights to address the research questions, and connect with the real world of medical education. Furthermore, it forces me to make choices about what and who are included[43].

Medical schools can be understood to form a coherent "*organisational field".* These are defined as:

> *'Sets of organizations that, in the aggregate, constitute a recognized area of institutional life; key suppliers, resource and product consumers, regulatory agencies, and other*

[43] Bronfenbrenner (1979) offered a similar model for understanding human activity consisting of the individual's immediate environment, surrounding environments, and experiences occurring in the larger social, economic, and cultural contexts. It is strongly associated with psychological strategies of interpreting and modifying behaviour which I felt was less applicable to the research questions, although it resonates with aspects of symbolic interactionism.

organizations that produce similar services or products'

DiMaggio and Powell (1983, p. 64)

The concept has been widely used in research aligned to my area of interest especially diffusion of knowledge, associated policy, and regulatory and educational change (Borum, 2004; Marsh and Sharman, 2009; Nutley, Davies and Walter, 2002; Snow, 2004). Medical schools thus serve as my principal empirical field. The canon of organisational studies and institutional theory is large and complex but from it I can draw a framework that links the organisational field of the medical school to the institutional role of the regulator. Refining DiMaggio's concept, Scott separates out organisations from their systems of governance:

> *'Fields identify communities of organizations that participate in the same meaning systems, are defined by similar symbolic processes, and are subject to common regulatory processes.' Scott , 1994: p71 (in Borum, 2002)*

As Nutley, Walter and Davies (2003) and Borum (2004) argue, institutional theory emphasizes that no organization can be understood completely separated from its wider social and political environment. "These environments create the institutions (regulative, normative and cognitive) that constrain and support the operation of individual organizations." Nutley, Walter and Davies (2003). Both DiMaggio and Scott have revised earlier notions to include the contribution of agency within the theory recognising opportunities for *choice* and use of agency among actors, both individuals and organizations (Scott, 2008, p. 431). In the case of my research, these overlapping but distinct levels or fields are summarised in table 4.3.

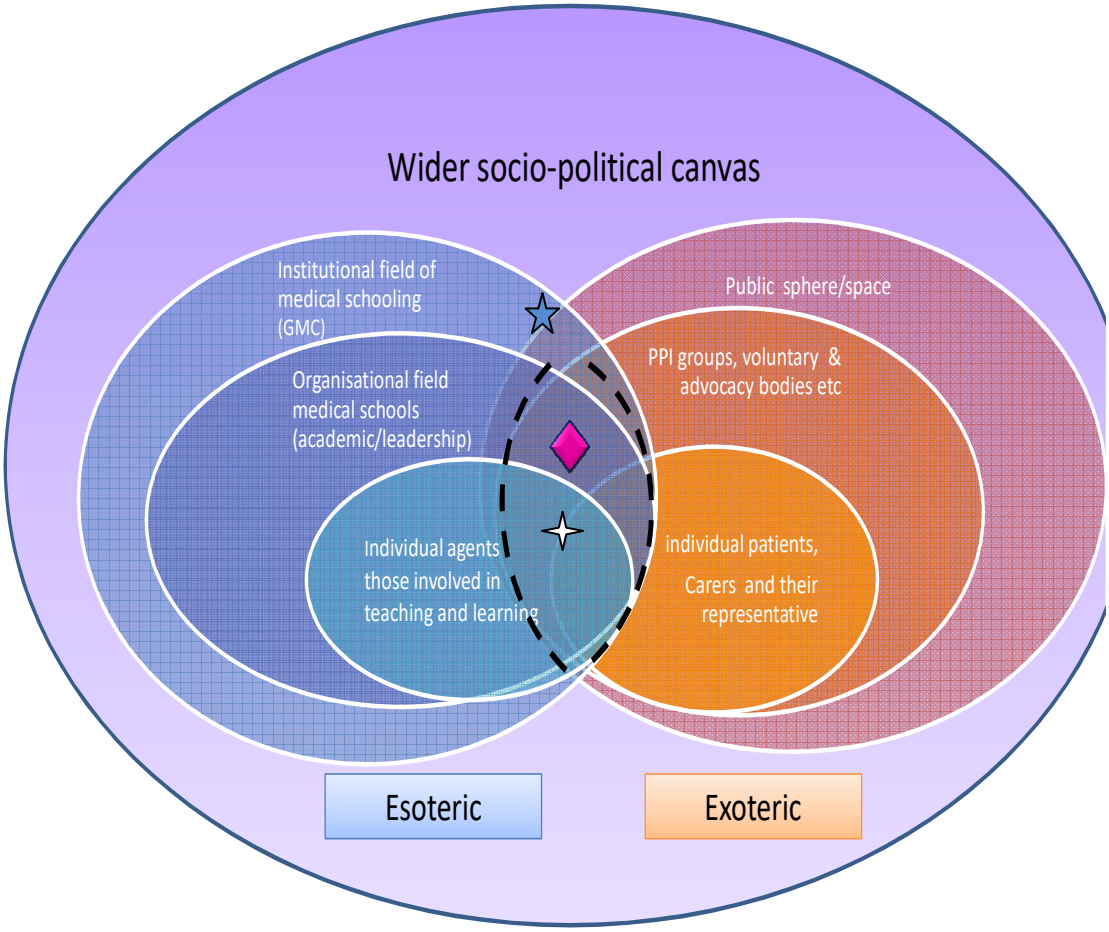
Table 4.3: Constituents of my empirical field

Field Level	Empirical field - settings & processes	Actors, agents & objects of interest
Institutional	The regulator (GMC)	"medical schooling" and its governance: established rule-based structure and mechanism with the social purpose of overseeing basic education for doctors.
Organisation	The medical schools	The academic body: formal leadership group, and administration, curriculum committees, syllabus documents etc
Inter & intrapersonal	Educating future doctors: teaching and learning	The human agents: Those who lead, plan, negotiate and enact (leading, designing, administering teaching and learning) in medical education (including the clinicians, patients, and students involved in teaching and learning).

Figure 4.2 (below) provides a overview of how these fields relate to one another within the wider setting. Using Flecks terminology, I refer to the *esoteric* (medical education)[44] and *exoteric* (the lay side or civil society) sphere. Anheier (2004) uses the same set of fields to describe strategies for researching civil society. This thesis is concerned with the framing of public engagement from the perspective of the esoteric aspect of each field-level *only*. The sampling process - based on this - is described in the next chapter.

[44] The study is partly a response by my earlier work exploring the lay- (or exoteric) side of the relationship (Berlin *et al.*, 2011).

Figure 4.2: The empirical field of the proposed study



Legend for Figure 4.2:

Fields in two structural spheres associated with public engagement The study uses data from sources in the esoteric sphere - left hand side (blue) of the figure.

KEY

- - - boundary and liminal spaces (ellipse in black broken line) between them

◆ = liminal space between macro levels in the two spheres

★ = intersection between meso/micro level within the medical school & with bodies in the public field

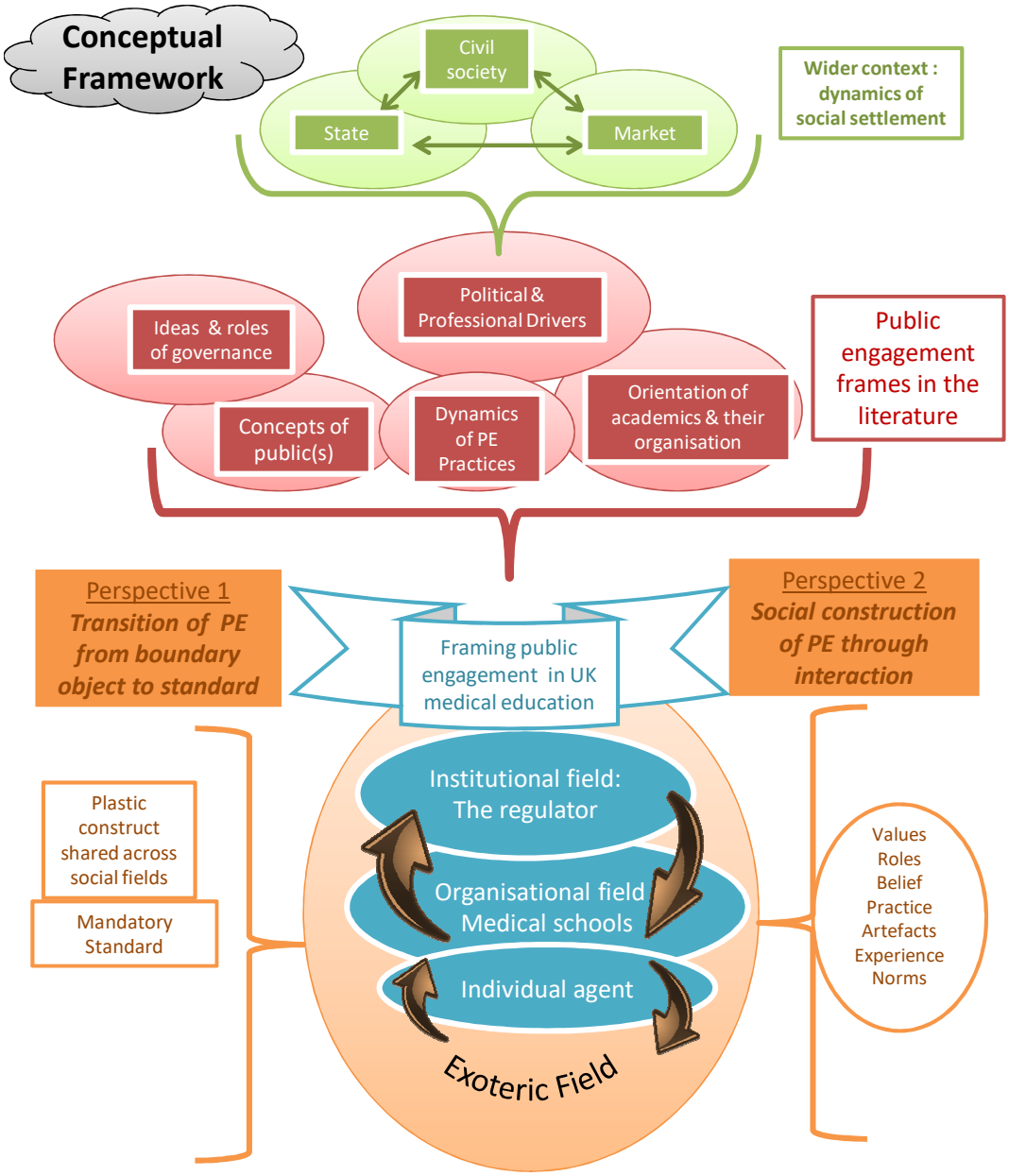
✦ = liminal space between micro levels on medical school-public sides (individual field[45])

[45] Lewin suggested the idea of the field of the individuals psyche as a combination of psychosocial factors in various *lifespaces* linked by vectors of different strengths

4.3 Conceptual framework

This section is the final piece in the methodological jigsaw. The concepts described above and elicited from the literature are joined to form the assumption that underpin the framework for this study of public engagement and its regulation in UK medical education. Figure 4.3 provides a bird's eye view of my approach to addressing the research questions. I bring together the bigger picture, and the key conceptual concerns and assumptions, and then link these to my empirical fields (medical schools and the regulator) through two theoretical perspectives - frame analysis and boundary object theory. Combining these perspectives in this framework is intended to give greatest purchase on "peeling back" interpretations of public engagement, and the role of agents, brokers and spanners in the tacking back and forth involved in the translation of the heterogeneous concept into a regulatory standard. It facilitates the exploration of how social interactions shape group "epistemic quality", and institutional "epistemic consequences". This provides the rationale for my methodological plan described below in Figure 4.3 (overleaf).

Figure 4.3: The conceptual framework



Principal research question:
How is public engagement policy framed and enacted in UK medical education in the context of evolving regulatory requirements and organisational diversity of medical schools and what are the implications for leadership?

4.4 From methodology to method

4.4.1 Designing the study

The framework laid out in Figure 4.3 is applied though case studies: a practical approach to research that facilitates a rich understanding of organisations through the combination, and triangulation of data. Case studies facilitate enquiry into interconnected ideas and holism, consistent with symbolic interactionism (Thomas, 2011). Case studies lend themselves to research into regulatory processes (Levi-Faur, 2003), and of boundary objects at institutional and organisational levels. The case study is not a method in and of itself. Rather, it is a design framework that may incorporate a number of complementary data gathering methods (Thomas 2011). Simon (2009: p. 21) defines a case study thus:

> *'An in-depth exploration from multiple perspectives of the complexity and uniqueness of a particular project, policy, institution, program or system in a "real life" context.'*

Case studies provide intensive as opposed to the extensive data. Rather than seeking to produce generalisable conclusions from a large sample, the case study looks at the complex interaction of many factors in one or a few situations. It affords the possibility of the descriptive, evaluative, or theoretical. George and Bennett (2005) (drawing on Eckstein, 1975) talk of theory-testing and theory-seeking. Theory testing case studies assess the applicability and conditions of single or competing theories. The work proposed hopes, by using frame analysis, to test the idea of the boundary object with regard to public engagement policy (See for example Banner, Donnelly and Ryder, 2012; Emad and Roth, 2008; Oborn, Barrett and Dawson, 2013; Trompette, 2009). In addition, it will be possible to seek theory around the development of a social epistemology of public engagement as a socially mediated moral and knowledge project. Benn and Martin (2010) have amplified the idea of the materiality of boundary objects to encompass the following:

- Artefacts - i.e. things such as text, terms, technologies, tools, representations,
- Visionary objects–i.e. best practice, organisational vision
- Discourses or processes –i.e. a change process, innovation project

Using this typology public engagement policy can be understood as material artefact (policy and standard texts), as a vision (a requirement for best practice in medical education), and articulation of different epistemological and doxastic positions (to widen the scope of the

curriculum, increase trust, social justice and reciprocity). The cases and methods are selected to expose this dynamic relation between subjects/agents (medical school actors) and object/artefact (public engagement policy (Bassey, 1999 in Van Wynsberghe and Khan, 2007) and the abstract visions within the current social, professional and academic structural contexts. Thomas (2011) suggests three types: specialist knowledge cases, key cases; or outlier cases. By applying specialist knowledge to a case study, that is researching in your own situation, "you can gain access to the richness and depth that would be unavailable to you otherwise." He goes on to say you "know and can 'read' the people who inhabit the arena – you may know it like the back of your hand." (Thomas, 2011, p. 76). This of course strengthens the case studies but raises significant issues for the researcher's relationship with the participants and the data which I address in the next chapter. The case study aims to generate a "thick" understanding, and, depending on the methods used, acts as a prism through which concepts, relationships, reality, and hypotheses can be analysed and synthesised (Simons, 2009a).

4.4.2 Linking the conceptual framework to design and analysis

If engagement was the solution - what was the problem?

The theoretical perspectives are applied through a set of parallel processes as depicted in the conceptual framework (Figure 4.3 above). First, the focus is on the social construction (as framing) of public engagement within the organisational and institutional fields, and the role of social and knowledge interaction. Next, the emphasis is on the transition of public engagement from heterogeneous boundary object to regulatory standards. Finally, attention is paid to the dynamics of framing and reframing at the intersection between the different social fields, and the agents and structures involved.

Guides to case study research (Keen and Packwood, 1996; Thomas, 2011) stress the need for an analytical approach or structure to help facilitate the interpretation of findings from different sources. In this way, the analysis is shaped by, and is coherent with, the conceptual framework derived from the literature and theory. The rationale for the cases selected, the development of the topic guide, and the procedures of data gathering, are described in the next chapter. The range of traditions in frame analysis is associated with a set of procedures

and principles to elicit narratives from both textual and verbal (dialogic) sources and offer various options also addressed in detail later.

4.5 Reprise and chapter summary

What then is being researched? For the purposes of this study public, engagement has a plastic, relational ontology. I apply Fleck's social epistemology to ideas of public engagement, arguing that they arise through social relations and are concerned with both epistemic and doxastic interpretations in different, but adjacent, knowledge communities. Research precedent suggests that this process is best understood through the perspective of symbolic interactionism - using the technique of frame analysis. Public engagement is framed, re-negotiated (that is, re-reified) and enacted in two dimensions (1) in the boundary spaces between the professional-academic domain of medical education, and the public sphere at various levels; and (2) across internal structural fields or levels of medical education. This study focuses on both, but only from the perspective of the professional-academic community. How can public engagement in this context be researched and understood? Boundary objects help us think (and work) across boundaries and offer a potentially useful device to focus theory testing and theory building around these liminal processes in which regulatory standards and practice are brokered and enacted. Case studies combining first person narratives[46] and document analysis from the different parts and levels of the empirical field form a useful framework for the study design. How this was done is addressed in detail in the next chapter .

[46] Or 'testimonies' to use the word favoured in symbolic interactionism research .

CHAPTER 5 CONDUCTING THE STUDY - METHODS, SETTINGS, DESIGN & ANALYSIS

5.1 My approach to the research

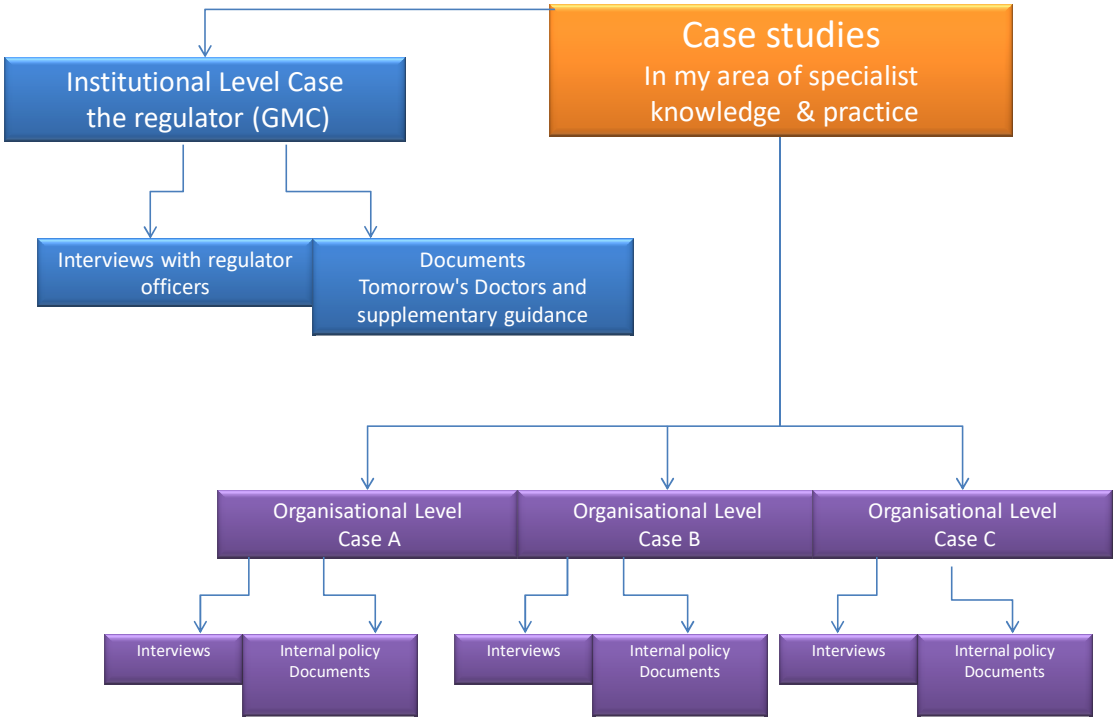
This chapter is divided into three parts: the first details the organisation of the study, how the cases were chosen, and how data were collected. This section also deals with issues of access to participants and ethics. The second section provides a description of the settings of the medical school case studies and the regulator case study. In the third section I summarise the data collected and how this was analysed. This includes a description of frame analysis procedures, the coding strategies used in NVivo, and how my theoretical framework was tested and further developed. The section ends with a comment on the limits of the methods and researcher reflexivity.

5.2 Planning and organising the case studies: from topic guide to data

In order to understand public engagement and the process of its institutionalisation in medical education, gathering data from medical schools and the regulator seemed appropriate. As mentioned in Chapter 1 (p25), I divided UK medical schools (the organisational field of this research) into three broadly distinct types (see p80 and Appendix 11). The study design aimed to exploit this phenomenon in order to enrich the data and add depth to the analysis. Given my focus on the translation of public engagement from plastic boundary object into regulatory standard, the institutional level case studies added to the theory testing aspect of the research. This combination of cases proved sufficiently constrained for the limited size of the thesis but rapidly generated relevant and diverse material. Taking into account my responses to Benn and Martin's (2010) typology of boundary objects and Simons's (2009a) and Thomas's (2011) guidance regarding data sources, both documentary and narrative accounts, from participant interviews, were included in the initial study design (Figure 5.1 , overleaf). While the purpose of the study had been established, in line with Robson's considerations of qualitative research, a degree of *flexibility* - in term of data sources - was built into the design. As Robson advises "*Ideas for*

changing your approach may arise from involvement and early data collection" (Robson, 2002, p. 164).

Figure 5.1: Overview of the study design



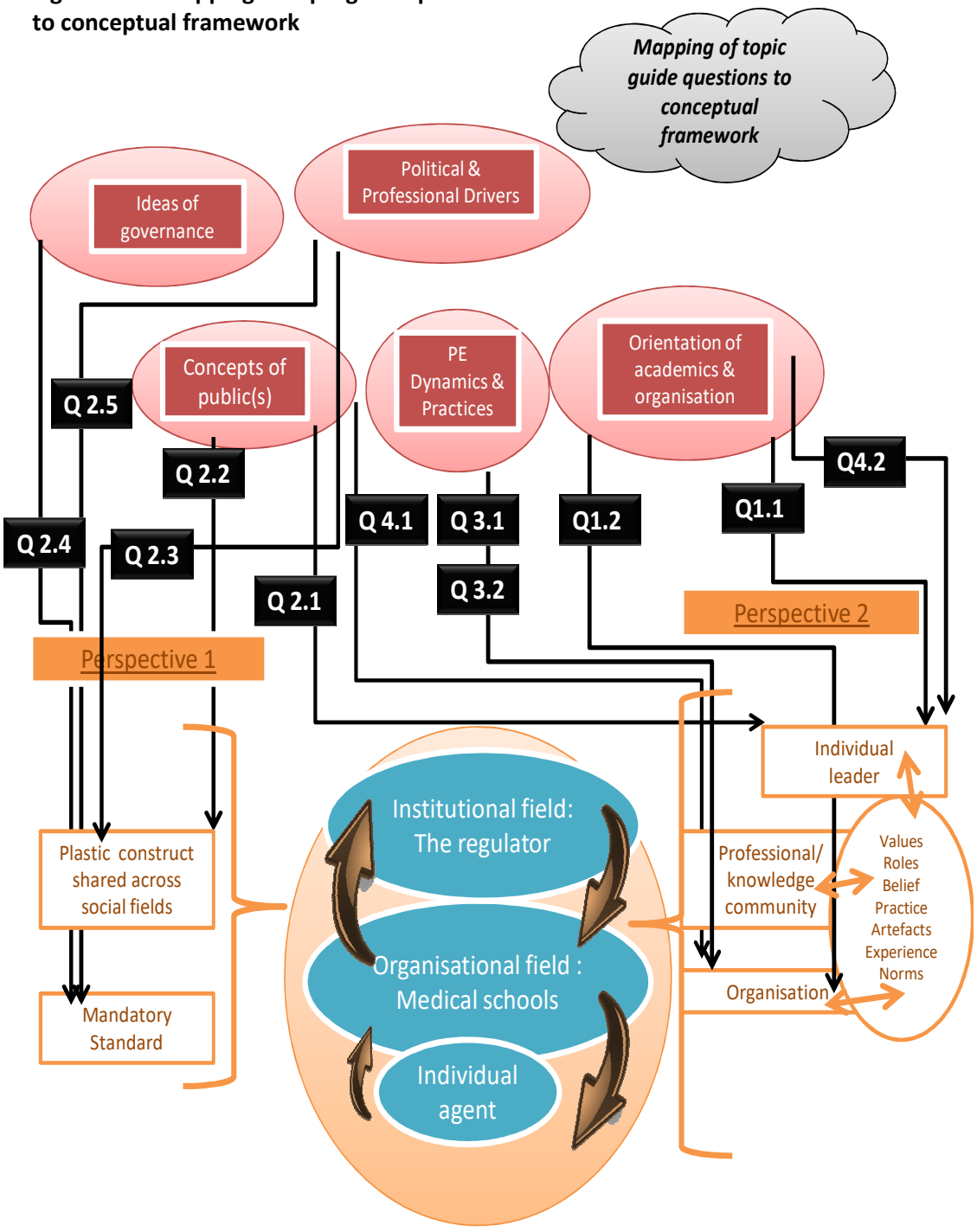
In the next section I describe the process of linking the conceptual framework to a semi-structured approach to data collection through a topic guide. Details of sampling, recruitment and what actually happened - who was interviewed and what documents were collected from each case studied are then described, alongside a comment on the plan-reality mismatch.

Development of the topic guide from the conceptual framework

The topic guide was informed by the conceptual framework, based on the research questions. It was also informed by the field guide used by Watson *et al.* (2011) in their project , published as *The Engaged University* (p261), which reassured me that my approach

was both practicable and, looking at their report, would yield the responses I sought. I used a sequence of four topics that divided the interview into more or less distinct sections that would allow a natural flow of discussion (Figure 5.2). (1) Introduction and participant leadership roles; organisational history, mission, culture, and decision making processes (2) PPI/PE in medical education (in general) - (a) what do the terms mean (etymology) (b) why has it been introduced - what have been the influences in its development - what perceived problems is public engagement trying to solve? (3) PPI/PE specifically in this medical school - who were the key stakeholders / what steps were taken to implement public engagement (4i) Examples of public engagement practice - focussing on relationships inside / outside, and story/narrative of these developments (academic/non-academic). (4ii) Prognostics - challenges and what would be the ideal future for public engagement in medical education. A modified topic guide for the regulator was devised with edited questions and section 3 omitted. A similar but abbreviated topic guide was applied to the document analysis. The topic guides are included in Appendix 8 and TGR. The topic guide was modified slightly as a result of my reflections after the first two interviews, and adjusted to account for the different roles of some of the medical school participants, however, the overall structure of the original worked remarkably well.

Figure 5.2: Mapping of topic guide questions to conceptual framework



Choosing and recruiting the cases : sampling process

The next task was to select the type of cases, and the specific sources of data, that offered the best response to the research question. The potential for theory testing or building47 is enhanced by appropriate case (subject) selection, although this is not a sample in the scientific sense :

> *'The subject **is in no sense a sample, representative of a wider population**. Rather, the subject will be selected because it is an interesting or unusual or revealing example through which the lineaments of the object can be refracted.'* Thomas (2011a, p. 514)

This type of specialist case study - in which I am researching within my own field of practice - provides access opportunities and practical foreknowledge. In the absence of a formal classification of UK medical schools I developed a rubric dividing the 28 medical schools in England and Wales[48] into three groups (full details in Appendix 11) to maximise diversity - in particular with regard to experience of quality management and regulatory processes[49]. Group 1 are the established schools - largely in Russell Group universities[50]) [n= 14]; Group 2 are the established schools that sponsored new schools - from which they subsequently demerged (or de-coupled) [N= 5]; and Group 3 are the new (post 2000) schools [N=9]. My familiarity with the field allowed me to recognise the three distinct types of school and this was verified by checking the Medical Schools Council A-Z List (2016) and each individual medical school website as well as consulting QABME reports in the GMC archive.

The sampling process can be described as purposive and convenience. In order to answer my research questions (Chapter 1, section 1.5) I purposively sought to maximise diversity of schools for case studies. My original intention[51] was to include three *pairs of schools* from Group 2 as cases. However, after my pilot I realised the quality and quantity of material

[47] Whether theory can be tested or generated through case study is contested, a point I address in my discussion (Chapter 7, section 7.4).

[48] I excluded the 5 Scottish schools and one in Northern Ireland as I was unable to travel due to carer responsibilities.

[49] As explained in Appendix 2 new medical schools are subject to annual QABME visits from the GMC, usually until the first cohort of students graduate, in order to be licensed to have degree awarding powers (DAPs) for primary medical qualification (PMQs)

[50] Increasingly these schools are associated with *academic health science centres.* At the intersection between higher education and healthcare the UK Academic Health Science Centres (AHSC) (Dzau *et al.*, 2010) represent a new economic, academic, and service model incorporating healthcare delivery with 'world class' research and professional education, and, notionally, community orientation. Based on the US original, AHSCs are ill-suited (perhaps knowingly) to the NHS (Hofmeyer, Newton and Scott, 2007; Rubin *et al.*, 2012).

[51] This paired sample was presented in my upgrade proposal - I was warned off for being too ambitious!

generated by each interview in each medical school would produce such a large body of data I simply would not be able to do it justice in terms of analysis and display (see below). I then modified the design to include one school from each group - anticipating this would lead to diversity but with a manageable data set. A short list of three schools in each group was drawn up - in order to be systematic. As this is an exploratory, theory testing, qualitative project there was no need to use randomisation nor would it have been professional or consistent with the design to approach schools that I would subsequently exclude (as might be done in a fixed survey or experimental design, consistent with more objectivist research tradition). Convenience was deployed though the use of existing contacts to make initial approaches to relevant leadership teams. In the event, the first school I approached in each group readily consented (following appropriate ethical guidance described in section 5.3).

Through my work as quality sub-dean at a UK medical school, I knew, and was known to, officers within the GMC, who also facilitated the regulator case study. Collecting data from these four cases has allowed me to approach the analysis in two complementary stages. The first - following Thomas's taxonomy - uses a multiple, parallel design which provides detailed data about concepts of public engagement and its framing in the three medical schools and the regulator, from which local narratives emerge and some limits links can be made between school. The second stage allows combining of the data to test the theory that public engagement in medical education acts as a boundary object at a number of levels, most particularly across the organisation field and in the dynamic process of its institutionalisation as a standard.

Data collection within the case studies - the *plan-reality* mismatch

"There's many a slip 'twixt the cup and the lip" (proverb)

The study design (Figure 5.1 above) aimed to include three medical schools and the regulator. For the medical schools my intention was to interview a minimum of *three* key members of the senior management team, and to examine appropriate documents at each site. While aware that job titles and descriptions vary substantially between schools, as do leadership structures, the hope was to include: the head of the school (Dean equivalent); programme

director; and lead for public engagement/patient and public involvement, or lead for quality assurance. Bramhurst Medical School[52] was intended to be the pilot site.

In reality, a number of factors led to revised set of data gathered (as laid out in Table 5.1, below.) First, the quality of the data gathered from Bramhurst Medical School proved generous, interesting and appropriate, so after discussion with my supervisor, I decided to make this as my first case, and include this data (as consent had been given by the participants). Secondly, as can be seen from the matrix, at two schools (Bramhurst and Casterbridge) the chair of the Medical School PPI Forum was also the programme director - obviating the need for further interviews. In Anglebury Medical School, there were two co-directors of the programme and responsibility for PPI was shared between the chair of the PPI forum and the quality and standards officer. The head of Anglebury School facilitated the five further interviews which led to this more detailed case study.

Interviews for Anglebury, Bramhurst and the Regulator were conducted in July and September 2014, and for Casterbridge Medical School in December 2014. Interviews took place in the offices of the participants at their convenience, with the exceptions of C1 which took place in a small meeting room, and A3 and C2, which were conducted via Skype. Interviews lasted between 50 and 90 minutes (mean 65) and all were recorded and professionally transcribed, yielding nearly 150 pages.

With regard to the Regulator case, the Head of Education Policy (R1) was interviewed alone. The three more junior GMC officers agreed to be interviewed, but only together, the reasons given were for completeness and consistency. The transcript for this interview is treated as from a single participant (R2).

Document yield was much less than anticipated. The story regarding the planned rewriting of the Terms of Reference for the PPI group at Anglebury Medical School is presented as a detailed vignette in the findings (next chapter) but these were not made available. The two participants from Casterbridge Medical School explained that they were hoping to publish details of their own public engagement work and for that reason would not give me access.

[52] The medical schools have been pseudonymised using fictional English towns created by Thomas Hardy. This is not to suggest that the schools are in the South West. Participants are then assigned a code beginning with their school's initial.

Paradoxically, they were by far the most generous and informative in the interviews - which reflected their wider experience of the field. It is likely that the case studies would have been enhanced by including a greater number of interviews, or ethnographic data collection. A pragmatic decision was made not to do so based the word limit of the thesis (half a full doctorate), and the large amount of relevant data gathered through the interviews.[53] The final list of participants, their titles, and their code are detailed in Table 5.1.

[53] I could add here that my mother went into a coma on the day of the penultimate interview (C1). What turned out to be the last interview (C2) took place between her death and her funeral, leaving me to care for my distraught demented father. Such is the nature of life, death and solo research! Focusing on the quality rather that the quantity of my data analysis thus became my priority.

Table 5.1: Matrix of case data gathered

CASES	DATA	PARTICIPANTS INTERVIEWED				
Anglebury Medical School	A1 Head of School of Medicine (Dean) [7,500] F	A2 Programme Co-director [8,321] F	A3 Programme Co-Director (clinical) [8,691] M	A4 Academic Quality & Standards Officer [7,919] F	A5 Director of Post-graduate Programmes Chair of Medical School PPI forum [7,866] F	A6 Under-graduate Director (non-medical courses) [7,115] M
Bramhurst Medical School	B1 Associate dean School of Medicine [7,359] F	B2 Programme director for clinical & communications skills Medical School Lead for PPI [9,866] F				
Casterbridge Medical School	C1 Head of School of Medicine (Dean) [14,387] F	C2 Programme Co-director Medical School Lead for PPI [13,501] M				
Regulator Case (R)	R1 Head of Education Policy GMC [12,262] M	R2 (joint interview, (a) & (b)Two GMC Education Policy Officers + (c)Quality Assurance Officer [9,411]				

[Total word count of transcripts appear in square brackets]

5.3 Ethical considerations, access & challenges

A successful application was made to UCL Research Ethics Committee which covered key areas. Informed consent was ensured by the preparation of an approved Information Sheet and Consent Form (Appendix 9). These stressed participants' right to withdraw consent at any point after the interview. Assurances were given regarding confidentiality and protection of identifiable third parties. The Information Sheet also covered issues of access and use of published or internal documents, although in the event its assurances were not required. Data management, storage, and participant protection were also specified, whereby all sites and participants were allocated a code with which they were identified. The key to coding was kept apart from the data files. Data was be kept and presented anonymously (in accordance with the BERA guidelines and Data Protection legislation). All text and MP3 files were saved on UCL computers and password protected. Every effort was made to ensure that quotes cannot be traced back to individuals except via a coding system. Participants were offered the opportunity to validate data transcripts. Identifying information about third parties, patients, students and members of the public were deleted from transcripts and none have been included.

Case study research may be fraught with ethical dilemmas due to the gathering of detailed data in a limited number of settings. As Simons (2009b) and Thomas (2011) both stress, the key is to consider wider potential harms than those assessed by the ethics committee, including compromising a participant's standing or even causing embarrassment. Although ostensibly low risk this study raises issues akin to **insider research**[54] relating to access and handling of transcripts. Medical education is a small field in which I have been working (in three different schools across the UK) since 1989 - although I have never worked at any of the schools in the sample and have no collaborations with them. Nonetheless familiarity may have facilitated "convenience" in terms of access and increased positive responses, and possibly openness - although it is impossible to tell if generosity constituted unwitting candour. Good interviewing depends on establishing a rapport. On balance this prior experience of the field and the actors was an advantage . The related issues of rigour and phronesis are address in section 5.6 below.

[54] See Appendix 13 - Rigour in different research traditions - in which I comment on the special challenges of insider research.

With regard to ethics - two safeguards applied. First, relating to consent, secondly to anonymity , the use of language in direct quotes, and triangulation.

I followed key ethical requirements of free consent to participation and withdrawal at any point (Appendix 9). I conducted the interviews in accordance with good ethical and interview practice - meticulously following my topic guide (Appendix 8) while putting respondents at their ease and encouraging an open and conversations style. In terms of impact, this approach appeared to yield open and full responses to me as a researcher in which the participants clearly assumed I had some prior knowledge of their context.

An essential part of the case study method is the process of triangulation, deliberately seeking responses to the same issues and events from different perspectives. These different perspectives are central to my investigation of public engagement as a boundary object and to the process of frame analysis but could raise concerns regarding anonymity. This process involves individuals' accounts of, and opinions about their organisations - that reveal starkly different positions. The data includes implicit and explicit critiques of policies and actions. This is illustrated in exquisite detail in the vignettes about public involvement in student selection interviews, and the handling of the proposed terms of reference for the PPI group at one of the case sites. In holding the transcripts I held the balance of power. In compiling excerpts from the transcripts, I strove to retell these stories in a way that all participants and represents all stakeholders, without losing the depth of insight and meaning that were refracted through this polyhedral prism.

My concerns regarding anonymity are twofold: first there are a limited number of medical schools in the UK each with a unique story. In the following section I paint a portrait of each – hopefully with enough detail to distinguish the case, but insufficient to expose its identity fully. Nonetheless, a very well informed reader may be able to make a correct guess about the identity. All the data is presented in the results section with this possibility in mind. Secondly, there is only one regulator of medical education in the UK, the GMC, and there is only one Head of Education Policy. The final transcript will be offered to all participants for discussion redaction of sections of concern prior to submission to UCL library. Care will be taken to further disguise the Cases for any paper submitted for publication.

5.4 Settings

Brief descriptions of the cases can be found in Table 5.2 and attributes of the participants are listed in Table 5.3.

Table 5.2: Profile of the organisational field and cases

The medical school field		
UK medical schools form a single organisational field.. All medical schools must comply with GMC *Tomorrow's Doctors* standards and curriculum outcomes but, nevertheless retain considerable autonomy. All are subject to the GMC Quality Assurance procedures to retain their licence to train doctors (see Appendix 2). Schools are also subject to internal quality review by their parent university. All UK graduates must be registered with the GMC and employed by a Foundation School (linked to a medical school) to complete an internship or "foundation year". The effect of *Tomorrow's Doctors* and expectations linked to full registration have led to a number of trends. Some of these have resulted in convergence of curricula, others have facilitated diversity. • Convergence: methods of assessing competence; early identification of unprofessional behaviour; apprenticeship style final year. • Diversity: selection procedures; underlying pedagogic principles and practice; length of programme (with or without additional research year)		
The medical school cases		
Anglebury Medical School: Transitional School in new Russell group university arising from demerger [Hybrid]	**Bramhurst Medical School: Established medical school in a new Academic Health Science Centre [Old]**	**Casterbridge Medical School: New school - arising from demerger from a Russell group university [New]**
Anglebury Medical School is one of the youngest in the UK, established less than 5 years ago in a Russell Group university. It evolved from a formal de-merger that created another medical school, Marygreen. Anglebury Medical School has a small intake (in the lowest quartile in UK), with a plan to expand. The senior students are still following the old joint curriculum with Marygreen , under a joint leadership team. The new Anglebury curriculum is a mix of lectures, workshops and clinical placements with a greater emphasis on research and science than the previous joint curriculum. The school is located in a region with significant socioeconomic (and rather less ethnic) diversity. Anglebury is still undergoing the GMC QA *annual* review procedures for new medical schools. Participant C2 is the co-leader of the GMC visiting team for Marygreen Medical School.	This medical school is in a Russell group university . It resulted from the merger of two old "hospital medical schools" - both over 150 years old. The host hospitals were absorbed into the NHS in 1948, and the medical schools became small, single-programme public higher education institutions. In the 1990s, to improve research productivity and cost effectiveness, hospital medical schools were merged and absorbed into a research-intensive universities. Bramhurst now forms part of one of the UK's seven Academic Health Science Centres. Located in an urban area of great socioeconomic and ethnic diversity. It has a large intake (in the top quarter of UK schools). It offers a small access programme for local pupils. The curriculum blends a mix of problem based-learning, supported by lectures, workshops, and a wide range of hospital, general practice and other community placements.	Casterbridge Medical School is also a new school. It is part of a post War-university - a forerunner to the so-called plate-glass universities. Casterbridge evolved from a satellite campus of a much larger medical school. It gained degree awarding powers about 10 years ago and has had a new curriculum approved by the GMC. The curriculum uses a blend of small group, lecture and clinical placements, focusing on clinical performance with a substantial involvement of local GPs. It has a small access course, and is located in an industrial area with relatively high levels of deprivation and a moderate level of ethnic diversity.

.Case R: The GMC - professional regulatory body
The General Medical Council (GMC), established in 1858, has the statutory obligation to maintain a register of medical practitioners and to license training programmes of doctors. The Education and Standards directorate has three sections : (planning, education policy, and education quality assurance). It is: "responsible for setting standards and monitoring every stage of medical education and training as well as overseeing continuing professional development (CPD)" . It runs the quality assurance programme which assesses how effectively medical schools meet the standards in *Tomorrow's Doctors*." The five directorates are answerable to the Council's committees and are informed by the work of Advisory Boards (i.e. the Education and Training Board) and Liaison Groups. There are lay representative at all levels of this structure.[55]

Table 5.3: Participant attributes

Participant Code	Background	Dominant Discipline	Gender	Leadership	School Type	Site
A1	Scientist	Research	Female	PPI Lead	Hybrid	Anglebury
A2	Scientist	Education	Female	Unassigned	Hybrid	Anglebury
A3	Scientist	Education	Male	Unassigned	New	Anglebury
A4	Administrator	Quality Assurance	Female	Unassigned	Hybrid	Anglebury
A5	Clinical	Education	Female	School Lead	Hybrid	Anglebury
A6	Clinical	Education	Male	Unassigned	Hybrid	Anglebury
B1	Scientist	Education	Female	School Lead	Old	Bramhurst
B2	Clinical	Education	Female	PPI Lead	Old	Bramhurst
C1	Clinical	Education	Female	School Lead	New	Casterbridge
C2	Clinical	Education	Male	PPI Lead	New	Casterbridge
R1	Officer of the regulator	Education	Male	Education policy Lead		Regulator
R2	Officers of the regulator x 3	(a)Education	Male			Regulator
		(b)Education	Male			Regulator
		(c)Quality Assurance	Female			Regulator
Me	Clinical	Education	Female	PPI Lead	Old	School U

[55] As I was concluding this work In January 2016, new standards for medical education were published (*Promoting Excellence*, GMC 2016). The implication of these changes for my thesis are considered briefly in the discussion (Chapter 8).

5.5 Handling the data

Managing the material using NVivo

All the text sources were converted to Word documents and uploaded to NVivo 10 software. These included the transcripts of audio-recorded interviews, (Table 5.1), and my own field notes. The software maintains the integrity of the sources while facilitating multiple levels of coding, making connections between them and producing visual representations. I used the *attributes* facility in NVivo so that I could later cross check within and between participants with similar characteristics - for example when searching for item coded for all clinicians, or all PPI Leads.[56]

5.5.1 Frame analysis procedures

The next task is deciding how to use frame analysis to analyse the data. Frames are mental structures that hold and shape our view of the world (Goffman, 1974): they underlie our beliefs, perceptions, and appreciation of reality, through which we make meaning. (Schön p23). This meaning only arises in the process of social interaction, interpretation and contextualisation - although we are capable of simultaneously framing a single issue in a number of ways, some complementary but working at different levels, some contradictory. Frame analysis is, thus, a research tool principally concerned with dissecting how an issue is defined and problematised (Hope, 2010). In frame analysis, a form of qualitative coding, the task of the researcher is to identify frame elements, in text and or speech, concerning descriptions of actions, events and beliefs. The researcher needs to filter and arrange the data in order to display frames in a way that informs, and insightfully responds to, the research question. Frames are said to share certain axioms (Vliegenthart and van Zoonen, 2011) that resonate with symbolic interactionism (see Box 3.3, previous Chapter). In summary, frames are:

- multiple and can be contradictory or oppositional;
- part of a struggle for meaning between different actors that have unequal material and symbolic resources;
- the result of situated social and routinized processes in which the agency of the individual actor is relative; they are the result of socially situated articulations between particular issues, individual and collective differences, experiential knowledge, popular wisdom and media discourse.

[56] As I coded my own field notes to increase reflexivity, I also included "me" , the researcher.

- preferentially negotiated and contested in people's discussions (personal/social) - but also arising through policy (political/ institutional)

(Cornelissen and Werner, 2014; Creed, Langstraat and Scully, 2002; van Hulst and Yanow, 2014; Vliegenthart and van Zoonen, 2011)

The challenges for the researcher are the many definitions of frames in the literature and thus identifying those that aid choice of useful analytical tools - Vliegenthart and van Zoonen (2011, p. 105) observe, referring to Entman's seminal paper (Entman, 1993):

> *'Despite Entman's call for conceptual preciseness, these 2,200 (papers citing his work) and other frame/framing articles contain a cacophony of new definitions, divergent operationalizations and a wide, often incompatible range of empirically established content features.'*

As I join this extensive, but diffuse, tradition of frame analysis research, I seek the best fitting model(s) for *my* purposes. To this end, I have focussed on models that work at different levels - in my case individual (agent/micro), organisation (field/meso), and institutional (policy/macro)[57]. As Benford and Snow (2000) warn it is easy to get distracted by discussions of the overlapping morphological minutiae of frames (see Appendix 12 in Table A12.1) - instead of using frame analysis as a tool to inform the enquiry at hand.

I have, therefore, drawn on research in the areas of policy/regulation and education/knowledge as precedents and reference points (Anderson and Rodway Macri, 2009; Gray and Williams, 2012; Mills, Francis and Bonner, 2007; Rodriguez Castillo, 2008; van Bekkum and Hilton, 2014; Virkki *et al.*, 2014). Despite the wide range of frame taxonomies and nomenclatures, authors tend to agree (using slightly different terminology) that frames elements manifest in key social processes: problem definition; cause identification (diagnostics); making moral judgements; and suggesting remedies.

5.5.2 Frame analysis model used in this study: displaying of action, agency and structure

The model I use (Box 5.4) is based on a synthesis of the approaches used by Schön and Snow (described in van Hulst and Yanow, 2014) and Gray, Purdy and Ansari (2015) which follow a

[57] See Figure 4.2

trajectory of framing regarding public engagement. Appendix 14 includes a full typology of frames and their roles.

Box 5.4: Model of frames and framing used to inform analysis in this study

Concerns<-> causation<->problems<-> responses<-> motivation <->solutions

(with reference to actors/ structures/ language / dynamics)

- Level 1: Micro level, using primary cognitive framing looking at priming and activation of knowledge schemas, which then guide individual perceptions, inferences, moral evaluation and actions in context using signature matrices
- Level 2: Organisational/meso level framing of strategic actors (medical school leaders) who, in turn, seek to frame courses of actions and social identities, derived from knowledge used by their (professional/knowledge) community (with reference to collective action framing process and field frames)
- Level 3: Institutional framing: how field-level meta-frames are negotiated to become institutionalized and provide abstract scripts and rules/regulations (with reference to policy and organisational frame analysis)

Noting that *"frames do not come about intentionally but are the result of interactions and conflicts between collective and/or individual social actors"* (Vliegenthart and van Zoonen, 2011, p. 107) during the coding of frames, I sought, within the data, examples of events and key policy moments that show how the framing arises. This is not solely through the agency of the individual participant, but also at the level of processes in each organization, and via the discursive tendencies of the organization fields, as a whole : the medical schools, on the one hand, and the institution of the GMC, on the other.

Passages were selected where participants were talking explicitly about public engagement in a definitional or descriptive sense. These statements were conceptualized as an issue, a problem, or an event. The topic guide (Appendix 8) then elicited what were the underlying concerns in medical education, and what problems public engagement might be addressing - these were coded as frames along the trajectory towards interventions or solutions. It was possible to do this for all the participants. The next step, as the literature suggests, was to look for 'frame alignment' (or frame conflict) between individuals, and within organizations. Frame analysis involves discursive techniques to elaborate the how the elements connect different narratives into a coherent frame. A number of processes have been described

(Benford and Snow, 2000; Cornelissen and Werner, 2014) that highlight how framing may work within and across organisational or epistemic fields. Frames may be fixed, even frozen cognitive or moral structures but, importantly awareness of frames and these framing processes allows us to see or even promote, emergent, new frames. In addition Gray, Purdy and Ansari (2015) advocate researchers focus on the bidirectional dynamic institutionalisation. Details of coding, frame finding and frame building are included in Appendix 10.

I was able to indentify holistic processes across some of the cases (in transcripts and documents) which were consistent, to some extent, with what Goffman (1974) called frame amplification, frame extension and frame transformation, defined in box 5.5.[58]

Box 5.5: Holistic processes that act across and link frames

(a) Frame bridging - where two or more ideologically congruent, but distinct, concepts link frames)

(b) Frame extension - linking non-data sources (such as existing policy or political rhetoric) with frames in the field of study

(c) Frame amplification - where the sponsor appeals to more universal beliefs and values that resonate with multiple frames, or the wider discursive field (for example discrimination) that are influenced by structures of power and authority or when respondents introduce their own prior knowledge or experience to push "the boundaries ...so as to encompass interests or points of view that are at the margins of their belief, but of salience to potential adherents"

(c) Frame transformation - “changing old understandings and meanings and/or generating new ones” (Benford & Snow, 2000 p. 625) when opportunities arise for a change in society, transformation may find traction with existing sponsors, new third parties, and the public (Cornelissen and Werner, 2014).

Presenting frames - levels and display

I considered a number of options for data presentation, based on a matrix. As this study moves across the registers of micro (individual) – meso (organisational) - macro (institutional) I have used different display devices: initially matrices at different levels as suggested by Gray, Purdy and Ansari (2015), and Vliegenthart and van Zoonen (2011), and later diagrams. The micro accounts of my participants concentrate on framing by individual actors or agents - often informed by their unique identities - best displayed in signature matrices; meso level

[58] Informed by symbolic interactionism.

frames become more collective and may coalesce into strategic frames shared by a number of participants in a single organisation (or case) which I display in higher level alignment matrices; and finally I display macro level meta-frames and highlight the dynamic bi-directional processes that take place across the field boundaries using diagrams and low charts. Johnston provides a useful heuristic for the research to apply at this stage (Box 5.7).

Box 5.6: Johnston's rules for frame analysis (2002)

1. Demonstrate understanding of the speech situation - the context in which the data is gathered
2. Use a holistic approach to the text/transcript - that is, place the content within its textual context
3. Refer to how the text is produced as part of the speakers "role perspective" (as say, an administrator or a clinician)
4. Note that speech is shaped by interactional goals or intent - participants may be making "pronouncements" to the interviewer, or in focus groups, to the other participants
5. Non-verbal cues should be considered - as indicators of affective or emotional emphasis
6. Where possible, make explicit the tacit process of data reduction and highlight omissions
7. Use a systematic method of presentation - aided where possible by software

The frame analysis findings are presented in the following devices: medical school cases are illustrated at micro level with individual signature matrices (which provide examples of thick data analysis[59]) and then master frames for each school (which demonstrate within-case *frame bridging* and *alignment* and *counter-frame* misalignment). As will be seen in the next chapter, two vignettes are used to further elaborate elements and functions of selected frames at this level: similar incidents (related to the recruitment of lay members to committees) described in both Anglebury Medical School and Casterbridge Medical School, and a story of service learning at Casterbridge Medical School, all from more than one perspective provide the narrative. These illustrate the role of social interaction in framing

[59] The signature matrix enables an analyst to capture and display the defining ideas of a principal frame, (Anderson and Rodway Macri, 2009) and therefore gives the reader an insight into the selective and analytical processes that inform the "higher level" master and meta frames. The signature matrix is a way of moving "*closer to the action at a micro level, to study the ongoing and interpretive processes of framing and meaning construction across actors* " that hold an individual's primary frames together

and frame analysis, as a way of responding to Goffman's cardinal question: 'what is going on here?'.

At the meso level, the organisational field, a master frame illuminates responses to the GMC standards across *all* the schools and the underlying "diagnostic" frame elements involved (that are responses to the questions: what problem is public engagement solving, and who is responsible for the problem and the solution?). The regulator case frame analysis is enhanced by using data from the transcripts of two participants (C1 and C2) acting as boundary *spanners*, within seconded roles within the GMC regulatory structures[60] Two meta frames are described that work across the entire empirical field of the study. First, 'the deal' between the medical school and outsiders arising from negotiating uneasy compromise between conflicting conceptualisations of patients and the public (patient–lay–public frame). Secondly, the identity meta frame, and amplification of student centred and person centred frames. These higher level multidimensional frames are presented using diagrammatic devices (see Johnston (2002)) supported by verbatim excerpts illustrative of commensurate and incommensurate elements and perspectives.

Limitations of frame analysis and mitigation techniques

Frame analysis has a number of limitations - some of these are general to its application (and are common to many forms of qualitative research - see Appendix 14), while others are particular to the type of quasi-insider research undertake herein, compounded by the obligatory solitary nature of a doctorate. The limitations[61] and mitigation strategies aimed at increasing potential inferences and reduce biases - are summarised in Table 5.7 below. Some limitations could not be overcome and these are discussed in detail in Appendix 13.

[60] C1 as a member of Education Standard Review Group and C2 as a quality visiting team co-chair.

[61] There are a number of other ways to mitigate against shortcomings that would been challenging or impossible in a doctorate of this size are also included in Appendices 12 and 13

Table 5.7: Limitations of frame analysis and mitigation techniques applied

Limitations of frame analysis	Enhancing research - techniques to mitigate limitations
Taking and presenting statements from transcripts out of context Selectively or unconsciously ignoring or overemphasising statements or frames (Ransan-Cooper *et al.*, 2015) Applying unwarranted preconceptions Relying on the text without reference to other cues or clues (Gray, Purdy and Ansari, 2015) Presenting frames as static where clearly framing, at all levels, changes over time due to individual and contextual phenomena (Ransan-Cooper *et al.*, 2015) Small samples may allow inference to other contexts or situations but not robust generalisations Underestimate the power and structural influences in the data collection process Underestimate the power and structural influences in the data analysis (Gray, Purdy and Ansari, 2015; Van Gorp, 2007)	Use a strict and transparent system of analysis and data display applied meticulously (Johnston, 2002)(see detailed and structured analysis displayed in matrices used in Chapter 6 and laid out in Appendix 10) allow the research and reader to trace back the frame from the raw material. Use of *marker* concepts or terms and identifying associations - for example "public engagement is a requirement" associated with "providing evidence of compliance"; "involving patients" is associated the teaching and learning whereas involving "lay people" is associated with committee membership (Dombos *et al.*, 2012) Include data from more than one context (in this study *four* cases) Use *holistic* data analysis strategies to link across the field and upwards through individual-organisational-institutional levels (Cornelissen and Werner, 2014) as per Johnston Rules see box 5.7) (frame alignment/bridging/resonance) Researcher reflexivity and "insider knowledge" through the process of phronesis described in section 5.6 below

5.6 Research Rigour: "trustworthiness", reflexivity and phronesis

Ideas of rigour are complex in qualitative case study research[62] As Crotty (2003)says -

> *" a single objective truth... is never realisable ...at best our outcomes will be suggestive rather than conclusive . They will be plausible, convincing, - and helpful ways of seeing things but not the one true way" (p13)*

Nonetheless attempts must be made to consider and minimise bias. Commonly concepts applied to qualitative case studies are transparency, credibility (or trustworthiness) rather than claiming a reliable, generalisable objective truth. Thomas (2011) citing Whittemore lists ten different terms for validity, only to reject the concept entirely. Richards (2009) offers

[62] Concepts such as reliability, validity and generalisability do not apply as they are associated with a very different, objectivist or experimental/positivist research traditions (see overview of "rigour" in Appendix 13).

more pragmatic advice for addressing a justifiable need to reassure an audience (and, of course, participants) that the findings genuinely reflect the data, and follow some coherent procedure. She suggests the four methods: triangulation (looking for consistency across sets of data); member checking (showing summaries and reports to participants for feedback); cross coder checking (between a research team - not possible here) and transparency using coding trails. In this project the use of three different cases/schools offered some degree of triangulation when coding frames at the field level. Member checking was used (by presenting a short report to each cases after the analysis was complete). In addition, I presented the preliminary findings at an Institute of Education seminar and at the Bradford University School of Health (including members of the school's PPI group). I received thoughtful critique. A lay member of the Bradford PPI group observed that the relationship presented should not be seen as rigidly binary (*us versus them).* He suggested, that in his experience the situation is more fluid, flatter and participative, an observation that encouraged me to revisit the data.

In a small, single authored project options are limited, and questions of bias, blind spots and preconceptions arise. This is compounded in (quasi-)insider research which has been described as a "double edged sword" (Mercer, 2007). In some respects being an insider researcher both adds to, and threatens, the credibility of the data as all interpretations are coloured by foreknowledge of the context. Richards advises that the best we can achieve to mitigate this is provide evidence of our consistency through coding records (as laid out in detail in Appendix 10), and evidence of our reflexivity.

Creed, Langstraat and Scully (2002) highlight particular challenges associated with social construction of validity in frame analysis taking the concepts of *etic* and *emic* validity from linguistics and anthropology. These concern the relationship between, on the one hand, the analyst's wish for acceptance of results by others in their field or epistemological community (the etic), and, on the other, emic validity, that strives to reflect the position of the analytical subjects (the participants) as they, themselves, would describe it. There is no correct balance that must be struck between the two forms. This depends on the researcher's own "projects" (academic, ethical and /or political). If the intention is to lay bare the underlying logics used by participants from conflicting positions to invite discussion and mutual understanding, then the researcher would strive for emic validity. If the a greater degree of deconstruction is

desired then etic validity may be prioritized. Creed, Langstraat and Scully (2002, p. 49) conclude:

> *'Thus, in engaging in a frame analysis, the purpose of the analysis, its intended audience, and the ethical project of the analyst will determine the type of validity for which an investigator strives.'*

Case studies have been dismissed as mere anecdotes from which nothing of general value can be learned (Dowling, 1998): are they method, methodology, or research design, and how much is sufficient data to form a case (Van Wynsberghe and Khan, 2007)?

The principal concerns, my own included, are that bias, and researcher preconceptions, render conclusions invalid. Doctorates being, by definition, solo projects, are more susceptible to these flaws. I used memos, field notes, and journals to log the evolution of my coding. On paper and within NVivo I recorded coding at different stages, using diagrams, flowcharts and models for my reflections, inspirations, doubts, and blind alleys. (see Appendix 10 and others are available on request.)

Case study advocates highlight the need for a particular approach to reflective thinking that researchers may use to address these inherent defects (Flyvbjerg, 2004; Thomas, 2011), aligning with abductive and holistic methods. These approaches follow the Aristotelian tradition of building understanding by linking a knowledge base (episteme) with practical experience (praxis) using the process, or stance, of phronesis. Roughly speaking this is a form of knowing that combines factual knowledge, reflection and experience tempered by judgment, prudence, humility and healthy doubt. It is a form of higher order tacit knowledge (Nonaka and Takeuchi, 1995). Through the application of this practical wisdom, the researcher engages with the data and findings, using prior knowledge and experience, actively, but cautiously.

The concept of phronesis resonates very particularly with this work. Flyvbjerg, Landman and Schram (2012); and Schram, Flyvbjerg and Landman (2013), in discussing phronesis, bring together three of my core topics: professional practice; learning and teaching; and the case study. Creed et al (2002) also stress its value in frame analysis - allowing the researcher-practitioner to recognise familiar "idea element" that may act as triggers, like *soundbites*, rapidly connecting with prior experience and knowledge, accrued from multiple contexts.

Each case study allows in-depth exploration in diverse settings , and must be regarded as free-standing and not intended to be comparative. Nonetheless links can be made between cases and between structural levels **included in the study** using "holistic" frame analysis strategies. These include seeking *resonance* with wider socio-political and historical context; *bridging* between frames across a field; and *alignment* with dominant master frames. Therefore a limited consensus can be inferred but cannot be assumed to apply to others cases/schools not included.

Coming to a doctorate relatively late in my career, means I have a cluttered academic-professional attic. However, much of my experiential professional knowledge base is, in fact, stored in a reasonably accessible and ordered library, which includes hundreds (possibly thousands) of remembered cases from my clinical practice, many of which I use to exemplify and amplify my teaching. I am, therefore, as Schram, Flyvbjerg and Landman (2013) and Schön (1994), reassure me, already experienced in applying the underlying logic of the case study and frame analysis (Cornelissen and Werner, 2014)[63]. It follows, in the tradition of symbolic interactionism and Fleck's notion of social epistemology, that my approach to analysis is effectively an interaction between my own epistemic and doxastic knowledge base and the data. Therefore, it can be argued, my closeness to the field and the participants, rather than being a handicap, gives me a speedier, more informed and nuanced grasp. As a practitioner-researcher I am able to identify and draw inferences from what "*rings true*" (Richards, 2009 p. 151), and also to acknowledge what are informed guesses, and confess what I do not know for sure. This phronetic approach allowed me to "*examine backstage*" (Goffman, 1974) in medical education and tell a story which I hope others (with an interest in the topic) can connect with (Thomas, 2011, p. 215) while attempting to ensure the gaps, workings-out, and warts are exposed in the margins (Diefenbach, 2008; Flyvbjerg, Landman and Schram, 2012).

5.7 Reprise of the study design

[63] Where I have lacked direct experience I have endeavoured to do "the next best thing to actual engagement in the field...to read detailed case studies of others' engagement, to develop one's expertise vicariously" (Flyvbjerg, Landman and Schram, 2012).

In this chapter I have described the organisation of my research involving four case studies - three medical school and a case study of the medical regulator. I have provided a brief portrait of each and then summarise the attributes of the 14 participants (p53, table 5.3). I describe how I developed my topic guide, derived from concepts from my literature review (Chapters 2 and 3), and the theoretical underpinnings detailed in Chapter 4, informed by social epistemology and symbolic interactionism. The data collection and my approach to frame analysis has been described. Throughout, I try to avoid the trap of merely *naming* frames, and instead to draw out the trajectory of frames across and between the three levels of the empirical field. I concluded this chapter with consideration of concerns regarding trustworthiness, and critiques of case studies and frame analysis. I argue that the application of phronesis is consistent with this practitioner research. In the next chapter I lay out my findings: what I have discovered about the framing of public engagement in UK medical education. Perhaps a little ambitiously, the aim of my design is to respond to this invitation from Cornelissen and Werner (2014, p222-3):

> *'We point ...to specific research opportunities and methods that enable ... progress beyond "naming frames", and explore framing as dynamic processes of meaning construction within and across groups and organizations. To a large extent, these opportunities will also involve research designs and methods that make stronger connections across levels of analysis... '*

CHAPTER 6 FRAME ANALYSIS APPLIED: UNDERSTANDING ENGAGEMENT

Principal Research Question

How is public engagement policy framed and enacted in UK medical education in the context of evolving regulatory requirements and organisational diversity of medical schools, and what are the implications for leadership?

6.1 Structure and overview of findings - The interpretive arc and selection of data

This chapter presents the study findings[64]. After a brief summary I divide the chapter into four sections: first, findings at the organisational level, for each of the three schools cases, and in the medical school field as a whole; second, the results of the regulator case study; and thirdly, findings that work across the entire empirical field, including those informed by boundary object theory. In the fourth and final section, I reveal an emergent reframing of the relationship between the public, medical education and its regulation, and identify and reflect on the notable absences - that is, results I anticipated but that did not emerge, which are elaborated in the following chapter.

Overall, I identified three clusters of frames around public engagement in medical education: curriculum frames; identity-agency frames; and governance frames. The curriculum frames include: the engaged medical school, and the "better doctor" frames. The identity frames include '*the deal* ' (or the patient–lay–public) frame; the 'patients versus students'; the person-collective agent frame, The governance cluster frames include: compliance/ influence, 'negotiating the deal', and the emergent safety shift (or the Francis effect). There is considerable diversity within, and across, cases and levels, some master and meta frames do emerge linking public engagement with the GMC standards. Findings support the notion that public engagement behaves as a boundary object and leaders act as boundary agents and boundary spanners in a range of ways.

This study is an exploration of how *participants* (from the esoteric circle) frame the potential contribution of "others" (the exoteric circle), outsiders to medical education. My focus is on

[64] Institutional profiles, participant attributes and codes, can be found in Chapter 5, Tables 5.2 and 5.3

participants' perceptions of public engagement, of the patient and of the public in relation to the curriculum and its regulation. Furthermore, all the findings are effectively a temporary settlement, the result of one individual engaging in a systematic, but ultimately one-sided, dialogue with the data which underscores its contingent nature.

In line with Johnston's rules (Box 5.7 p94), framing is approached holistically, both in the context of role perspectives and the speech situation in which the data was gathered, and the wider factors outside the individual that influence their framing processes. The frames presented below thus emerge through the abductive process described in Chapter 5, of tacking back and forth from the data and my experiential knowledge of the context, to the literature (Chapters 2 and 3), and the theory (Chapter 4). The major themes are summarised again for convenience in Box 6.1. I attempt to make this tacit process of *phronesis*, described in Chapter 5, explicit where it might be helpful.

Box 6.1: Themes and perspectives "in mind" during data selection and frame building

Five themes arising from PPI literature (Chapter 2)	**Two perspectives from theoretical framework (Chapter 4)**
Concepts of Publics Individual or collective Lay or patient **Ideas of governance** Regulatory/ social **Political and professional drivers** Neoliberalism and marketisation, accountability, responsibility individual choice and safety **Dynamics of public engagement** Push in, pull in; push out; co-production **Orientation of academic organization** Communities of knowledge /practice Concepts of curriculum	**Perspective 1 - the social construction of public engagement through interaction** draws on social epistemology, and different conceptions of knowledge invoked in framing public engagement by knowledge communities, leaders and their organisations. **Perspective 2 - transition of public engagement from boundary object to standard** examples in the data that illustrate boundary object theory, boundary work and the role of boundary agents and boundary spanners finding evidence of the putative relationship between a plastic construct shared across social fields and its evolution of mandatory standards.

6.2 Full findings

6.2.1 Medical school cases: Frames and framing process of public engagement

Anglebury Medical School

This school had been through recent changes and was still in the process of embedding its new curriculum, after splitting from a partner with whom it established a new medical school some 10 years ago. The school still requires annual GMC quality assurance visits. I undertook six interviews here. First with A1, the head of the school, who has been in post for less than a year. I present her primary frame alongside that of A5, the lead for PPI, an established biomedical scientist, who has more links with postgraduate programmes than the undergraduate medical course and a prior interest in PPI in research. They provide contrasting insights into the evolution of engagement and involvement in relation to the GMC standards - A1, from her perspective as a hospital specialist and experienced clinical educator, and A5, through her work as a researcher, drawing on her experience of the REF[65], and, as she stresses, her identity as a person living with a chronic illness (a patient). The primary frames they deploy form signature matrices (Table 6.2). The matrix 'idea elements' (Creed, Langstraat and Scully, 2002) are populated largely with quotes to give voice to their underlying interpretations and arguments.

[65] REF research excellence framework, described in Appendix 6.

Table 6.2: A1 & A5 Signature matrix for primary frames in public engagement

	Who is this:	A1 - **Head of Anglebury Medical School** **A clinician**	A5 - **PPI Lead for medical Anglebury Medical School** **A scientist**
Primary Frame->		*Making better doctors frame*	*Personal collective agent frame*
Elements	**Theme**	***Reflecting politics of healthcare***	***A mission - embodied health movement***
Depiction & interpretation: making frame vivid, memorable & accessible	**Metaphor**	'Make it a habit "stop, pause, ask the patient what they want to know " '	"We are absolutely committed to our cause"
	Exemplar	**Positive** - well informed medics can use their knowledge to help patients **Negative**: Not all patients are as professional as the patient who went to Downing street to talk to PM	**Positive**: "Me and my PPI reps are experts as well as regular human beings" "we have all been through some challenges , as patients , as carers" **Negative**: The faculty used jargon, talked too quietly , and didn't provide any water.
	Catch-phrase	PPI leads to well informed medical graduates	"The "I" in PPI should be influence , not involvement"
	Depiction (visual image)	**Pulling in (from the clinic not the community)** Real patients are "illustrators" of real conditions for students, but most are not capable of shaping the curriculum Medical students "don't wear white coats, no one knows who they are"; stripped of their professional identity	**Pushing in (through the boundary) - on our terms** "We have locked horns. We have the bruises….We chucked out their Terms of Reference…this is not just about governance" We take off professional hats, we are open and honest about a different lens for looking at the curriculum."
Argumentative devices: causal attributions &	**Roots**	Our education and research missions are to be part of the health services Lay participation " is completely political, driven by Westminster to justify the cost of medical education that's paid for centrally."	We come from the community of suffering Patients need rights through citizen empowerment. Shifting control to benefit those who understand need
	Conse-quences	If we don't engage with patients and lay representative our graduates will not be fit for the health service Patients need doctors to have stronger professional identities	If we do it the medical school's way (sitting on their "dull committees") nothing will change. PPI just endorses status quo - doctors do not truly understand or serve patients To be representative we need group power.
	Appeals to principles	Asking patients what they think in the consultation makes them feel valued Asking patients what they think about the curriculum is a regulatory requirement	If it's just ticking off a regulatory requirement "we can't work here anymore. Our principles are too strong" It's about "No decision about me without me" [66] - and researchers do this better than educators

A1, in articulating her frame, draws almost exclusively on her experiences as a clinician and the importance of a strong professional identity for students, as well as their future patients. She stresses the value of engaging patients, particularly through knowledge sharing in everyday clinical encounters; thus her framing of public engagement is an educational strategy to strengthen individual student's professionalism in order to enhance individual

[66] A reference to the Department of Health document promoting the so-called patient choice agenda: *"No decision about me without me*" (Health, 2012).

patient encounters. The frame argument is that medical knowledge confers authority, often valued by patients, and she is concerned that politically driven interventions will undermine this dynamic. As I explore later, she is *unsure* about the role lay people can play in the curriculum, aside from satisfying a political imperative. A1 sees the new school's mission as contributing to the regional health economy, in partnership with the NHS, rather than as a commitment to the host community. While the mission aligns with the parent university's research intensive orientation and international aspirations, for A1 this can be framed as 'making better doctors':

> *'Yeah, the medical school has written a sort of mission statement, and it's to create sort of health, wealth and wellbeing in the [Region], and create good doctors and scientists. The University's educational mission includes creating a cadre of critical thinkers and problem solvers who are international citizens and good collaborative team workers. And I suppose the mission of the undergraduate medical programme is for all of those. So, to create, you know, well informed doctors.' (A1)*

By contrast, A5's narrative, although a senior member of staff, is spoken in the voice of the patient. She is the only participant who uses the language of struggle so strongly associated with early patients' rights campaigns, and social movements more broadly. She speaks from a unique subject position - which involves removing professional garb and, importantly, a position that is , in her view, unavailable to clinicians in the medical school:

> *'Yes I'm not just a professional, I'm also a human being … and I think that probably our clinical, medical colleagues forget that.' (A5) .*

The catchphrase, ' *"I" is for influence*' (in Table 6.2 above), is reminiscent of Arnstein's original concept of citizen power (Chapter 2, Section 2.2). The essence is consistent with Brown's notion of the *'embodied health movement'* (Brown *et al.*, 2004) in which movement members seek endorsement for health related human rights often by forming alliances with research scientists (sometimes funded by commercial pharmaceuticals) who work with specific "communities of suffering", sometimes to legitimize politically controversial, clinically unrecognized, or marginalized conditions. The essence here is of someone who perceives themselves to be on the outside speaking as if they need to push in - but on terms set by their community. There is a claim to vulnerability "*open, honest*" but "*not incredibly confident*" and she suggests a need to protect and speak for members of her "group", perhaps as if they were her followers. This was a very particular speech situation (Johnston, 2002), and I sensed an underlying "pragmatic intent" - the opportunity to tell her version of events to an

interested outsider (who happened to be a clinician) who she guessed would also hear the story from others. The transcript included some pertinent critiques that are supported by my literature review. The first, relates to the problematic of representativeness and legitimate advocacy. She argues for the establishment of a collective voice, in the shape of a Patient Forum or PPI Advisory Group. This would contribute to medical school social governance but not by co-opting individual PPI representatives into institutional structures as committee member, who are then sequestered and separated from their group or pack. A forum or advisory group, she argues, has collective authority, informed by their humanness and patienthood, combining a range of perspectives, prior knowledge, and experience. They would be equipped to discuss issues of concern to the medical school, as well as the wider community, unencumbered by jargon and *"university-speak , trying to look animated, listening to timetabling and reports on things.(A5)"*

While the majority of participants mention the Francis Inquiry as a PPI driver (discussed later), A5 understands the vital point made in the Report (Francis, 2013a) that formal PPI had failed at Mid Staffordshire NHS Trust, due to the co-opting of the patient and public representatives, and their complete assimilation into the culture of the Trust, where they chose to, or were expected to, endorse the position of the organizational leadership. It was the determined outsiders who fought for the rights of the neglected patients at Mid Staffs, effectively acting as a social movement (see Chapter 2, Section 2.6):

> *'I was very, very lucky as one of my group is the Patron of National Association X ..who knows exactly the difficulties of PPI. But he was very clear about lessons learnt from the Francis Inquiry that the lay representatives were just as culpable, because they sat on the trust's board. And if they had been truly representative of an advisory group rather than sole representatives, they would have been able to say 'I'm sorry I cannot possibly concur with you …'(A5)*

I find here that A5, with the PPI Advisory Group, has created, what Fleck might call, an exoteric circle, a specific, separate knowledge community, *within* the medical school. Although A5 is a senior academic, she identifies herself, first as a researcher not fluent in what she calls 'education-speak'; secondly, as a professional who can "take off" her hat to be a "regular human" (mentioned three times) and see though a patient's lens. There is a strong argumentative logic in this signature matrix that builds into a collective action frame (Benford and Snow, 2000). How this framing may affect development of a coherent master frame for Anglebury Medical School, as an organisation as a whole, is addressed next in the context of a

particular process - the development of the Terms of Reference (ToR) for the proposed PPI Group. The participants agreed that the need for this was prompted by feedback following a GMC QA visit as part of the process to approve the new curriculum. In terms of analysis story related below, in multiple voices, provides a step between micro-level signature matrix analysis and the school's master frames. Different data sources show initial frames are constructed" to inform broader frames, principles, and institutional logics" (Cornelissen and Werner, 2014). A1 suggests that curriculum work is simply above the heads of lay people - and that simplifying the committee's role is the solution. A5 draws on her role in PPI in research in response to recognised good practice, funder expectations and REF impact evaluation:

> *'It's not that they're just sitting there – lay members are active researchers now. they learn how to formulate a research question, they write grants themselves, they help to steer people towards the research they should be doing. It's an absolute strategic imperatives . So given we have experience of doing that (applied health research) it was felt ideal to build on that, to inform what we could do in medical education.' (A 5)*

A5 sees the entire process so far in the medical school as disrespectful to 'guests' and an abuse of power. Having established a PPI Advisory Group it is being used to feed the GMC beast - merely to show compliance. A2 (undergraduate medical programme co-director, like A5 a scientist, not a medic) is more balanced, conciliatory, seeing the merits of the PPI approaches used in scientific research, and welcoming the challenge of a bigger "human" agenda. A4, a senior administrator - neither scientist nor medic - is responsible for QA . She sees delivering on the GMC requirements as an opportunity as well as a mandatory issue of regulatory compliance. She compares it with the Faculty's processes in response to the REF impact assessment, and research funders' expectations for PPI: '*It does create an atmosphere of openness and transparency which is always beneficial … it promotes critical reflection on things that you take for granted*' but she stresses the need for lay representatives to be informed and attuned to the educational and governance needs of the medical school.

Table 6.3: Anglebury Medical School Vignette - committee participation and Terms of Reference (ToR) of PPI Group (all verbatim quotes).

A1 Head of school	A2 Programme co-director	A4 QA Lead admin	A5 - Lead for PPI
So X (previous Dean) ... invited a number of people from [Medical school PPI Group] to join a committee which was essentially completely unwieldy at that time.. unfortunately those PPI people came and witnessed that committee in its most cumbersome sleep generating format– it was before I came ... and they decided they didn't want to be involved in anything else like that because it was too difficult to understand what was going on and what the purpose of the whole thing was.	A first draft of, which the group looked at and didn't really like the way they were written, they didn't feel able to engage with, I think quite rightly, it was committee-speak, you know … …, And there are people with a research interest who have of experience in how this can work	When they (GMC) first visited us, 2 years ago, we had devised a PPI group that was going to be created – a mix of kind of true lay and informed lay, and we had exciting ideas that we would be able to use representatives on all of our senior committees, that they would be looking at curriculum change, play a role in clinical skills. So we had a lot of big ideas for PPI, ..we were brand new we could take the GMC guidance and we could just deliver … all of the best bits of [TD09[67]] But ...what the PPI Group want to do and what we wanted them to do were very different things - due to their…fear of tokenism. As it stands the PPI advisory group, operates at kind of arm's length to the rest of the governance structure, and there isn't a codified link into anything, whether it's into me (QA) or senior committees	So six from my group were invited to attend one of our Education Committees … I was told they would be asked to account for themselves … they won't, thank goodness … and I turned up half way through, because I'd come off from being a patient … and I went 'Oh my goodness' - I saw was people sitting round like that, [glum face] … no water, in an inaccessible room … some colleagues spoke very quietly in spite of two of the guests having hearing aids. … they were so polite, but afterwards they said 'Can we come back to you for tea?' and then they just burst out 'That was terrible'. 'Unintelligible language, everything in acronyms, jargon. And a feeling of isolation'. So we locked horns, … we had a formal meeting with the then Dean (X), and we almost got to the point of saying 'Oh we can't work here anymore' – our principles were so strong. And X said 'This is not the way to do it, it's not about medics being authoritarian. This is about absolute engagement, involvement and influence.' So we went away thinking 'Oh my God!' And just suddenly there was a little bit of 'Oh okay, you really mean this don't you?'
Solution rewrite Committee ToR	**Solution making it theirs.**	**Solution - find the boot**	**Solution - a PPI advisory group or nothing**
one of the first things I did was re write its terms of reference and make it much more focussed, and made it much less frequent –	... through an advisory group that's proactive... they reworked those terms of reference in interesting ways, and said they were	Interviewer (Me) : And that's sort of where it's sitting .. not clear who's foot the boot is on – is that it…? Well they seem to have claimed the boot, that's the thing, they seem to have	We then managed to get the OK for a PPI advisory group … but took over a year … the feedback's extraordinarily positive – the hum, the chatter, excitement, … even from staff who've attended. And then we were hastily asked to produce a summary of all the

[67] TD09 is a common abbreviation for *Tomorrow's Doctors* (GMC *2009*)

because it was just trying to do too many things too often.	interested in humanity … big picture things… gave us a challenge … how do we engage ? everybody wants to do that, but there's frustration in the pace of dialogue .needs time for us to listen to each other come up with something meaningful rather than tokenistic.	claimed and hidden the boot. (laughs)	conversations, and discussion and list of the names just before the GMC visit.....And I've said I'm not going to call the group back again without proper liaison and some tasks.... so … I've just spoken to our new [Head of School,A1] .. come on, we now need to get involved, probably around redesigning assessments, particularly in clinical skills, curriculum design.

Anglebury Medical School - meso level alignment matrix and master frame

At the time of my data gathering Anglebury Medical School lacked a shared overall vision regarding PPI, but had reached an uneasy way forward; the PPI lead's rewritten Terms of Reference for a collective PPI Advisory Group had been accepted and (as envisaged at the beginning of the process) were set to contribute to student assessment and clinical skills teaching. Moving up from the individual level three frames co-existed (see table 6.4): (1) PPI as a curriculum strategy to make better doctors; (2) a policy frame based on lay involvement in governance - as Creed (2002) suggests this had a polemic tone; and (3) a rights-driven collective action frame. The process described in the story above suggests some bridging across frames - for example regarding the value of the REF model; and some frame transformation - through A5's partially successful struggle for acknowledgement that for representatives to be effective, they need a collective presence and some say in defining the PPI agenda.

Table 6.4: Anglebury Medical School - alignment matrix frames for PPI

		Curriculum: Better doctor Frame	Governance - Compliance Frame	Knowledge / authority Frame
Diagnostic framing	**Frame Typology**	Strategic	Policy (polemic)	Collective action frame [Embodied health movement]
	Diagnostic: what is the problem?	Contemporary patients like to feel involved healthcare and education	Need accountability in education and scrutiny of health professionals As a new medical school we are under intense scrutiny	Insufficient understanding of patients as human
	Who is responsible? **(actor roles: "goodies" & "baddies")**	Faculty design curriculum to bring patient and student together	Politicians say patients are clients whose voice increases quality, transparency and value; GMC pursues political agenda through regulation,	The medical school is just ticking the GMC's boxes We advocate models used in research consultations, impact statements and co-production with patients
Prognostic framing	**Prognostic Intervention / Intended or actual outcome**	Maximize patient contact, strengthen student's knowledge and professionalism	Give informed lay people a voice in organizational structures (i.e through committees)	Empower a PPI Advisory Group to provide the genuine voice of the patient
	Motivation for engaging ***(the call to arms)***	students learn from patient contact - then doctors use their knowledge/authority to help patients	Regulation is a useful route to ensure informed lay people have a voice can help with patient centredness	All patients are experts (who need to fight medical authority)
Discursive field		Development and deployment professional knowledge & identity	Compliance with regulator to satisfy consumer public by controlling professionals (Neoliberalism)	Empowerment and patient rights Break down medical power through collective action

Where there is alignment in Anglebury Medical School's framing of public engagement is around the individual - as patient, patient rep, student, or professional. The collective (the advisory group) are a group of individuals, who are a source of outside, exoteric, contributions - to be pulled in and drawn upon. There is little sense of a wider collective social or public engagement. The community is something fairly remote. For Anglebury Medical School the community is neither framed convincingly as a locus for education of individual students (save for some mention of formal GP placements and informal volunteering), nor as a focus of organisational engagement, social governance or wider social responsibility. From

what appeared initially to be a discordant, but very candid, narrative emerges a single master frame - despite unresolved disputes and elements of epistemic incommensurability.

Table 6.5: Anglebury Medical School - master frame

	Name	Empowered knowledgeable individuals
Diagnostic framing	**Diagnostic: what is the problem?**	Patients and medical students are all individuals who need empowering
	Who is responsible ? **(actor roles: "goodies" & "baddies")**	Faculty need to work this out The GMC regulations are driving this as a QA process
Prognostic framing	**Prognostic Intervention / Intended or actual outcome**	• Individual student-patient contact is the key to making better doctors • Lay people/patients can contribute to curriculum scrutiny and improvement The two are unrelated processes
	Motivation for engaging ***(the call to arms)***	Re -negotiate knowledge/ authority (albeit in different directions - to make students more professional and authoritative empower lay people/patients to use their (experiential) knowledge
	Alignment / resonance/disputes	Aligned in: • focus on micro (rather than meso level) concerns • GMC standards are both helping and hindering Dispute: • capability of real patients/ trained lay reps to make higher level contribution • whose knowledge confers greater authority - patients or students **Incommensurate perspectives** [68] : the importance of representatives developing a collective "patient" voice outside existing governance structures versus the need to train and potentially co-opt selected reps
Discursive field		Individual subjective identity and inter-subjective construction of meaning (patient/lay/student/academic/doctor). Individualism (Beck and Beck-Gernsheim, 2002) The use of knowledge/authority (for justice or coercion)

[68] Incommensurability is the term used by Kuhn and Fleck to describe the challenges of interaction and communication across different, even close, knowledge groups (Fleck, 1979/1935; Kuhn, 1977; Mößner, 2011)

Leadership for public engagement and Anglebury Medical School

The situation at Anglebury Medical School demonstrates the complex roles leaders have in managing the boundaries of their organisation. A1, the most senior and newly arrived, had to manage upwards - to align with the parent university's Russell Group aspirations - to set it apart from its 'less academic/scientific' former partner, and to reflect this back to the school. Her personal "primary frame" aligned her closely with the clinical practicum - an outer boundary she felt comfortable moving across. Her more urgent boundary work was to broker a relationship between a new community that had emerged as the school's optimistic response to the GMC's PPI standards, but was occupying a puzzling new epistemic space. A5 was clear about her responsibility as sentry, protecting representatives until a just deal had been reached. Her expressed motive for holding out was to become an exemplar of good practice:

> *'We can understand the fear because we're new and the GMC is looking at us, and there was a feeling of having to address the GMC. We were saying "but we are better than that, we should be able to influence and inform and engage to say "Look, PPI is this, it's not that." .'(A5)*

A2, from her leadership position inside the curriculum structures saw PPI as a moral process of opening up :

> *'Open to scrutiny is being able to say 'Look we're not perfect, we are blind to some of... our imperfections.... and some of the things we say that we think absolutely fine – maybe it's not okay actually. You have to be humble to do that, ...open for those conversations, that's incredibly positive ... in terms of being clear about the decision making process. And potentially being ... seen by a wider group, the [decisions] need to make sense, the narrative needs to weave through ... we do need to be telling a story, they're not stand-alone events, they need to make a coherent sense over time.' (A2)*

In the next section of the interview A2 described what happened when she asked A5 to identify a member of the PPI Advisory Group to sit on the selection panel for a new lecturer in humanities

> *'Well .., I think I saw the word 'gatekeepers' in your introductory information ... I suspect ..... cos it seemed it would be a really nice way for them to be involved and for us to have conversations. So I was a bit disappointed that I didn't get any response. But then I was thinking it through– having met some of the people on the advisory group, they are wildly enthusiastic, and my hypothesis is more that the opportunity didn't reach them, so we ... the channels of communication ... I'm going through middlemen .. gatekeeping this process.'(A2)*

When the boundary is perceived as a frontier to be guarded, rather than porous structures or shared spaces for exchange, opportunities for engagement may be limited. So, regardless of the goals, and structures that might be in place, the way in which each individual leader uses their agency at the organisation/public boundary may be the most important element of enacting PPI.

Bramhurst Medical School

Bramhurst Medical School - alignment and master frame

Bramhurst was formed around 20 years ago, a merger of two established medical schools with a research intensive university, part of an Academic Health Science Centre. It has a very large, ethnically diverse student population (many are local, some entered through an access project) and it is located in one of the most ethnically diverse urban communities in Britain, with significant socioeconomic deprivation. The two academic leaders (B1 , is a biomedical scientist, Programme Lead, Dean for Quality; and B2, a clinician Lead for PPI and Professor of Communication), convey a harmonious, congenial culture that formed a coherent single organisational frame. The school is more or less embedded in its community, with clear, multiple, but structurally loose, connections. They gave a sense of having tried many engagement strategies to establish an appropriate equilibrium, changing over time, often limited by cost and logistics related to the school's size. The faculty prioritises community orientation through voluntary sector partnership and GP placements focussing on student-centredness, student engagement, and the development of the students' sense of social responsibility through advocacy and agency.

B1 and B2 both cited perceived external drivers behind recent conceptions of PPI: research activity (the REF agenda), and consumerist dimensions of patient-centrednesss. They viewed the latter concept as a significant influence on the introduction of the GMC requirements. All needed '*to be balanced with a degree of scepticism and realism'(B1)*. They agreed empowering patients is essential for better health outcomes and fostering this is, in turn, essential to professionalism. They framed public engagement as a sum of; community links, developing student social awareness (the engaged medical school frame - although with minimal evidence of strategic partnership), ample contact with real and simulated patients

(the better doctor frame), and establishing patient-lay involvement in governance (the patient-lay-public frame). They had produced a written PPI section for the school's educational strategy and favoured a combination of lay representatives on the committee as well as a more autonomous advisory forum :

> '...like a retired head teacher with a chronic illness won't bring necessarily their experience of chronic illness – they will bring their understanding of governance regulations and fairness. ... a lay person with experience of public involvement, like having a governor on our committees who can engage at that level and a group of patients, a forum, to observe our processes, like our selection process, our admissions process...' (B2)

I have been able to generate a single master frame for Bramhurst Medical School (Table 6.6) .

Table 6.6: Bramhurst Medical School master frame

	Frame	Hybrid - better doctor / community engaged
Diagnostic framing	**Diagnostic: what is the problem?**	• PPI as GMC regulatory agenda • PPI as neoliberal manifestation of patient-centredness • PPI as very helpful but needs careful mediation
	Who is responsible ? (actor roles: "goodies" & "baddies")	Faculty in partnership with students, local community and GPS Public/patient expectation GMC pursuing a prevailing a neoliberal political agenda
Prognostic framing	**Prognostic Intervention / Intended or actual outcome**	• PPI as **<u>patient</u>** *involvement*-with caveats(who defines a patient (lay/patient/simulated/ professional) • enhancing student engagement and social agency • Public engagement is a sum of community links, ample contact with real and simulated patients, and establishing patient-lay involvement in governance
	Motivation for engaging (*the call to arms)*	Socially aware graduate Community orientated curriculum
	alignment and resonance/disputes	PPI is a bit of a fad and the current trend. We already are an established medical school with established community links Aligns with some aspects of surrounding research intensive environment
Discursive field		Duty of faculty leaders to balance student centredness & patient power/authority (epistemic justice)

Leadership for public engagement Bramhurst Medical School

Leadership for B1 and B2 involved maintaining equilibrium across boundaries - without a dominant dynamic of pushing out or pulling in community. B1, as QA lead, focussed on managing the relationship with the wider university and the GMC. She seemed to perceive GMC surveillance as less intense (than Anglebury Medical School) perhaps because, their curriculum was established. She adopted a more questioning stance to GMC requirements.

B1 and B2 considered there to be benefits and tensions to leading education in a research intensive environment. The requirement for patients to be involved in research was seen as helpful bridging across two essentially separate academic communities, but overall:

> *'The profile is moving much more towards high quality research. it's in a continual state of .. I was going to say 'tension' – but pulling in different directions really. The uni has actually increased in its research standing, then there is a concern from people on the more practice side of medicine - that the research agenda is driving a lot of the decisions around funding and development' (B2)*

Casterbridge Medical School

Casterbridge Medical School, like Anglebury is new, and the product of a demerger. Casterbridge completed the cycle of annual GMC QA visits a couple of years ago. It is one of only two schools that had students placed at Mid -Staffordshire NHS Trust during the time covered by the Francis Inquiry. The narrative from the two participants provides a rich insight into the possibilities of public engagement and patient involvement, and how a dynamic between ill-structured and more tailored interpretations generate frames that can be reconciled and aligned. (As might be expected from a boundary object.) I have produced detailed signature matrices for C1 and C2 to demonstrate their different underlying primary frames. I have then produced a single alignment matrix of three encompassing strategic master frames which arise from the bridging, extension, and, to some extent, transformation of their primary frames.

Table 6.7: C1 & C2 Signature matrix for primary frames in patient and public involvement

Who is this		C1 - **Head of Casterbridge Medical School** **A clinician**	**C2 - Director of Programme** **A Clinician**
Primary Frame->		*Socially just medical school frame*	Community centred curriculum *frame*
Elements	**Name**	*Creating an equilibrium*	*Formalising connections*
Depiction & interpretation: making frame vivid, memorable & accessible	**Metaphor**	Balancing benefits for individuals and the collective	Championing community centred education for medical students
	Exemplar	A new medical school has a social responsibility to make a local contribution A new curriculum aims to serve each person - student and patient	Every day, collectively, our new graduates will conduct 1,000 patient consultations - this is a big responsibility
	Catch-phrase	"...after all these years .... I have an inbuilt belief that PPI helps education and practice"	'Socially responsible and globally aware'
	Depiction **(visual image)**	***Bringing together (across the boundaries) pushing out and pulling in*** PPI can be a leap of faith, I've seen organizational partnerships actually work. The wide angle lens - *"Lay people, what a great contribution - they make you open your eyes wider.* "	***Structuring connections (across the boundaries) pushing students out / pulling lay people in*** A building block of being a good doctor is being a good citizen A diagram "with 'the excellent clinician' in the middle and 'socially responsible' and 'globally aware' feeding in."
Argumentative devices: causal attributions & bases for judging situation	**Roots**	I come from inner city family practice with a firm belief that we're here for patients and community Lay people and students must both have a voice in governance.	We are following the engaged history this University has with local communities, not the traditional separation of most medical schools
	Conse-quences **(what would happen if)**	Without partnership with the community and lay participation in the curriculum, education is insular and local health economy does not benefit . But …if we only focus on patients from this community, we do not prepare students for the wider world	The community provides an essential locus for our students to learn Our lay representatives in governance are critical friends and help us comply with GMC requirements
	Appeals to principles	To lead well is to be just : to serve all responsibly, thoughtfully, and fairly. PPI draws our attention to the diverse identities of patients and future doctors.	Educating socially responsible graduates to be excellent in areas that go beyond demonstrable knowledge and skill,s is about developing different identities.

C1 is by far the most experienced educational leader in my study. She always speaks from the inside (within the esoteric circle as it were) but sees PPI as an invitation to doctors to "open their eyes wider" and see differently. She highlights the importance of engagement for medical education at multiple levels - individual, collective and organisational: in teaching and in governance structures. She underscores the role of *patients* in learning and assessment but *lay* people in governance - a distinction I elaborate below.

Between C1 and C2 the differences are subtle. It can be seen that C1 and C2 share some key frame elements - in particular their emphases on a new medical school's organisational role in the wider locality, and the notion of individual identity formation. Overall, however, their framing processes are underpinned by different orientations, and thus different fundamental arguments. While C1 uses her experience-knowledge gained elsewhere to stress the need to balance organisational and individual benefits to education and healthcare, she takes both a local and national perspective. She also seeks to balance patient-centeredness and student centredness. The tenor of the interview was highly reflective - C1 often posing rhetorical questions or asking my opinion. In responding to my agenda she highlighted how she came to the area as an outsider, and how her role as Head of School was to balance a range of interventions, requirements, and stakeholder expectations - she sounded to me like the harbour master of a busy port, or the conductor of a symphony orchestra.

She (C1) described a crucial social interaction that, for her, framed the wider social responsibility of the university to this declining manufacturing community, with the following anecdote:

> *'It's a fascinating community, because there's never been the expectation of education. I think the industrial owners wanted everybody to go straight into the factories – that was their workforce. The mayoress came to see the anatomy suite … and … I don't know how we were talking about it, but she said she'd been to a school and met one girl. She said "'What do you want to do?" And it must have been her instinct because the girl said "Oh I don't want to be a nursery nurse", and the mayoress said "What do you really want to be?" and the girl said "A lawyer". So she said "Why not"' she said "My Nan said it would be above my status'. So I think that's what we're dealing with [here]".'. (C1)*

C1 used this tale to express her commitment to increasing educational participation in the face of low expectations and self-esteem, across the generations of a white working class community. She also acknowledged local aspirations to retain new locally produced

graduates. However, she drew on the anecdote to highlight the risks of a parallel parochialism amongst the resident medical faculty: the local demography does not reflect the ethnic diversity of the medical students, nor could it prepare them appropriately for practice in many other parts of the UK.

C2, with the direct responsibility for the curriculum, framed his work as creating "community centred " structures that would directly benefit *his* students and *his* course, and, indirectly, "1000 patient consultations a day". Central to this wider engagement was the formation of partnerships, citing Boelen's *pentagram* (Boelen *et al.*, 2007) (see Chapter 2, Section 2.4.2) including '*a large number of organisations across two counties who view themselves as having a link and an input into the medical school'*. The focus is on medically under-served areas and developing a network of third sector organizations with which *'we are properly engaged' .* While he saw developing connections with the local community as innovative in the context of UK medical schools[69], he framed this as primarily a strategy to develop students' social identities and sense of agency. Two events at Casterbridge Medical School stand out as significant findings, deepening my understanding of public engagement and responses to the regulatory environment: the recruitment of lay representatives (a contrast with Anglebury Medical School's experience); and the implementation of service learning using the north American model (described in Chapter 2, and elaborated in Appendix 6).

Recruiting lay representatives

C1 communicated her personal commitment to social governance through lay representatives embedded in organisational structures. Casterbridge Medical School was much further ahead in this process than Anglebury Medical School, but had experienced many similar (and predictable) challenges; staff involvement in selection; diversity ; preparing and empowering reps; and issues of compensation. The solution seems to come through the clarity of her "argumentative logic" - a conviction that lay involvement makes a difference; her role is to take the faculty with her. This was the first challenge:

> *'When I came we had a lay person on the admissions interview panel, but the fascinating thing about your boundaries is that most of those lay people were drawn from our staff. I felt she wasn't thinking about whether the candidate would make a good doctor, she was thinking "Are they going to do what I tell them". So I was pretty firm...we had a meeting*

[69] It is interesting to note that Bramhurst Medical School ran a similar, well regarded "innovative" project in the 1990s which was abandoned due to administrative burden, cost, and resistance from some faculty and students.

where we appointed somebody to look at lay representation. The senior manager was furious – she really was cross – because she said that her staff were lay, and we were trying to say no they're not lay because they're part of our team – really upset, an awful meeting, the girl who was charged with looking at how we might recruit lay representation was reduced to tears.' (C1)

The process rolled out thus:

- advertised through voluntary partners and direct to the public, advertise locally.
- only pay for travel, *("get people who are retired, not a good mix ,really*")
- selected and trained, *("was just one lady who really was just there 'cos she had a gripe – we hadn't taken her son … our admissions team had turned him down*!")
- Now two reps on all committees

Within her framing the key frame element of "responsibility - the direction of accountability" for supporting lay presentation is borne by the academic staff:

They're finding their feet in their role. The big issue … is ensuring they understand what's going on. So when you're chairing you have to keep saying "Dave do you understand that? Phil do you understand that?". I've seen it work, I know how valuable it can be. (C1)

It was C2's role to operationalise C1's vision:

'We were quite careful, we interviewed 60 lay people, appointed 38 into our various roles ... we interviewed so many lay people we've set up a group … so not just the people who attend committees .. a wider group who we're doing once or twice yearly conferences with 'How do you see the doctor of ..tomorrow differing from the doctor of today?' 'What levels of professionalism should we seek in students compared with doctors?'... and the next one would be a joint one with students.'

As part of this aligned and coherent commitment of representation, and to facilitate it, is the inescapable finding that it is the clinical faculty who hold the authority to define and select who can be a representative. In Casterbridge Medical School, "patienthood" was an exclusion criteria :

'We were quite careful about people who might have a single interest as a patient, because we didn't want a single interest focus from someone sitting on a committee. The question is do we want input from someone through the prism of their illness, or do we want the input from someone where it's not about that illness, it's about being someone who isn't medical.' (C2)

His summary is :

'There seems to be complete buy-in. Considering that it is a bit unusual for some of our consultants, you know from their viewpoint, we have no objections at all. And the Curriculum Committee that I chair, and various other things, you know the surgeons and so on, don't bat an eyelid.' (C2)

Governance & safety - the 'Francis effect' frame

Casterbridge Medical School's proximity to Mid-Staffs appears to have propelled them forward with regard to the recruitment and deployment of lay reps. Francis highlighted QA processes of NHS sites that host students as a blind spot, suggesting, at worse, collusion between the Trusts and the medical school. Casterbridge Medical School's enhanced procedures rely on visiting panels of lay reps, academics and students. With regard to the hospital visiting panel, C2 shared this anecdote:

'First time we did it, the hospital dean was very angry with us indeed ... because I think he felt he was the medical school ... this was our main teaching hospital, and suddenly we were telling them what to do and we set requirements and said "You must do this.".'

'So the quality assurance agenda served political uses, but … us wanting to achieve it wasn't just because we needed to, it's because we wanted to do it as well. And a lot of that was about patient safety. So in terms of drivers, obviously the regulator's stance is important, but it's actually something that we were wanting to do as part of our ethos. Fairly fundamental change in our processes suggests to me that people were bought into the ethos question.' C2

This emergent governance frame - the shift of focus which invokes the effect of the Francis inquiry on approaches to safety is discussed in more detail later in the findings from the Regulator.

The engaged curriculum and service learning

One of the more intriguing findings in Casterbridge Medical School was their service learning initiative, which reveals considerable extension and bridging of frames across the engaged curriculum to the 'education of the better doctors' frames. The focus is on developing students' professional identity as social, as well as clinical, agents. However, this project flagged up the potential misalignment with the emerging concerns for safety, a framing underscored by the effect of the Francis Inquiry. C2 described in detail a mandatory

community-based service learning attachment for all final year students - influenced by development in the pre-eminent community engaged school - in Northern Ontario, including hosting a visit by its foundation Dean, Roger Strasser:

Table 6.8: Casterbridge Medical School vignette - service learning

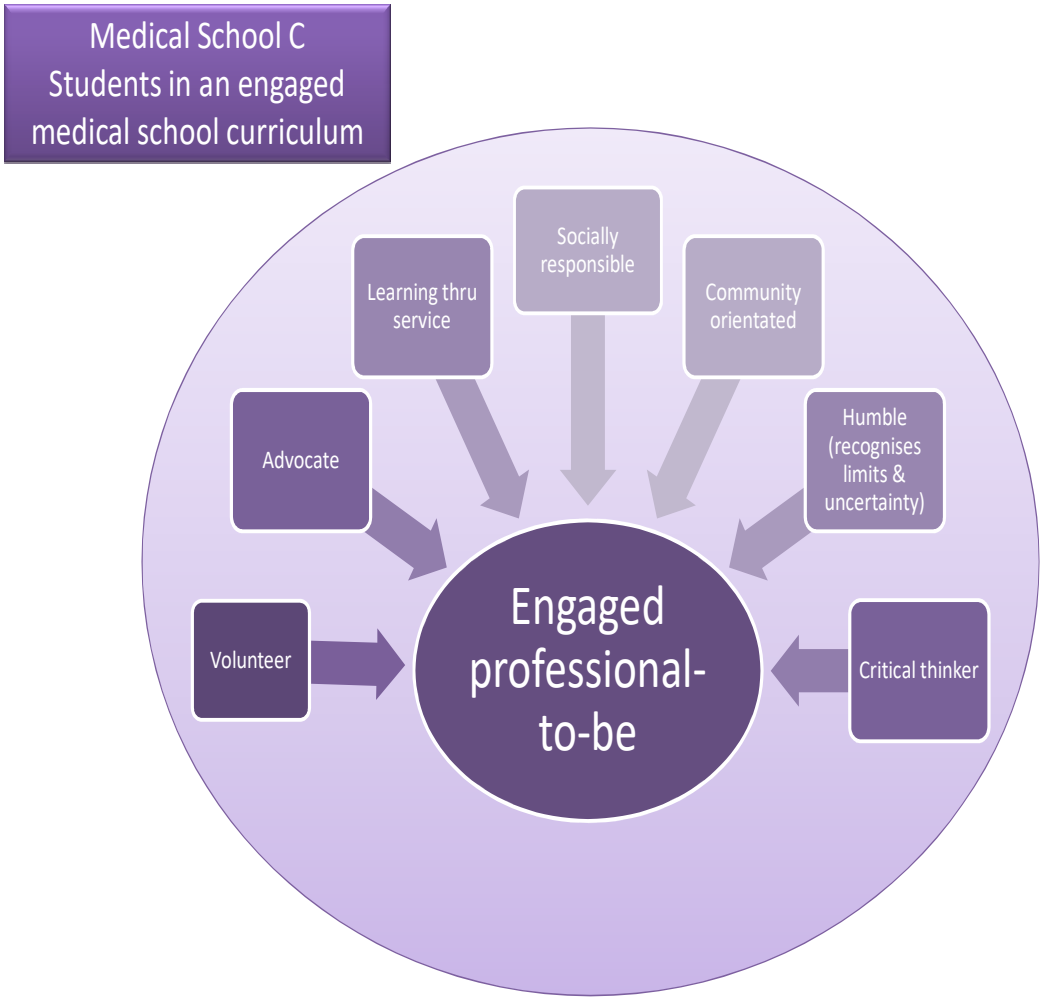
C2 - describing the Service Learning Project	C1 - the Head of School comments
It's true service learning – the project's developed by students and the organisation and not by us. Charities have put in successful bids for funding and a fuel poverty charity now uses the resources developed by students. There's meaningful gains to the organisations, a true engagement with communities. The third sector organisations' feedback is they feel listened to, more engaged with medicine as a profession. Students ... their formal evaluation looks great ... … but to be fair, the negative stuff … like 'I don't see why I should do this, this is what I did to ***get into*** *medical school' And so we have a few who don't get it. ....may be we're more tuned to promoting things in a way which buys into what the students see as important, and we've rebranded.....I changed the name of the projects to 'Community Leadership Projects', and when I talk to them about it, I refer to 'leadership frameworks' and the NHS leadership models and things.*	*Yeah, and there are risks to it, we've just had some students who are working for the HC (a homeless charity) coming in because HC had set them up to run clinics for their clientele, with the BNF and electronic record, making notes. And the students came and said 'We don't think this is right' so we've had to pull them. And they're (the charity) quite cross with us, because they don't see why we've done it. It's not fair to the students ... So you can just imagine if one of them …. It's awful, it's morally awful, but it's a huge risk, I mean ... if there was a suicide. Yeah, and they don't understand why we've pulled them.*

The result is that, despite some core differences, C1 and C2, are able to formulate a triad of strategic frames (Table 6.9) , that generally align, to encompass a coherent, yet plural master frame for their medical school.

Table 6.9: Casterbridge Medical School - alignment matrix forming three coexistent master frames

	Frame	Curriculum Engaged medical school frame	Governance : Compliance frame	Curriculum The "better doctor" frame
Diagnostic framing	Theme	Social justice Pushing out /	What the regulator wants: patients and safety	Community based curriculum socially aware graduates
	Diagnostic: what is the problem?	Improve health economy in an under-served area Retain medical graduates in area Widen participation - raise local expectations	Respond to Francis. Improve pt safety & include PPI Why didn't medical school know? Why didn't students know Why didn't GMC know ?	School in small town is too inward looking . Needs an external [exoteric] perspective (not medical or scientific knowledge) to *'prepare graduates for patients & communities wherever they work'*
	Who is responsible ? (direction of accountability?)	School especially GP academics , and revised governance structures University ethos Locals: statutory and third sector orgs , GPs	GMC requires compliance with PPI standards. School gets ahead of the regulator with new safety-focussed QA process . Teachers train students to raise concerns	School leadership to transform governance structures and learning priorities and opportunities Some clinicians and students still resist
Prognostic framing	**Prognostic Intervention/ Intended or actual outcome**	Apply Boelen's pentagram (p39) reaching out Engaging with NHS & partnerships with third sector orgs, recruit lay reps social engagement which includes social governance	Recruit and deploy lay reps QA panels with lay reps . Break down collusion	Service learning projects - make a contribution - and develop students social (and professional) identity + 15 weeks in general practice -> Graduates commitment to community (making GPs is NOT a key goal)
	Motivation for engaging (the call to arms) ?	A school committed to the community. A curriculum incorporating wider social determinants ...	*Patient safety enhanced by* lay involvement. Fundamental change in processes in response to ethos Francis and the GMC	Develop students' identity as advocates and agents for change.
	Alignment / resonance/ disputes"	Lay rep selection criteria align with safety and *person* centred discourse, (deliberately) not *patient* centred	Service learning misaligns with safety dominated frame Recruiting lay reps aligns with both curriculum frames	Service learning extends the engaged school frame. Branding service learning as leadership undermines social intentions
Discursive field		• Socially just organisation • Balancing needs of all: • Community -school • Collective (critical theory) • Student -patients	The safety shift - emerging frame where priority of educational regulation is to protect patients	Align with ' justice' -person-centred curriculum means student-centred as much as patient-centred

Figure 6.1: Casterbridge Medical School: Engaged medical school frame - intended characteristics of students



Casterbridge Medical School Leadership - managing meaning at the boundary

There are two salient features of the leadership roles C1 and C2 represent. The first is how they have clarity and consistency in their conceptualisation of how the various spheres of their educational endeavours intersect and to what purpose. C2 sums up their shared vision - encompassing, students, curriculum, and the school:

> *'Our approach to carry on ensuring that the curriculum's kept sort of refreshed and does what we want it to do. ... an emphasis on trying to enhance our students' sense of social responsibility and the school's social engagement and to an extent social responsiveness.'(C2)*

Most striking is how C1 seems to be managing meaning at the boundaries. Bringing her knowledge and expertise from outside, she has defined in as new setting, to some extent, facilitated and then delegated movement across the boundaries. While finding common ground across these liminal spaces at micro and meso level she continues to reflect on balance:

> *'Much more worried that we're so patient-centred now in our curriculum that we're not thinking about the students themselves. It's a two way interaction and I'm very worried that we've gone the wrong way … we ought to be working much more with their diversity, identity . ..Patient centredness, I think should be person centredness, and the person should be the doctor or the student and the patient.' (C1)*

Similarly C2 describes how he was inspired by his interaction with northern Ontario medical school - how community centredness became an aspiration. While calling himself a 'community engagement champion', he is at pains to ensure he is perceived as serious and part of a mainstream hard (pointy) clinical project.

> *'I think part of this is having a champion, and because I've been the champion and because I'm not ... viewed particularly as a sort of fluffy GP, even though I am one ... but I've been very careful in my role to ... you know to make it very clear that I've not got a personal agenda when it comes to community centred education or anything like that. So I think having a champion who is also willing to promote the very pointy end of medicine as well, means that it works really. And it might have been different if someone who didn't do things like trying to increase the acute and critical care elements, was involved with that.' (C2)*

C2 was putting on a play in which everyone had a scripted role, from lay representatives on committees, to family practices providing extended clinical attachments ('*the use of 15 weeks in general practice placements is probably the most unusual bit of the course, and the rest is not that dissimilar to any of the other modern hybrid)*', and students undertaking mandatory community-based service learning placements. Whereas C1 was conducting a symphony, C2's play was carefully stage-managed around his curriculum plot.

Boundary spanners

The second striking finding is their roles, not just as local boundary agents, but as boundary spanners (see page 51). Perhaps I had not done my homework well enough, but I was unaware of the extent of their roles and their potential influence, or reach of their agency,

most significantly with the GMC, until just before their interviews. I discuss this more in the regulator section (that follows) but briefly set the scene here. To start with C2: having come to the end of Casterbridge Medical School's cycle of annual GMC QA visits, C2 was recruited to co-chair the GMC QA visit team to two schools in the throes of a de-merger -Anglebury and, its soon-to-be ex, Marygreen Medical School. (Like a GP talking to different members of the same family, I ensured they were not aware of this connection.) C2 described the experience as 'poacher-come-gamekeeper' and described how he used his own insights into the way school leaders make regulation work for them:

> *'So um … I'm slightly Machiavellian, but … you can use the external regulator to drive internal development and part of the way we engaged with the GMC was to try and do that. And so you can effectively use the regulator as a sort of mandate for taking things further.' (C2)*

C1's reach is at a different level altogether: a woman with many hats, local, national and international - involved with institutional and policy leadership at undergraduate and postgraduates levels.

6.2.2 Medical school field as a whole - meso-level master frame

Moving up from the individual organisations to the medical school field itself, a single encompassing "master frame" clearly emerged - the only framing on which all respondents agreed, which I have called the compliance/influence frame. The logic of this PPI frame is so simple no matrix is presented: The key unifying diagnostic element was the GMC's concern regarding the lack of lay involvement in curriculum governance and design; the responsibility rested with the GMC, as regulator, for making this a regulatory requirement in *Tomorrow's Doctors* 2009. Thus the medical schools' solution was to have lay members on committees. Their motivations were mixed - but were aligned on the simple need to comply. Every medical school respondent had understood that medical schools were expected to be able to provide evidence of compliance, through committee Terms of Reference (ToRs), membership lists and minutes. Concern regarding a school's ability to demonstrate compliance if requested was expressed by many. What varied was the moral evaluation of this perceived requirement, as illustrated by the following vignettes.

Further tales of committees: PPI in Student Health & Professional Conduct hearings

The contrasting framing of committee membership as (a) compliance with GMC requirements70. or (b) an independent voice - bringing lay knowledge and challenging medical authority are further illustrated in the events described in box 5.10

Table 6.10: Field Vignette Anglebury Medical School - PPI in student conduct hearing

A1 Head of School	A4 QA Lead	A5 PPI Lead
Frame: Compliance	Compliance	Influence
[there was] a lay participant in a Fitness to Practice hearing ... And he was very useful I think, ... he came from a sort of health charity background so was really a sort of expert lay person, well informed... My colleagues who were presenting the case for the student to be suspended felt somewhat aggressively cross-examined by that person - I explained... my colleagues didn't need to take it personally, it was just the duty of the person on the committee to ensure that the student had been supported and hadn't been disadvantaged by any sort of lack of .. appropriate guidance from the medical school. *But anyway what struck me is they (lay reps)... seemed to think that the medical school ought to be sort of in loco parentis for this young man... whose fitness to practice was being considered ... and didn't really have an understanding of the fact that we were not paternal and that he was an adult learner, he had to adhere to the standards that were set by the GMC for the behaviours and attitudes of medical students as well as doctors, and they [the rep] weren't informed about... you might say [student] life style choices.*	*if you take the example of … as I said, we had lay involvement in the fitness to practice panel, and it was incredibly difficult for that lay person to scrutinise in the way that we needed them to scrutinise. You know it was … yeah … [Challenging]. And you know potentially caused more problems than the benefits we accrued from having that lay involvement.* *And I feel had that person you know been involved in some of the committees that had looked at the original fitness to practice policy, that talked regularly about the GMC's expectations for fitness to practice, they would have had a context that would have then enabled them to direct their scrutiny appropriately and fulfil the function we needed them to fulfil more effectively.*	*Yes, yes. What has subsequently happened though is one member sat on a Fitness to Practice... and did anecdotally a fantastic job in doing what they should do … but I think probably the expectation that somebody might just sit there and not say anything (laughs) was not actually what happened.*

[70] Health & Conduct Committees (formerly Fitness to practice, FtP) consider a student's "fitness" to continue studying , with or without restrictions/sanctions, in the face of unprofessional or concerning conduct. Health and Conduct Hearings are governed by guidance produced jointly by the GMC and the MSC, to coincide with TD09. Students should have a supporter (often a pastoral tutor) and the panel should include (inter alia) : a. someone from outside the medical school; b. someone with legal knowledge; c. a student representative who does not know the student being investigated; d. a doctor registered with the GMC. All members should be trained and act without bias. http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp

This event, related from three different perspectives, explores the extent to which a lay presence in governance structures may be expected to, or even permitted to, challenge clinical academic authority. A5, as we would have expected from her primary frame discussed above, considers active participation to be the core purpose of a lay presence. No doubt she had heard that her lay representative colleague had been considered "challenging" and this aligns with the discourse of underlying the "influence/rights" frame(Table 6.4 above). The framing logic is that appropriate scrutiny is achieved *through* the use of lay knowledge which can challenge authority. At Anglebury, A5 recruited representatives on the basis of their "patienthood" and humanity which confers their required expertise. A1 and A4, on the other hand, share an aligned "compliance" frame, although they use different logics. For A1 , the lay representative failed to *understand* a fundamental need to comply with the GMC - for the medical school, and the individual student; for A5, the reps need to "fulfil the function we needed them to fulfil " - that is scrutinise rather than "challenge" - and this requires greater policy awareness. We can contrast this with the situation at Casterbridge Medical School. (Box 6.11)

Table 6.11: Field Vignette Casterbridge Medical School - PPI in Student conduct hearing

C 1 Head of School	C 2 Head of Programme
… on all the committees because I've always found lay people really helpful .. I really wanted them on Conduct [committees] Because you can see so much collusion happening there with students who come round again and again, and many times I thought crikey, if we had somebody who was representing a lay view, they would say '*For Christ's sake, you don't want this student, they've had three psychotic breakdowns, what are you doing?*'	….on our health and conduct, our former fitness to practice committees, we have people on our progress committees. And interestingly, amongst the people we appointed there are people who have specific and extraordinary medical stories, but part of what we explored when interviewing them was - was that the only thing they were interested in? ... and it wasn't. And so I was on the committee last week with someone who'd had X problems, and a transplant, all sorts of things, and that never seems to directly influence how he contributes to the committee that he's on.

Rather than the language of compliance, C1's framing of this type of PPI representation overlaps with the influence frame. Here the application of lay knowledge and authority - as was probably intended by the GMC - is used to break collusion between the clinical academic and a student they may already feel some professional (or pastoral - it's not clear) allegiance to[71]. As C2 explains, in this variation of the frame, authority is conferred by being a *lay* person

[71] It should be noted that Health and Conduct Hearings are governed by guidance produced jointly by the GMC and the MSC. Students should have a supporter (often a pastoral tutor) and the panel should include (inter alia):

who is selected precisely because s/he is able to leave her/his patienthood and suffering to one side. This is very different to the epistemic authority valued by A5 (the PPI lead at Anglebury).

These two vignettes draw attention to some of the subtle findings regarding the effect of making lay representation on such committees a regulatory requirement. The moral or justice dimensions of this type of social governance highlights the tensions between the lay member's duty to the medical school, and the GMC (the professional priorities) on the one hand, and to represent wider society, on the other. In the middle is the uncertain duty to the individual student, in transition from lay person to professional.

At a practical level - what is "*the deal*" here and how, when, and by whom should *'the deal'* be struck? The idea of lay-patient-public and of knowledge-authority are considered later as meta frames. First, I need to share my findings from the regulator case study. If, amongst the many framings of PPI across the medical school, the single master frame was that of compliance through lay memberships on committees, how did this relate to the frames at the level of the regulator?

6.2.3 Regulator case study - macro level frames

Handling the data from the regulator case study, presents some interesting challenges, that arguably constitute findings in themselves. First, the conditions of the data collection were unusual, influencing my approach to the frame analysis displayed in Table 5.11. The 'speech situation' was itself 'regulated' - in that three of the four officers asked to be interviewed together and for no quotes to be directly attributed to any particular one. The fourth, the Head of Education Policy was happy to be interviewed alone. I assented, unsure of the origins of the request, but confident that what was effectively a small focus group would not generate a problem. In the event, two very different perspectives emerged - education policy on the one hand and quality assurance on the other - with frequent explicit contradictions, and even a hint of jostling for authority, between them. The impression was that, although education policy *thought* they were responsible for setting the direction of medical education

a. someone from outside the medical school; b. someone with legal knowledge; c. a student representative who does not know the student being investigated; d. a doctor registered with the GMC. http://www.gmc-uk.org/education/undergraduate/professional_behaviour.asp

and training (by researching and writing standards, and producing supplementary guidance), quality assurance, were, by managing the regulatory inspections and operationalising the standards, re-interpreting them in the *real* world of regulation and compliance. While this process may seem both logical and inevitable, I was unsure if policy-practice conversations were common.

Second, was the opportunity afforded by the dual roles held by C1 and C2, described above, which yielded key findings regarding the role of medical school leaders as agents who work across the boundaries between the different levels within the medical education field. A significant section of each of their transcripts was dedicated to their perceptions of the GMC, and observations of their work in interpreting and shaping the GMCs standards. From the research perspective, this proved an unexpectedly rich opportunity adding important dimensions and therefore is included in the frame analysis at this level.

Thirdly, and perhaps most importantly, at the time of data gathering the GMC were in the early stages of completely revising their quality improvement framework (QIF) and the associated educational standards. The fact that the regulatory machinery and underlying principles were on the cusp of change, contributed a layer of complexity for the participants in different ways, which I highlight below, and are reflected, as best I can, in the frame analysis.

Four frames were identified, displayed in Table 6.12 which invite elaboration of the intricacies of the framing process at this institutional level, and support the notion of standards-as-boundary objects and the crucial role of agents in their transmogrification.

Table 6.12: Regulator case study frame analysis [continued on next page]

	Framing of PPI standards	GMC Education policy **frame***	**GMC Quality Assurance** Frame*	QA implementation Frame GMC Visitor (C2)	GMC Education & Training Standards Advisor (C1)
		PPI reflects contemporary society Frame	PPI **was** a standard requiring compliance	PPI is (still) a valid requirement	PPI is a core principle of medical education
Diagnostic framing	**Diagnostic: what problem was PPI in TD09* addressing**	Medical schools must produce graduates ("capable professionals") who respond to expectations and concerns of contemporary society	PPI was a small part of the process of institutionalising good, clear QA structures ('*the priority is safety*')	The GMC added PPI to TD09 as a "good idea" but didn't really know what they wanted	To graduate "good doctors" Responding to social expectations of student involved needs schools to be more responsive
	Who is responsible? **Which actors in which roles? (direction of account-ability)**	Society's expectation of openness . Healthcare adopted PPI, the GMC followed the NHS The profession had failed patients: self regulation not fit for purpose - regulator needed to reinvent itself with a lay majority	We (GMC) had to ensure medical schools had their QA house in order. Now we (GMC) can develop more robust regulation to assure patient safety in the clinical learning environment (NB PPI suggested GMC QA processes had failed.)	Good medical schools were already trying to incorporate PPI - GMC used TD09 to ensure ***all*** schools did it GMC standards (unhelpfully) vague. Visiting QA teams left to interpret and actively promote compliance	GMC was reflecting patient-centred agenda in TD09 Schools were left with the option to interpret locally It is "good schools" that produce "good doctors"
Prognostic framing	**Prognostic : Intervention/ tactic** **Intended or actual outcome**	PPI standards in TD09 aimed at increasing patient involvement in teaching and feedback, and lay people in educational governance. New medical graduates will involve patients in their own care - a culture change in professionalism reflecting concerns in society	Medical schools should follow model adopted by the GMC - "use" patients on their committees Now all medical schools have complied with TD09 so we (the GMC) have moved on to patient safety (Job done!)	PPI means : lay involvement in committees, patient participation in learning, and community engagement for the schools and the students Each organisation must be helped to comply - but in their own way, (balancing the other 140 requirements in TD09).	Standards support changes that should be happening anyway Culture change to include lay voice in curriculum and governance is good - bringing new perspectives

	Motivation for engaging (the call to arms)	The regulator must demonstrate that patients, not the profession, are at the centre of everything they do Legacy of public inquiries and increased lay presence at GMC	The GMC is a regulator - we must regulate We (the GMC) set the QA standards, thanks to regulation everyone becomes compliant	PPI is an essential theme for contemporary undergraduate curriculum QA Visiting Teams should keep the PPI torch burning	PPI is a core principle. It goes beyond patient centredness, it is social accountability and responsiveness
	Alignment/ resonance/ disputes	Alignment: a culture change in education to patient centred	Incommensurability: QA agenda has moved on - Safety is the new PPI	GMC view was in fact muddled - didn't understand how schools work made PPI a standard	Dissonance : Patient voice replaced student voice Concern about shift of gaze away from medicals schools
Discourse	**Discursive field** **The language / moral tone of frame**	Regulator is responsible for creating culture change across medical education and training Language/Discourse: Individualisation Improving professionalism of individual medical graduates (for patients and the profession) Responding to political agenda to reassure civil society	Regulator ensured PPI was institutionalised via QA structures because it made PPI a clear, required standard (it's simple!) Language/Discourse: corporate agency and responsibility, compliance, institutionalisation of standards (for GMC QA)	QA Visiting Teams are clinical educators and lay members who use their agency to translate & interpret GMC TD09 (vague) standards into practical guidance - it's the right thing to do Language/Discourse: operationalisation of standards, making PPI real and realistic (for medical schools & their communities)	Complexity Boundary work Negotiation, to reduce adverse effect to regulation Language Transformative Social justice

Note: *As agreed with the GMC participants the two frames are generated from the combined transcripts of all four GMC participants, R1, and R2a, b, and c, without specific attribution.)

Frame dynamics – bridging, dissonance and conflict

Although just a snapshot taken at a given moment, the framing of public engagement at this macro level reveals some striking dynamics. As was expected from the review of the frame analysis literature, it is at this level of policy formulation that wider political and civic agendas

are brought to bear. Through the education policy officers it is possible to develop a sense of narrative over time. It is also possible to follow the trajectory of PPI from idea, to policy and then to standard, incorporated into *Tomorrow's Doctors* 2009, then absorbed into the QIF, interpreted and implemented by the QA visitors and then effectively handed back for monitoring. Finally, as at the time of the data gathering, revised in *Promoting Excellence* (GMC 2016). The officers described that in the run up to the publication of the TD2009 standards they were attending to two parallel processes. One was to roll out a more structured approach to quality assurance, consistent with wider trends in governance - *' an emphasis on quality management, a quality machine sort of' R1*. The other (partly in the wake of the public inquiries listed in Appendix 3 Summary of healthcare policies, codes and inquiries with the governing council moving to a lay majority) , was a policy strategy known internally as *'reflecting contemporary society'*, RCS : This aimed to:

> *'...push the boundaries a bit - and PPI was part of RCS along with equality and diversity, and interprofessional learning, and other bits of work. So... it came from a sort of policy perspective that this is what the GMC should be interested in.' (R1)*

R2 saw this as part of a continuum, a policy logic in its own right. As the GMC became (or was made to be) more concerned regarding its own responsibilities ***to the public*** for professional 'fitness to practise', it assumed a more serious interest in its role regarding educational regulation:

> *'I don't think PPI has ever been trying to solve a problem, I think we recognise that we are a public regulator. Our sort of principal aim is to ensure patient safety, hence good medical practice, hence fitness to practice. And education I think has come more to the centre of gravity within the GMC, it's much more pivotal now I think to ensuring that some of these objectives are met...It's our role ...it's important that we're seen to be leading on this ... but I think there's a balance we have to do between managing expectations of every group and setting something that is workable.' (R2)*

This is, in effect, a process of frame extension - through which the frame sponsor, in this case the GMC education policy section, links to a wider political rhetoric or ideology. At the same time there is considerable bridging between the frame elements employed in this frame and that expressed by C2 in her GMC 'hat' , such as responding to society, creating equilibrium between stakeholder expectations, and managing complexity. While this may represent mere endorsement by a practitioner from the field my impression was of a more considered, and as we see later critical, position.

In simple terms the Education Policy Section generates the standards in *Tomorrow's Doctors* which are handed over to the QA Section to be operationalised through the QIF. By contrast the QA framing of PPI in my data shows considerable incongruence with the education policy, suggesting it emerged from a separate community. Consistent with a discourse of compliance the focus is on identifying tangible items of evidence, rather than reflecting an overarching ethos:

> *'PPI bit is more kind of making patients part of delivering education, patient-centredness is kind of teaching about the patient isn't it? And I think the PPI specific bit of QA is quite a small bit. I mean it is you know checking to make sure there is patient and public involvement on committees as you say, looking at feedback mechanisms .' (R1)*

Although the education policy officers observe *that 'the relationship with us and quality is an interdependency, because the data we need to inform policy development projects obviously comes from their intelligence gathered through visits' (R2),* they are mindful of a disconnection :

> *'Quality assurance is probably fit for purpose as it currently stands, because it has so many different checks and balances ....[but] how are standards being met?... we [the policy team] don't see and don't approve. So I would say ... the question is how we marry those things up?'.*

When asked if the policy section might have a say in the interpretation of standards, R1 commented:

> *'I think that's where I'd like to get to, very much. I know it's a sort of internal matter, but [we're] very keen the team understand how the system works, both in terms of policy, but also quality assurance ... and the effect of the policies and the standards that we're putting on people out there. So [we] introduced staff development of visits, not part of the quality assurance, this is purely to get into [the policy team] bloodstream the effect of what we do.'*

Here different role perspectives standout. As the standards shift out of the policy level, they come to life through the agency of the seconded quality assurance visitors, in a role C2 describes as poacher-turned-gamekeeper. Having *'lived and breathed QA for 6 years while getting the GMC to make this [Casterbridge Medical School] into a proper medical school,'* he was then appointed to co-direct the ongoing approval of Marygreen Medical School, until it is fully accredited in four years time. He frames his priorities in this role as establishing a partnership with the school under scrutiny , in order to help them be as good as they can be - mirroring his own experience (we should recall that he described some of his choices as the

head of curriculum as Machiavellian - in order to use the regulatory process to drive desired, but resisted, changes). He judges the written PPI standards as "confused" and therefore the visiting team has to use its judgement. C2 sees it as a conversation between the GMC QA representative and the co-opted visitors on the team but, as Co-chair he says "*it is not viewed as optional... It is at least as important as achieving core skills" (C2)* . He describes the need to be '*pernickety*' citing *' the experience with places like Swansea where things have gone awry*"[72].

C2 and the visiting team have the ongoing role in moving the original *Tomorrow's Doctors 2009* standards across the regulator-medical school boundary.

> *'It's for the regulators to set the sort of baselines, it's for the experts then to interpret those at the local level. (R2)The GMC quality frame is rooted entirely within the Quality Framework and reports visits and self assessment from approved school with a discourse of compliance. QA makes no reference to education policy or to any wider discourse. Their analysis was that TD09 had in part achieved what it set out to.' (R1)*

> *'We have evidence that the systems and processes are in place, we're now focussing on the next stage... 140 requirements, to map each one individually ... it was hugely burdensome approach – for us and for other schools – which is why we're taking the risk-based approach now.' (R1)*

Frame break and transformation

My reading of the GMC transcripts is that we are on the cusp of a new dominant discourse - the transformation of the master frame from patient-centredness to patient safety. Patient safety was in fact a major focus of *Tomorrow's Doctors 2009* but it was the structural underpinnings of the QIF with its blindness, or at least bluntness, with regard to the clinical learning environment:

> *'We have to mention the Francis report, and you know that it's a national trend, an increased focus on patient safety and we have to respond to that...We are currently reviewing the standards and going back to square one. Patient safety is the catch phrase .. it weaves through all of the themes… I expect we'll mention PPI less ...And when I think about ... our risk based approach and adjusting patient safety I'm thinking … in the process of addressing these patient safety issues ...we don't engage directly with patients. But we ask for those who are delivering the care, we want to know that they're engaging with patients appropriately, if you see what I mean.' (R1)*

[72] The GMC required students on Swansea's new programme to be moved to Cardiff to complete their course as the GMC judged assessment had not met standards despite a number of QA visits. (Described in the minutes of the GMC education committee(GMC, 2011b).

This of course aligns strongly with the framing at Casterbridge Medical School, (Table 6.8 above) although they, by contrast, stress the role of lay involvement in regulating this space.

Emergent Frame

The educational policy has made an additional significant, but somewhat different, discursive and pedagogic shift moving from competence to capability:

> *'Competence are the things you're able to do to a certain standard, capability is how you integrate all those things into care, for independent work ...' (R1)*

Bridging that can be seen across R1 and C1 (the many-hatted Dean at Casterbridge) arises from the latter's role in shaping the new standards (GMC, 2016) . Here for the first time we see the wider public and social concerns that some in the medical schools frame as core to PPI:

> *'The generic professional capabilities framework is set at a high level... the core skills that all doctors should have by the time they ..complete training. A subset is relevant ... around cultural and systems awareness, understanding the diversity of the populations that are served, understanding global health issues, and an awareness of legislation that governs what they do, like the Mental Health Act,– all those patient-related things'.* (R1)

Level and field confusion - what is being regulated

The focus and approach to regulation inevitably changes what we are seeing. What this might mean in terms of the social settlement and the relationship between the public and the professions, patients and doctors, is discussed in the next chapter. However, one point related to regulatory structures should be noted. Medical schools' regulation, had until the time of the data collection remained separate from that of postgraduate training.

> *'Medical schools are part of the universities .., so we don't have a legal jurisdiction over what they do, however we have a regulatory responsibility for standard setting, and the medical schools have a dotted line back to us on that. So it's a really unusual relationship.' (R1)*

> *'The medical schools are autonomous … well have a low autonomy and guard that very closely. And we don't approve their curricula, their individual curricula.' (R1)*

By reframing its regulatory priorities as the clinical environment, in order to address the diagnosis made by Francis, the GMC is using the discursive language of risk and safety. Structurally, the regulator is aligning itself more with the new NHS educational commissioning process. Within this framing patients and the public are understandably fearful, and need to be reassured, but are no longer actively engaged. Furthermore, we end up with some confusion regarding whether the GMC will be concerned with medicals schools and their curriculum, or will fix their gaze on the exams and the clinical learning environment. C1 had been the only medical school representative on the Advisory Group and concluded with the concern: they are probably '*.... not going to be deliverable for us in the undergraduate environment.*'

6.3 Meta level frames

Among the various taxonomies of frames available, Gray (2002) identifies three generic frames: (1) identity frames (how I define myself); (2) characterization frames (how others are characterised); and (3) conflict management frames (preferences for how conflict should be managed). There are two meta frames across the entire field of study: the first which I call "the deal" brings together the characterisation frame with the conflict management frame; the second I will simply refer to as the identity-characterisation frame - combining both the subjective and objective.

"The deal" meta-frame

In every transcript participants, referred in one way or another, to the challenges of defining *patients* and *public*. It should be clear from the frames and quotes displayed above that this incorporates a wide range of definitions. Furthermore, it is in the process of framing engagement with a range of "others" that the speakers provide some clarity regarding their organisational and pedagogic perspectives, while revealing doubts, prejudices and strongly held views - the stuff of frames. As such this meta frame is primarily about how characterisations based on knowledge and expertise are used to control access, and the conflicts to which this gives rise. The tree diagram (Figure 6.2) displays the more concrete elements of the frame I have marshalled, which also reflect the concepts identified in the

literature review. This provides an overview in the form of the broad continuum from collective to individual framings. The relative lack of attention to the collective (public and community) side is discussed at the end of this chapter. Overall PPI is seen as a focus on the individual:

> *'I hadn't quite worked out how I was going to deal with this PPI thing and what the (inaudible) of it should be … but I think respect for patients is really, really important.' (A1 , Dean at Anglebury)*

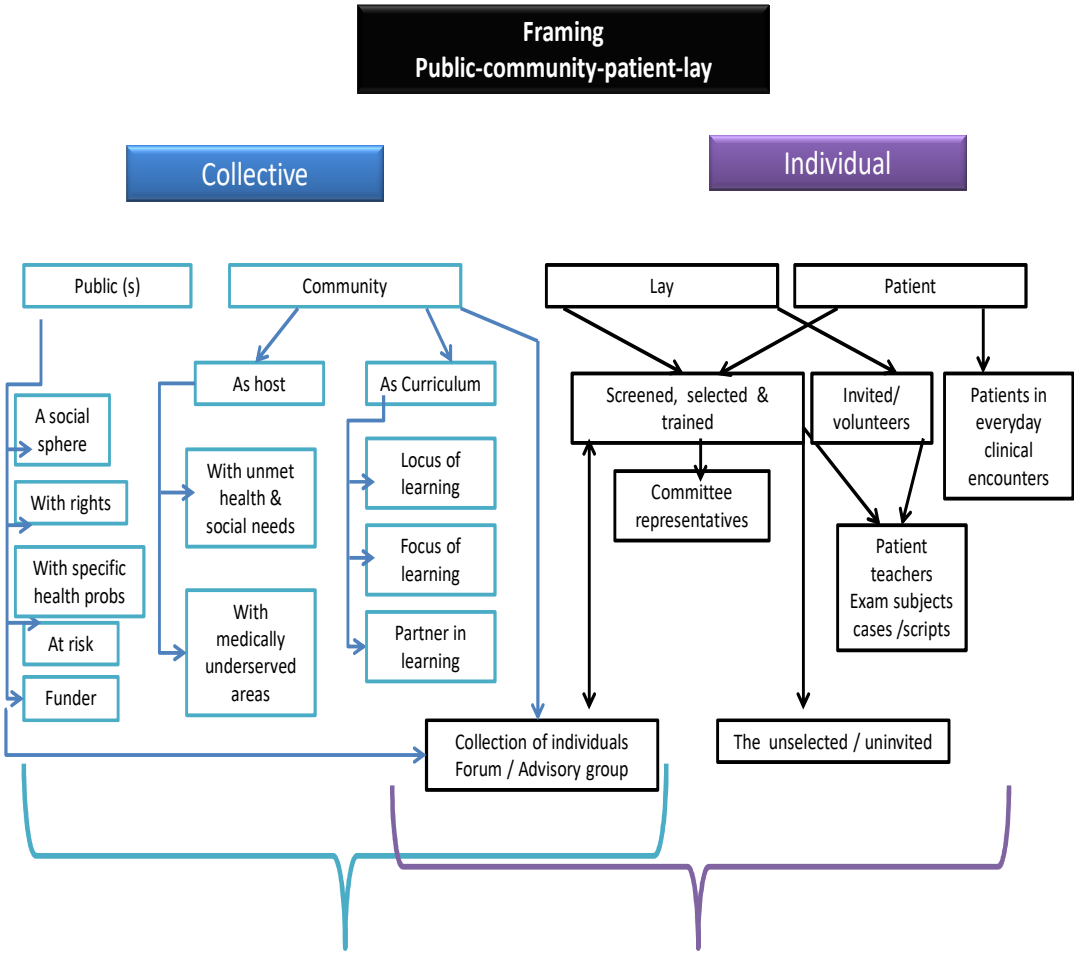
By focusing on examples from the transcripts around the role individuals might play within the medical school, we can see how perceptions of knowledge, and of the knowledgeable, beggar questions about how to broker engagement.

> *'How we very much involve patients in our programme is through the clinical skills particularly. We also have, you know, some expert patients that come in, we have simulated patients involved in some of the clinical skills assessments. ' (A3, curriculum co-lead at Anglebury)*

The primary diagnostic frame straddles notions of real, selected and even simulated patients - in both clinical and the governance activities, raising key questions about framing solutions:

> *'Are we expecting to train them [patients/lay people] to become educators, or to tell their story, or to ask do you include this in the curriculum?. Is it curriculum content, or involvement of them talking about their health problem?' (B2, PPI lead at Bramhurst)*

Figure 6.2 "The deal" meta frame - bridging across public-community-lay-patient components



With regard to identifying representatives, all participants favour selection by faculty, for example:

> *We all sort of self select ourselves into work roles, to get [my job] I applied and had been competitively interviewed. So ... you're dependent on volunteers … it's not a two way relationship ... In every other activity the University will have a say in who they employed and worked with. And whilst there's benefits of not having that relationship, you are the non exec … it also means that you're open to, you know, potentially damaging or sort of slightly toxic kind of diversions ... But I qualify that by saying that there really hasn't been enough integration ... And what you don't want is for that to just become an extremely unpleasant relationship that has to be tolerated in both directions. (A3)*

A3 goes on to say that 'people who are outside of education' are in a good position to contribute because they *'aren't poisoned by years and years of working in it. I don't think they have to be patients, because in some respects we're all patients ...'*

The study participants have invested considerable thought to disentangling this perceived lay–patient bind. We have seen in the case studies arguments for and against the involvement of members of staff as lay representatives. The case studies also show a general discomfort with patienthood, and patients' rights-based legitimation, leading to "uninvited" individuals and groups. Not defining *'the deal'* and losing control of selection is a major source of conflict:

> "*what they want to do and what we wanted them to do were two very different things.' (A4).*

Even with the rigorous process employed at Casterbridge Medical School questions arise regarding what constitutes legitimate use of lay knowledge:

> *'… We've had difficulties with them … a businessman who thinks he knows everything, so after a two hour meeting he'll say 'My solicitors would have had all this done in 20 minutes.' (C1)*
>
> *'The assessment committee's had an issue … a weird presentation from the lay rep ...wanted to tell us how to do thing.' (C1)*

Sentiments echoed by others:

> *'I think it's extremely important that the patient voice is seen in aspects of the curriculum and in aspects of this is how we assess our students. What do you think? And having it in layman's terms so they understand the principles.' (B1)*
>
> *'Sometimes people don't understand educational processes and so they might be advocating things to do which maybe not a good way of going about it.' (B2)*
>
> *'If a patient comes to be a regular member of the Medical Education Committee all they are is educated in the ways of universities. They're not actually giving the patient voice. ... we need is a mechanism by which we have the patient voice at different areas of our activity, but not to be, it's not the right word, academicised.' (B2)*
>
> *'But she's a real 'professional patient', I've met her, you know she's got a chronic condition, she's very articulate – she's not your average patient.' (A1)*

And A1 went on to explain, quite candidly, regarding the potential for PPI in teaching and governance:

> *'I suspect we'll end up with some of our PPIs with professional patients, well informed, intelligent ... your average patient will have an IQ of 100, aged ... 75, really a median of about 84 in our area – they just want to get home usually. So to say who ... who is*

representative of the true patient population out there, is going to be the real challenge. (A1)

There was repeated mention of jargon, boredom (committees **are** boring) and fatigue. Amongst solutions endorsing an advisory or reference group or patient forum was identified as a positive option - providing a space for a more collective type of *free range comment* in areas *they felt passionate about.* This, in turn, generated concern about institutionalisation within formal governance structures. Overall it was acknowledged that managing this conflict is fundamental to sustaining PPI:

'You know if challenges and conflict arises over lay people there's less incentives for the medical schools to push forward and find solutions.' (A4)

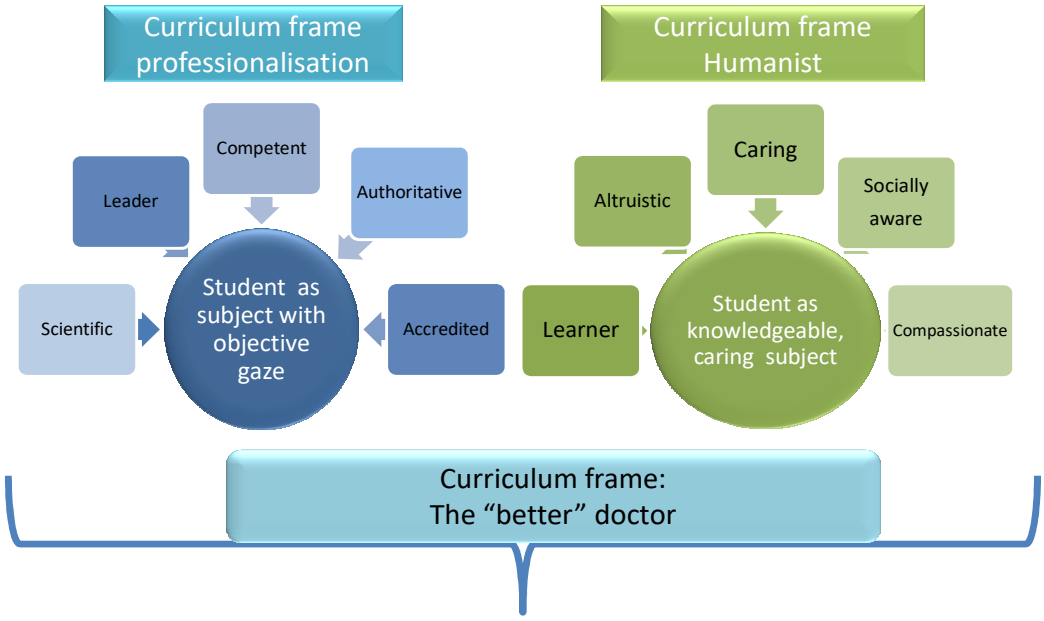
Summarising, the lack of a clear 'deal' was acknowledged to be the source of conflict (the diagnostic), and selection by clinical faculty, and lay/patient professionalisation were seen as solutions (the intervention). Faculty struggle to find ways of sharing and working with different types of "exoteric" knowledge, and the individual 'outsiders' who are generally regarded as knowledge deficient. The way in which this position may be sustained, by the use of discourses of authority or co-operation, is discussed in the next chapter.

The identity - intersubjective meta-frame

While issues of identity and subjectivity are less salient, they nonetheless form, an intriguing frame that appears to represent a nascent frame transformation - that is "changing old meaning and generating new ones" (Benford and Snow, 2000 p625). These arise when opportunities within society or specific communities of practice find traction with existing sponsors (Cornelissen and Werner, 2014). The application of humanistic discourses to the framing of clinical and curriculum practice, as the literature review reveals, are far from new. In *Tomorrow's Doctors* 2003 we saw a clear re-framing of medical education as a student-centred project. In *Tomorrow's Doctors 2009* this shifted to patient-centred as the master frame, of which the PPI standards formed a small but key part. These humanistic orientations aimed to shift the culture away from didacticism and paternalism - to foreground the subjective experience of students and patients respectively. In the interviews with participants two interesting re-workings of the humanist frame emerged. First was a shifting back to the paternalistic frame through the discourse of professionalisation. A curriculum that increased involvement with individual patients should ensure students move

appropriately from the subjective position back to the objective gaze - this I have called the "better doctors" frame (see Anglebury Medical School and Casterbridge Medical School) displayed in Figure 6.3 below.

Figure 6.3 frame bridging to yield the components of the "better doctor" frame



Patient-centredness has many guises, from informed patients, involved in their own care to autonomous patients and empowered consumers. This shift away from student-centredness to patient-centredness, combined with early professionalisation, raises question about the purpose of a medical school in relation to students 'identities and their relationships with patients.

> *' Tomorrow's Doctors did ...patient centredness. Now I'm not sure it's right because I'm much more worried that we're so patient-centred now in our curriculum that we're not thinking about the students themselves. It's a two way interaction and I'm very worried that we've gone the wrong … we ought to be working much more with **their** diversity..., that's why I'm hesitating because I'm really worried about patient centredness...' (C1)*

> *'We {the GMC] are interested in students, the environment of learning – what looks good, what role models there should be that people can follow, good practice ... But also within that how you value trainees as a part of the system, not just, as has been said, a commodity to deliver service.' (R1)*

'Are we abdicating our responsibility to the students? I'm tussling with these notions of involvement, engagement, empowerment , thinking about some boundaries .. more time you spend in education you realise that there's lots of things going on – it's about the learners' needs, it's about the system they're going to work in, it's about assessments, clinical practice, having to say no or deal with people you don't like - you have to balance the communities.' (B2)

For A1 the concern is similar but the solution is the retreat to paternalism.

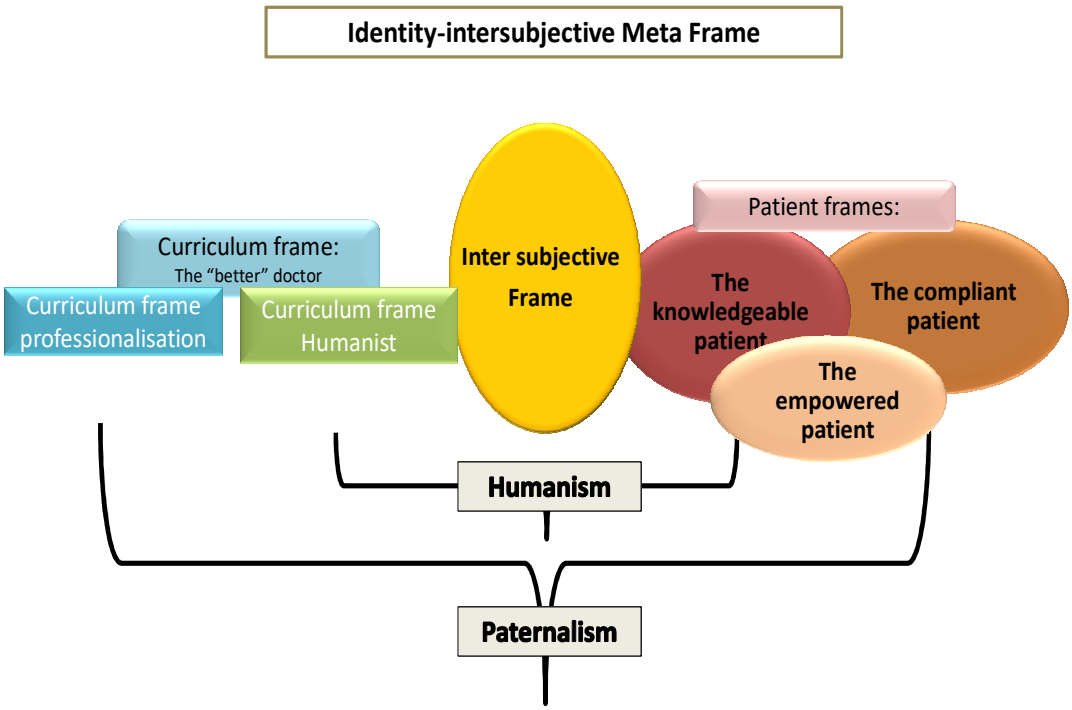
It's getting people to develop that emotional intelligence to be able to project their feelings into your own, so you become conscious of what your effect, how you behave....it should be embedded, should stay, so that paternalism sometimes will have to persist, cos some patients need to be. (A1)

The idea of inter-subjectivity in human relations is also not new but it is only recently gaining purchase in medical education and practice. Heath {, 2015 #2599} writes *' a human being is simultaneously both a subject and an object. Within a consultation both doctor and patient need to oscillate between perceiving the body as an object and as a subject'.* The education of the doctors does not subordinate the student's subjectivity to the patient's (see Figure 5.4) - in this framing the practice is objective, subjective and intersubjective. This is the solution C1 appears to offer (and invites me to enact):

*'I think it should be person centredness, and the person should be the doctor or the student and the patient. I'm looking for people like **you** to pull it back (laughs) please.' (*C1)

What these ideas of person centredness means in terms of the social epistemology, PPI and how this framing might interact with the *safety* frame is of relevance to the conclusions of this thesis .

Figure 6.4: Identity-intersubjectivity meta-frame



6.4 Gaps & residues - what remains in the shadows

There are a number of areas that have not emerged from the data as I might have expected which I summarise now.

Collective perspective:. First, the *engaged medical school* forms a clear and coherent frame in Casterbridge Medical School. This is not, however, present in transcripts from other schools or levels - and represents a notable absence at the level of the regulator. How others schools will produce socially responsible and critically aware graduates, and have anything other than passing relationships with host communities, in a context in which individualism is so dominant is addressed in the discussion. Theory and practice, such as health inequalities and public health, that can only be understood through a community oriented engagement, will struggle for curriculum space and legitimacy.

Organisational culture: Secondly, the literature reviewed for this thesis, and that on leadership and learning conducted for my IFS, suggests that culture (the context of practices, customs, values, and vision) are key concepts affecting leadership in their organisations, and the management of change (positively and negatively). It is striking that only four participants mentioned culture at all. Of these C2 and R2 referred repeatedly to the role of institutional culture in relation to educational policy. This appeared to be linked to their shared interest in balancing the capability agenda and the effect of Francis.

Patient Feedback: This is one of the key requirements in relation to the standards in *Tomorrow's Doctors* 2009 (see Appendix 1). Although I raised this as an interview question - it was almost universally dismissed as either unclear (is this about students or the curriculum?) or, if intended to be in the clinical setting, attractive but virtually unworkable.

Higher education agendas: although research in various guises was manifest in many participants frames , trends in public engagement in higher education (as seen for example in north America) and prospects of educational excellence measures were not raised.

> *'The agendas I hear are Russell Group, internationalisation, research, blah … you know … you know worldwide focus, you know. You know that's what this is about, we need to collaborate with these places in China.' (A2)*

Frames currently emerging related to safety, increased professionalisation and intersubjectivity - in the context of an NHS under strain raises issues regarding potential framing of relationships as collaborative or conflictual.

6.5 Reprise of the findings

The principal concerns are the frames medical school leaders and GMC officers employ to articulate the agenda for public engagement. These have been considered and presented across a register from individual, to case, to field which has provided insights into the processes of curriculum implementation, regulation and institutionalisation. Frame analysis has proven to be a taxing but rewarding method, greatly helped by the richness of data. By using a number of frame analysis techniques, I have generated frame "packages" of data

content in context (where helpful describing actors / sponsor and speech situation of the interview). The detailed and open descriptions of events shared with me by participants, have been used to ensure narrative fidelity by using verbatim quotes. I have been able to align policy and strategic frames with the literature and wider policy environment and, to the best of my ability, identified the discursive field(s) as well as strategic processes such as alignment, bridging, conflict and transformation. The wide range of frames highlight both the plasticity of the key concept, public engagement in medical education, at micro level , as well as the processes and effects of regulatory standards at each level. Salient findings include issues related to identity, curriculum orientation and governance in which the use of authority thought the privileging of different forms of knowledge plays a significant role. These findings are discussed in the next chapter with reference to the role of leaders, in the context of a revised regulatory environment.

CHAPTER 7 LANDFALL - DISCUSSION OF WHAT HAS BEEN LEARNED

'Simply by sailing in a new direction
You could enlarge the world.'

Allen Curnow, 1942 (Landfall In Unknown Seas)

7.1 Purpose and approach

In this penultimate chapter, I synthesise and interpret data already reported and discuss them in relation to my research questions, and to the current context outlined in Chapter 1, the literature (reviewed in Chapters 2 and 3) and the theoretical framework (developed in Chapter 4). After offering a response to the research questions, I provide a tentative, integrative model of public engagement and medical education, and consider the strengths and limitations of my methodology. I conclude the chapter by reviewing implications for policy, practice and further research - across institutional levels from medical education leaders, to medical schools, and the regulator, and how these empirical and methodological insights may be of significance to those in public sector leadership and regulation, more widely.

I set out to garner greater understanding of two phenomena prompted by responses to *Tomorrow's Doctors* (GMC, 2009 - see Appendix 1); first, public engagement, an intriguing, highly contemporary, but ill-defined, concept; and, second, the process and consequences of turning this into a regulatory standard. The literature revealed multiple interpretations - or framings - of public engagement aligned to different philosophical and political standpoints. Furthermore, I found regulation of medical education in the UK to be under-researched. The heterogeneity of public engagement and the gap in the literature allowed the thesis also to become an exploration of theory and methodology - allowing me to test approaches to enquiry hitherto little used in medical education research. The novel combination of social epistemology with boundary object theory, through the vehicle of case studies, and the application of frame analysis, demanded rigour in terms of coherence, clarity, and consistency. What has been learned by applying this process to my research questions is discussed below, after a brief comment on terminology.

I use a number of terms applied in various ways in social research. Three are worth highlighting here: *field* is used in the sense applied in organisational research (DiMaggio and Powell, 1983) not in the ways used by Bourdieu ; *individualism* arises from Beck's usage and *collective* is applied as used in critical theory, by, for example, Tritter (2009) and not in a Taylorist functional sense. Finally, I tend to use the term *authority,* as used by Lukes (2005) and De George (1985, in Eddy Spicer, 2010)[73], when adjacent to knowledge, rather than *power* - so as to avoid suggestion of a Foucauldian treatment of knowledge/power relations.

7.2 Answering the questions

The research pursued the following principal question:

> How is public engagement policy framed and enacted in UK medical education in the context of evolving regulatory requirements and organisational diversity of medical schools, and what are the implications for educational leadership?

This exploration of public engagement and its framing was supplemented by six further questions, (see Chapter 1, Section 1.5) derived from the literature review, focusing on: boundary object theory, the institutionalisation of standards, social epistemology, and epistemic justice. Although the study is small, my efforts to apply meticulously the principles and processes of frame analysis yielded ample evidence of a wide range of frames used at, and across, institutional levels. These frames, in turn, inform our understanding of boundary objects in relation to public engagement and standards.

7.2.1 Frame convergence and diversity - contextual influences

To start with the frames and vignettes presented in Chapter 6: these encompass the entire gamut of interpretations flagged up in the literature, from individual to collective orientation, from strategies to increase professionalisation focused on students, to the application of transformative pedagogies in curriculum design. For me, perhaps the most striking observations regarding this range is how it is dominated by an individualism discourse. Predominant amongst this frame cluster is a convergence across the field on issues regarding

[73]- Authority encompasses forms of positional influence (Lukes), and epistemic authority - assumed, or conferred by others, with respect to an individual's or group's field or area of knowledge (De George).

doctor-patient and student-patient relationships (which I explicated as the "*better doctor*" meta-frame, Figure 6.3 in Chapter 6) underpinned by motivations to present a revised authoritative *and* caring professionalism.

The *embodied health* frame, so clearly articulated by one participant (A5), enriches our understanding of issues related to knowledge and authority in the use of agency (which I return to later). While invoking much of the argumentative logic of a social movement in the articulation of a collective action frame, I come to the conclusion that, at least in this context, this is also aligned with an individualistic perspective. The insistence on the establishment of a *Patient Forum* advisory group at Anglebury, the evidence would suggest (Bartels, 2013; Stirling, 2007), was an entirely logical strategy to engage a range of patient viewpoints. However, it lacks a truly collective underpinning as there was no reference to a wider public or community in the data.

The strength of viewing and analysing the medical schools as unique cases allows me to expose frame heterogeneity and homogeneity within cases, and assemble frames between cases, and within levels of the organisational, and the institutional fields. Nonetheless, any suggestion of generalisability needs to read with caution. From the clusters of frames laid out in the previous chapter the prevalent framing of public engagement in medical education (in this sample, at least), as an act of *compliance,* is to be expected. The findings elicit a parochial pre-occupation - at once illuminating and disappointing (at least to me) - with committee membership. This focuses attention onto the salience given to instrumental interpretations of public engagement-through-regulation by some participants and the interaction between their use of agency and creating organisational structures. The vignettes highlight the role of leaders, as boundary agents and the boundary work they do. The problematic negotiation of "*the deal*", in which issues of knowledge and authority seem to play such an important part, has implications for leaders that are elaborated in the following sections.

While my study shows meta-frames across the entire field - in response to common field factors, it also strongly supports the notion of diversity between, and within, schools due to highly contextual forces. I discuss this in more detail when considering institutionalisation, but here it is worth noting, with regard to diversity between medical schools, Brosnan's (2010) convincing argument that there are many reasons why schools may wish to capitalize on, and make a virtue out of, difference. This point was highlighted by participant C2. The process of framing, whether a deliberate front-of-house (to use Goffman's metaphor) act or

something more tacit, or even unconscious, backstage, will influence how schools - here using Bourdieu's terms - *'compete for different forms of capital, such as students, funding and prestige.'* (Brosnan, 2010, p. 645). What my findings show is how medical school leaders may be more or less able to work with (or simply 'work') their local context.

In Anglebury Medical School, we see what appears to be a relatively unstable situation: a new Head of School; a recent demerger; and an ongoing period of intense regulatory scrutiny. The need to re-align with the master-frame of a research intensive university (what A2, the programme co-coordinator calls "*internationalisation, research, blah"* Chapter 6, Section 6.4*)*, following the break with the more community-oriented frame of its former partner, is a further factor in the frame dissonance I found.

In Bramhurst Medical School it is possible to identify a more harmonious, hybrid framing, characterised by a rather circumspect view of both public engagement, and compliance with the related standard. The context is comparatively stable, locally well-established with a longer period within a research-intensive regime. Bramhurst Medical School does not have the more explicit engaged structures, seen in Casterbridge. Bramhurst was in fact well-known for its innovative service learning and community oriented projects in the 1980s and 90s. Two possible reasons why this was not sustained may be: the flux of its local demography; and secondly, as the largest school in my study, the constraints of the administrative, pastoral, educational, and placement needs of 300 students per year.

Casterbridge Medical School, having come through its demerger and its GMC accreditation, and unencumbered by Russell group pressures, is able to respond and engage with the enthusiastic expectations of its host community. Here we find the only convincing collectively-oriented framing of public engagement. This reflects significantly on the importance of leadership coherence, with a transformative and socially accountable curriculum vision, and active organisational partnerships. The argument logic is consistent with the principles of the transformative curriculum, increasing relevance and the socially accountable medical school advocated by Wollard and Boelen (2012) and others (Frenk, Chen and al, 2010). The relationship with Northern Ontario Medical School, suggests an alignment with a transnational framing (certainly as would be represented by the THEnet (2015)). In this school the framing of both the curriculum and the student includes, but transcends, the individualistic orientation (central to the "better doctor" frame summarised above) that assumes a relationship between *equal*, but different, others. Here the purpose of

engagement is allied to the critical aspirations that facilitate collective empowerment with the goal of social change, in particular to reduce social and health inequalities. This emancipatory discourse goes beyond democratisation, and, as discussed in the literature review, can lead to, at its best, an organisation committed to producing benefits for the community, and students equipped as advocates and change agents. The potential of this pedagogic approach has currency both from the research perspective - with a large critical realist review of community relationships in medical education led from northern Ontario, published at the end of 2015 (Ellaway, 2015; Strasser *et al.*, 2015), and from the governance perspective - with ongoing international calls for both voluntary and mandatory accreditation (AMEE, 2013b; GCSA, 2010)of the accountable, or engaged medical school.

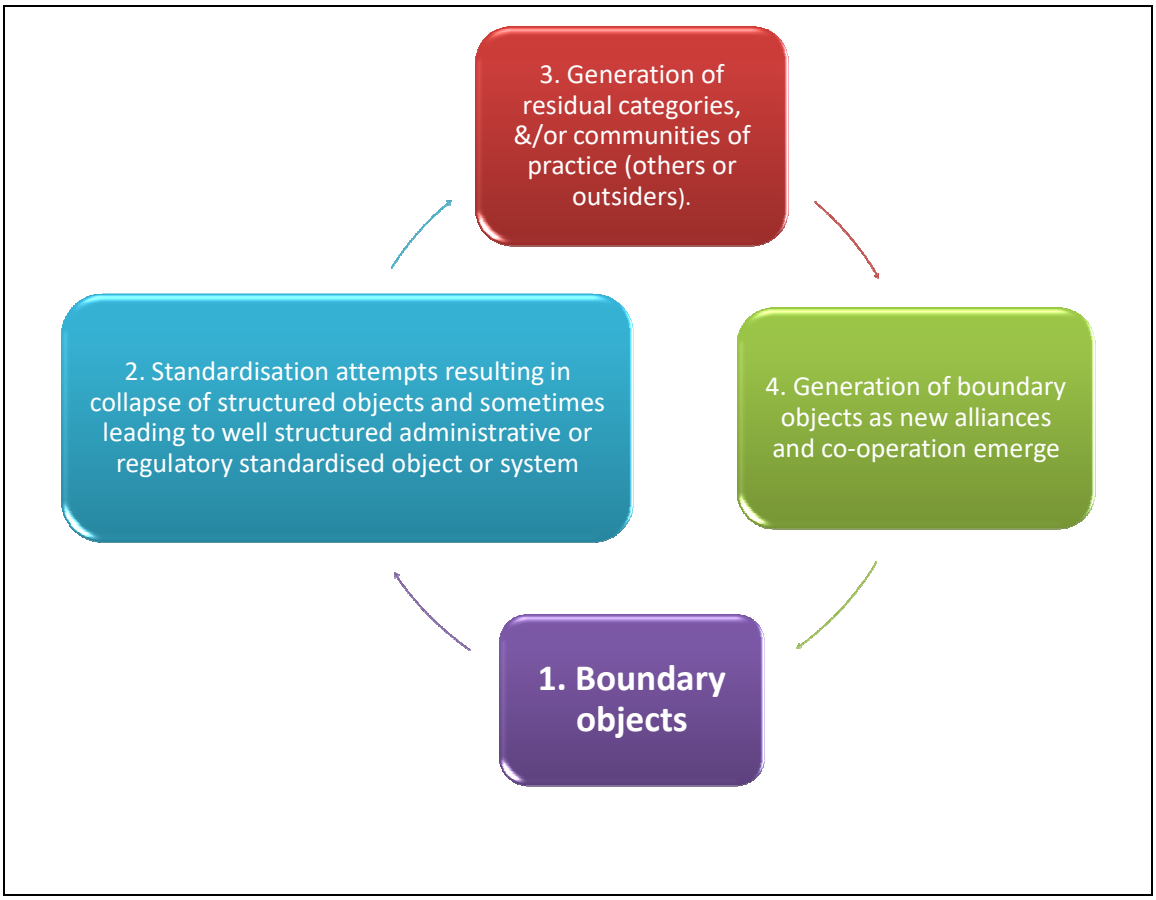
7.2.2 Public engagement as boundary object - a new understanding

The transition in the framing of public engagement from shared enterprise to externally validated standard, leads to new insights derived from boundary object theory. In her posthumously published paper, Star (2010), identified three key criteria that define boundary objects: their scale, their scope, and their behaviour. With regard to scale, Star states that boundary objects operate best at organisation level, as in my study. In terms of scope, the limits are those of specificity - public engagement in general demonstrates an interpretative flexibility that might be considered too wide to be consistent with a boundary object, however in the context of the specificity of my sample, i.e educational leaders in UK medical schools, public engagement conforms to the scale of a boundary object. It is in regard to its behaviour, however, I would suggest, that public engagement, at least as a process of institutionalising and standardising of a diffuse concept, widely shared between different groups, is truly consistent with the notion of a boundary object.

In the process of defining public engagement as a regulatory standard, frame elements used by some, are, inevitably, left behind or abandoned. The identification of this "boundary residue" (the remnant that remains after standardisation) adds further to meeting Star and Griesemer's (1989) original behavioural criteria of boundary objects. I argue that the wider collective aims of public engagement, concerned with social accountability and justice, were effectively omitted in the *Tomorrow's Doctors* framing of patient involvement and public engagement. Below, I consider how this remnant may be understood from the perspective of institutionalisation (Scott, 2008), on the one hand, and "epistemic justice" (Anderson, 2012),

on the other. Star offers a cyclical model (see Figure 7.1) in which existing boundary objects become standards, leaving new boundary objects to evolve from the "residual categories" of practices that are not encompassed by the original standards (Star, 2010, p. 615). I suggest there are two residues to emerge from the data regarding *Tomorrow's Doctors*: (1) the ostensible omission of a school-wide expectation of accountability to a local community (as advocated elsewhere (i.e. GCSA, 2010) and already enacted by Casterbridge Medical School); and (2) safety in clinical settings - which shapes a new incarnation of standards, *Promoting Excellent* (GMC 2016). It remains to be seen if participant C1 is right - that the revised standards in *Promoting Excellent* will - by virtue of their focus on the clinical space - convert undergraduate education itself, as an organisational field, into a fresh boundary residue, to be reshaped anew.

Figure 7.1. Relationships between standards and residual categories (adapted from Star, 2010, p615)



7.3 Expanding concepts: boundary agents, boundary work and boundary crossing

This study supports the proposition that public engagement acts as a boundary object: conforming to the fundamental notion of plasticity, and to the cyclical process by which boundary objects are transmogrified into standards in a professional field (as described in Chapter 3, Figure 3.2). I also suggest that that the one-sided nature of this project - a study of engagement (an essentially relational phenomenon) *only* from the educational side - has the advantage of making accessible concealed influences and processes at the boundaries *within* the cases (most notably in Anglebury Medical School and the regulator) and *between* cases (Stirling, 2007).

The boundaries identified include the self-evident structural boundaries between the organisational level of the medical schools, and the macro institutional level of the regulator. In addition, we can detect more metaphorical within-case *discontinuities* which arise from virtual spaces, or inter/intrapersonal interactions, that reflect sociocultural, epistemic and moral (or doxastic) challenges (Akkerman & Bakker, 2011, p.139 cited in Daskolia, 2014).

It is at the more tangible organisational–institutional boundaries (medical school-regulator) where I see the distinction between structures and agency most clearly. It is in the roles of C1 and C2 that the work of the boundary agent, and in a more complex way, that of the boundary spanner, is enacted. C2, in his role as a GMC quality visitor, was confident in taking the regulatory standards and reinterpreting their intention through the application of his own values (in his case, to be supportive) and meaning making (that is the use of his moral and epistemic agency). For example, the unworkable requirement - to gather feedback from patients - was left to one side while he encouraged greater engagement with lay representatives and the wider community, drawing from his own ethos, practical knowledge and experience (effectively a process of phronesis). As Coburn (2006, p. 344) says:

> *'Research on policy implementation suggests that local actors are also policymakers in that their decisions and actions shape how policies play out in practice. Sociological theories of sense-making provide evidence that local interpretation shapes the direction of policy implementation.'*

As a boundary spanner, working across a number of key organisations, (including at the invitation of the regulator) C1, has the potential to help align education policy, across national and international institutional structures, and again draws on her direct experience in the field.

Within the cases there are two powerful examples of frame conflict arising. Each can be attributed to discrepant or incommensurate *'thought styles'*. The epistemic differences, for example, between A5 (a scientist and academic lead for PPI at Anglebury) - with her knowledge based on personal illness experience - and her curriculum and administrative colleagues, create a boundary at which a significant amount of work was being undertaken. We also see here the way in which apparent structural and epistemic boundaries can be transcended - through the work of her colleagues A2, another scientist, and A3, a physician, who co-direct the medical undergraduate programme. Within the regulator, boundaries exist between the policy and quality assurance sections. In these examples a key factor is the

exercise of actual or perceived authority. When this is linked to an affective component, a sense of transgression may be powerfully experienced and provoke attempts to use either positional or epistemic authority to protect the boundary (Eddy Spicer and James, 2010; Welsh and Wynne, 2013).

7.4 Adding to theory: social epistemology and epistemic justice

The conflicts of "thought style", just discussed, lead to consideration of the value of the underlying conceptual framework in use. As mentioned in Chapter 4 and Appendix 12, critics of symbolic interactionism, and allied approaches, suggest it is relatively blind to power. I specifically chose the lens of social epistemology to foreground the role of knowledge and expertise, and it has served me well, allowing me to focus on the epistemic issues. However, the unequivocal role of authority and the use of control by different individuals and groups to facilitate or potentially impede public engagement - across knowledge groups *within* organisations, (medical schools and regulators alike) cannot be ignored. I have adopted the grid based model I originally encountered in a seminal text on patient-centred medicine (Stewart, Brown and Weston, 1995) to bring the potential effects of control arrangements back into the frame. Using the device shown in Table 7.1 we can broadly see which cell each schools' narratives were located it at the time of data gathering .

Table 7.1: Consequences of different possible control arrangements between professional and patient/public "communities" in a medical school (adapted from Stewart 1995)

		Professional/academic (esoteric)	
		High control	**Low control**
Public/Patient representatives (exoteric)	**High control**	**(I)** conflict or mutualism	**(III)** Consumerism or Empowerment
	Low control	**(II)** Paternalism *"Ils profitent" [**they** benefit]*	**(IV)** Default /chaos

Casterbridge Medical School, at least in intention, is using its careful procedures to create a more mutually beneficial and just institution, to locate arrangement in cell (I). To what extent the knowledge contribution of the exoteric community (the PPI reps) will be facilitated, rather than controlled by, the school's intensive screening and selection of representatives, remains, in my mind, a key question. Looking again at Table 7.1, is this arrangement one of mutualism, (I), or paternalism, (II) ?

The conflictual situation at Anglebury Medical School locates it in cell (I). A4 (the quality assurance manager) suggested that her colleague A5, the PPI lead, in trying to shift the balance of power, has not placed the boot on the other foot, but has *'taken the boot and hidden it.'* Within the terms of A5's rights-based frame, her role is to ensure that the PPI representatives are not merely co-opted into the organisational structure to satisfy a compliance need (cell II). The vignette (Chapter 6, Table 6.3) suggests that there is potential for the conflict to evolve into a mutually acceptable model, based on sharing knowledge and authority, but with the risk of it dissolving into chaos (IV). Reminiscent of the illustration in Arnstein's classic paper (reproduced in Figure 7.2 overleaf) A5 was not prepared to see her participation, as just a paternalistic opportunity for *"ils profitent*[74]*"* (see Figure 7.2 below). As she observed*:*

> *'We [the patient reps] can understand the fear because we're new [Anglebuty School] and the GMC is looking at us, and there was a feeling of having to address the GMC. We were saying "but we are better than that, we should be able to influence and inform and engage to say 'Look, PPI is this, it's not that'" ' . (A5)*

[74] I would suggest the French verb 'profiter' is better translated here as 'to benefit or gain advantage ' http://www.wordreference.com/enfr/profiter

Figure 7.2: Image[75] used to illustrate the subversion of the ladder of participation in Arnstien (1969: p220).

I suggest for a successful model of public engagement - at this (micro) organisational level (located in cell (I) Table 7.1) we connect insights from social epistemology, and Fleck's epistemic communities, with the notion of *epistemic justice*. My proposed idealised solution is encapsulated in the title of Tuckett et al's 1985 paper on the doctor-patient relationship: *'Meetings between experts'*. The essential ideas that underpin epistemic justice in medical/patient relationships are not new. Carel, writing in 2014, by reframing the *'meeting between experts'* as a quest for epistemic justice places, or elevates, it into the canon of social epistemology. The idea of valuing the special knowledge or expertise of other, is fundamental to the enactment of any cross disciplinary project, but more so in those that traverse significant social and epistemic boundaries such as public engagement and patient involvement:

> *'Boundary crossing can be also viewed as an ability for members of a community to put themselves in the shoes of another with respect to norms and epistemologies and vice versa, and to be explicit about their own as if they were members of a different community.' (Kynigos & Kalogeria, 2012).*

What I further suggest, is linking to Anderson's work (2012) on epistemic justice as an *institutional* goal. She argues that Fricker (and by extension Carel) are right to identify

[75] This was developed following the student unrest in Europe that erupted in Paris in 1968.

epistemic injustices arising at boundaries between those with different epistemologies or thought styles. According to Anderson epistemic injustice must not be conceived in terms of abstract epistemological analysis alone, but be sensitive to a socially situated account which acknowledges that human beings, as epistemic *agents*, *"who stand in relations of power to one another''* (Fricker, 2007, p. 3). Anderson extends the application of epistemic justice to organisational and institutional *structures* arguing they can facilitate - through their processes, ethos and governance - just relationships. I suggest this perspective would apply well to public engagement in general - which depends on structures and interactions at the level of the individual contact (in learning, between colleagues, and in the clinic), the organisation, and the overarching institution. This has interesting implications for medical school leaders in their pedagogical, governance and engagement choices. I would contend that my participants at Casterbridge Medical School, and to some extent Bramhurst, - reflect these ideas in their own framings of curriculum practice.

7.5 Implications for leader & regulators: framing and institutionalisation

Thus, just as leaders have options regarding their use of knowledge and authority, they also must be alert to how they manage the effect of regulation. We have seen that public engagement and patient involvement activities have become institutionalised through *Tomorrow's Doctors* 2009. My study confirms that this standardisation process exhibits key characteristics identified by Lampland and Star (2009) (see Chapter 3, Box 3.2); namely their implementation is distributed unevenly across the sociocultural landscape in a way that is relative to disciplines or communities of practice (well fitting in one, an impossible nightmare in another[76]). As Heimer noted (quoted in Quick, 2011, p6):

> *'Rules often work through mechanism of shifting peoples attention - these shifts sometimes lead to the intended result and sometime have quite different effect.'*

Public engagement standards aim to codify, embody, or prescribe values and as observed by Lampland (2009), and, as seen in my data, these can be framed as moral goals by some. It may be helpful for leaders and regulators to consider the complex, multidirectional interaction between different framings of received policy and standardisation more generally.

[76] In the case of *Tomorrow's Doctors 2009,* this may in part be due to the awkward phrasing - neither specific or measurable - and the focus on patient feedback which was always unachievable

Scott (2008 p442) writing about the three ingredients of *institutional order,* differentiates between*:* regulative (concerns for rules and sanctions); normative (aimed at attaining socially agreed goals); and culture-cognitive which emphasises *"the shared conceptions that constitute the nature of social reality and the frames through which meaning is made."* (Scott, 2008 p57). The application of boundary object theory and frame analysis has allowed me to unpick this triad. We can see how the cognitive-cultural order relates to social epistemology and influences what happens at micro level between knowledge communities, while the normative and regulative operate at the meso and macro level. Where the regulative *takes hold* at the micro level implementation may be "thinner" (Scott p 429), more superficial. Table7.2 further adapts the high/low control model taking into account Scott's typology. I suggest we see in the meta-concern for committee membership, evidence of medical school responses, especially at Anglebury, located in cell (II) - with a weak local grasp of what public engagement *could* be, dominated by a superficial concern with compliance.

Table 7.2: Consequences of different possible control arrangements between the regulator and medical schools (adapted from Stewart , 1995)

		Regulator	
		High control	**Low control**
Medical schools	**High control**	**(I)** Normative -Mutual understanding/ tension between social, pedagogical and policy/political agendas	**(III)** Cognitive-cultural Leadership Creativity / curriculum gaps due to other institutional frames
	Low control	**(II)** Regulative-Compliance / Superficial response to standards	**(IV)** Chaos / Space for commercialization

Scott goes on to say that where the cognitive-cultural logic prevails this is because key actors are driven, not through moral compulsion or fear of sanctions, but because they simply could *not conceive of acting in any other way* - a reflection of their identity or sense of self.

Combining this idea with Anderson's notion of the *epistemically just* organisation I would argue that Casterbridge Medical School and to some extent Bramhurst Medical School, pre-empted regulatory standards for public engagement. In C2 this was a curriculum wide project informed by ideas of a socially accountable school - as participant C2 said "*this is not just what we have to do, it is who we are.*" This clarity allows leaders at Casterbridge, to move between cells (I) and (II) in Figure 7.2 as they see appropriate to the context. Unlike in the USA (described in Chapter 2) GMC standards stopped short of prescribing an organisational role with regard to the host community - leaving local leaders to use their epistemic and positional authority in these relationships.

As would be expected from frame analysis across the institutional strata, it is at a macro level we see the *earliest* changes – influenced by wider rhetorical, political and discursive rearrangements. At the level of the canopy, the institution is more exposed to alterations in the prevailing climate than those on the forest floor. Thus, while the schools were still attending to the requirements of *Tomorrow's Doctors* the GMC officers were prioritising a different framing for their quality assurance and regulatory practices. Seemingly as a result of the Francis Inquiry, but following wider trends in civic engagement (Welsh & Wynne, 2013) the primacy of the rights of patients discourse is being subordinated to a risk-based frame motivated by the discourse of safety. This had in fact been incorporated into practice at Casterbridge Medical School due to its proximity to mid Staffs.

> *'How a policy problem is framed is important because it assigns responsibility and creates rationales that authorize some policy solutions and not others.' Coburn (2006: p343)*

7.6 Reflections on rigour & limitations: novel methodologies and methods

A major challenge in this research has been integrating the methodological perspective of symbolic interactionism, and the focus on social epistemology, with the dynamic theoretical model of the boundary object and the mechanics of frame analysis. The ideas of symbolic interactionism and social epistemology, drew my attention initially away from the inevitable issues of power to focus on the role of knowledge. It was necessary to analyse the clear effects of power and authority in the interactions under scrutiny, but the methodology ensured I saw them in context. Nonetheless it was hard to truly distinguish different thought styles as these tended to either overlap, sometimes obscured within a more general

organisational-institutional narrative. Boundary object theory proved a rich thinking tool – it gave me a structure for approaching both engagement and the development of regulatory standards.

With regard to methods, foremost is my use of the term case *studies*. The intention at the outset was to conduct studies that would triangulate and combine sources including interviews from the site participants and analysis of documents. As access to documents became limited (either because they did not exist or because I was denied permission) and the richness of my transcripts, and the work involved in frame analysis emerged, it became apparent my design had to be adapted. Thus they remain case studies in as much as undertaking the frame analysis with the transcripts of each case side-by-side, proved to be revealing and enriching, and allowed me to develop a convincing feel for each site.

Frame analysis proved to be an exceptionally demanding approach to analysis not least because a number of different strategies are advocated for approaching the data and displaying findings. After many doubts I feel confident that the frames identified are as true to the principles and spirit of both the method and the data I had to hand. For practical reasons I was unable to complete a verification exercise with the participants prior to completing the draft. One of my strategies for enhancing the narrative fidelity has been to use as many verbatim quotes as possible, as Creed et al (2002:p48) say:

> *'There are better or worse frame analyses in terms of the following: how richly they capture a frame; how deeply they peel away the layers; whether they initially move to present frames in ways that are recognizable and ring true to sponsors of the frame; whether the researchers' interrogation of their own perspective informs the analysis and gives readers further understanding and assurance that the analysis is not packing an ideology covertly; whether the ultimate exposure of contradictions or underlying logics elicits an "aha" from readers; and sometimes whether the frame analysis is a gateway to dialogue, action, policy, or change.'*

7.7 Summary: significance for professional education leadership and public sector regulation

The literature (and my experience) suggest that medical education is subject to a high level of formal regulation and informal accreditation - a phenomenon that appears to be under-researched and under-theorised. The implementation of public engagement and patient involvement has been studied widely (see for example Wilson et al 2015), as has the effects

of curriculum reform and regulation, especially in schools (see Ball (2003)). Although the GMC reviews its own process regularly (GMC, 2013; GMC, 2014; GMC, 2016; Wright and Associates, 2012) intended and unintended consequences are not well understood (Quick, 2011). The "struggle for guardianship" with which I set the scene in Chapter 1 is being played out in a complex landscape where regulation, civil society, and the market have (competing) interests regarding the quality and relevance of medical education.

Taking, what is in reality, a small fragment of a regulatory document as its starting point, this study brings a novel empirical and theoretical focus to a specific gap in otherwise well-researched fields. It contributes to an understanding of rarely analysed phenomena: the relationship between medical schools and their regulator; the impact of regulation; the relationship between medical schools and "outsiders"; and the dynamics of these interrelationships - from the perspective of medical school leaders and regulatory policy makers.

Engagement of the public and patients in healthcare, while exceptionally difficult to define encompasses many positive and virtuous practices. Its translation into the setting of the medical school is not straightforward and the introduction of regulatory standards may not have achieved what was intended. Furthermore, where the standards appear to be met this seems to be despite and not because of them, and hinged more on the local context and local actors. There is some evidence in my data that the GMC quality improvement framework (the combination of written standards and peer-led visits) at the very least was catalyst for discussion in schools, but also had the potential to provoke confusion, even tension - between compliant and creative interpretations.

How notions of public engagement and standards are developed and framed at institutional level proved a fascinating story from which wider lessons might be learned. These insights, and the methods used, could inform research, particularly at a time when the focus and approaches to governance have been revised (PSA, 2015) and the training and deployment of tomorrow's doctors is making headlines.

The key question is how might regulators and medical school leaders achieve a balance between the open, flexible account of patient and public engagement as a boundary object and the specification that is required when it is translated into a regulatory requirement? And how does this relate to the tectonic shifts in the social settlement laid out in Chapter 1 and 2?

The following is a very tentative summary of possible implications of this research. First, I focus on the regulator, recognising that some points have been addressed in recent changes to quality processes, and acknowledge the need for proportionate "right touch" regulation. It should be possible to utilize the cyclical process of standardisation described by Lampland (2009) (from flexible, informal practices to mandated regulation) when reviewing documents and procedures, and training visiting teams (as boundary agents). There could be greater recognition that not all emerging "good practice" - such as patient involvement and public engagement - lends its self to, or benefits from, articulation as a measurable standard but can nonetheless be helpfully promoted through a more open requirement (underscored by trust in school leaders). Medical education might benefit from regulatory practices that consider the pedagogic and organisational implications of seeking compliance in areas that rely on local autonomy and innovation and actively encourage more transformational curricula - where the competency model clearly does not enhance learning or professionalism. The use of flexible requirements may be essential in improving trust, patient safety and student agency by actively promoting *socially just* and engaged practices that address *organisational culture,* rather than individual practitioners/students. The GMC may seek to identify "residues" omitted from earlier standards as emergent areas (as they have effectively done in *Promoting Excellence,* GMC, 2016)- and therefore direct school leaders to voluntary codes and accreditation (such as ASPRE (AMEE, 2013a) and GCSA (2010)) to benchmark good practice against international consensus statements.

With regard to medical school leaders: the key here is their own agency and autonomy in interpreting and implementing standards on the one hand, and shaping their curricula on the other. Thus leaders need to provide (or co-construct) an account for themselves, for their own organisation, and to the regulator, that goes beyond compliance. With regard to public engagement, the challenge for leaders is balancing the individual needs/expectations of students (and the patients they encounter) with a more collective, socially oriented and accountable agenda - without immediate incentives - which may suggest a more moral enactment of leadership (Shale, 2012) (not easy - but perhaps urgent - in a complex politico-economic, healthcare and education environment). For leaders, aligning with international codes brings them into wider, networked, global communities of practice (Frenk, 2010;) as well as appealing to a bigger potential market (Ball 2012).

For higher education institutions - we already see some clear steps in the UK towards the engaged campus in the broadest cultural sense (NCCPE, 2016) and to embedding patient involvement in research (Wilson *et al.*, 2015). Translating this into medical education at large scale is possible (see the Manchester initiative) and may increase relevance to local healthcare need. However commitment and funding are required. Local community engagement may become a pragmatic and *just* way to offset pressure for income-generation through, for example, educational consultancy. How this will play out in private-for profit medical schools remains to be seen.

Finally there is a need for all stakeholders to fully harness the positive potential of civil society - as a vital "buffer zone" (Anheier, (2004)) - as discussed in Chapter 2 - in the complex process of governance - in tandem with formal regulatory structures, student experience, and informal declarations and projects. Furthermore, stakeholders could support further research into public engagement *and* standards - their interpretation (using methods such those used in this thesis) and implementation - (using realist methods such as Normalisation Process theory (May and Finch, 2009)).

Possible fruitful further research would divide into those building on the methodologies and those that develop the empirical understanding of public engagement and social governance. Frame analysis, rarely used in medical education, might be used to explore policy and media narratives (say around 7-day working and doctors' strikes); boundary objective theory may inform follow-up studies of new GMC standards and proposed voluntary accreditation of social accountability in the same or different settings; and finally there may be research opportunities linking epistemic justice with curriculum leadership.

This thesis captures a point in time but offers an original perspective that transcends the specific contexts of my medical education case studies: it adds to our understanding of the wider landscape of public sector leadership and regulation, and policy discourses, and the relationships between professions, their education, and civil society. It also contributes new insights into the role played by knowledge and authority in these processes. Overall, I suggest that the thesis makes a distinctive empirical contribution to the field, and is methodologically robust and original.

CHAPTER 8 CONCLUSION - HOW ARE WE BEING FRAMED ?

> *'You know the power of words. We pass through periods dominated by this or that word - it may be development, or it may be competition, or education, or purity or efficiency or even sanctity. It is the word of the time.' Conrad J. Chance, 1913.(cited in Heath, 2015).*

The word that started this thesis was 'engagement'. Time has moved on - the dominant word now, post Francis, appears to be 'safety.'[77] Public engagement seems to have lost currency, or is assumed to have been embedded through compliance.

I have found exploring engagement....engaging and arduous in equal measure. I believe I had immense good fortune to have been given such interesting and honest accounts of their endeavours by my participants. Most important now is to disseminate and share what I have learned from their generosity.

The process of frame analysis has genuinely changed the way I see, read and listen - framing is a powerful phenomenon, deserving our attention. Grappling with the idea of the boundary object is an interesting and enlightening challenge. Together these approaches have provided a focussed but deep insight into the application of knowledge and the use of regulation in one corner of modern society. The analysis in this thesis provides some idea of how theory may inform public engagement and patient involvement practice, and how standardisation might be better understood and judiciously applied. Both engagement and regulation remain important processes across reformed higher education, health and social care sectors, and therefore merit ongoing constructive and critical appraisal.

We can observe how, as discussed at the beginning of this work, services until recently understood to be in the public domain, fair in a changing world, always reshaped and reframed by relationships between the political, the civic and the professional (McFarlane in Strain, Barnett and Jarvis, 2009). To use the GMC's term, RCS, (reflecting contemporary society) - as the NHS shrinks a new rhetoric emerges. As I write, I see junior doctors' strikes and 80% of GPs wishing to resign. These are not responses to the wishes and perceptions of the public or individual patients but, it can be argued, to a highly managed reframing of the fundamental NHS covenant, to produce increased marketisation, but presented as strategies to improve safety and quality. The struggle for epistemic (and social) justice in healthcare,

[77] Writing last year, the word Iona Heath was referring to, using the quote above, was 'quality' - one that raises similar ontological and epistemological issues to both engagement and safety.

and hard won moves towards better collaboration and participation, are being subverted into a politicised conflictual dynamic through the deployment of a potent risk-safety framing. (Junior doctors are being framed: workshy and irresponsible, putting patients at risk by not embracing a 7 day NHS, etc).

It is, as yet, unclear, how we, in the institution of medical education (regulators and educators), can in our turn reframe and reconcile the focus on the doctor-to-be with a focus on the individual patient, and on the wider collective health needs of an increasingly unequal society. In this new framing of arrangements, where is the balance between knowledge and power?

On a more positive note, the regulator's gaze is turning (probably quite appropriately), to the clinical environment, and the burden of surveillance on medical schools is becoming more 'right-touch'. Leaders may be freer to foster diversity across the field. Creative approaches to public engagement may fare well when the pressure to *comply* recedes. We should see the green shoots rising from the residue of the earlier standards. Will there be more, like Casterbridge Medical School, in the story I have told, designing engaging and socially accountable curricula? This research suggests that the framing of regulatory standards will continue to be a revised by shifting discursive rationales. Being alert to ways in which our endeavours are framed (by us and by ourselves), provides new ways for educators and regulators to use better the opportunities we have to improve the training of tomorrow's doctors.

"We must cultivate our garden."

Candide, Voltaire[78]

[78] Candide (Voltaire, 1759) http://www.gutenberg.org/cache/epub/19942/pg19942.txt

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Appendix 1 Extracts from GMC documents: Tomorrow's Doctors & Supplementary Advice

Box 1. Standards for Public Engagement in *Tomorrow's Doctors* GMC, **(GMC, 2009)**

Domain 2 – Quality assurance, review and evaluation (my emphasis)

43 Quality data will include:
(a) evaluations by students and data from medical school teachers and other education providers about placements, resources and assessment outcomes
(b) feedback from patients
(c) feedback from employers about the preparedness of graduates.

48 Apart from the medical school officers and committees, all education providers of clinical placements, and all clinical tutors and supervisors, students, employers and patients should be involved in quality management and control processes. Their roles must be defined and information made available to them about this.

51 There must be procedures in place to check the quality of teaching, learning and assessment, including that in clinical/vocational placements, and to ensure that standards are being maintained. These must be monitored through a number of different systems, including student and patient feedback, and reviews of teaching by peers.

Domain 5 - Design and delivery of the curriculum, including assessment

111 Students must receive regular information about their development and progress. This should include feedback on both formative and summative assessments. Clinical logbooks and personal portfolios, which allow students to identify strengths and weaknesses and to focus their learning, can provide this information. Using these will emphasise the importance of maintaining a portfolio of evidence of achievement, which will be necessary once they have become doctors and their licence to practise is regularly revalidated. All doctors, other health and social care workers, patients and carers who come into contact with the student should have an opportunity to provide constructive feedback about their performance. Feedback about performance in assessments helps to identify strengths and weaknesses, both in students and in the curriculum, and this allows changes to be made

Tomorrow's Doctors. London; (GMC, 2009)[paragraph numbers in bold]

Box A1.2: Summary from Patient and Public Involvement In Undergraduate Medical Education: Advice Supplementary to *Tomorrow's Doctors* 2009. (GMC, 2011a)

Box 3 Theme 2: Educational governance

Purpose This theme is about making sure that organisations have effective systems of educational governance to manage and control the quality of medical education and training.

- **Responsibility** Medical schools (and the universities of which they are a part) manage and control the quality of their primary medical qualifications (PMQ). They make sure LEPs appropriately educate their medical students.
- **Standards** S2.1 The educational governance system continuously improves the quality and outcomes of education and training by measuring performance against our standards, demonstrating accountability, and responding when standards are not being met.
- **Requirements R2.3** Organisations must consider the impact of policies, systems or processes on learners. They must take account of the views of learners, trainers, local faculty and, where appropriate, patients, the public, and employers.

What Tomorrow's Doctors says about patient and public involvement

8 The idea of putting patients at the heart of healthcare and learning to work in partnership with patients permeates *Tomorrow's Doctors* (2009). It requires early and continuing student contact with patients (paragraphs 84 and 103–105 of *Tomorrow's Doctors* (2009)).

9 Additionally, *Tomorrow's Doctors* (2009) fosters a culture which enables patients and the public to contribute actively to the educational processes. It calls for systems which give patients an opportunity to feed back on the quality of teaching, learning and assessment as well as individual students' performance.

10 Specifically, patient input is sought in Domain 2 of the 'Standards for the delivery of teaching, learning and assessment'. The overarching standard requires systematic monitoring, review and evaluation of the quality of medical education programmes, based on quality data including feedback from patients as well as students, teachers and employers (paragraphs 38and 43(b)).

13. ...examples of specific areas of medical education where patients and the public could be directly involved, [include] student selection, teaching, feedback and assessment, curriculum and assessment development and, finally, quality processes and governance.

[paragraph numbers in bold]

Appendix 2 GMC's Role in Education & Quality Improvement Framework

'We promote high standards and make sure that medical education and training reflect the needs of patients, medical students and doctors in training, and the healthcare systems across the UK.'http://www.gmc-uk.org/education/27007.asp (accessed 1 Jan 2016)

Approval processes

The GMC is the sole authority responsible for the approval of bodies awarding UK medical degrees. Approval at undergraduate level relates to:

(a) the process through which new, merging or de-merging institutions are quality assured and recognised by the GMC and added to the list of bodies able to issue UK PMQs

(b) the continued approval of bodies able to issue UK PMQs through annual reporting and the visit process, and by the approval by the GMC of any major changes. Approval of curricula and their associated assessment systems is against the standards and outcomes of *Tomorrow's Doctors* (2009) and through the other elements of the Quality Improvement Framework (QIF). These include the evidence base, visits and responses to concerns.

GMC QA Visits and Annual Returns (during the time to this study)

- The GMC periodically visits to medical schools to verify schools' compliance with *Tomorrow's Doctors* (2009), particularly in areas where new standards differ significantly from the previous edition.
- Visits also address schools' quality management (QM) of clinical placements and student assistantships within education providers and inform or combines with postgraduate visits.
- New and de-merging schools are visited annually. Annual returns from established schools focusing on themes such as risk , raising concerns, standards for curricula and assessment systems.

Composition of GMC visit teams

The visitor teams for the 2011-2012 pilot visit will always include a team leader, a member with direct medical school or deanery experience, a student or trainee and a lay member. The GMC and team leader will agree, dependent on the risks identified for exploration, the skills and experience required of the remaining team members. The pool of visitors available will include:

(a) medical educationalists
(b) medical specialists
(c) foundation training programme directors (or equivalent)
(d) employers
(e) specialty trainees
(f) foundation doctors
(g) medical students
(h) lay members.

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The table below describes the GMC's role at different stages - the education and training continuum http://www.gmc-uk.org/education/27007.asp (accessed 1 Jan 2016)

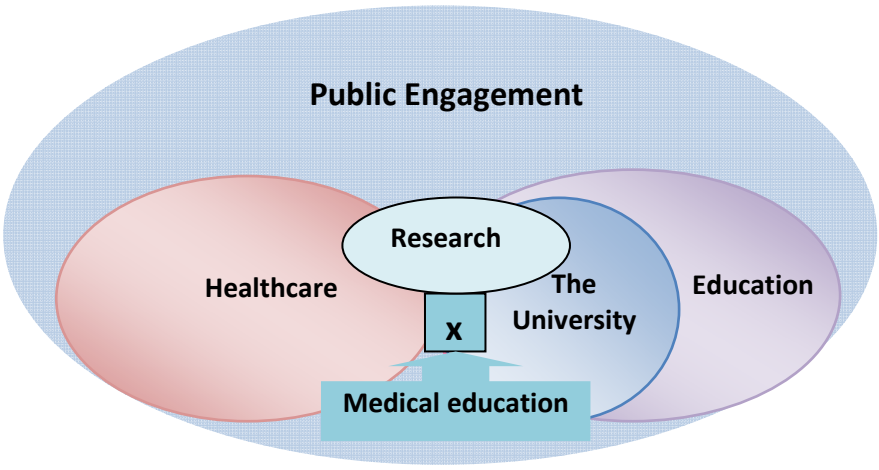
	Selection into medical school	Medical school years	Foundation training	Specialty training
Context	Around **100,000 applicants** apply for a place at medical school each year. Only around **6,000 are chosen**.	There are **41,000 medical students** at the UK's 31 medical schools. Degree courses last between four and six years.	The Foundation Programme is a **two year training** programme for doctors after leaving medical school. There are around **15,000 doctors** on the programme currently.	After Foundation training mos doctors enter specialty trainin There are over **100 specialties** and sub-specialty courses. There are around **40,000 doct** doing speciality or GP training in the UK.
Our role	We set the standards that medical schools have to meet. We say selection methods must be 'open, objective and fair'.	We set the standards around the education medical students receive. These include: ▪ the standards medical schools must meet in teaching and assessing students ▪ the skills and behaviours students must have learned to complete the course. We monitor and check to make sure these standards are maintained. Ultimately it's our job to decide if a university should be allowed to issue medical degrees.	We set the standards for the programme, including the level the doctor must reach by the end of the two years, and we approve the curriculum. We monitor and check to make sure the standards we set are maintained.	We set the standards which training organisations must mee and the standards that doctors in training must reach by the end of training. Our role includes approving th curricula for each training programme. We monitor and check to mak sure the standards we set are maintained., One way we do t is by conducting a comprehen survey of all doctors in trainin each year.
The role of others		Medical schools set the curricula and provide the education to medical students. Degree courses last between four and six years.	Medical graduates have to apply to regional postgraduate training bodies called deaneries – or in England, local education training boards (LETBs). They co-ordinate, supervise and monitor individual doctors' progress. The curriculum for the Foundation Programme is developed by the Academy of Medical Royal Colleges.	The UK's Medical Royal Colleg and Faculties set the curriculu for specialty and GP training courses. Deaneries and LETBs manage t delivery of specialty training. Trainees receive training at approved hospitals, clinics and GP surgeries.

Appendix 3 Search Strategy

Public engagement has invited attention from many angles: public policy, politics, popular journalism, and research in philosophy and the social, and economic sciences. The review presented here is based largely, but not exclusively, on academic literature. Much is discursive, theoretical, or descriptive, with a relative lack of empirical work of direct relevance. Possible reasons for this are considered. I also consider prescriptive and aspirational works in the form of reports, policies, strategies, and declarations of bearing to the framing of public engagement.

My full literature review considers the literature at the intersection between these two areas - healthcare and higher education, adjacent to my field of interest, the medical school (denoted by an ***X*** in figure A3.1).

Figure A3.1: The focus of interest (x) - overview of the literature searched



Dealing with the multiple, overlapping terminological couplings required repeated, systematic searches. The key search terms combined the two components of a coupling (eg. public + engagement) with an institution or setting. The combinations used in the literature vary according to setting with an inconsistent tendency for one form to dominate (Table 2.1) - therefore searches were rerun combining each coupling. I systematically included

publications in English from UK, Australia, New Zealand, Canada and the USA. The English speaking Commonwealth countries share many characteristics of healthcare and medical education; the literature from USA, despite many contextual differences, emerges as a point of reference in the UK literature and in my data. Electronic databases were searched in 2011 including PubMed, Education Resources Information Center (ERIC) and the British Education Index (BEI), going back to 1965 and then updated in 2014-15 and in January 2016. I ran the same searches in Google, Google Scholar, Web of Science, Directory of Open Access Journals (DOAJ), ETHOS (the repository of theses) and UCL library search engine, Explore. I searched websites pertaining to key organisations associated with public engagement in education and healthcare notably the Picker institute, (2015), the public participation think tank, "*involve*" (2015a), the National Advisory Group on Public Involvement in the NHS, INVOLVE (2015b) and the National Co-ordinating Centre for Public Engagement in Universities (NCCPE, 2015). Keywords used are summarised in Box 2.2. After initial triage items were stored in Endnote bibliographic manager.

Terminological couplings: Search strategy, etymology & a working definition

As Benhabib (1992), and Towle (2010) suggest, the literature forms a web of overlapping terms and concepts which cannot realistically be fully unravelled. I am aware, nonetheless, that choice of terms (mine included) aligns with particular traditions and communicates certain standpoints. Ideas of what (and where) *the public* are or what a *patient is* in medical education are central to this study, as are notions of how, and with what, they may be involved or engaged. Core to understanding the field, is the recognition that public engagement and allied terms refer to a "relationship" – between an institution (including the individuals therein) and those that are served by it. The literature logically and largely assumes a two sided relationship generally perceived from the institutional side.

Box A3.1: Keywords used in searches

Couplings				Setting	Governance[#]
Public Civil / Civic Citizen Lay Community Social Patient /carer User	**&**	Involvement[$] Participation[$] Engagement[$]	**In** *or* **with**	*Medical education*[#] } & *Medical school*[#] Health professional education University Higher education Campus Research	*Standards* *Regulation* *Policy/diffusion* *Leadership** *Quality assurance* *Social Accountability* *Social Responsibility*

KEY

$ these terms were also searched with truncated stem and $ - such as particpat$, engage$, and involve$
* For the literature review on leadership of medical schools I updated the review I undertook for my IFS submitted for an earlier part of the EdD programme
# Searches related to governance were only combined with medical education and medical school, not the other sectors

Terminological couplings: Search strategy, etymology & a working definition

As Benhabib (1992), and Towle (2010) suggest, the literature forms a web of overlapping terms and concepts which cannot realistically be fully unravelled. I am aware, nonetheless, that choice of terms (mine included) aligns with particular traditions and communicates certain standpoints. Ideas of what (and where) *the public* are or what a *patient* *is* in medical education are central to this study. as are notions of how, and with what, they may be involved or engaged. Core to understanding the field is the recognition that public engagement and allied terms refer to a "relationship". The literature logically and largely assumes a two sided relationship generally perceived from the institutional side (see Figure 2.1)

Two initial issues arise from this collection of near synonyms. First, the challenges of undertaking, and then sustaining, an up-to-date literature review. Dealing with the multiple, overlapping terminological couplings required repeated, systematic searches. - explained fully in Appendix 3. Secondly, the need, for ease of reading, to settle on a limited set of terms. From table 2.1 it can be seen the most common term in the settings of interest are *public engagement* (which I will use in full) and *patient and public involvement*, which I will use where directly appropriate, with the abbreviation *PPI*.

Table A3.2: The most widely used combinations by setting

Terminological couplings (Abbreviation)	Setting	
Public engagement (PE)	Higher Education	Healey (2010); Facer, Manners and Agusita (2012)
Civic engagement	Higher Education	Watson *et al.* (2011) + McIlraith, Lyons and Munck (2012)
Patient and public involvement (PPI)	Healthcare & healthcare research	Ocloo and Fulop (2011); Tritter (2014), RaPPORT (Wilson *et al.*, 2015)
Patient participation	Healthcare (especially general practice)	National Association for Patient Participation
User, lay and/or carer participation	Health and social care	
Client engagement	Health and social care (especially mental health)	
Patient and public involvement Public engagement User or lay participation	Medical education	GMC (2011a); Towle *et al.* (2010), , Jha et al (2009b)

While consideration of etymology is key to the literature search it is also a *product* of that search. A discussion the key terms is of relevance because their changing meanings over time(Adler and Goggin, 2005).The way in which terms have come to coexist provides the base on which my review and synthesis of the literature sits. Facer, Manners and Agusita (2012, p. 3), in their literature review of public engagement in research, state that the question of terminology 'bedevils the field'. Research orthodoxy suggests it is incumbent upon me to provide a clear definition of the terms I am using (public engagement and PPI). However, I resist this and accept possible opprobrium:

> *'Imprecise definition of key terms in the "public participation" domain have hindered the conduct of good research and militated against the development and implementation of effective participation practices.' (Rowe and Frewer, 2005)p 251*

It is precisely this imprecision that is of interest to me. As Parry *et al.* (2012) observe, writing about their work with the public on stem cell research:

> *'...these weakly structured heterogeneous visions enable public engagement to operate at a site where diverse actors with diverse interests and agendas can come together and achieve something which all find meaningful, albeit in diverse ways.'*

It is important that the term remains "weakly structured" (a so called boundary object (Star and Griesemer, 1989)) to encompass all theoretical perspectives and accommodate their diverse, coexistent manifestations in my field of interest. Exploring this pluralism is a key *object* of my study, incorporated in the interview topic guide and pursued in the data analysis.

Appendix 4 Spheres of influence and the dynamics of engagement - a detailed review

Introduction

This appendix provides a more in depth analysis of literature exploring the ideas of civil society and the dynamics of public engagement. The relationship between state, market and society (introduced in Chapter 1) is a central preoccupation of social, political and economic theory of the 150 years and underpins public engagement practice and research . It is not feasible to attempt to properly reprise the major discourses on this relationship which can be traced back through the philosophy of Hegel, Weber, Marx , and Gramsci (Anheier, 2004; Fleming, 2000; Keane, 1988; Wildemeersch, Biesta and De Bie, 2014). These give rise to contemporary understanding of participatory democracy (Fleming, 2000). Nonetheless, some reference is necessary to set the scene for the rest of the chapter and indeed thesis itself. In simple terms the settlement comprises three components held in a dynamic relationship. Two terms for the societal component of this trinity dominate the literature: the public sphere and civil society. They have become intertwined and at times used as synonyms. Depending on the philosophical genealogy an author aligns with the two terms imply different etymologies. They may coexist, one may precede or preclude the other, or - most commonly - one is a subset of the other. Fleming provides an idealised summary locating the public sphere within civil society:

> *'The public sphere is located in civil society and is where people can discuss matters of mutual concern as peers, ...in an atmosphere free of coercion or inequalities that would incline individuals to acquiesce or be silent.' Fleming (2000 no page)*

Most authors agree that the modern notion of the public sphere originates from the work of Habermas(see for example Anheier, 2004; Fleming, 2000; Flyvbjerg, 1998; Fraser, 1990; Keane, 1988; Wildemeersch, Biesta and De Bie, 2014).. Delli Carpini (2005) defines civil society as : *"Societal institutions that are not part of the official state/governmental apparatus (polity) and that structure private (e.g., family) and public (e.g., religion) life." (*No page). Keane (1988) observed 25 years ago that the separation of state from market is a key

characteristic of modernity. However it is the state/civil society axis on which he focuses. He identifies a set of gatekeepers of the state/civil society boundary which include professional organizations and institutions such as universities, healthcare services , and the courts.

Keane ascribes the revival in interest in state/civil society relations in the late 20th century, in part, to the collapse of totalitarian regimes in some regions. In the USA and western Europe scholarly examinations have focused on the reshaping of the public sphere through the social movements of the 1960s and 70s. The development of a large post-war welfare state notably in the UK led to what Keane referred to a "magma" of overlapping hybrid institutions which, due to the size and reach of public services, blurred but did not dissolve, the state/civil society boundaries. (In fact a fusion between civil society and state to form the "regulated society" is Gramsci's ultimate goal (Keane, 1988) p 22.) As he concluded, modern civil societies comprise "a constellation of juxtaposed and changing elements that resist reduction to a common nominator, an essential core…" p15

Anheier (2004) and Edwards (2014) describe how it is now the distinction between state and market that has become blurred with important implications for the role of civil society within the trinity. Economic restructuring, reduction of public services and of welfare support has left a vacuum - a space between the state and the market - into which private-for-profit organisations can expand and so-called third sector providers emerge. This is of major significance to both higher education and healthcare in the UK - with indirect effects on medical education. The trend draws our attention to a revised dynamic of the shrinking state, the expansion of the economic sphere through growing commodification of services, on the one hand, and an array of nongovernmental and social enterprise organisations filling the gaps - arising from within civil society[79].

As Goddard (2009) contends in this new configuration the role of civil society expands , the public sphere is strengthened - to hold the state and the markets to account. This potential strengthening has been assigned, by scholars, two broad interpretations (Anheier, 2004; Gaventa and Pettit, 2010). In the first civil society has a neo-conservative role in supporting and endorsing the emergence of new civic institutions which straddle the state and the

[79] Anheier (2004) is at pains to stress that the third sector arises from and overlaps with civil society, but is not synonymous with it ." *Nor is it identical to the non-profit sector, or other terms like third, voluntary or NGO sectors, however defined. The third sector and civil society overlap in terms of organisations, and it would be fair to say that civil society includes large parts of the third sector, even though some non-profit organisations can be close to market firms or state agencies in constitution and behaviour."*

market: "*fundamentally reducing the role of politics in society by expanding free markets and individual liberty*" (the Cato Institute cited in Edwards, 2014). Despite the smaller state, government nonetheless exerts control - directly or via proxies - through tighter scrutiny and governance often citing concerns regarding safety and probity as justification (particularly so in healthcare - see next section). The role of civil society maybe is radical, even transformative, - to challenge from without, build civic capacity and articulate new ideas . The gatekeeper organisations thus assume more complex roles with regard to engaging with civil society (Facer, Manners and Agusita, 2012; Watson *et al.*, 2011). Institutions acquire, commission and sponsor their own publics choosing how they frame their relationships in their context . The blurring of the boundaries between the spheres requires adjustments in the dynamics. These arrangements raises questions regarding who are the purveyors of institutional social accountability and responsibility - state, market or civil society.

In summary, civil society scholarship is wide ranging although (or perhaps because) it lacks a single definition, the concept is plastic and continues to evolve (Anheier, 2004). It is essentially concerned with distinctions between state apparatuses, economic markets, and public discourse. These distinctions, however imprecise and contested, are key to understanding contemporary democratic theory and processes (Fraser, 1990) of which public engagement is an essential element (Delli Carpini, Cook and Jacobs, 2004). As Edwards (2014) concludes:

> *'...it is precisely its flexibility and openness that makes it useful as a framework for exploring the great questions of the day, a function civil society has performed since the days of the Ancient Greeks.'*

The literature deals with three dimensions of civil society: the space (where) ; the actors (who), and the purposes and processes (why and how).

2. Where

Habermas (1962) conceives of discursive spaces in which debate takes place that effectively shapes, indeed even regulates, political, economic and cultural processes outside the state and market. Questions about Habermas arise as to whether these spaces are real and public (such as a café or the street (Hauser, 1998), or private (i.e. the home (Benhabib, 1992; Cohen and Arato, 1992)) and virtual spaces such as broadcast and social media (Delli Carpini, Cook and Jacobs, 2004). For Wildemeersch, Biesta and De Bie (2014) the "public" is a space for a particular type of relationship in which the individual political , rather than social, identity is fostered:

> *'Public relationships are in this sense different from private relationships of family and kinship, but also from economic relationships of transaction and exchange.' p.xiv*

This rather rigid distinctions have invited critiques from feminists (many traditional civil associations are male dominated; why are home and family excluded? (Benhabib, 1992; Fraser, 1990), and anthropologists, as being predicated on fundamentally (western) ethnocentric view of society and culture (Hann and Dunn, 1996). Nonetheless, they flag up the link between locus, discourse, knowledge creation and identity formation - individual and collective.

3. Who

With regard to terminology in the literature the most revealing are the specific prefixes chosen by authors to describe the members of their relevant public or indeed publics. The terms that authors and the institutions select (lay person, citizen , consumer, stakeholder, patient, activists etc) may signal - deliberately or unconsciously - political and philosophical allegiances. Cohen and Arato (1992) describe the *who* of civil society thus:

> *a sphere of interaction between economy and state, composed above all of the intimate sphere (especially the family), the sphere of associations (especially voluntary organisations), social movements, and forms of public communication (1992, p. ix).*

Within this description we can identify all the individuals and collectives, (the societies, community groups, voluntary associations, patient representative forums, campaigns, lobbying networks etc) that constitute the public side of public engagement. Hauser (1998) and May (2007) argue that there is often no single public - but many publics that are recruited by institutions or emerge and coalesce for a time, at different levels around specific concerns. The potential constituents - individual and collective in healthcare and education are considered in Part 2. For now a line on the fundamental effects of 'new managerialism' and the reframing of citizens in receipt of public services as consumers - customers or owners (Osborne & Gaebler, 1992). For customers the onus is on the service to satisfy needs and wants efficiently; owners however might expect a stake in setting direction. In this market model individuals are unlikely to represent the community, as de facto they speak for themselves and their own self interest as shareholders thus diminishing , even obviating, at least in theory, a role for civil society (Barzelay, 2001).

4. The role of the civil society and the dynamics of engagement

In addition to its contested locations and multiple constituents civil society is seen as serving widely differing purposes. It provides support for the political processes that, on the one hand, shape and sustain the state and the provision of public services - aimed primarily at increasing responsiveness to public needs/wants and reducing inequalities, while, on the other, its purpose is to facilitate the reduction of state provision (and responsibility) to allow expansion of the market. Anheier summarises this succinctly:

> *'The prevailing modern view sees civil society as a sphere located between state and market--a buffer zone strong enough to keep both state and market in check, thereby preventing each from becoming too powerful and dominating.' Anheier (2004) p1*

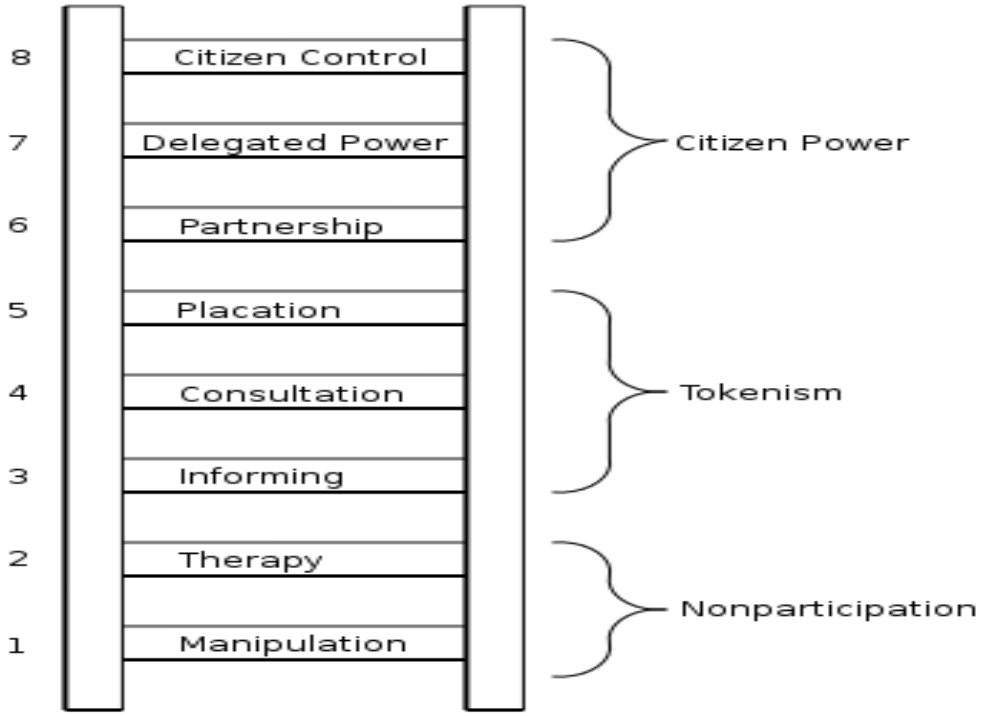
It is largely through the processes of participation, involvement and engagement that this buffering and accountability - across these "dual purposes" (Gibson, Britten and Lynch, 2012) is expected to be enacted and to which I turn now. As Ramaley (in Adler and Goggin, 2005) notes

> *' [how] engagement is defined depends on the perspective and interests of the definer. What is striking is how wide the range of definitions for the term is. When looked at*

together, these definitions help suggest the extent and variety of activities that the term encompasses and help to illuminate the various points of view about the concept.'

By far the most cited framework for public engagement or “citizen participation” is Sherry Arnstein’s (Arnstein, 1969; Conklin, Morris and Nolte, 2015; Innes and Booher, 2004; May, 2007; Rowe and Frewer, 2005). This uses a ladder metaphor - framed around citizen empowerment (Figure A.4.1). The bottom rungs, "non-participation", are described as surrogates for genuine engagement simply aimed at informing, "educating" or even "curing" participants. "Tokenism" allows the public to hear and to have a voice without a guarantee of being heard themselves or of making a difference. Increasing empowerment leads to partnership and ultimately control

Figure A4.1 Arnstein’s Ladder of Citizen Participation (Arnstein, 1969, p. 60)



This seminal work also forms part of a broad-based scholarship of social movements and is based on Arnstein's work in urban regeneration in the United States of the 1960s involving large urban movements pressing for civil rights, fair access to housing, and economic justice.

Arnstein foregrounds the struggle for power inherent in public engagement and the overt and covert ways in which the deal between the public and institutional sides are brokered (Litvia, 2009; Landzelius (Landzelius, 2006). Tritter and McCallum (2006) while recognising the central importance of power stress the limitations of the ladder as a rigid two dimensional linear model, with missing rungs, which ignores the potential of including the use, even the production of forms of knowledge and expertise through engagement. Arnstein's paper remains the antecedent to other widely cited ladder models, notably Towle et al's regarding medical education (2010) and foregrounds the ongoing relevance of social movement scholarship to public engagement research, with its highly contemporary significance (della Porta, 2015).

5. Defining the engagement relationship: to share, to consult, to serve, or to transform

Having considered the terminological options for the public-side of the equation here I consider the adjectives available to describe the relationship. They all have their roots in participatory democracy (Wildemeersch, Biesta and De Bie, 2014) but with different implied means and ends - broadly speaking: consultation, endorsement, service, community development, and/or radical transformation. In the literature and in practice, involvement, participation and engagement convey similar ideas (Charles and DeMaio, 1993) and are often used interchangeably, as this sentence from Rowe and Frewer (2005) illustrates:

> *'.. there has been an international trend toward increased involvement of the public in the affairs and decisions of policy-setting bodies—a concept that is frequently referred to as public participation.'*

Nonetheless usage of these terms may vary in deliberate attempts to specify the dynamics and power gradients of the relationship (Gibson, Britten and Lynch, 2012) – whether this be predominantly “push out” or ”pull in” from the institutional side to the public side or vice versa, or something suggesting greater partnership.

The literature identifies, broadly, three fields of thought and empirical research.

(i) institutional needs and intentions - Pull-in/Push out

The first has, as its starting point, institutional needs and intentions and arises largely from fields of science and technology (Data; Parry; Stirling) healthcare (Tritter, Landzelius, Ocloo & Fulop;) development (UNDP) and planning (Innes) inter alia. This work is associated with the terms *involvement* and *participation* and is premised on the idea that the public sphere is needed to fill an institutional deficit (Stirling, 2007) (Datta, 2011); Rowe and Frewer (2005) Clark, 2007) and thus, to address the "crisis of legitimation" - improve trust and relevance.

Despite often taking Arnstein as a starting point and acknowledging that these forms of engagement result from pressure from social movements and activists much of this literature is relatively de-politicised. It includes non-participative institutional processes of communicating and informing, and participative "forming dialogues" that seek active shaping and endorsement of institutional policy. They are often aimed at endorsing service reform, and developing research. In general issues of power are not acknowledged or addressed - as the institution decides who participates and how.

Authors disagree on the exact meaning of words: for example Bovaird (2007) states engagement encompasses involvement and participation intended to denote meaningful, equally respected, effective dialogue between the involved parties towards achieving mutually defined goals. Gibson, Britten and Lynch (2012) deride engagement as a "cosy" word with passive connotations. Regardless of the semantic hair-splitting this first body of literature expresses relationships in which the institution is leading, commissioning and sponsoring the process with their corresponding “public side” that can be summarised as:

'A dualist approach, combining ideologies of democratic participative public engagement with an economically motivated ‘consumerist approach’ aiming at greater efficiency.' (Stirling, 2007)

(ii) The public perspective and public good

The second body of work, while also rooted in the notions of civil society, arises from a very different scholarly tradition and uses the term civic engagement. It appears frequently in the higher education and youth education literature but has assumed a much boarder currency drawing on the work of Putnam and ideas of social capital (Putnam, 1993; Hallberg and Lund in Watson *et al.*, 2011). In this reading engagement is viewed from the public perspective with the broad goal of the pursuit of public good at the expense of individual and private ends.

"Civic engagement may be defined as the means by which an individual, through collective action, influences the larger civil society" (Van Benshoten, 2001p)

This is rooted in the idea of civic virtue and sustaining democracy, and the literature is skewed to the USA, derived from the ideas of de Tocqueville (Macfarlane, 2000) on the importance of social collaboration and the benefits of an *associative* life. Diller Diller (2001) simply defines civic engagement as :

'Experiencing a sense of connection, inter-relatedness and, naturally, commitment to the greater community' (Diller, p10)

In their lucid review Adler and Goggin (2005) acknowledge that the range of interpretation arises from different philosophical conceptualisations of citizenship. They provide a taxonomy of four more or less distinct usages. Civic engagement can be framed as: community service; collective action; political involvement; and social change and transformation. Importantly here the sponsoring institutions are seen more as part of the community, their staff and especially their students, enact engagement across the institutional /civil society boundary through benign, benevolent processes (such as sharing resources or providing pro bono services) (Peters, 2010) or activities of mutual benefit (such as service learning) (Calleson, Jordan and Seifer, 2005; McIlraith, Lyons and Munck, 2012). This literature has considerable importance to development of public engagement in medical education in the UK.

(iii) Co-construction

The third literature arises largely from critiques of public engagement and empirical evidence regarding the limitations of the first two interpretations. It focuses on the goal of social change and transformation through the process of co-construction of the agenda and goals and co-production of the outcomes. These articulations frame public engagement as bidirectional underpinned by an explicit concern for justice and equality. In this framing the intention is transformative, even emancipatory (Gibson, Britten and Lynch, 2012; UNDP, 2013): to produce social change and increase institutional accountability to the community. Transformation through engagement affects both institution, its relevant publics (individually and collectively) and the relationship between the two (UNDP, 2013). This can be seen as a continuation of the more politicised conception of engagement, which we can trace back to Arnstein and is centrally concerned with issues of agency.

Critics have written despairingly from all the sectors about the perennial challenges of public engagement, summarised in Box A4.1 (Bovaird, 2007; Innes and Booher, 2004; Nelkin, 1979; Tritter and Koivusalo, 2013; UNDP, 2012); others are more positive regarding civic capabilities and aspirations (Benhabib, 1992; Innes and Booher, 2004; Wilson *et al.*, 2015). Some theorists argue that engagement is unworkable in the modern bureaucratic state (Dahl, 1989); the broad, but shallow, interests of citizens will always be trumped by the narrow, deep interests of institutions - through greater knowledge or power. Some suggest the whole public engagement project is doomed at worst (Olson, 1965 - in Innes), utopian at best (Gibson, Britten and Lynch, 2012).

Box A4.1: Common challenges to public engagement (my summary from literature reviewed)

Purposes

- Co-option of the public for institutional ends
- Conflicting agendas and personal motivation
- Focus on instrumental concerns of risk or cost benefits
- Fulfilling a regulatory requirement or institutional marketing strategy
- Endorsement of existing policy without involvement in design and innovation

Processes

- Establishing and reviewing “rules-of-engagement”

- Experts/institutions frame and control '*the deal*' and the process
- Information asymmetry - personal knowledge versus professional expertise
- Use of terminology and jargon
- Managing group dynamics (personalities or power imbalances)
- Administration and resources

Participants

- The "usual suspects" - groups that already have influence are often the only ones consulted
- Representativeness and diversity – especially rarely-reached, marginalised groups
- Recruitment and selection - how and by whom
- Briefing, training, & support - inadequate processes

Outcomes

- Acceptance or commitment to outcomes in rigid institutional cultures and hierarchies
- Failing to act on outcomes and failing to respond to feedback

The literature reveals a trend towards written public engagement norms and guidelines, intended to apply evidence of benefits, minimise risks , and overcome challenges. This follows the general increase in regulation and accreditation - described in Chapter 1 page 14. Attempts to codify and institutionalise engagement may arise from pressure from civil society itself - through community activism, social movements and patient pressure groups. But this formalisation may be a '*flight **to** empiricism*' (Gibson, Britten and Lynch, 2012, p. 535) reflecting search for safe, institutionally defined , divorcing engagement from messier, risky concepts such as politics, justice and ideology (Bartels, 2013). It is striking that - despite (or perhaps because of) attempts to advance public engagement through institutionalisation - it remains so challenging for the public, professionals, and institutions. Tritter (2009) suggests a rights-based approach, rather than normative, regulatory or mere instrumental ones, may be preferable for all. The inquiry led by Francis (2013b) into avoidable deaths at mid Staffordshire NHS Hospital Trust[80] was a painful indictment of all the possible failures of formalised public engagement - and at the same time - an endorsement of the potential of the determined public voice :

> *...patients' voices were ... not heard by the local bodies that should have been representing them, including the patient and public involvement forum (PPIF) and the overview and scrutiny committee of the local authority. The failure of these bodies adds a*

[80] From here on the Francis Inquiry.

truly Orwellian flavour to the sense of hopelessness described by campaigner(s. (Thorlby, 2013)

So far this overview reveals how public engagement defies easy definition and is rooted within the broader scholarship on constantly changing social relationships. I have identified four core dimensions of public engagement: (1). There must be a public side: a collective (such as the community or social movement) or individuals (such as patients, carers, citizens, representatives, activists, lay/users.); (2) It is a dynamic process - across the public/institutional boundaries with directionality (in/out) and, often, across a knowledge and power gradient (up/down); (3) The purposes may be defined and driven from either or both sides and concerns the use of agency; (4) The multiple framings coexist, leading to instrumental or normative attempts to address problems, underpinned by different discourses .

Appendix 5 Summary of healthcare policies, codes & inquiries

Key: Major public inquiries in pink

Policy, legislation and public inquiries related to public engagement in healthcare in UK*		Implications of Individual/ Local engagement	Implications (? Strategic Frame)	Dominant policy frame
Foundation of Community Health Councils	1973	Local advice outside formal healthcare (Based on the high streets)		Advocacy and advice
National Association for Patient Participation	1988	Charity supporting GP practice-based PPI		
Patient and public involvement in the New NHS, DoH Health Service Circular	1999	Tasking letter for health services to develop PPI & inform patients	Voice	Informed patients Citizens voice
Marchioness Disaster Inquest (which revealed the retention of drowned victims severed hands by coroner)	2001		Consent	Voice (media outrage)
Alder Hey Inquiry ((Redfern, 2001)) (into retention of children's body parts without consent by pathologist)	2001		Consent and institutional complicity	Voice Informed parents (media outrage)
Bristol Inquiry (Kennedy) (into paediatric cardiac surgery deaths 1984-95)	2001		Finding "bad apples" Publishing clinical outcomes	Whistle blowing
Health & Social Care Act	2001	• PALS (patient advice & liaison services (in hospital & community) • NICE Citizens Council	Governors on Trust Boards	Voice
INVOLVE established (from "Consumers in NHS Research".)	2003	National advisory group to promote public involvement in health and social care research		Voice
Commission for Patient & Public Involvement (abolished 2004 in Arms Length Body Review)	2003	Patient & Public Involvements Forums in every NHS Trust > 500 beds established		Governance
Shipman Inquiry (Smith) (into multiple murders by single GP 1975-98)	2005			Trust & monitoring of doctors' performance
Concluding Review of Patient and Public Involvement (DoH)	2006			
Chief Medical Officers Report (Donaldson) "Good Doctors, Safer Patients"	2006		Revalidation	Risk & Safety Professionalism
"Our Health, Our Care, Our Say" White Paper	2006	recommends local people given 'a stronger voice" to drive improvement		
NHS Centre for Involvement established (disbanded 2009)			Promote culture of involvement throughout NHS	
Local Government and Public Involvement in Health Care Act (?*A stronger local Voice?)*	2007	LiNKs (Local Involve Networks) PPI Forums loose powers	Social Care Scrutiny Panels	Scrutiny
DoH *"Real involvement"*	2008			

NHS Constitution	2010			Commitments and patient rights
Equity and excellence: Liberating the NHS (White Paper)	2010	HealthWatch (replaced LiNKs) (promote choice thru information, no longer voice in planning services (challenge is prohibited[81])	Care Quality Commission (CQC) established regulatory oversight including **PPI arrangements**	Choice
"No decision about me without me" Consultation document	2012	Individual shared decision making "person centred care"	NHS choices websites	Consumer
Health & Social Care Act	2012	was based on the assumption that market based solutions would be more efficient than previous approaches		
Mid Staffordshire NHS Trust Inquiry (into avoidable hospital deaths) (Francis Report)	2013			Care & compassion/ Failure of governance & PPI
Hard Truths & Berwick reports Responses to Francis Inquiry	2013			
Transforming participation in health and care. 'The NHS belongs to us all'	2013	http://www.england.nhs.uk/wp-content/uploads/2013/09/trans-part-hc-guid	"NHS England sets out call to action to staff, public and politicians to help NHS meet future demand and **tackle funding** gap through 'honest and realistic' debate."	
"NHS Citizen" established	2015	http://www.nhscitizen.org.uk/		

[81] See Tritter and Koivusalo (2013)-This was later modified to permit "advocacy" for change by HealthWatch groups.

Appendix 6 Public engagement in healthcare and higher education - a detailed review

This appendix is an extended review of the literature on the two fields adjacent to medical education included in Chapter 2.

Patient & public involvement in healthcare

> *'Everyone who is born holds dual citizenship, in the kingdom of the well and in the kingdom of the sick. Although we all prefer to use only the good passport, sooner or later each of us is obliged, at least for a spell, to identify ourselves as citizens of that other place.' Sontag, (1978, p3)*

PPI focuses on issues of trust in professionals and the accountability of services they provide; and the individual's role as part of both a humanistic patient-centred project and as a consumer in a commodified health economy. The field has attracted numerous policies and legislation, which I display chronologically, interleaved with the consultations and public inquiries that have shaped them in Appendix 5. Key among these are inquiries into Bristol paediatric surgery (Kennedy *et al.*, 2001), the Shipman murders (Smith, 2004); and the Francis Inquiry (2013a & b)

Much of the literature is concerned with concepts of patienthood, legitimacy and representativeness, leading to complex pluralism of the patient personae (Donnetti, 2009)(Landzelius, 2006). In general a *patient* is taken to be someone currently undergoing treatment and can connote medicalisation of, and passivity in, engagement. Collectively patients may form “disease constituencies” or “communities of suffering”. Other terms include ‘client’ and ‘user’ (Coote in Andersson *et al.*, 2007; May, 2007) and 'consumer/customer' (Litvia, *et al*, 2009). 'Lay' is succinct, however, it defines a person or group not by what they are (or may be) but by what they are not – a professional - , or what they lack - expertise. It is, therefore, challenging to be consistent in usage, and remain faithful to original authors. Williamson (2007) includes carers, patient representatives, and advocates as subgroups essential for effective PPI.

Tritter (2011) makes a distinction between approaches based on *individual* rights that promote “wants” over needs, and those based on *collective* rights (concerned with social

equity and population priorities[82.] Public involvement was given as an essential collective voice to feed into local healthcare policy through statutory bodies (originally Community Health Councils, and then LINKs). Recent legislation explicitly restricts the advocacy role of local HealthWatch groups, undermining the collective voice within the NHS and shifting to individualised feedback:

> *The Health and Social Care Bill erodes public ownership of the NHS, a key mechanism that drives the coproduction of well-being now and in the future by weakening PPI and strengthening individual patient choice" . (Tritter and Koivusalo, 2013, p. 118)*

Following the Francis Inquiry, (2013b) the current trends are complex and somewhat incoherent. Berwick (2013) advocates PPI at every level as the route to a zero-risk culture:

> *"The goal is not for patients and carers to be the passive recipients of increased engagement, but rather to achieve a pervasive culture that welcomes authentic patient partnership – in their own care and in the processes of designing and delivering care."*

Keogh in *Hard Truths* (Department of Health, 2013), supports deployment, training and monitoring of lay representatives within the NHS regulatory bodies (Care Quality Commission and the GMC)[83]. The newest initiative, *NHS Citizen,* (NHS England, 2015) gives everyone (patients, public and NHS staff) a route to circumvent institutional barriers to "raising concerns" (i.e. whistleblowing) in a system which aims to be at once open and transparent, as well has highly regulated and under constant scrutiny.

Coulter argues that collective PPI involvement in strategy and policy is a fallacious attempt '*to tackle the "democratic deficit" '* (in Andersson *et al.*, 2007, p. 32) in the NHS - a worthy distraction from the main goal of making individual doctor-patient relationships more patient-centred. She claims that, since the inception of the NHS, patients have adopted a passive role sustained by a resistant, paternalistic professional culture. She advocates patient choice measured through satisfaction surveys (The Picker Institute, 2015). Others take the individualist view of PPI as essentially collaborative patient-centred interactions (Barr, Ogden and Rooney, 2014; Gibson, Britten and Lynch, 2012; Hogg, 2004 ; Mead and Bower, 2000).

[82] Such as legislation creating smoking free environments, and the fiscal controls of the cost of alcohol.

[83] The newest initiative, *NHS Citizen* (NHS England, 2015) is a novel social media and web-based approach linked to participatory "Gather" events for all NHS "citizens" - a transparent route for their input to reach directly to the NHS Board. My reading of this virtually unknown initiative is that it gives everyone (patients, public and NHS staff) a route to circumvent problematic institutional barriers to "raising concerns" (ie whistleblowing) in a system which aims to be at once open and transparent, as well has highly regulated and under constant scrutiny.

The emphasis on the individual follows wider trends both in the framing of disease causation and intervention. As Brown (2013) points out this exculpates policy makers from addressing wider factors such as environment, ethnicity, economic inequity – placing responsibility for many, often complex, problems on individual patients and their doctor.

Empirical studies of effectiveness are important as they frame PPI in a way that aligns with dominant concepts of evidence and its relationship to policy and practice. Improved clinical outcomes and satisfaction can be demonstrated, such as access records (Fisher, Bhavnani and Winfield, 2009) shared decision making (Charles and DeMaio, 1993), service choice (The Picker Institute, 2015); and self management for people with long term conditions (Tritter & McCallum, 2009)[84]. Reviews show limited outcomes at strategic or service level (Amis and Livingstone, 2014; Andersson *et al.*, 2007; Conklin, Morris and Nolte, 2015; Florin and Dixon, 2004). Qualitative, participative methodologies, focusing on soft outcomes (Hawley, 2015) can capture wider PPI outcomes related to empowerment, advocacy, safety and trust (Brett *et al.*, 2014; Calnan and Rowe, 2008; Ocloo and Fulop, 2011) but have been dismissed by the profession as lacking rigour and used to undermine and de-legitimise PPI.. Nonetheless, post-Francis, Keogh (Department of Health, 2013) and Berwick (2013), are advocating more 'soft intelligence' in systems of governance.

Higher education: the engaged campus, the engaged student & the UK university

The literature related to the university sector reveals different conceptualisations of engagement to those identified in healthcare due to the sector's varied roles and stakeholders. We see references to all three traditions identified earlier (Chapter 2 , Box 2.1 and Appendix 4): *pull in/push out* to address legitimacy and a perceived democratic deficit; *a public good* for civic and community enhancement; and *co-production/ transformative* approaches to achieve social change. A changing context is a key theme: the once protected, elite ivory tower for the pursuance of intellectual activities by scholars and their students, are now popular, heterogeneous, and permeable, and subject to greater scrutiny, and competition (Facer, Manners and Agusita, 2012; Goddard, 2009).

Many authors refer to the economic and political value or capital ascribed to knowledge, as well as its potential for moral and social good (Fernandez-Pena *et al.*, 2008; Goddard, 2009;

[84] Which now includes participation through the web and social media.

Jacoby, 2009; Olson and Worsham, 2012; Peters, 2010; Schuetze, 2012; Scott, 2010; Scott, 2015; Strain, Barnett and Jarvis, 2009; Watson, 2008a). There is considerable critique of post-Fordist, neoliberal framing of higher education as "knowledge capitalism" (Dyer-Witheford, 2005 ; Lall, 2011; Watson 2012) for the enhancement of personal and economic, rather than social capital. Different types of universities are associated with different ideas of public engagement raising questions about how knowledge is created, legitimized and used across varied knowledge and social communities (Barnett and Di Napoli, 2008). Engagement is therefore about both social and knowledge relationships, about individuals and the organisations, within a local, national and even global political and economic dynamic (Watson *et al.*, 2011).

The scholarship of engagement in higher education is further predicated on two different understandings of the university itself. The first - arising largely from north America – assigns the university three roles: the so-called three legged stool or three ringed circus (Toews and Yazedijian, 2007) of research, teaching and service. The second, used in the UK, is largely limited to dual roles of teaching and research. These difference have significant impact on understanding public engagement in medical education, addressed later. Civic engagement was embedded*, de jure,* in many US universities through the land grant covenants[85] (Dempsey, 2009; Gelmon, 2012; Goddard, 2009; Hart, Northmore and Gerhardt, 2009; Healey, 2010; Holland, 1997; Kellogg Commission, 2000; Watson, 2010; Watson, 2008a). The "Engaged Campus" (Edgerton, 1994) is used as a generic label for a diverse range of institutional commitments - in research, education and service - linking the academy to community priorities and needs (Holland, 1997).The engaged campus combines *push-out* enterprises to increase access to education and resources (Kellogg Commission, 2000), alongside service and volunteering (usually professional), provided by faculty, and students' service-learning programmes.

This has generated a specific body of “engaged scholarship” (see Healey, 2010 for summary). The "engaged campus" is promoted as an holistic project joining learning with research and service through critical enquiry (Boland, 2012; Boyer, 1990; Boyer, 1996; Calleson, Jordan and Seifer, 2005; Healey, 2010; Hofmeyer, Newton and Scott, 2007). Holland (1997) refers to the

[85] In the north American literature authors agree the triple mission results from the founding obligations of Land and Sea Grant universities. The under-pinning principle of these universities established in nineteenth century is sharing knowledge for the benefit of the land or coastal communities - an instrumental and moral project where : *“Needful science for the practical avocation of life shall be taught”* Morrill, J (1863) (quoted in Watson, 2010, p. 63)

challenges of sustaining the “service movement” and aligning the contractual obligations of staff, and the learning needs of students, with the interests of the community (Holland and Ramaley, 2008).

S*ervice learning*, a credit-bearing educational experience 'that meets identified community needs' (Bringle and Hatcher 1996, 222,) is extensively explored in the US (Butin, 2010; Holland and Ramaley, 2008; Jacoby, 2009) and recently in other settings (McIlrath and Mac Labhrainn, 2007). It may include pro bono work in the US, often in healthcare, and CBPR research on topics selected by local groups. Informal extracurricular volunteering is well established in the UK - a legacy of the Victorian civic universities (Goddard, 2009). Both volunteering and service learning are associated with conceptions of curriculum informed by transformative pedagogy (Rubin *et al.*, 2012) aimed at advancing collective social justice while shaping individual social identity and encouraging agency, with evidence that participation increases civic engagement in graduates (Tansey, 2012) See Box A6.1

Box A6.1: Purposes of patient involvement and public engagement by curriculum model for health professional education

Purposes /concerns to be addressed by engagement	Curriculum Model	
	Competency-based person-centred medical curriculum	*Transformative* socially accountable "engaged" medical curriculum
Specific to curriculum model	Goal is graduates competent to address patient needs and wants Integrate hard science with "soft science" Communication skills to involve patient in their own care Respect unique patient experience Highlight risk, professionalisation and leadership (individual) to delineate pedagogic practices Develop students humanity Lack of available patients Align assessments in line with professional codes of conduct	Goal is to orientate entire curriculum project towards social benefit and reducing health inequities Develop students knowledge relevant to address patient and population needs Highlight participation, agency and advocacy (individual & collective)to delineate pedagogic practices Improve selection of staff and students to increase diversity Facilitate long term patient & community contact Increase recruitment to underserved communities and specialities (especially primary care) Reduce reliance on overseas trained medical graduates
Shared by curriculum models	Develop professional identity Ensure clinical knowledge , diagnostic skills and patient safety (*First do no harm.)* Application of clinical evidence (individual and population based)	

At the same time be considerable personal and institutional self-interest at play (Avalos in Tansey, 2012) - students can augment their CVs, and institutions can fulfil regulatory requirements. Formalising public engagement through education is framed as a socially oriented moral, collective project, *and* as acts of individual self-realisation (Cote, 2002 ; Schuller, 1998). Coles warns:

> *What does teaching values mean, when many of these values are often articulated in ways that are complicit with this system of power/suffering, or relatively silent about it, or incapable of disturbing the production of deafening indifference or lead only to the occasional trip to the soup kitchen on the way to the oblivious high-paying job in the corporate firm? Coles (2010 p. 77)*

Efforts to institutionalise civic engagement as a core duty of US universities through standards (Kellogg Commission, 2000) are matched by concerns of a gap between practice and rhetoric (Calleson, Jordan and Seifer, 2005; Dempsey, 2009). The idea of the engaged campus has been promoted in the UK (Goddard, 2009) but, as Watson reminds us, (2008a; 2012; 2011) without a coherent understanding of the different historical and political environment. Three works of significance to this thesis - *The Engaged University (Watson et al., 2011)* ; *Reinventing the Civic University* (Goddard, 2009) and *Higher Education and Civic Engagement* (McIlrath, Lyons and Munck, 2012) - are summarised in Appendix 6.

With regard to the UK, what my search of the literature revealed, is a tendency to consider engagement in higher education as synonymous with *research* engagement, to the exclusion of education, and broader community development. Most authors agree that the principal driver for this bias is the requirement for funding applications to describe how research relevance and impact will be established (Bubela, 2006; Dempsey, 2009; Devonshire and Hathway, 2014; Gelmon, 2012; Goddard, 2009; Kitson *et al.*, 2009; Krejsler, 2006; Parry *et al.*, 2012; Pickersgill, 2011; Scott, 2013; Watson, 2008a; Weisbrod, Ballou and Asch, 2008; Wilson *et al.*, 2015). This instrumental process is inexorably linked to criterion-based systems of evaluation such as the Higher Education Funding Council's Research Excellence Framework which places a measurable value on impact[86] only achievable through evidence of engagement. Studies (such as Wilson *et al.*, 2015) and a literature review (Facer, Manners and Agusita, 2012) identify similar challenges to public engagement to those listed in Box 2 XR. Facer et al (2012) note a rich range of approaches but poor cross-disciplinary diffusion. Wilson et al (2015) in the detailed realist RAPPORT study of PPI implementation in healthcare research in the UK using an NPT[87] approach found considerable evidence of embedding but very wide range of practice - from superficial to comprehensive and collaborative. The general effect of current research policy and funding is that UK academics (as with my own participants) tend to equate public engagement with lay participation in individual research projects. As the late David Watson (2012, p. 6) succinctly states:

> *Despite Herculean efforts everything reduces to peer-reviewed research...*

[86] Impact criteria are: *Reach* - the extent and diversity of the communities, environments, individuals, or organisations that have benefitted from the research; and *Significance* - the degree to which the impact has enriched, influenced, informed or changed policies, opportunities, perspectives or practices of communities, individuals or organisations (Higher Education Funding Council, 2011).

[87] Normalisation Process Theory (May 2009)

The focus of the modern UK university is on *extractive* activities (Barnett in McIlrath and Mac Labhrainn, 2007) that yield a return in terms of money, *World Class*[88] aspiration, reputation and global ranking - particularly in the research-intensive universities (Dyer-Witheford, 2005 ; Holmwood, 2011; Watson 2012). in which medical schools are traditionally located (Park, 2011). Despite political and economic pressures, and a loss of civic orientation, higher education has managed to buffer itself from direct government interference, avoiding the catastrophic events[89] , subsequent inquiries, and political and regulatory fallout seen in the NHS (described earlier) (Gourley, 2012; Ocloo and Fulop, 2011; Scott and Engwall, 2013)[90].

There is evidence of a rekindling of traditional civic missions the sector (Goddard, 2009), and as well as newer universities emerging from community colleges. The establishment of the National Co-ordinating Centre for Public Engagement (NCCPE, 2016) is both evidence of, and key to, promoting this process. Overall public engagement in UK higher education can be framed as a predominantly push out/pull in process, an offsetting strategy (Boland, 2012; Gourley, 2012) to remediate claims of irrelevance, commercialisation, and elitism. However there is also a genuine will to connect with the community (Barnett, 2012) by individual students, academics and institutions, for the public good.

> *The—intriguing—implication is that the university of the 21st century should re-engage with its urban and regional environment rather than float off into a virtualised globalisation... Scott (2013, p. 230)*

Box A6.2 Engagement and higher education - key texts

1. *The Engaged University (Watson et al., 2011)* is both a detailed review of historical and contemporary narratives of civic engagement as well as original empirical research of twenty case studies from universities across the world (summarised in Appendix W). The methodology has greatly influenced this thesis and is described in Chapter 4. Watson is

[88] *World-Class* ranking criteria does not include any element of community engagement or social accountability

[89] Despite near bankruptcy at Cardiff, ghost written doctorates awarded to the son of a dictator at the LSE, and underwear terrorists at UCL.

[90] Although increased regulation based on the Quality Assessment Review (QAR) is on the horizon with the proposed TEF (Teaching Evaluation Framework). (Quality Assurance Agency, 2015)

"fundamentally interested in the behaviour of institutions and in how to influence ..their decision making" (p33) regarding strategies for engagement with civil society to promote social justice. The monograph begins with the declaration from the Talloires Network - an international association of universities committed to social responsibility and ends with a call to institutionalise civic engagement through policy and regulation. When considering the future they raise two points relevant to this thesis.

- less prestigious universities in high income countries, and many in the global South, demonstrate great innovation and commitment to civic engagement with a particular focus on the work of healthcare students in communities;
- better endowed research-intensive universities prioritise public engagement through their research agendas. In the UK these host only the most elite health qualifications (medicine, dentistry and pharmacy) with the less prestigious programmes (nursing, physical and occupational therapy, and social work) provided by the post-92 bodies.

2. Goddard's "call to arms" *Reinventing the Civic University* (2009) draws explicitly on the US Land Grant model. He argues that all publicly-funded UK universities have a civic duty to engage with wider society - locally, nationally and globally, linking their social and economic endeavours. He calls for a new covenant - an obligation for engagement led by vice chancellors through regulation. He provides a two dimensional analytical tool to distinguish levels of civic engagement[91].

3. *Higher Education and Civic Engagement* is a collection of essays edited by McIlrath et al (2012) covering similar issues, emphasising global pressures and social accountability (Gourley, B in McIlrath, Lyons and Munck, 2012) focussing on "Service as Primary Mission" (Schuetze, 2012), illustrated with narrative cases studies.

[91] For research intensive and post-92 universities across teaching-research and academic-society/employer axes.

Appendix 7 Documents that include standards (instruments) for public engagement in medical education

Sector	Title of document	Who (type of entity)	type of standards	Purpose / *framing of PE/PPI*	Yr	Locus	ref
Medical education	Tomorrow's Doctors 2009	GMC (Regulatory body)	Mandatory standards	Licensing of medical schools *PE = PPI essential for good governance*	2009	UK	GMC, (2009)
	Commission on Education and Training for Patient Safety,	Health Education England (Arms Length Body, ALB)	Benchmarking	*PPI = safety* Students as eyes and ear of health service (?spies)	2016	UK	https://hee.nhs.uk/our-work/hospitals-primary-community-care/learning-be-safer/commission-education-training-patient-safety
	Global Consensus Statement On Social Accountability Of Medical Schools	Informal coalition	consensus statement & recommended standards	• Promote self assessment • Lobby regulatory bodies PE = Social Accountability	2010	Trans national	GCSA (2010)
	ASPIRE: Recognition Of Excellence In Social Accountability Of A Medical School	Association medical education in Europe (AMEE)	Benchmarking	Criteria for voluntary accreditation *PE = Social Accountability*	2013	Trans national	AMEE (2013a)
	Towle et al (Cambridge framework)	Community of practice (i.e. a bunch of academic chums)	Framework for organising curriculum (aspirational)	Influence practice ; *PPI essential for good learning and governance*	2010	UK/ Canada	Towle et al (2010)
	Standards for Accreditation of Medical Education Programs (Inc IS-14-A: Service-Learning	Liaison Committee on Medical Education,	Mandatory Standards	Accreditation of Medical Education Programs *PE = engaged scholarship & service learning*	2015	USA	http://www.lcme.org/standard.htm
	Commission on community – engaged scholarship in the health professions framework	Community-Campus Partnerships for Health. Informal coalition	Framework for assessment of faculty (voluntary)	Documenting & assessing community engaged scholarship for promotion and tenure		USA	Seifert el 2008
	A Core Curriculum for Learning About Health Inequalities in UK Undergraduate Medicine	Royal College of General practitioners (Formal professional body)	consensus statement & recommended learning outcomes		2015	UK	Williamson et al
	Can patients be teachers? Involving patients and service users in healthcare professionals' education	Coalition Health Foundation & PERC (Patients as Educators Research Collaborative)	Recommendations		2009		PERC (2010)
	Tool for service learning sustainability	Community campus partnerships for health	Code of practice (voluntary)	To promote good practice in community-based service learning	2007	USA	
	Educating Health Professionals: an Intersectoral Policy Approach	Caerum (Informal Policy Group)	Policy & governance framework			Europe	Kickbusch (2013)
	The role of the patient in medical	British Medical Association,	Guidelines			UK	

	education.	(Membership organisation).					
	Basic Medical Education Global Standards for Quality Improvement	World Federation for Medical Education (membership org)	Voluntary Standards	Criteria for voluntary accreditation	2003	Trans national	WMFE (2003)

Appendix 8 Topic Guide

Principal Research Question:
How is public engagement policy understood, reshaped and enacted in two medical schools in the context of evolving regulatory requirements and organisational diversity of medical education and what are the implications for leadership?
a. ***Who are the boundary agents*** *with regard to PE and what is their role in the reification of PE policy in medical schools ?*

b. ***How do these agents articulate the process of public engagement policy diffusion*** *in the cases (medical schools) studied?*

c. ***What appears to be happening in the contested boundary spaces*** *between professional, academic and public sphere?*

d. How ***can this "boundary work" be used to generate socially-oriented change*** *in curriculum practice ?*

Ask for documents: L&T, QA PPI strategies

GROUND RULES : What is EdD Part of Thesis Info sheet/consent,–withdrawal and data sharing , Complete and sign
Time 45, recording , Writing / negotiating content / transcript

Start time: Finish time : Any questions?

4 sections, (1) (a) intro your role leadership , (1)b your organisational mission - culture, history decision making (2) PPI/PE in medical education (in general) - (a) what (b) why (3) PPI/PE specifically in this medical school - who / what (4) examples focussing on relationships inside / outside & story/narrative of these developments (academic/non- academic)

(**1) Intro You & job**
Q Introduce yourself summarise your job title *principal roles & responsibilities* related to Undergraduate education
Q So to clarify –, your, title(s) , leadership roles are in this medical school?
(??vis PPI) [previous roles - when- date]
Do you have roles in ME outside this MS
Are you/have you been a GMC QABME visitor/.....

Q How would you describe the organisational mission of this MS ? What, if anything, is distinctive? - perhaps a little history
(how) Is this reflected in the organisational culture ?
Q What is the ethos regarding community/patients ?

(**2) PPI/PE in medical education (in general)**
Q. Two terms - PPI / PE :
what is your understanding of Terms (vis medical education) what is your preference (PATIENTS .../ PUBLIC ???) & why?

Q. What, in your opinion, is the *intended purpose* of PPI/PE in ME?
[what prob solved?] QA or Curriculum
what therefore might be the intended outcomes & measures of these

Q What have been the influences on PPI/PE in medical education /-
Tell me the story/Why now? Tensions , left behind
Specifically - what has been the influence /impact of the GMC (TD 2009)
Are you familiar with the Supplementary Guidance ? Is this POLICY; ? intention ?

Q Idea of the educational environment & the role of patients in: Learning; & Feedback and shaping clinical activities (in care and training – other have mentioned Francis ..can you comment
Q Role in Expert Advisory Group To Review Of Standards: Intentions, Relationship with TDs 2009 & future

(3) PPI/PE in medical THIS medical school : - who / what

Q Who is involved in PPI/PE in this MS ? (if I asked you to introduce me
[under what umbrella - QA/community/GP/volunteering ?]
Is there a PPI /PE policy / leader / groups ?
What they up to ?

Examples ??HERE

(4) RELATIONSHIPS

Q Describe relationship between this org and outside orgs NGO/ Community

Q describe relation with regulator(s)

if possible - please draw your idea/view of relationship between the medical school and other organisations

Narrative - how were these established - tell me the story
Were there any significant events that triggered these developments

[what type of (outside orgs]
What type of relationships
[this is about "engaging upwards" / outwards - inwards]

Q how do you see Future directions.....
PROGNOSTIC What is the ideal "SOLUTION" ?

Ask for documents: L&T, QA, PPI strategies

THANK YOU , TRANSCIPT , CONSENT , F-U MEETING

Appendix 9 Information Sheet & Consent form

Information Sheet for Participants in Research Studies

Title of Project:

Boundary objects & policy diffusion: Case studies exploring the implementation of public engagement policy in UK medical schools.

This study has been approved by the UCL Research Ethics Committee (Project ID Number): **0167/002**

Name Anita Berlin

Work Address Department of Primary Care & Population Health
Rowland Hill Street
London NW3 2PF

Contact Details a.berlin@ucl.ac.uk 07712587608

I would like to invite you to participate in this research project.

Background and aims of Study:
This study aims to explore public engagement (PE) practice in UK medical schools and its relationship to the General Medical Council's (GMC) PE policy and regulatory requirements. PE is important to organisations concerned with education and health. The GMC reports variations in interpretation and practice regarding PE in medical schools . The proposed study focuses on policy diffusion and the role of educational leaders and policy makers . It complements earlier research into lay views of PE in medical schools (Berlin et al 2013). Using case studies in medical schools I plan to explore public engagement focussing on the role of "boundary agents" - organizational actors with capacity to adapt policy across intersecting settings.

Study design and methods
1. Medical School Interviews and document analysis: the study will comprise between two and four case studies. The case studies will be built on interview transcripts and analysis of organisations policy documents. During interviews you will be asked to share your vision, ideas and experiences of PE, and the approach your school takes to PE policy and practice. I will ask your permission to access and analyse electronic copies of relevant medical school policy documents.
2. GMC interview and policy document analysis: Data from your interviews will be pooled with those of other officers and analysed for themes. Documents in the public domain such as Tomorrow's Doctors, Supplementary guidance on Patient and Public Involvement and GMC Education Strategy will also be analysed.

Recording , transcribing and approving
The individual interview will be audio-recorded and fully transcribed. I will take field notes

during the interview. You can be sent a summary of your interview and, if you wish, the audio-file or transcript of your interview together with a copy of the field notes. The names of participants will be concealed by removing all names and identifying features to the best of my ability in both the submitted report and any other documents arising from the study.

Storing data
Material will be held in accordance with the Data Protection Act 1998. All files will be password protected and use codes rather than names. All transcripts and recordings will be deleted at the end of the project .

Reporting of findings
Each medical school will be *pseudonymised* using a name agreed with the participants on that site. Data will presented anonymously. Participant roles and job titles at case study institutions will be ascribed generic labels such as Head of Quality Assurance or Programme Director. Data from GMC interviews will be pooled and not ascribed to any individual officer. A meeting will be arranged at each site for presentation and discussion of preliminary findings. The final results, including excerpts from the transcriptions and field notes, will be used in the report submitted for examination towards my Doctorate in Education, at the Institute of Education. This report will only be seen by my supervisor (Prof. K. Riley)and examiners and a copy of this report will be held in the archives of the Institute.

Potential Benefits
I hope your participation with this study will contribute to understanding PE in your own institution and to further enhance scholarship and practice in a complex and critical field of professional education. In addition to contributing to my doctorate I hope that the findings might benefit those involved by generating a deeper insight into how policy makers and educational can enhance public engagement and the diffusion of policy in an increasingly pluralistic environment. In addition to providing you organisation with a report and a summary of key observations I plan to submit a paper for peer reviewed publication circulation and, if appropriate abstracts for academic meetings. All such documents will be offered to participant for comment and any decision to publish will be negotiated with participants individually

Consent and withdrawal
It is up to you to decide whether to take part or not; choosing not to take part will not disadvantage you in any way. If you do decide to take part you are still free to withdraw at any time and without giving a reason and any data already collected will not be used. If you decide to take part you will be given this information sheet to keep and be asked to sign a consent form before and after interview.

Thank you for considering taking part. If you have any questions please contact me (details below) .

Dr Anita Berlin, UCL Medical School , a.berlin@ucl.ac.uk
Contact: 07712587608

Informed Consent Form for Participants in Research Studies

Please complete this form after you have read the Information Sheet and/or listened to an explanation about the research.

Title of Project: ***Boundary objects & policy diffusion: Case studies exploring the implementation of public engagement policy in UK medical schools***

This study has been approved by the UCL Research Ethics Committee (Project ID Number): ***0167/002***

Thank you for your interest in taking part in this research. Before you agree to take part, the person organising the research must explain the project to you. If you have any questions arising from the **Information Sheet** or explanation already given to you, please ask the researcher before you to decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

Participant's Statement

I

I confirm that I have:

- Read the information sheet and the project has been explained to me verbally;
- Had the opportunity to ask questions and discuss the study;
- Received satisfactory answers to all my questions or have been advised of an individual to contact for answers to pertinent questions about the research and my rights as a participant and whom to contact in the event of a research-related injury;
- Understood that my participation will be tape recorded and I am aware of and consent to, any use you intend to make of the recordings after the end of the project;
- Consented to the processing of my personal information (such as contact details) for the purposes of this research study;
- Understood that the information I have submitted will be published as a report and I will be sent a copy. Confidentiality and anonymity will be maintained and every effort will be made to ensure that it will not be possible to identify me from any publications;
- Understood that I am free to withdraw from the study without penalty if I so wish and I consent to the processing of my personal information for the purposes of this study only and that it will not be used for any other purpose. I understand that such information will be treated as strictly confidential and handled in accordance with the provisions of the Data *Protection Act 1998.*

Signed: Date: (Before interview)

Signed: Date: (After

Appendix 10 Coding: categories, finding / building frames ; using NVivo

How are frames identified in the first place? There is a scope for both "seeking" frames - using a deductive process - indicated in my conceptual framework, and a more inductive approach, finding frames that arise from the data. This so-called *abductive approach* is well established in case studies - especially combining sources from interviews and texts. It provides what Thomas (2011) refers to as a holistic strategy for drawing in anticipated ideas and those that derive *de novo* from the sources.

Holism is consistent with symbolic interactionism - generating what (Geertz, 1973)called thick data. The process of abduction facilitates theory testing - providing an opportunity to confirm or refute the theory under question (in this case that public engagement in medical education is functioning as a boundary object) and also to be alert to alternative theoretical perspectives. The key to my approach to analysis was focusing on being "insightful" – looking for surprises in the data – what Richards (2009) calls "seeing the difference". Having initially coded all my reflective field notes, I started to look for (i) frames that resonated with those anticipated from the literature and then, (ii) as a secondary analysis, what was new, unexpected or interesting in the participants' responses. Step (iii), was making connections, across levels. Rather than seeking confirmation of my preconceptions at this stage I was searching for novelty and dissonances. While this picks up some strategies advocated by grounded theorists I was keen my approach was openly abductive (Du Bois & Gadde 2002; Coffey & Atkinson 1996; (Thomas, 2011)). Like frames, as Richards (2009) points out, theories do not just emerge from the data. My stance was to be mindful of what had gone before - drawing on my emerging knowledge of theory, the literature, and the context. I also wanted to consciously connect with my own personal, professional knowledge.

Figure A10:1 Abductive reasoning process used in data analysis[92]

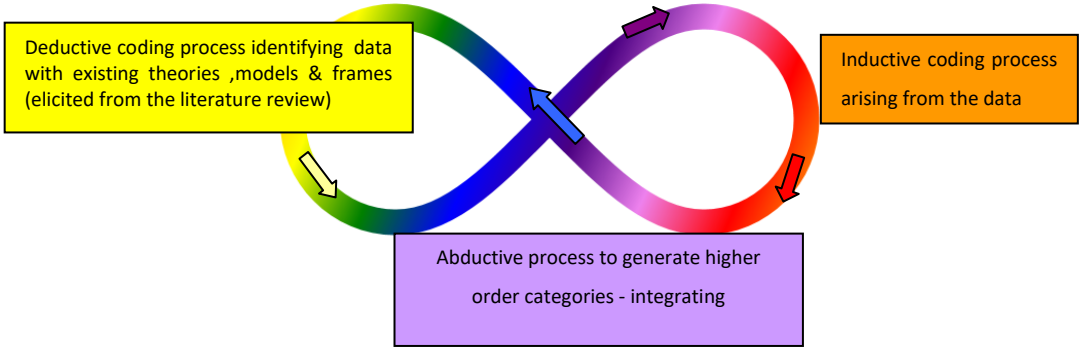
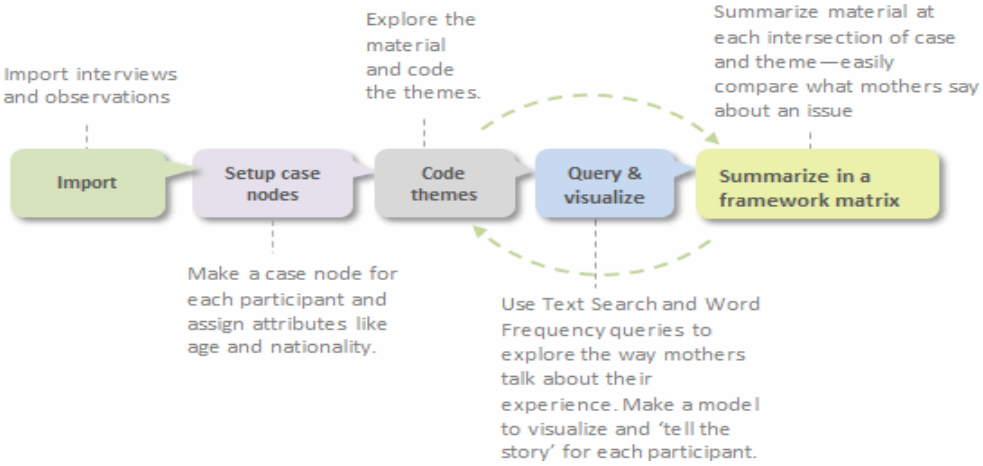


Figure A10.2 : steps in the coding - from Richards in " Using Nvivo : " [93]



[92] I developed this figure for my IFS.

[93] Using Nvivo:http://help-nv10.qsrinternational.com/desktop/concepts/using_nvivo_for_qualitative_research.htm

Stories and institutional narrative

Eliciting and coding "storytelling" is key to frame analysis as it is "at once a medium for problem setting and a way of a way of discovering the tacit frames that underlie our problem settings" (Schön and Rein, 1994). Citing Czarniawska (1998) Griffin (2014, p. 74) states:

> *Researchers only have indirect access to the experience of others; access to the 'real' events through stories is a particularly important way of gaining insights into learning and meaning making*

Focusing on policy stories explores the ways in which situation-specific framing may contribute to divisions among "policy relevant actors" (Schön and Rein, 1994) , in this case the medical school leaders and the GMC officers. It also explores whether individuals or groups, promoting and maintaining conflict deriving from and supported by frame-based communication, thereby prolong the intractability of the policy controversy (this is seen in case A - described in the next chapter).My approach is exemplified by the following example: I chose the quotes in Box 4.5 because I remember B2 being thoughtful, reflective and informed during the interview. I was therefore a struck by the affect-laden word *danger* in the transcript and the reference to "*undue power*"[94] .

Box A10.1: Identifying affect- laden phrases in Participant B2 transcript

*"There is a **danger** I feel of how one works with people without giving them undue power – which would be **abdicating our responsibility** to the students ... and I don't want to ... and compromising as a result of potential political correctness"*

*"Distinguishing features [of this medical school] .... It has a very **strong** student body involvement and it has an **emphasis on care** and **relationships** and student support."*

*"I'm **nervous** about that [direct patient feedback to students]... I have to say, because I think that ... well a couple of things really ... Similarly, they don't represent everybody (**laughs**)*

*"Because I have found it **quite difficult** when I have talked with patients sometimes to counter a particular patient's viewpoint on how things should be done [by a student] , because it's a patient saying it."*

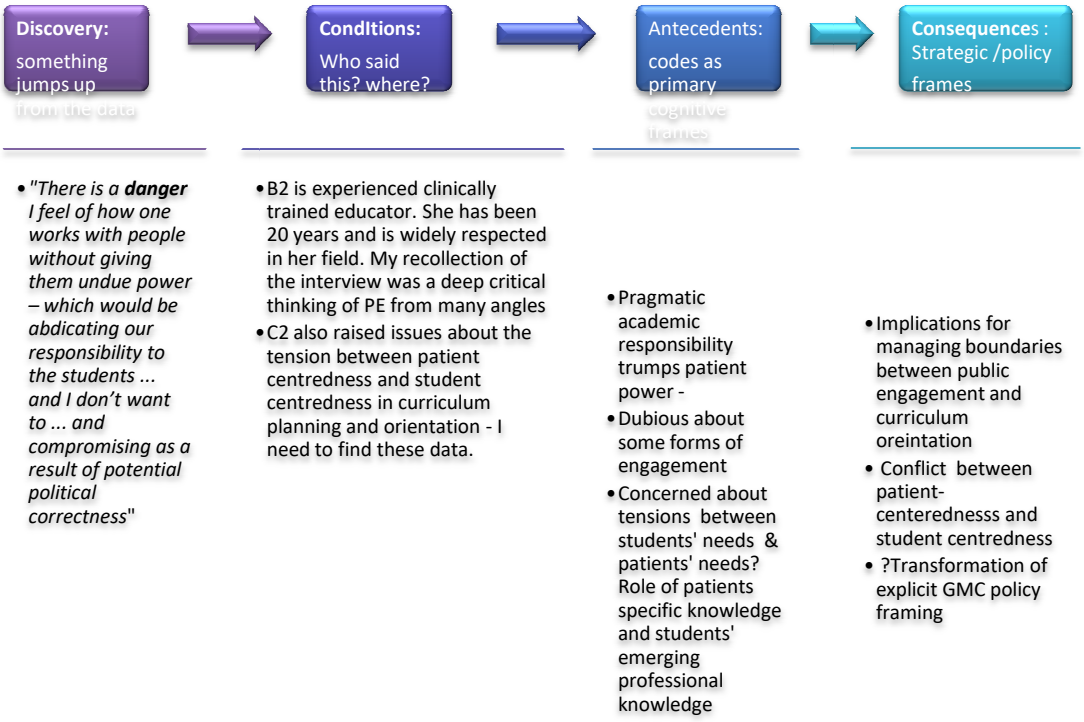
*"You know because it's only when you spend more time in education that you sort of realise that there's lots of things going on – it's about the learners' needs, it's about the system they're going to work in, it's about assessments. Actually I think it's quite **dangerous** to sort of expect students to respond to every patient, and then when they find themselves in clinical practice, having to say no or ... **dare I say it, you know deal with people you***

[94] In the original quote B2 in fact repeated the assertion "*abdicating our responsibility*".

***don't like**, and people who you think ... don't know, you might have all sorts of attitudes towards them, **you may think they're abusing the system**, you may think that they have you know ... you don't know how to manage you know people who may be quite demanding of you, and other people who are not so demanding, but you know you feel you need to give them time ... because you have to balance the community"*

This led to analysing the framing process used by this individual laid out in Figure 4.6. I then looked at other transcripts for other affective language. I found I had coded a similar point made by C2 and looked carefully at what was actually said – I asked myself whether this was confirmatory or in fact largely unrelated? At this stage in the coding and analysis I was unsure of the likely significance to the whole project - but I wanted to be sure to keep this clearly "in mind" as I progressed and to compare with detailed reflective notes on "recollection of interviews" rather than the transcript themselves. Eventually, this did in fact evolve into a collective field frame - *"the better doctor frame"* .

Figure A10.3 Identifying frames - noting and coding affect



Testing and developing theory

Following Richards's suggestions and in keeping with this abductive approach I tackled the data analysis by coding each transcript. I chose to code in chronological order of interviews – because I gradually and sometimes consciously, adapted my questioning style and elaborated my topic guide as a result of preceding interviews. Richards recommends a strategy for opening up and taking off from the data which follows the following sequence: firstly identifying unexpected, interesting or perplexing discoveries. Discoveries were recorded in memos - in which I noted why they had been striking, how they compared to my prior knowledge and preconceptions, and to other study data. I then "played with" the discovery, thinking about three further questions: what were the conditions under which this was said ; what might be the consequences of the idea, or attitude expressed in the coded phrase: and what might be the implications for the resultant strategies or actions. So an example of "opening up the data" arose from the phrase shown above in transcript B2 (the second transcript I coded).

Making connections: data reduction and intuitive coding decisions

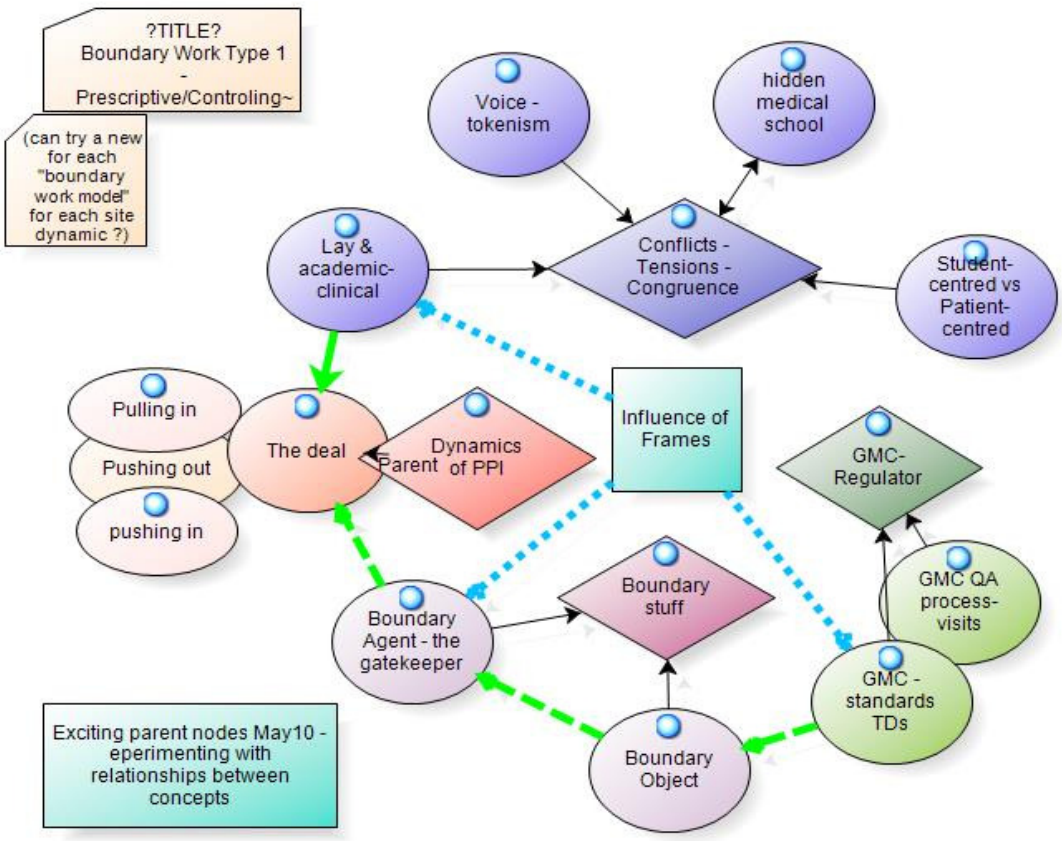
"We focus, we aggregate, we synthesize, we reduce, ultimately we extract " Horcea-Milcu

In the initial stages, as I coded the transcripts, I also added parent and child nodes as new

insights emerged from the data. As is often the case the number of nodes began to grow unmanageable and tended to be merely descriptive. So, for example, after coding all my reflections and four of the transcripts I started regularly collapsing and renaming nodes into higher order categories and becoming more selective about what I coded. I had managed to reduce the parent nodes to 12 - but there were still numerous child nodes in some areas - giving a total of 123 individual nodes. This degree of divergence and coding density was becoming unmanageable - a phase Richards says makes the researcher feel like the Sorcerer's Apprentice. This led to the development of a rubric for focussing and identifying redundancy to achieve disciplined data reduction. Analysis became more intuitive - looking for connection between frames, and between the theory being tested and new theoretical insights. Concentrating on this "meta" I noticed that I was beginning to

like some coded data more than others - I experience a small frisson of excitement when I identified data that belonged in certain codes or seemed to suggest /support frame trajectories. To facilitate this mental process I used NVivo to create relationship maps (Figure A10.4))

Figure A10.4 : Example of coding relationships created in NVivo

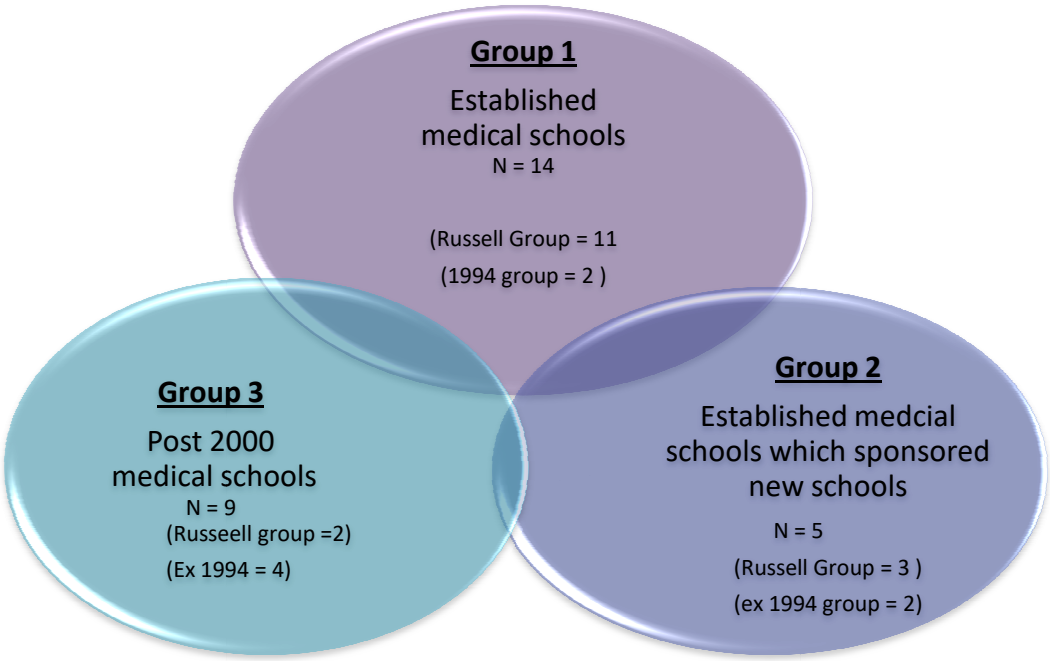


The final stage - from codes to frames

Many authors provide helpful guidance and heuristics. Johnston (2002) is widely cited for his helpful rules designed to "bolster confidence" in the analyst. He states that frames are made available via text which contains symbolic manifestations of beliefs, behaviours, and their structure expressed by individual and collective "frame sponsors". Each frame is affected by a varying set of functions and modifiers (Figure 4.8) . In presenting findings the researcher needs to find language that distils the frame elements making them available to the reader without losing the story and perspective of the sponsor. Frames are packages or assemblages

that peel back and expose the speaker's logic argument. It is important to be able to link back to the empirical evidence in the data and to be cautious about using terms that that might prejudice further analysis. However the essence of frame analysis is to move beyond mere narrative fidelity and "pierce the veil" of ostensibly bland statements (Creed, Langstraat and Scully, 2002, p. 45) to reveal underlying morally or politically charged differences in discursive characteristics.

Appendix 11 Summary of UK Medical Schools with DAPs considered for Inclusion as Cases Studies.



Group 1 - Established schools (pre 2000) (<u>not</u> sponsoring new schools)

1. Barts and The London School of Medicine and Dentistry, Queen Mary, University of London(#)
2. Birmingham (University of), School of Medicine
3. Bristol (University of), Faculty of Medicine
4. Cambridge (University of), School of Clinical Medicine
5. Imperial College School of Medicine, London(#)
6. King's College London School of Medicine (at Guy's, King's College and St Thomas' Hospital) (#)
7. Leeds (University of), School of Medicine
8. Newcastle University Medical School
9. Nottingham (The University of), Faculty of Medicine and Health Sciences
10. Oxford (University of), Medical Sciences Division
11. Sheffield (The University of), School of Medicine
12. Southampton (University of), School of Medicine
13. St George's, University of London
14. University College London, University College Medical School (#) ***EXCLUDED as my home institution***

Group 2 - Established schools which "sponsored " *new schools* which subsequently decoupled ("de-merged")

1. Cardiff University, School of Medicine -> *Swansea*
2. Leicester (University of), Leicester Medical School-> *Warwick*

3. Liverpool (University of), Faculty of Health and Life Sciences -> *Lancaster*
4. Manchester (University of), Faculty of Medical and Human Sciences -> *Keele*
5. *Peninsula Medical School -> *Plymouth & Exeter*

Group 3 - New medical schools post 2000

1. Brighton and Sussex Medical School
2. Hull York Medical School
3. Keele University, School of Medicine
4. Lancaster University, Faculty of Health & Medicine
5. Norwich Medical School, University of East Anglia
6. Swansea University, School of Medicine
7. The University of Warwick Medical School
8. *Plymouth University Peninsula Schools of Medicine and Dentistry (ex Peninsula)
9. *Exeter University, Medical School (ex Peninsula)

Group 4 - Schools Excluded due to distance and separate healthcare jurisdictions

1. Aberdeen (University of), School of Medicine
2. Dundee (University of), Faculty of Medicine, Dentistry and Nursing
3. Edinburgh (The University of), College of Medicine and Veterinary Medicine
4. Glasgow (University of), College of Medical, Veterinary and Life Sciences
5. Queen's University Belfast, Faculty of Medicine and Health Sciences
6. St Andrews (University of), Faculty of Medical Sciences

Notes

a. Seven schools were ***excluded*** (five in Scotland, one in Northern Ireland, and my own institution)

b. DAPS = degrees awarding powers

c. *- Peninsula medical is unusual - having been establish in 2000 as a joint venture between Plymouth and Exeter Universities and subsequently undergoing de-merger in 2013.

d. # - This denotes a London school established through mergers following the Flowers (1980) and Tomlinson (1992)Reports.

Source of list **:** The Medical Schools Council **(2016)**

Appendix 12 Arguments against symbolic interactionism

The main critique of symbolic interactionism is that it is descriptive and apolitical. By focusing on social interaction it does not address the role of power or wider structural influences in the interactions studied. This is potentially an important shortcoming, given the critical roots and democratic purposes inherent in ideas of engagement (considered in earlier.) Furthermore, when exploring the link between meaning and practice, one must consider concepts such as norms, codes and standards and, by extension, the enforcement of norms (and rules) and the associated use of authority.

Symbolic interactionism, however, has been expanded through the idea of frames (Goffman, 1974) and how these are used in social groups to transfer predetermined ideas and norms to new members. When frames are evoked, the degree of freedom an individual has to shape interpretations, choose modes of communication, and determine their own goals is lessened (van Hulst and Yanow, 2014). This framing process can be studied: for example, Snow (2003) has developed symbolic interactionism and frames to explore ideologies in social movements; and Schön and Rein (1994) focus on framing to examine how social and political *structures* (such as public services), as well as individuals, make meaning, hold values, and have agency.

So, symbolic interactionism does not merely generate descriptions of the tendency to conform for the sake of the status quo, it also facilitates a rich exploration of meaning making through social interaction arising from doxastic and evidential knowledge. This includes responding to meaning held by other groups (i.e. the exocentric circle), to counter criticism, or to recruit members, as well as to address processes of standardisation and institutionalisation. Unlike critical theory associated with Gramsci (Gaventa and Pettit, 2010) and Habermas (Fleming, 2000) it is not restricted to the analysis of power or (as in the case of Foucault), resistance (Flyvbjerg, 1998).[95]

My interpretation, therefore, is that (following Crotty's suggestion) symbolic interactionism, and its pragmatic underpinnings, do not bar the researcher from considering and responding to considerations of power and authority, as they may arise, situated in a particular context of meaning-making and practice. Remaining open to multiple interpretations does, however,

[95] Nor does it prioritise the communication of ideas and power over epistemic concerns as in Latour's activity network theory (Goldman, 2001). Engagement (and its regulation) is primarily about interaction – best aligned with symbolic interactionism.

have particular implications and moreover limitations, for the positions adopted by the researcher, and their subsequent responsibilities to research participant and data - which I discuss later. Symbolic interactionism is flexible (Crotty, 2003; Robson, 2002), it can be associated with any methodological approach that facilitates the exploration of the concepts in question - choice is based on the best fit. Nonetheless, linking symbolic interactionism to practical research procedures can be challenging[96]. Given the heterogeneous nature of public engagement in medical education two key concepts associated with symbolic interactionism are highly relevant: frames and boundary objects, addressed next.

96 The question "How do I apply the symbolic interactionism principles to empirical research and data analysis?" posted by Prof Kirsten Lomborg of Aarhus University Hospital on Researchgate (April 2014) with the following statement generated e-reams of valuable comment to illustrate this point: "*Together with my ph.d.-students (sic) I still find it challenging clearly to demonstrate in our empirical research how the SI framework is activated when we enter the study field and when we analyze our data material.*"

Appendix 13: Frame analysis: typology, roles and limitations

Table A13.1: Types of frames (not exhaustive)

	Frames	Area used / associated authors
Cognitive frames	• Individually held interpretation from personal knowledge, social experience often influenced by affective, value laden factors or a striking event	• Social psychology Lakoff
Issue frames:	• At the core of the framing process are issue frames which provide a relatively coherent story/reasoning in which specific prognostic elements responds to the issue • specific diagnostic elements	• Critical social policy, Dombos et al, Hope
Collective action frame:	• The predicted or expected social movement response to a policy - involves sense of moral imperative • collective action frames of social movements, *'offer ways of understanding that imply the need for, and desirability of, some form of action'*	• Social Movement research p. 7, Gamson In Vleigenthart)
Dominant frames	• Broad positions invoked by government and economic elites	• Social Movement research • Snow , Benford
Rhetorical frames	• from politician - to argue case to garner public support ...as used in a public ***performance*** (links to Goffman and the stage / dramaturgic) [97]	• Policy development research
Primary policy action frames	• Official argument or reasoned discourse underpinning policy "evidence base" that determine the content of laws, regulations and procedures ("objective truth")	• Policy development • Schön
Critical frames	• Developed as an articulation of experiential knowledge, popular wisdom and discourse often In response to a dominant or rhetorical frame	• Policy development research • Media studies - Gamson and Lasch (1983)
Means-ends Frames	• Used to articulate a desired plan or project with associated outcomes (often restructuring an organisation).	• Organisational research • Policy development research • see Borum (2004)

[97] According to Schön and Rein (1994, p. 32) even in cases where policy action and the rhetorical frames overlap, more often "*the rhetorical frame language used to win the allegiance of large groups of people differs from the [policy action] frames implicit in the agreements that determine the content of laws, regulations and procedures.*"

Role and Limitations of frame analysis

Why Use Frame Analysis?

'Frame analysis is an interpretative process in which scholars across disciplines (political science, sociology, criminology, and communications) consider the social interactions of persons to comprehend societal issues..... it is a way of selecting, organizing, interpreting, and making sense of a complex reality to provide guideposts for knowing, analyzing, and acting'.. (Lewicki, Gray, & Elliott, 2003, cited in Rinfret, 2011, p. 234)

'A frame is a perspective from which an amorphous, ill-defined problem is understood and acted upon' .(Schön and Rein, 1994)

Different approaches research assume different relationships between concepts. To explore the relationship between standards and their interpretation a qualitative approach to gathering data in the form of interview transcripts requires making links between participants words/statements and the underlying concept of interest. My research questions are informed by my observation that public engagement has been subject to multiple interpretations and therefore data analysis benefits from in depth analysis. The rigorous application of frame analysis aids the careful explications of differing interpretations (framings) from the perspective of problems they seek to address and actions required. Some limitations and the mitigation strategies I used are discussed in Chapter 5, Section 5.6. There are a number of other ways to mitigate against shortcomings and increasing trustworthiness, however most would have been challenging or impossible in a doctorate of this size for example:

- Include other coders/ analysts
- Use computerised text analysis on preset codes(widely applied in media frame analysis)
- Make full transcripts available to readers /reviewers/examiners
- Supplement data with ethnographic devices such video and audio - and make these available
- Increase the size of data set
- Include other sources of data
- Use more detailed conversation / discourse analysis

Rigour in frame analysis

The researcher should evaluate the validity master frames by identifying cultural resonance, that is evidence of application of similar frames in other adjacent fields (such medicine /nursing ; education/research) as through themes seen in the literature review.(Gray, Purdy

and Ansari, 2015; Ransan-Cooper *et al.*, 2015) During analysis it may be possible to demonstrate how frame sponsors construct legitimacy accounts which foster alignment with already accepted rhetoric within the field (Snow & Benford, 1988;) such as "person centredness" or patient safety

Techniques used to consider and the relationships between the content of alternative framings of the same issue(Anderson and Rodway Macri, 2009)

Four frame alignment or strategic processes

1. frame bridging (linking two or more ideologically congruent but distinct frames),
2. frame amplification (emphasizing frame resonance with existing beliefs, policies and practices),
3. frame extension (linking frame to other stakeholder interests - "legitimation"),
4. frame transformation (changing old meanings/generating new ones)

Appendix 14 Concepts of rigour in different research traditions

> *'Assessing the reliability of study findings requires researchers ... to make judgements about the 'soundness' of the research in relation to the application and appropriateness of the methods undertaken and the integrity of the final conclusions.' (Noble and Smith, 2015)*

This Appendix covers rigour and integrity in sections: overview of in different traditions; realist methods; tests of good research; and special considerations of insider research.

Research traditions overview of rigour and integrity

The propensity in some academic communities to apply a broadly binary distinction in research methods: and to assign a hierarchy to the evidence they generate (quantitative more valuable than qualitative) has largely been superseded by a more inclusive understanding of contribution of different forms of enquiry. Different traditions are potentially complementary ways of understanding a complex world and complex interventions needed to resolve contemporary challenges. Each traditions brings different strengths and purposes, and different challenges regarding demonstrating rigour. This is largely due to the different philosophical traditions with different epistemological and ontological assumptions that underpin them and hence the criteria by which each type of research should be judged.

Realist methods

There is an increasing interest in realist research using mixed methods to study complex topic. Two projects relevant to this thesis are the RAPPORT (Wilson *et al.*, 2015) study (into the implementation of PPI in healthcare research) and a realist review of the literature on community-medical school relations (Ellaway, 2015). Realist methods assume objective reality(ontology) as an ideal researchers should try to reach, and that objective reality can be separated from our knowledge of reality, but cannot be apprehended in a perfect way (epistemology). Realist methodology favours rigour in sampling and analysis to get as close as possible to 'objectivity' as an ideal. It often uses mixed methods aiming for reliability and generalisability through large samples and multiple sources of data / coding. While the ontology assumed in this study is essentially realist (see p58) the exploratory research question (requiring interpretative depth), and the limited size of the project did not lend themselves to a realist method or design.

Insider research - special consideration

While insider research normally applies to research with one's own organisation this project has many feature due to the way in which UK medical education (as I have argued) is a small but recognisable institutional field in its own right . highlight the way insider research may distort the normal sense of reciprocity between colleagues so participants may find themselves more inclined to consent, disclose or self-censor . Participants may be current, past or future peers, senior, reviewers or supervisees/employees so careful attention needs to be paid to how power dynamics play out and ground rules need to be negotiated and agreed as well care to use appropriate methods o pre and post interview consent and meticulous attention to the topic guide.

The idea that one is both subject and object of the study raised constant questions about my "authorial" voice. Most difficult was, in addition, to prior knowledge per se , my prior affective, political and moral impressions. These had to be managed both in terms of my experience of some of the participants and some of the topics they were discussing. Without the assistance of a more "objective coder" I cannot be sure that own subjectively has not corrupted the data – but, applying the concept of phronesis that very subjectivity perhaps adds a special authenticity.

Tests of "good research"

The tests and measures used to establish generalisability through the validity and reliability used in quantitative research cannot generally be applied to qualitative research. Thus qualitative methods and case study designs are frequently criticised for lacking 'scientific' rigour. This is compounded by the fact that there is no single consensus about the standards for qualitative research may be judged. The CASP checklist (CASP, 2014) is often used in healthcare research peer review but lacks detail (see Box A13.2 below). For readers my adaptation of Noble's table(with reference to Coffey; Lincoln & Guba; Robson; Crotty; and Richards) below may be of some help (A13.1) It lays out quantitative concepts of rigour against terminology widely used in qualitative methods. I have added a detailed colour in rigour or integrity in interpretive research.

Table A13.1: Mapping concepts of rigour and integrity across research traditions Adapted from Noble and Smith (2015)

Quantitative research terminology and application	**Alternative terminology associated with rigour in qualitative research** (Coffey and Atkinson, 1996; Crotty, 2003; Lincoln and Guba, 1985; Richards, 2009 ; Robson, 2002)	**Specific criteria for evaluating research from an interpretivist perspective** (Angen, 2000)
Validity *The precision in which the findings accurately reflect the data*	***Truth value/ Trustworthiness*** Recognises that multiple realities exist; the researchers' outline personal experiences and viewpoints that may have resulted in methodological bias; clearly and accurately presents participants' perspectives	Careful articulation of research question Carrying out inquiry in a respectful manner Articulation and evidence of the choices and interpretations the researcher makes during the inquiry process and evidence of taking responsibility for those choices Written account that develops persuasive arguments **Validity is a moral question** (etic and emic) located in the discourse of the research community ethical validity - recognition that the choices we make through the research process have political and ethical consideration. self-reflect to understand our own transformation in the research process(see comments on insider research below and phronesis in section 5.6)
Reliability *The consistency of the analytical procedures, including accounting for personal and research method* ***biases*** *that may have influenced the findings*	***Consistency/ transparency*** Relates to the 'trustworthiness' by which the methods have been undertaken and is dependent on the researcher maintaining a 'decision-trail'; that is, the researcher's decisions are clear and transparent. Ultimately an independent researcher should be able to arrive at similar or comparable findings. ***Neutrality (or confirmability) & researcher reflexivity*** Achieved when truth value, consistency and applicability have been addressed. Centres on acknowledging the complexity of prolonged engagement with participants and that the methods undertaken and findings are intrinsically linked to the researchers' philosophical position, experiences and perspectives. These should be accounted for and differentiated from participants' accounts	
Generalisability *The transferability of findings to other settings and contexts*	***Applicability/Inference*** Consideration is given to whether findings can be applied to other contexts, settings or groups or whether exploratory questions have been addressed by adding depth and diversity of understanding of phenomena. Researchers need to ask if research is helpful to the target population, and seek out alternative explanations to those the researcher constructs	

Box A1.2: CASP Quality checklist for peer reviewing (CASP, 2014)

Screening questions

1. Was there a clear statement of the aims of the research?
2. Is a qualitative methodology appropriate?

Detailed questions

3. Was the research design appropriate to address the aims of the research?
4. Was the recruitment strategy appropriate to the aims of the research?
5. Were the data collected in a way that addressed the research issue?
6. Has the relationship between researcher and participants been adequately considered?
7. Have ethical issues been taken into consideration?
8. Was the data analysis sufficiently rigorous?
9. Is there a clear statement of findings?
10. .How valuable is the research?

To reiterate my statement at the beginning of Chapter 6: all the findings herein are effectively a temporary settlement, the result of one individual engaging in a systematic, but ultimately one-sided, dialogue with the data which underscores its contingent nature

Useful websites:

Cohen D, Crabtree B. "Qualitative Research Guidelines Project." July 2006. http://www.qualres.org/HomeInte-3516.html (accessed 2 July 2016)

Qualitative research
https://en.wikiversity.org/wiki/Qualitative_research#Introduction (accessed 2 July 2016)