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**Perceptions on the development and implementation of a
care pathway for people with schizophrenia**

(Volume One)

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the requirements of the City University for the degree of
Doctor of Philosophy

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Declaration

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Abstract

There has been a concerted effort to enable a managed response to the delivery of mental health care. This has been made through various Government initiatives such as 'general management' and clinical audit. Methods have developed, such as a care pathway, to control the way care is delivered along planned treatment trajectories. In this qualitative study the researcher explored how respondents on a psychiatric ward and community team developed a care pathway for people suffering from schizophrenia, including the process of admission and discharge from hospital. Findings from this study showed that respondents argued for the individuality of the patient in shaping the way care should be delivered. Individual clinician-patient relationships and the unpredictable nature of schizophrenia were also important factors. Other respondents pointed out that some aspects of the systems of care could and should be standardised such as the procedure for finding accommodation upon discharge. The difficulty in describing the process of care influenced perceptions of evidenced-based care. On the whole, respondents were in agreement with the necessity to use evidence to drive the delivery of care. The purpose of a care pathway is to work in a co-ordinated way and this is reliant on knowing how interventions are known to work. Findings from this study demonstrated that clinicians were not always aware of how or why they carried out psychiatric interventions.

Over the span of time covered by the study, while the care pathway was being developed and implemented, various external factors had a significant influence. Particularly influential was the rapid turnover of staff on the study ward and the impact this had on motivation for developing and implementing the care pathway. Important too were the approaches taken by the researcher and how the respondents perceived this. These findings are relevant for other health service areas that employ large numbers of temporary staff and staff groups that feel disenfranchised by managerial approaches. Using a care pathway to deliver care has implications for the training of all discipline members and for the way they work together. Ultimately, the acceptance of a care pathway for psychiatric services will be influenced by the way in which they are perceived by clinicians and managers, each of whom have different interests to be served.

Introduction

Conception of the research study

A care pathway has been proclaimed as a managerial and clinical approach to both control and deliver health care. The majority of studies have focused on whether a care pathway is able to reduce length of stay (Cook 1998), however the study of how care pathways are developed and implemented within clinical practice remains unexplored. In this study, factors for the development and implementation of care pathways for people suffering from schizophrenia will be explored. This is relevant given the explicit political context of greater managerial scrutiny over care and treatment practices and the imperative to balance cost over quality of care.

The management of care

Traditionally, psychiatric patients were incarcerated in institutions but over the years with a greater awareness of the clinical effectiveness and costs of this form of treatment, coupled with a libertarian public consensus, alternative methods were proposed (Butler 1993). Community care was advocated to meet the needs of the mentally ill (Department of Health 1989) within the National Health Service (NHS). However, the form of community care has proliferated in many directions with different types of teams, legislative powers and management approaches developed to meet the needs of this complex service user group (Thompson *et al.* 1990).

The majority of people with mental illness continue to be managed within a primary care setting with the General Practitioner (GP) being the main 'care giver' (Kendrick *et al.* 1991), although some people require hospital care.

Patients who present to the service are differentiated by both their diagnosis and needs for care, treated in various sites with services being delivered by both health and social statutory services, voluntary groups and self help organisations (Leiba 1997).

There have also been attempts to present the mentally ill as a group that can be managed using various approaches. For example, hospital systems have developed such as task allocation, primary nursing and care pathways that aim to present a co-ordinated attempt to care and treatment. Community systems have evolved such as case management and a co-ordination of professionals within community mental health teams. All of these management systems have as their aim to improve the co-ordination of care for the patient through a complex and costly system. Greater consumer power has also challenged the provision of resources (Anthony & Crawford 2000).

The development of care pathways is widespread across the United States and there are advocates of this approach for the improved management of NHS resources (Johnson 1995). Managed care can be described as an organisation wide method of inter-professional practice and includes a care pathway, an in-patient case manager, and a variance tracking procedure (Petryshen & Petryshen 1992). The care pathway attempts to display the

interventions and outcomes that should occur for a particular case type (Coffey *et al.* 1992).

The researcher was interested in developing a care pathway for people diagnosed with schizophrenia and how services could be configured across hospital and community sectors. Particular challenges would be the complexity of the disorder and the ability of clinicians to compartmentalise the care and treatment into a preformatted system. Moreover, the ability of the multi-disciplinary team (MDT) to work on joint health and social care systems. As the following chapters will explore all are relevant and challenging for the development and implementation of a care pathway for psychiatry.

Researching the development & implementation of a care pathway

The majority of studies have traditionally been concerned with the effect of a care pathway on service level outcomes such as length of stay and costs of care (Muluk *et al.* 1997, Chang *et al.* 1997). In the main, care pathways research has not focused on mental health conditions or with the perceptions and interpretations of them within a defined clinician group. A research approach that sought to explore the particular context of change and how clinician groups worked with the development and implementation of a care pathway is most applicable.

The process of studying a culture of change calls for an action orientated approach (Greenwood 1984). Action research provides a framework by which groups of people within an organisation or society are empowered to identify problems and set in place a process of change (Hart & Bond 1995). The researcher can facilitate the process and the purpose of analysis is the actual process of change itself (Rolfe 1996). Exploring perceptions towards new systems may best be explored using a more informal approach and less interested in structured quantitative findings. The principles of ethnography suit this approach where the aim is to observe and question the participants and context to produce both descriptive and interpretative analysis.

Chapter profiles

The aim of this ethnographic presentation is to allow a general understanding of the context of mental health policy and practice and to provide an argument for studying the development of a care pathway in a certain way. Throughout the course of this ethnographic account the intention is to present an analysis embedded in the context in which it arose. The analysis will serve as one possible version of events subject to bias and subjectivity inherent in qualitative designs.

Chapter one

A central argument throughout the first chapter will centre on the increasing drive to improve the management of NHS resources. Over the last 50 years mental health services have changed considerably resulting in a diversity of

service provision. The emphasis has been upon a mixed economy market orientation to health care and a pressure to maximise expensive health care resources (Klein 1989). However, clinicians have not readily accepted these management inspired changes and given the nature of care pathways, may lead to differences of opinion on their value and acceptance. Increasing control has also been placed over where patients receive their care and treatment (Department of Health 1995a). As a balance between these two managerial tensions, greater powers and managerial support have been given to user groups and this has been instrumental in questioning how resources are delivered (Health Advisory Service 1997).

Alongside a proliferation of services has come the emergence of clinician groups who care and treat the mentally ill. How these professional groups are educated and configured may have an impact on the efficiency and effectiveness of patient outcomes. Critical appraisal of these issues is relevant for the development of care pathways because they provide an essential context for the views expressed in the following chapters.

Chapter two

In chapter two an in-depth analysis of the historical and structural components of a care pathway will take place. Considerable attention is given to defining the variants of managed care systems such as patient focused care and disease management. The care pathway has been extensively tested for medical and surgical conditions, although not so for mental health. The

analysis proceeds on whether a care pathway is most suitable for disease states such as schizophrenia given the nature of evidence based practice for this condition. Considerable debate remains on the aetiology and treatment of schizophrenia with little prospect of consensus (Kendell 1993).

Attention is given to the commentary on the development and implementation of care pathways and its application to mental health. Aspects include how other facilitators have carried out the development process and how the team should be assembled for successful implementation (Hainsworth *et al.* 1997). This is directly relevant given the central question of this study and how these factors affect the development and acceptance of a care pathway.

Chapter three

The analysis chapter describes the foundations of the study and argues the case for using qualitative methods for this line of enquiry. The difficulties of undertaking the research have been raised as an important issue such as gaining access to the study participants and ensuring compliance with the study and organisational objectives. The process of data collection, analysis and influence of bias are reviewed for the presentation of qualitative text.

Chapter four

The first analysis chapter focuses on the reactions of respondents to the development and implementation of the care pathway. This is presented as those respondents who advocated for care pathways as a method to

standardise care processes. Alternatively, other respondents reacted against care pathways for its attempt to minimise the individualised approach to care. The nature of clinician patient relationships is a decisive factor. This individualised-standardised continuum provides the central crux throughout the following analysis chapters and possibly fundamental for the development and implementation of care pathways for psychiatry.

Chapter five

Many commentaries have presented the argument that a care pathway leads to more integrated care (Hall 2001) and chapter five discusses how and in what ways a care pathway does bring about closer team working and role extension. A particularly striking feature of this chapter is the tendency to critique the ability of colleagues in providing health care for this group of clients as a response to conflict with their own role and function. The analysis attempts to demonstrate how professional groups justified their role by placing ownership over certain tasks in the care process.

Chapter six

In the third analysis chapter, some of the issues in describing psychiatric work will be illustrated. The care pathway literature assumes that care processes can be described or that respondents are able to give accurate details about their role. If a care pathway does not represent the reality of practice, it could lead to problems for implementation in clinical practice.

Although essential to provide a context to understand qualitative studies, the changes incumbent within this research study make this paramount. The development of the care pathway was started with a relatively full complement of the staff team although this changed dramatically thus affecting the viability for fully implementing the care pathway. Inevitably the themes of morale, staffing levels and wider management changes became important.

Chapter seven

The final analysis chapter attempts to link the wider socio-political context to the study. The political imperative of the NHS has been to produce cost effective and efficient methods of delivering care (Maynard & Bloor 1995). This has manifested itself as management inspired changes that have impacted on both the structures of services and upon the staff groups. Views are expressed about the ability of a care pathway to extend this managerial agenda but also of the consequence of greater scrutiny over working practices. Considerable attention is given to the impact of the evidence based practice movement within health care and how the study participants view this. The care pathway draws out the problems of the drive for evidence based work culture and links them to the wider practice of psychiatric care.

Chapter eight

The final chapter attempts to draw together the main findings of the study and relate them to the current management led changes within the NHS.

Issues of most relevance include the capacity of a care pathway to improve the co-ordination of care between different agencies and the ability to control health care risk for the clinician and organisation. Other areas of consideration are the impact of a care pathway on psychiatric nursing and the wider staff team. Attention is given to the issues of autonomy, role extension and professional stature.

Attention has been paid to the ability of a care pathway to inform service planning and provision and so some conclusions are drawn on the impact of a care pathway on teaching and training psychiatric professionals. This will also include future treatment and care directions for people with schizophrenia. A care pathway may be a vehicle to introduce innovative methods of treating people with schizophrenia or make best practice a feature of routine care.

A critical evaluation of the research approach taken within this study will take place with suggested ways forward for future enquiry into care pathway research. The researcher outlines the problems encountered in the study and undertakes a reflective account on the occasional naïve routes taken in conducting the research. It is concluded that given the relative dearth of qualitative and quantitative research into mental health care pathways an action-orientated method appears most appropriate.

Chapter One

The management of psychiatric care

Introduction

The purpose of chapter one is to give the reader the context they require to understand the location of care pathways in National Health Service (NHS) policy, organisation and psychiatric practice. This includes a consideration of a 'managerial agenda' that has permeated NHS policy development over the past 20 years and is evidenced in both community and in-patient settings. It also involves a consideration of how psychiatric professions are organised and how teamwork may contribute towards the care and treatment of people with schizophrenia.

The nature of a care pathway

The care pathway movement is widespread across the United States (US), but many questions have not been answered regarding their development, implementation and potential benefits (Pearson *et al.* 1995) and this is especially so for people diagnosed with schizophrenia. The care pathway attempts to detail the actions of professional groups along the care continuum within a 'stand alone' document (Pettryshen & Pettryshen 1992). Those who deliver the care can refer to the care pathway and work towards achieving previously identified outcomes for the patient and the organisation (Laxade & Hale 1995a,b). For example a nurse can refer to the care pathway to check

whether a patient has completed a post discharge questionnaire before going home.

The principal aim of a care pathway is to co-ordinate resources in what may otherwise be a fragmented care process (Ethridge & Lamb 1989). The care pathway attempts to make sense of the roles and responsibilities of different care providers and the myriad of decision-making processes that go on to form a care delivery episode. A care pathway provides a structural format from which to plan and audit the provision of mental health services. These potential benefits have led to some hospitals in the NHS developing care pathways to manage and co-ordinate health resources.

National Health Service (NHS)

The NHS was created in 1948, funded by taxation and represented one of the most significant post-war social welfare developments (Cox 1991). However, the structure of the NHS has changed rapidly to embrace a more cost-effective system (Hughes & McGuire 1992). From the 1950's, ministers were aware that costs for services were rising faster than expected leading to a fragmented service that was variable in quality (Bryne & Padfield 1990). This led to a series of management changes. One of the most fundamental reviews was the Griffiths' enquiry (1983), that introduced the concept of 'general management' into the heart of delivering health care. Some have argued that its intention was to curb medical hegemony and control resources

(Austin & Dopson 1997) although others have suggested the impact was limited (Cox 1991).

A major piece of legislation to change the way services were managed in the NHS was through the NHS & Community Care Act (Department of Health 1990). This enabled health authorities to assess health need but for the resources to be purchased from hospital and community services. Financial reserves were also given to groups of General Practitioners (GP's) to form fund-holding practices that were also permitted to provide a wider range of services. In a sense, an internal market was created which sought to dismantle the monopoly over both supplying and providing services by adding incentives and competition between different service providers (Mohan 1996).

The changes to the NHS have placed great emphasis on health care as a product that is subject to prediction and control. This has led some to question whether health care can be perceived in this way (von Otter 1991). Both the giver and receiver of health care do so subjectively and are responsive to pressures that may be unpredictable or controllable. For example, the giver of health care is more likely to have information about the intervention compared to the receiver. This may place the patient at a disadvantage in choosing to accept the intervention. A second way in which this position is undermined is that professional bodies regulate practitioners and place certain restrictions on practice. These two arguments compromise the position that health care is a product subject to market pressures

(Trnobranski 1995). However, the perception of a quasi-market has had a profound effect on the philosophy and provision of health care resources.

Effects of a business management agenda

The intention of the managerial agenda has been to control the activities of health staff, which through their mode of work exert most impact on use of resources. The Government attempted to do this by changing the way decisions were made about delivering resources. The user of care has also been empowered to question how and where services should be received. These combined changes have sought to control and manage services in a more effective way.

One way in which the managerial role of nursing staff has been reduced was through the implementation of general management. General management principles aimed to identify single line management that was accountable for resources (Griffiths 1983). For example, Cox (1991) identified that senior nursing roles that traditionally were central to the decision-making bodies were effectively displaced into roles created to monitor quality assurance. A possible intended consequence of this change was to create a separation between the management and provision of nursing services.

A recurrent feature of general management was that resources were being continually 'cut-back' to reduce service expenditure. Flynn (1992) examined the perceptions of health staff towards this occurrence and found generally

negative responses. For example, health staff perceived that the role of general manager would be unable to solve problems of limited expenditure. Health staff were unable to appreciate how their role affected finite resources and this was especially so for medical staff. However, there was an acceptance that decision making had improved and had led to a rejection of managing health care by consensus. This study draws out the important point that health staff may have a variety of responses towards the principles of business management, which may influence acceptance of other management structures.

A further way in which health care has been managed more efficiently was the examination of the roles and skills of certain occupational groups (Bradshaw 1995). Use of the term 'skill mix' has been deployed to ensure staff resources were continually appraised and used efficiently (Department of Health & Social Security 1986). Although professions such as medicine and nursing rigorously defend the autonomy of their practice, the Government has used the principles of supply and demand to force changes in nursing and medical practice. For example, by reducing junior doctor's hours the Government introduced the extended role of the nurse (Shaw 1997). This change in clinical role demonstrates the process of delegating tasks to cheaper professional group's (Murray & McChesney 1998) and challenges professional boundaries. It also promoted the concept of generic practice, which supports the principle that core skills are applicable to many professional groups in the delivery of cost effective care (Norman 1998).

Although the Government has tried to introduce changes to the way staff should be managed and the roles they should undertake, it has not always been successful. There appears to be a difference between policy and practice and some have labelled this as 'implementation deficit' (Ham & Hill 1984). Some studies have observed clinicians to interpret and change policy to match certain cultures of care (Wistow *et al.* 1992). Other studies have found confusion over new policies such as the care and case management procedures, which formed the foundations for the Government's 'community care' philosophy (Caldock 1993). It appears to be the case that not all attempts to manage staff resources have led to the most desirable outcomes. This could be explained by the reluctance of staff groups to fully accept the intentions of a business model. Alternatively, the measures may have been perceived as a threat to professional autonomy.

In this section, examples have been given to demonstrate the presence of a managerial agenda of control within health care. It could be argued that health care has always been dominated by cost, although with progressive reforms, this relationship has become more explicit. The Government has attempted to challenge clinical structures by introducing management tiers, changing decision-making procedures and extending clinical roles to maximise skill mix in clinical settings. However, this managerial agenda has not been positively received. Evidence supports the case that clinicians interpret Government policy to suit their own local situation (Lipsky 1980). Some

scholars have suggested clinicians should use the language of managerialism to pursue their own enactment of the policy process (Hewison 1999).

However, the impact of a business model has been profound on the culture of care and challenges the positions and boundaries of all clinician groups.

Clinical audit

It has been considered possible that if clinicians were better organised, greater efficiency would be achieved. Clinical audit was advocated as a method to establish this control by setting in place projects to monitor progress towards established targets. However, similar to the introduction of general management, clinicians have not been positive about clinical audit processes, largely due to curtailed clinical freedom and increased work burden (Dent 1991). However, there are differences in perception towards clinical audit programmes. Lord & Littlejohns (1996) found doctors were less positive about clinical audit tools compared to nursing staff. Nurses and doctors that held senior positions in the organisation were more favourable. This study indicates that managerial techniques such as clinical audit become significant as the clinician becomes further removed from patient contact or more responsible to overall management.

Monitoring work through clinical audit has led some to question the purpose of the activity. Dent (1999) has argued that the Government has used clinical audit to renegotiate the relationship between clinical autonomy and the needs of the organisation by emphasising the use of evidence-based practice. In

doing this, the management of health care has been made more legitimate through 'scientific medicine'. The effect however has been to place greater controls over how clinicians practice. Tools to measure and control clinical work would have direct relevance for the acceptance of a care pathway. A care pathway would aim to make clinical audit a part of every day practice where the clinician constantly monitors the progress of the patient and the actions of the team towards set targets. This may explain possible negativity towards a care pathway by clinicians and a positive acceptance of them by management.

Role of the consumer

A business management agenda has attempted to challenge the foundations of health care provision by empowering the user of care. The roots of consumerism can be traced back to Griffiths (1988) who argued that people should be afforded choice and respect in the clinical encounter. In more recent times the role of user has been elevated to a position of being part of the planning process when setting up new services (Health Advisory Service 1997). The Government has provided avenues for patients to exercise their rights such as the patient's charter (Department of Health 1991b), importance given to user and voluntary groups and identification of users and carers needs within care planning exercises (Department of Health 1999).

Possibly, one of the main benefits through empowerment of the user has been more information being given to the patient during the clinical

encounter (Baker 1998). However, it is questionable if this can be said for people with mental illness who have been perceived as being disempowered within society (Brandon 1991). Godfrey (1996) found that psychiatric patients were not perceived as active partners in the care planning process. However, this observation has also been found in other settings such as primary care. For McIver (1999), there was a perception that users had trouble in being an active participant and were not particularly committed towards changing service provision. Behind the drive for consumer power, there is an underlying assumption that patients want to be involved in decision-making although this is not always the case. For example, Biley (1992) found that patients only wanted to be consulted when they felt able to and this was largely dependent on how ill they were. In many respects, the rhetoric of consumerism seems to be over shadowed by the complexity of the relationship that patients assume and want when they are the recipients of health care.

The rise in consumerism however appears to have greater impact on those who provide the services. Glenister (1994) suggests that clinicians feel threatened by a more interactive user. Lupton (1997) observed this in a study with an examination of the relationship between GP's and patients.

Respondents spoke about a sense of the profession being 'devalued' and being held as more accountable to the needs of the patient. This is a positive feature of the rise in consumerism and challenges the perception of 'they must know what they are doing' attitude, which features in the clinical encounter (Baker 1998). It also begins to shift the perception that health care

can be delivered without any accountability for patient outcomes. Placing the patient's satisfaction with care or involvement in care planning as an outcome enhances the business like agenda.

The impact of policy changes to enable greater control over the process of care has been reviewed. A business like agenda has permeated throughout the health care structure and challenged clinical roles, boundaries and perceptions. The impact of the 'general manager' radically altered how health care was managed. The Government also achieved this by placing explicit work control methods such as clinical audit as a central part of practice. Targeting the role of the user to challenge the accountability of care has also taken place but it is questionable if this has occurred for people with mental illness. These conclusions support the argument that greater work control methods are still being pursued and that a care pathway may both improve and extend the business like agenda.

Care structures in the community

The settings in which care and treatment are provided to mentally ill people have also been altered to reflect a business model. In this section, a range of structures will be reviewed that have attempted to control where and when patients receive treatment. The intention will not be to review all structures but to demonstrate that the Government has made on-going efforts to provide greater structure and control over staff and patients in community settings.

Case management was developed in the US to ease the resettlement of patients from the traditional asylum method of care into a community care setting (Test & Stein 1980). Case management includes an explicit rationing principle by identifying those patients most likely to benefit from limited resources (Crosby 1987). No universal model of case management exists although most definitions describe the approach as a mental health worker who both provides and brokers for services and is responsible for maintaining a relationship with the patient and family (Clifford & Craig 1989). There have been many reviews on the efficacy of case management services with some studies demonstrating reduced rates of hospital admission (Burns *et al.* 1993) whilst other studies have found no effect on health gain or use of hospital resources (Kluiter 1997). Case management has been deployed to focus on patients deemed to have a serious mental illness (SMI) and although the evidence for the approach has been mixed, case management continues to be practised in the UK. Case management has been an attempt to co-ordinate staff intervention although it has not been particularly well organised or effective.

To combat some of the structural problems of case management, the Government introduced the Care Programme Approach (CPA) (Department of Health 1995b,c). The intention of CPA was to provide an over-arching organisational process to tier certain types of services for particular client groups. An attempt was also made to ensure clinicians performed

assessment, care planning and review by set times (Ryan *et al.* 1991). However, CPA has not been totally effective with some hospitals being inconsistent in placing patients into tiered systems (Bindman *et al.* 1999) whilst others have perceived the process as too bureaucratic (Social Services Inspectorate 1995). CPA was also designed to empower the service user but some studies have found that patients experienced little improvement in the information they were given about the care process (McDermott 1998). Although the Government spent great time in detailing the CPA process, clinicians have felt reluctant to implement this very structured approach to care. Clinicians have also resisted a further attempt to empower the service user. The CPA has been a further attempt to manage the process of care although with limited success.

It could be argued that if clinicians were assembled into multi-disciplinary teams (MDT) in the form of a Community Mental Health Team (CMHT) then the practices of case management, CPA and a focus towards SMI could be properly managed. CMHTs were first established in the 1960's and gained prominence in the 1990's by acting as a gateway into secondary care services. The CMHT has clear advantages over how the MDT assesses and delivers care. For example, the dominance of the medical model in decision-making and direction over care has been eroded by the influence of social work and nursing perspectives (Peck 1995).

A primary reason for establishing a CMHT was to deliver more cost-effective approaches to care. Some studies have demonstrated cost savings compared to day hospital provision (Tyrer *et al.* 1998), whilst other studies have found reduced admission rates and length of hospital stay (Tyrer *et al.* 1999). These factors have been important in the drive for cost effective services. However, the CMHT has been ineffective in managing staff resources towards caring for those patients with a SMI (Onyett *et al.* 1994). Unclear management structures, conflict over roles and responsibilities has left staff feeling over-extended and exhausted (Onyett *et al.* 1995). These factors have led to other types of teams developing such as assertive community treatment (ACT) and home treatment teams.

The development of a CMHT has been a further attempt to improve the management of staff resources although problems have been found in their configuration such as blurring of professional identity and unclear management structures. These factors have possibly led to a poor focus on those patients with a SMI. It is important to effectively manage community services if other problems in costly hospital services are to be avoided. Factors underpinning the management of community resources are important for the consideration of care pathways, which would attempt to further control the focus on the SMI population.

There has been a great deal of criticism in managing people with a SMI in the community. This lack of focus prompted the Government to ensure that all

Trusts maintained a 'supervision register' of those patients deemed to be at risk (Department of Health 1995c). However, this was found largely ineffective with no lesser risk being demonstrated through being on the register (Hindler 1999). These problems led to further legislation to ensure a more restrictive care package was developed. This was to be called supervised discharged which was able to specify where the patient lived and what they did in the day (NHS Executive 1996c). However, there has been a complete lack of evidence to support the effectiveness of this political development and it appears to have been enacted for political reasons to control people with a mental illness (Eastman 1997). Some have argued that the supervision register (Nolan *et al.* 1998a) and supervised discharge have re-focused the clinician's attention towards managing this vulnerable group of clients, which previously had been ignored.

In this section, some of the main structures of care and policy have been laid out to demonstrate a concerted attempt to exercise greater control over clinicians and patients in the delivery of health care. Each development is a further attempt to add or improve on the controls over staff and therefore resources. There have been deficits with all structures and clearly, a different type of team or organisation is required to focus staff in working effectively with the SMI population. Tyrer (1998) suggested the problem of a fragmented approach to developing community care was due to the lack of input by professional groups. It seems more likely that staff groups have been resistive to work control methods that have featured so strongly in the

development of community services. How clinicians interpret and react to new care systems is important to understand the impact of a care pathway, which would extend rather than decrease work control methods.

Hospital care systems

The majority of resources continue to be spent on hospital care (Andrews & Teeson 1994) and so large financial gain is likely if this resource could be used more sparingly. Hospital care serves an essential function for assessment and treatment purposes although since the 1950's Government policy has been to reduce this expensive resource (Davidge *et al.* 1993). The question is determining what types of work control processes occur on hospital wards and if staff resources and patient admissions could be better co-ordinated. For example, Johnstone & Zolese (1999) found short planned hospital care to be equally as effective in readmission rate and contact with the service compared to standard hospital care because clinicians and patients were working towards set discharge dates. Other studies have found using day hospitals can make cost savings with no difference in clinical outcome (Creed *et al.* 1997a).

Psychiatric nurses are the largest group of staff in hospitals who have 24-hour contact with psychiatric patients. However, countless studies have demonstrated that nurses are both reluctant to engage with psychiatric patients (Altschul 1972, Cormack 1976) or to provide therapeutic activities for them (Ford *et al.* 1998). Muijen (1999) has labelled this type of environment

a 'care vacuum' and questions the actual component of effective hospital care. One could conclude that the role of psychiatric nurses would be to manage the ward and patient activities but nurses have been both reluctant (Gibjels 1995) and unable to do this. For example, Higgins *et al.* (1999) identified that nurses were using inefficient bed management practices leading to wastage of resources.

It could be argued that nursing systems should be developed to improve the structure of care. The use of care plans could determine therapeutic contact or improve therapeutic effectiveness however some studies have found no difference in patient outcomes if care planning does take place (Maloney & Maggs 1999). Neilson *et al.* (1996) found that self harm and violent incidents occurred at similar frequencies regardless of whether the care plan was in place or not. Other studies have demonstrated that nurses do not always follow the care plan (Aidroos 1991) or refer to patient needs when planning care (Chavasse 1981). Porter & Ryan (1996) observed that nurses completed the care plan as a symbol of bureaucracy as opposed to a core function of effective practice. These points correlate strongly with the observations above that hospital care appears largely uncoordinated and possibly ineffective in delivering psychiatric care. A care pathway would attempt to unpack what occurs for psychiatric patients on hospital wards although gaining compliance with a care structure designed to manage staff resources could be problematic.

Hospital care remains fundamental to psychiatric care although how it is used could be improved. For example, shorter hospital stays or day care alternatives could be a better use of resources. Moreover, the roles of nursing staff have been questioned because studies demonstrate both a lack of therapeutic contact with patients, an inability to manage psychiatric care or to comply with care planning which would install some focus to their work. Quite possibly, the lack of knowledge on what is required for effective hospital care is a result of the Government's focus on the management of community care (Walton 2000). A care pathway could be used to rekindle the debate on how and who should be applying and organising hospital resources.

Controlling patient care

Fundamental to both community and hospital settings is the idea that care and treatment can be controlled and delivered according to set procedures. This has led to various debates between clinicians that argue for an individualised as opposed to standardised approaches to care. An individualised approach to care could be defined, as one that reflects the care required that fulfil the particular needs of the patient (Reed 1992). In contrast a standardised approach to care assumes that patients have common needs and outcomes and therefore the care provider is able to refer to set protocols (McNicoll 1992). The ability to predict course and treatment also assumes that sufficient information is known about certain disorders that fall within the SMI sub-group. These issues are fundamental for understanding the development of care pathways for people with schizophrenia.

Certainly in the nursing literature, there is a rigorously defended position that care and treatment must be delivered on an individual basis (Redfern 1996). This has been operationalised through various nursing theories (Fawcett 1989), structures of care such as the nursing process (De La Cuesta 1983) and primary nursing (Marram *et al.* 1976). The rationale for this stance appears to be the importance of individual nurse-patient relationships, which in turn determine the process of care (Ramos 1992). There are two implications of this stance for the management of psychiatric care. The first is having sufficient control over clinicians if they are permitted to work on an individualised basis. Moreover, it is assumed that the claims to work in an individualised way are actually carried out during the process of patient care. For example, studies by Thorell-Ekstrand & Bjorvell (1995) and Waters & Easton (1999) have found that nurses wanted to provide individualised care but were either limited by organisational issues or just did not practice the rhetoric of this highly claimed principle of care. A particular stance on individualised care may prevent or question the ability to standardise clinical work within a care pathway.

Some parts of the care process could be considered 'routine' (Morgan 1993) such as admission procedures, the CPA process and medication guidelines although these structures of care remain undocumented. Others have argued that clinicians work in one-to-one relationships with a tendency to look at parts of one's role in relative isolation to the wider integrated care continuum

(McNicoll 1992). In other ways, psychiatric patients are provided with care according to the routines of the hospital (Goffman 1961). Advocates of standardised care suggest that the approach eliminates duplicity, permits an examination of health gain (Layton 1993) and enables doctors to maintain more control over patient care (Pearson *et al.* 1995). The downside however may be an inadvertent focus on the tasks of care and a rejection that care should be planned on an individual basis (Royal College of Nursing 1992).

The most important criticism of efforts to standardise care is that we are not able to predict the patient's illness. For this, sufficient knowledge is required to develop standardised care that fits both local and national policy parameters (Gilbody & House 1999). The Government has tried to give the impression that sufficient detail is known about clusters of disorders by its focus on the SMI and prioritising resources towards this group (Department of Health 1994a). Some have argued that the focus on SMI has been bolstered by the dominance of biological theories of the cause of mental illness (Gournay 1996). Others have asserted that the emergence of management inspired principles such as efficiency and effectiveness have promoted a medical model orientation to psychiatric care (Lego 1992). This produces both ideological conflict within the team but also gives the impression of control over the psychiatric patient (Hummelvoll & Severinsson 2001).

The exact definition of SMI is unclear (Barker *et al.* 1998) and some have suggested that biological determinism has produced a far more conclusive

assessment of its ability to predict patient outcome than is currently available (Dawson 1997). Others have questioned the validity of the construct of schizophrenia (Boyle 1990). This makes the picture further unclear because schizophrenia is considered as the backbone to the SMI category (Department of Health 1999). It seems more likely that an impression of control and prediction over SMI disorders has come to colour the landscape of psychiatry. This would have implications for the development of a care pathway, which is reliant on being able to predict patient care. Prioritising resources towards certain disorders is a further attempt to manage clinician groups and reduce clinical variation that may occur through individualised approaches to care.

Influence of inter-professional practice and education

The impact of professional groups working together is said to produce many benefits such as a sharing of views from different disciplines (Social Services Inspectorate 1991) to work on common problems (Department of Health 1994b). However, there are many complexities in the configuration of psychiatric teams such as relations between the team members and how teams are prepared for their practice (Sainsbury Centre 1997). Ensuring the team works cohesively has implications for the use of resources. A care pathway would challenge both the importance and ability of the team to work on common problems and interventions. This is because disciplines have tended to work according to set professional boundaries (Firth-Cozens 2001) and this tends to limit their awareness and appreciation of what other professional groups do within the patient care episode.

Ensuring that all team members feel valued in the team is important for morale but also for effective team working (Morrall 1997). However, countless studies demonstrate the opposite. For example, studies have observed conflict between nurses and doctors (Stein 1967) and nurses and social workers (Hugman 1995). This has led to some disciplines such as nurses to feel both devalued and disempowered in the team. In Harold's (1977) study, nurses perceived themselves to hold simplistic viewpoints on the patient's disorder compared to psychiatrists. Miles (1977) found psychiatrists to have exclusive management control over the patient's care and treatment. Care pathway development is reliant on professions asserting their role clearly and accurately and so if professions feel less important to others then co-operation and confidence may be stifled.

The practice of teamwork is possibly made difficult because of the contrasting positions that disciplines hold on a range of issues. For example, Patterson & Hayes (1977) found disciplines adopted a particular occupational language, developed during a period of training (Melia 1987). Teamwork could be affected when disciplines choose to align themselves to particular ways of discussing care or focusing on issues that are perceived relevant to them. As discussed previously however, some particular views such as the medical model may come to dominate the process and outcome of teamwork (Opie 1997). Important is the need to unpack the different perspectives that clinicians hold on the treatment of mental illness.

Teamwork also gives rise to clinicians taking on practices once previously completed by other discipline groups. This arises through the organisation using the most appropriate skill base to achieve the desired outcome (Onyett *et al.* 1995) and a need for generic working (Hurst 1996). This does give rise to boundary disputes where professions become defensive about certain parts of their care. Beattie (1995) has suggested that clinicians develop a 'tribalistic' culture, which preserves professional power and uniqueness of occupational identity. For example, Brooks (1996) perceived professional groups to own particular parts of work and this resulted in professions collecting the same information about the patient. In other ways, rituals of practice may be erected to support demarcation from other professional groups (Menzies 1970).

One way in which the problems of teamwork have been addressed is through inter-professional education (Department of Health 1994a, Salvage & Smith 2000). Teaching professional groups on a shared learning path serves to challenge the differences and similarities of professional groups across a range of tasks (Sims 1997). It also questions the autonomy of professional groups, which may conflict, with the priorities of the organisation (Humphreys & Quinn 1994). However, there are many problems with inter-professional education such as segregated learning facilities (Leiba 1997) and lack of support for the idea from within the professions (Hurst 1996).

Being able to co-ordinate the team across both hospital and community settings is fundamental for effective and efficient care (Sainsbury Centre 1997). The process of teamwork however remains fraught with difficulties ranging from perceived lack of equality across the professions and 'tribalistic' practices to protect occupational culture and identity. Inter-professional education may develop generic approaches to care and challenge deeply held professional beliefs but the approach is limited with very few resources devoted towards the approach (Goble 1997). However, understanding teamwork is central to the implementation of a care pathway, which is reliant on professional groups negotiating roles, eliminating duplicity in work tasks and focusing on common problems and interventions.

Conclusion

In this chapter an attempt has been made to give an overview of the management of psychiatric care in both hospital and community settings. It has been the general argument that successive managerial changes have led to greater control over clinical activity. General management principles, clinical audit and empowerment of the user have changed both the planning and delivery of care and this appears to be part of all structures in the NHS. A care pathway could be perceived as a method to both extend the managerial agenda but also be accepted as a positive development for psychiatric care. For example it could focus greater attention on setting outcomes for psychiatric care.

Developments within community care such as the practice of case management and CPA have attempted to focus and prioritise resources towards certain types of disorders. The procedures have also promoted a standard way of working regardless of individual need. It appears that less attention has been paid to the management of hospital resources. Evidence supports the case that much more needs to be done to use this resource more effectively. The development of a care pathway may be able to substantiate the inefficiency and ineffectiveness of the use of hospital resources, and provide a clearer insight into the workings of certain professions such as nurses and doctors in the planning and execution of psychiatric care.

Psychiatric care has also been re-focused by the priority towards the SMI group and this gives the impression that professions are able to predict the course and treatment for certain groups of disorders. This challenges highly valued principles of care such as the need to plan and deliver care in an individual way. Recognising the possibility for this conflict is important for the development of a care pathway. A care pathway would attempt to illustrate standard ways of working and so conflict with individualised conceptions of care.

The development of teamwork has led to different conceptions of care being used to challenge dominant professional groups such as doctors. The disadvantages of teamwork also lead to problems with professional identity,

conflict between the professions and defensive practice. Training and development may lead to professions adapting to the market requirement for generic practice (Baker & Perkins 1995) but again this is hampered by lack of resources and support from within the professions to support inter-professional education. A care pathway may uncover some of the problems of teamwork and offer some directions towards how the team should both work and be trained to care and treat people with schizophrenia.

Chapter Two

Care pathways for structuring patient care

Introduction

The aims of this chapter are to review the literature on care pathways for patients with mental health problems such as schizophrenia. There has been much confusion regarding the terms used to describe this method of organising care. Differences between case management, managed care, disease management and other similar terms are discussed.

The components of care pathways are illustrated by drawing from examples of physical and mental health conditions. Trials testing the effectiveness of care pathways against various outcome indicators such as length of stay (LOS), costs of care, and patient / care provider satisfaction are reviewed. Alongside this is a critique of care pathways for patients with schizophrenia covering issues such as the predictability of the disease process, agreement over outcomes, professional monopoly over interventions and flexibility of mental health resources to match the requirements of a care pathway.

Studies charting the development and implementation of care pathways are also described. Issues include the role of the facilitator, methods of construction and the role of the multi-disciplinary team (MDT). The chapter concludes with areas for further research and development. It is argued that qualitative research needs to be performed on the development of the care

pathway and the associated issues in relation to the care and treatment of in-patients with schizophrenia.

The history and background of care pathways

Community case management

Many terms have been used to describe case management such as case co-ordination, service integration, utilisation management and managed care (Lyon 1993, Cohen & Cesta 1993). The literature reveals the concept evolving in separate directions and environments simultaneously (Goodwin 1994a). For example, case management has become an established organisational approach to community mental health care, although not restricted to mental health problems (Greenwood *et al.* 1994). Case management can be traced to 19th century community nursing, although it was widely used by United States (US) and United Kingdom (UK) social workers during the 1960's (Sandhu *et al.* 1992, Erkel 1993) and re-emerged again during the late 1970's (Test & Stein 1980). In this sense, community case management can be described as a case manager either co-ordinating or delivering interventions to people in community settings.

Hospital case management and care pathways

Case management has also been used to describe a care delivery system within in-patient health care settings, which began in the early 1980's (Zander & Etheridge 1989). Hospital case management has been adopted extensively in US (Faundiller 1991), Australian (Potter 1998) and Singapore (Cheah 1998)

health care systems. The most widely known model is that pioneered at the New England Medical Centre in Boston by Karen Zander (Pettryshen & Pettryshen 1992). Zander's model seeks to manage the quality and cost of care by defining service delivery across the entire illness episode and different locations. The model sets patient outcomes within cost limited periods of in-patient treatment and advocates preformatted 'care maps' (care pathways) to provide a framework for planning and delivering interventions. A care pathway comprises a preformatted list of multi-disciplinary interventions and actions along a time-line (see appendix one). The primary nurse (see chapter one) acts as a direct care provider for one group of patients and as a case manager for another group. As a case manager, the nurse uses the care pathway to ensure patients receive multi-disciplinary care and achieve the predetermined goals and outcomes (Zander 1988a,b). In a variant of Zander's model, the case manager functions exclusively as a co-ordinator and facilitator of care across the total admission period (Ethridge & Lamb 1989). Incorporating a combined and expanded approach, Gibbs *et al.* (1995) describes a system where the organisation uses care pathways for 'internal' hospital admissions and external case management for discharged patients living in the community. Mackenzie *et al.* (1998) and Lee *et al.* (1998) have also described this two-tiered approach in community nursing pilots in Hong Kong.

All models of hospital case management develop care pathways based on a single diagnostic related group (DRG). A prerequisite of successful case

management is to identify those types of patients belonging to a high volume / high cost category with varying lengths of hospital stay and resource consumption (Ethridge & Lamb 1989). Cook (1998) distinguishes between Zander's model and the Tucson model by suggesting that the former is more suited towards acute management of care. A limitation of hospital case management is its bias towards homogenous groups of patients with similar treatment periods (Shikiar & Warner 1994). Very little is documented about the feasibility of hospital case management for diagnostic conditions that present with a heterogeneous collection of problems, such as those experienced by people with mental disorder.

There are variants of hospital case management (Wilson 1997a) such as 'managed care' (Lyon 1993) and the 'Professionally Advanced Care Team (ProACT) developed for critical care units (Tonges 1990). The ProACT model describes the nurse as a unit-based primary nurse and a clinical case manager. As a further fragmentation of the nurses' role, a critical care technician role was developed to perform clinical skills such as routine vital signs; electrocardiogram recordings and general hygiene needs. This splintering of tasks enables the primary nurse to concentrate on the complex activities and the case manager to co-ordinate and facilitate the MDT and the patient along the care pathway (Ritter *et al.* 1992).

Managed care

A type of hospital case management known as managed care evolved in the early 1980's (Lyon 1993). Managed care focuses on care delivery within a precise location such as the ward, rather than incorporating many different wards. Under managed care, the nurse acts as the case manager responsible for ensuring appropriate LOS and use of hospital resources (Zander 1988a). Similar to Zander's model, the case manager uses a care pathway. Hospital case management raises many practical difficulties and requires sophisticated organisational systems to ensure the degree of co-ordination to manage a care episode across several locations and to cost DRG's on a day-by-day basis. Most NHS Trusts do not have these systems in place (Jones & Waite 1995). Managed care is less ambitious in restricting the case manager to a single location and seems more likely to fit with the current NHS structure.

There have been many examples of managed care in the UK literature (Riches *et al.* 1994, Hunter 1995, Hale 1995a,b,c, Johnson 1995, Jones & Waite 1995, Laxade & Hale 1995a,b, Nelson 1995, Morris & Mylotte 1995, Townend 1997, Roebuck 1998, Wigfield & Boon 1996, Lowe 1998, Currie & Harvey 1998, De Luc 2000). Currie (1999) carried out a postal survey of all NHS Trusts ($n=471$) for the year 1997/98 and reported 86% either using or developing care pathways with 48% using a care pathway for a specific DRG. The most common care pathways were for fractured neck of femur (31%) and stroke (29%).

Patient focused care (PFC)

A development within the UK that encompasses the principles of managed care is 'patient focused care' (Hurst 1995). The principle aim of PFC is to increase the number of skills used by a smaller number of professionals (multi-skilling) and to concentrate resources to one care area (Hurst 1996). Various clinical examples of PFC have been described (see Morgan 1993). Similar to managed care, PFC uses care pathways although care leaders, rather than case managers, detect variations (Layton 1993). Hurst (1995) evaluated eight PFC sites within the UK. The case types included acute medical and surgical areas, although excluded psychiatric services. Improvements were found in reduced LOS and lower re-admission and treatment complication rates but at increased costs of care episodes. The use of care pathways appears to be a more specific component of PFC, which does not include the aspects of de-centralising care services to one ward area or the explicit requirement to cross-train workers. Some authorities have argued the danger of PFC in reverting care to a task orientated perspective observed in past care practices (Royal College of Nursing 1992).

Jenner (1998) conducted a qualitative study to identify the nurses' role, education and training needs for PFC using a semi-structured interviewing technique. The study explored the views of respondents ($n=23$) in a hospital that had piloted PFC for 12-months. Some respondents (managers) viewed PFC as the introduction of clinical protocols, whilst care leaders (nurses) viewed PFC as a cross training initiative. However, there were many perceived

problems with cross training such as the inadequate knowledge base and lack of resources for professionals to both teach and assess others and maintain a full case load. Respondents also viewed these skills as a 'bolt-on-extra'. One manager felt that nurses were failing to take advantage of the increased role autonomy that is associated with PFC.

Disease management

Disease management is a similar type of outcomes based care system, which attempts to reduce clinical variation (Svensk 1996) by linking resources across primary and secondary care and multi-agency locations (Mason *et al.* 1999).

The NHS Executive (1996a) has encouraged the NHS to work alongside industry to provide disease management programmes. Such organisations may be pharmaceutical companies working in a third party commercial relationship. Alternatively, such companies may take on a role in improving clinical practice through more efficient access to clinical information (Lawrence & Williams 1996). For disease management systems to operate, the care provider requires detailed clinical information technology (Richards 1998). Disease management also requires consensus and agreement on interventions and outcomes that span across the disease provider continuum. The picture is further complicated when patients present with multi-diseased states.

Protocols and clinical guidelines

The establishment of the NHS research and development strategy (Department of Health 1991a) has provided impetus to develop clinical practice guidelines using knowledge gained from randomised control trials (RCT) to improve patient care (Grimshaw & Russell 1993b, Kollef *et al.* 1997). Confusion arises when considering the nature of clinical guidelines, protocols and standards. A protocol or a standard is a formal documented procedure for clinicians to follow to address a specific clinical or managerial situation (Royal College of Nursing 1990). A clinical guideline however is to assist in decision making, permitting the clinician to follow the suggestions in a flexible and considered way (Grimshaw & Russell 1993a, West & Newton 1997, Jackson & Feder 1998). The NHS Executive (1996b) advises that only the Royal colleges develop clinical guidelines and that certain priority areas based on RCT's should be pursued. However, others have focused on the difficulties of implementing guidelines to change clinician behaviour (Eve *et al.* 1996). Eve *et al.* (1996) concludes that the development and dissemination of guidelines must remain a local initiative, characterised by political negotiation and interpretation of best practice literature.

Evidence based practice (EBP) can be used to inform the development of clinical guidelines and protocols. EBP is a method of asking clinical questions and answering them with critical review of valid research studies prior to implementation in practice (Rosenberg & Donald 1995, Sackett *et al.* 1996). Some commentators assert that EBP and its presentation (Jackson & Feder

1998) and source (such as the RCT) may be difficult to apply to individual patients (McGorry *et al.* 1997) or within the complexities of mental health services (Harrison & Eaton 1997). Others suggest that practice guidelines should be developed by MDT's that aim to use RCT's, and for guidelines to provide some estimation of treatment cost (Persons *et al.* 1996). Possibly, the use of clinical guidelines acknowledges the limitations of available evidence and so bridges the gap between evidence derived from an RCT and that what can be identified as 'best practice' (McGorry *et al.* 1997). Other commentaries acknowledge that some disciplines such as nursing may be unable to answer questions relating to evidence based practice due to the infancy of the research tradition (White 1997).

Political origins

The principles of managed care evolved during the Reagan administration in response to rising health care costs in managing DRG's (Etheredge 1986, Sandhu *et al.* 1992) and falling numbers of suitable qualified health care professionals (Ethridge & Lamb 1989, Crumer & Carter 1993). The federal US government introduced a variety of measures designed to contain costs such as standardised LOS and fixed reimbursement for care / treatment episodes (Gibbs *et al.* 1995, Kavanagh 1997). Elements of managed care (inclusive of care pathways) are used to structure the purchasing and providing of care within the US (Clark *et al.* 1994). The popularity of care pathways and the associated factors of increased productivity have also appeared in the UK health care industry.

The NHS has been steadily moving towards collaborative inter-professional health care to improve the quality and cost effectiveness of health care outcomes (NHS Management Executive 1993, Thomas & Bond 1995). The five imperatives of the NHS: quality of care, value for money, fitness for purpose, cost and clinical effectiveness (Holliday 1995) appear to identify care pathways as a potential cost effective system to structure patient care (Benton 1995, Laxade & Hale 1995a, Royce 1997).

Constituents of managed care / care pathways

For the purposes of this chapter and to reduce confusion, the terms managed care and care pathways will be used interchangeably. In essence, managed care comprises three central components: 'tools' called care pathways; a case manager; variance analysis and audit (Ignatavicius & Hausman 1995, Hale 1995b).

Tools: care pathways

Tools such as a care pathway detail the common problems occurring in a single DRG and provide a preformulated list of interventions along a time-line (Petryshen & Petryshen 1992). Care pathways have been primarily designed for hospital wards, although reported use has been made of them in home care settings (Goodwin 1994b). The tool is usually expressed as a Gantt chart with a time / task matrix (see appendix one). The care pathway details a list of patient problems with expected patient outcomes, and a list of

Interventions prescribed along a time-line. Many types of tools have been developed (Lumsden & Hagland 1993) and those currently in operation include care paths, critical pathways, care maps, anticipated recovery pathways, clinical pathways and integrated care pathways (Hale 1997). These tools differ, but most have three key features: a problem list; intermediate and discharge outcomes; and a list of multi-disciplinary interventions (Ignatavicius & Hausman 1995).

A problem list details the usual problems that occur for a case type (Guiliano & Poirier 1991). Any problems not covered within the care pathway are charted by exception and can be written on the document. The outcomes part of the care pathway outlines prospectively the goals a patient must achieve for the presenting problem to be resolved. These goals are placed along the time-line although the sequence depends on the nature of the patient's illness (Ignatavicius & Hausman 1995). Intermediate goals alert the health care team to implement certain specified actions if the patient is to remain on course for a timely discharge. Discharge goals are outcomes that must be achieved before the patient can be discharged from hospital. Typically, events on the pathway are grouped under eight categories: assessments or consults, tests, treatments, medications, monitoring, diet, activity, teaching, discharge planning (Salmond 1990, Guiliano & Poirer 1991, Petryshen & Petryshen 1992). The second section of the care pathway details the interventions for the discipline group to deliver (Rudisill *et al.* 1994). For example, a common problem for people with schizophrenia is a poor knowledge of their illness

process (Macpherson *et al.* 1996). Teaching interventions would aim to improve the patient's level of knowledge throughout their LOS.

Care pathways can be formatted in many ways such as multi-paged or single paged chronological documents, whilst others can include space to write additional notes alongside the actions detailed on the pathway (Zander 1993). Care pathways can form part of the documentation procedure or replace other parts such as nursing notes (Kitchiner & Bundred 1996). The care pathway can form an integrated package of multi-disciplinary interventions or the interventions and outcomes can be categorised within each discipline (Velasco *et al.* 1996). Pearson *et al.* (1995) note the problem of having detailed actions on the pathway, which may be irrelevant to some disciplines such as medicine, and argue that medical interventions should be distinct from that of other disciplines interventions for ease of completion. Within an uncomplicated cardiac surgical care pathway described by Pearson *et al.* (1995) the medical team was encouraged to review the care pathway in its entirety, but to also use the care pathway for the parts specific to themselves. Nurses signed and recorded notes on the care pathway, whilst doctors documented their notes in a separate section of the care pathway.

Hamilton *et al.* (1989) describes a 14-day care pathway designed for a renal transplant case type. This includes a list of the problems such as anxiety related to the transplant, pain related to surgical intervention, potential for infection and knowledge deficit. The care pathway also contains the expected

patient outcomes on subsequent days after the transplant, such as 'verbalise concern about the transplant', 'adequate pain control', 'surgical incision free from infection', 'no self management deficits' respectively. Inclusive on the care pathway is eight prescriptive categories. For instance, on the first post-operative day the case manager, the physiotherapist and the transplant coordinator will consult the patient.

Pearson *et al.* (1996) describes the contents of a 5-day care pathway for lower deep vein thrombosis (DVT). The care pathway details the tests, activity, treatment, medications, diet and patient / family education components with a horizontal time axis. The distinguishing feature of this descriptive account is the linking of the care pathway components to EBP in the literature and their distinction from 'best practice' interventions. For example, on the first day, the pathway prescribes the doctor to give heparin boluses between 7,500 to 10,000 units as advised by a consensus statement from the American College of Chest Physicians (Hyers *et al.* 1992). However, Pearson *et al.* (1996) identify the many ambiguous aspects of DVT treatment and argue that a care pathway presents a seasoned judgement, whether this is formed from a review of EBP or a view gathered from best practice.

The case manager

The second and third component of managed care details the role of a case manager and the process of variance tracking (Schriefer 1995). Although the registered nurse or other discipline member delivers the care, the case

manager attempts to ensure that interventions are being provided to meet pre-established outcomes. This is sometimes called variance tracking and involves both retrospective and concurrent auditing of the care continuum on a planned basis. It can also include altering the care delivery in response to a changed clinical presentation (Robinson *et al.* 1992). Variance data would be pooled together and discussed with the aim to produce a care pathway that is more accurate to the case type and cost effective for the delivery of care (Hoffman 1993). In effect, the case manager manages the MDT and minimises duplication and delays in the care process by identifying variance between the events on the care pathway and actual practice (Andolina 1995). Variations are classified and noted down for discussion in clinical audit meetings (Tahan & Cesta 1995).

Variance tracking

Variations are noted as codes and listed into categories (patient, staff, administration and community related sub-sets) (Schriefer 1995, Ignatavacius & Hausman 1995). Variations may not always lead to negative effects on patient progress or fiscal problems for the organisation (Shikiar & Warner 1994, Andolina 1995). The necessary function is to track and control how the patient is processed through the care system (Wilson 1997b). Each discipline uses the codes as appropriate to reflect their delivery of interventions and achievement of outcomes (Sandhu *et al.* 1992). For example, many patients with schizophrenia fail to respond to the prescribed medication (Brenner *et al.*

1990). This may result in the psychiatrist changing the type of medication and so extending the expected period of symptom control.

Pearson *et al.* (1995) suggest that variance tracking produces large amounts of data for analysis and argue that data should be collected on certain 'gateways' of progress that if unachieved would jeopardise a projected LOS. Information would be collected on the reasons for this and what actions were taken to remedy the situation.

Evaluative studies

The case manager role

Some studies and commentaries have attempted to explore the skills and knowledge required for the case manager role (Fralic 1992). Tahan (1993) undertook a descriptive study to identify the clinical, managerial and business components of the role. The central functions of the clinical role were the assessment, planning, construction and revision of the care pathway. The major managerial roles were skills related to co-ordinated collaborative problem solving, critical thinking, facilitation and evaluation. The financial role demonstrated the case manager as the main organiser of the multi-disciplinary team to contain costs and reduce fragmentation of services.

Nolan *et al.* (1998b) examined the impact of nurse case manager's ($n=20$) educational preparation (baccalaureate and masters) to determine role function. Masters prepared case managers rated system-related topics to be

more important than clinical issues when compared with baccalaureate trained nurses. Findings from this study lend support to staff development programmes aimed at training case managers at different levels of educational preparation. Building on this finding, it may be that masters prepared case managers are more sensitive to system barriers that prevent the patient progressing through the hospital episode. Using a random sampling procedure as opposed to a convenience sample could have strengthened the study design.

In a qualitative study of the case manager's role, Waterman *et al.* (1996) described the initial introduction of case management onto an elderly rehabilitation ward. Ethnographic style interviewing was employed to gather feelings and concerns of case managers alongside participant observation for seven weeks following the introduction of case management. The main themes were categorised under structure and process. One respondent commented that very little discussion and educational instruction had been undertaken with the case managers prior to the move to case management. Commenting on the process of being a case manager, respondent's felt that the new role gave a broader remit extending beyond the hospital ward. Other features of the role such as co-ordinating the entirety of care provided the case manager with a sense of corporate responsibility. Limitations of the study reside in the lack of detail concerning the model and description of case management employed given the absence of care pathways.

Shiell *et al.* (1993) attempted to evaluate the effectiveness of the nurse co-ordinator (independent variable) upon the MDT (Fractured Hip Management Programme) to reduce treatment delays, and decrease hospital re-admission by planned discharge and rehabilitation. The sample was comprised of patients with a fractured hip non-randomly placed into experimental ($n=67$) and control groups ($n=71$) in a before and after trial. Patients were treated under the programme for 6 months and evaluated at 12 months. Within the experimental group, hospital stay and waiting for surgery fell by 25% achieved through no extra burden on resources and no detrimental effects on health. Consequently, more beds became available for use, or alternatively fewer staff was required to be employed. Although the findings from this study appear favourable, there is a need for caution, as Shiell *et al.* (1993) did not examine the actions of other professionals in the team. Secondly, the study failed to address the detrimental effects the role may have on the stress and burnout levels for the nurse co-ordinator. Findings from this study indicate that positive benefits can possibly be achieved by the use of nurse co-ordinators without the use of care pathway tools.

Sherman & Johnson (1994) attempted to examine the effects of the clinical case manager upon the patient's perception of care and quality, and nurse's work satisfaction. Within this modality, unit based primary nurses delivered the care and the case manager co-ordinated the MDT. A convenience sample of oncology patients was recruited in a before ($n=24$) and after ($n=26$) design. Patients did not perceive the quality of care to be any different

although they did value the role of the 'named nurse'. The Work Satisfaction Index (Stamps & Piedmonte 1986) registered a slight decrease in work satisfaction after 6 months, although this could be attributed to role confusion. Alternatively, the primary nurse may perceive a loss of role autonomy as the case manager absorbs the managerial tasks.

Most studies identify the role of the case manager to be an important function within the structure of managed care. Important issues are the educational and practical training of the case manager, the impact of the case manager on patient related variables and perceptions of the case manager performing their role. Similar to the studies evaluating the impact of other management structures of care such as primary nursing and community case management, it is difficult to isolate the effect of the case manager from the effects of the care pathway structure.

Mental health care pathways

There have been very few reported quantitative studies developing and testing mental health care pathways (Anders *et al.* 1997), with most literature drawing on anecdotal accounts (McQueen & Milloy 2001). For example, Southwick (1995) in the US and Townend (1997) & Stephens (1997) in the UK provide no research evidence to support their argument for the positive benefits for hospital services to develop and implement mental health care pathways. There have been qualitative studies examining the impact of a dementia care pathway. Hall (2001) interviewed five different professional

groups to explore their perceptions of the process of implementing a pilot project. Advantages of the care pathway were found in team performance, effectiveness of care and practice development. Little detail was given to the exact description of the care pathway within the study and this is important when considering this study to others. Although most reported care pathways apply to general medical conditions there are examples of psychiatric care pathways in the literature (Homan 1994, Wheeler 1997, Chan & Wong 1999). The St. Elizabeth's Medical Center in Boston (1995) has developed a 14-day care pathway for acute schizophrenia. Under the category of assessments (day one), the care pathway instructs the nurse to perform a functional health assessment, assess and monitor mental status and monitor the patient's use of potentially hazardous items. For day two, the nurse repeats the same actions but also monitors the patients' response to medication. The teaching category from day one of admission instructs the nurse to provide information on the unit guidelines and patients' rights. For day eight, the nurse reinforces the need for medication such as teaching the patient about signs and symptoms of illness. As the patient approaches discharge, a stated outcome would be for the patient to demonstrate their knowledge of medication and illness management and actions to take following signs of relapse.

A noticeable problem with the care pathway is the absence of instruments to measure if the patient does respond to medication, understand about their illness and know how to access the mental health services. For interventions to be delivered and outcomes to be audited, mental health nurses would need

to be trained in the use of valid and reliable rating scales. Further, there needs to be agreement about what actually constitutes a good outcome. Secondly, the care pathway appears to lack a user perspective to the delivery of mental health services. The views of the user remain central to the planning of resources within the NHS and figure prominently within the latest review of mental health nursing (Butterworth 1994). Managed care systems may minimise the patient's influence over future delivery of care (Wedderburn Tate 1996).

Andolina (1995) describes a problem list and care pathway for an affective disorder covering 10 in-patient days. One noted problem was delusions of grandeur. The intermediate goal was for the patient to share thoughts and perceptions with staff and the discharge goal was that the patient's psychotic features become less severe and less frequent. The sequence of treatments and events on the pathway inform the MDT to facilitate a de-stimulation programme, promote rest and administer a prescribed neuroleptic medication. As the patient proceeds, the patient is encouraged to attend therapy groups until discharge. Similar to the care pathway for people with schizophrenia, this care pathway provides no indication of progress to decide if the patient's mental state has improved through out the period of hospital stay. The extent to which these prescribed interventions are research based is questionable, as is their applicability to individual patients.

The suitability of mental health care pathways is possibly best illustrated by considering its relevance to people suffering from schizophrenia. The costs of hospital care for patients with schizophrenia are expensive (NHS Executive 1996d) with more than 5% of NHS in-patient hospital resource spent on this DRG in England (Knapp 1997). This client group also consumes considerable social welfare resources (Andreasen 1991). The annual cost of treatment and care in the UK is £2,138 per patient, with an annual treated prevalence estimated at 185, 400 (Davies & Drummond 1990). However, there is an unequal spread of the costs of the illness with those patients requiring continuous community support and / or those requiring long term hospital care (less than 50%) accounting for 97% of the total direct cost (Davies & Drummond 1994). The high incidence and resource demands of people suffering from schizophrenia makes this DRG an ideal focus for managed care.

The potential benefits of managed care pathways lie in their ability to reduce hospital LOS, although it is questionable if this can be applied to people with mental illness. For example, schizophrenia has been identified as one of the most damaging of mental health problems and sufferers often require unpredictable LOS owing to the progressive and debilitating nature of the condition (Johnstone & Lang 1994, Andrews & Teeson 1994). The problems however in measuring outcomes are quite complex. For example, outcomes for people with schizophrenia may be weighted in different directions i.e. symptom remission versus side effects of medication; in-patient treatment

versus community care (Knapp & Kavanagh 1997). McCrone & Weich (1996) also consider the difficulty in calculating different dimensions of costs such as direct (i.e. in-patient services), indirect (i.e. criminal justice system), hidden (i.e. informal carers) and non-measured costs (i.e. aspects impossible to measure). Knapp (1999) considers both the short and long-term economic effects of psychosocial interventions (PSI) and pharmacological interventions, although the question remains as to how these should or could be configured into structured programmes of care.

General hospital settings

The benefits of care pathways have been well documented within the literature and in experimental trials. Frequently reported advantages range from more focused attention to care problems, interventions and outcomes (Petryshen & Petryshen 1992); increased professional awareness of own and other professionals boundaries (Newman 1995, Latini 1996); increased autonomy (Olivas *et al.* 1989a); increased nurses' work satisfaction (Schroeder 1993); clear intent to standardise care (Gordon 1996) and so reduce costly variations (Kowal & Delaney 1996, Yaksic *et al.* 1996); ease of comparison with other provider units (Arkell 1997); minimise risk through medical negligence (Wilson 1995, 1997b); decrease length of hospital stay (Gottlieb *et al.* 1996, Cohen *et al.* 1997, Valasco *et al.* 1996, Morris *et al.* 1997, Muluk *et al.* 1997, Chang *et al.* 1997). The majority of studies have employed quasi-experimental designs exerting varying degrees of control over the research procedure. For example, Cohen (1991) examined the impact of

care pathways on patient admission times, nursing demand and costs of care. Employing a non-randomised sample of patients receiving a caesarean section, a before ($n=64$) and after ($n=64$) group were tracked over 4.5 months. The amount of admission time was reduced by 19% with an 8% decrease in in-patient resources compared with the control group. Within the experimental group the aggregated nursing care hours were significantly higher ($p=0.001$) with a greater intensification of nursing personnel during the initial period of hospitalisation. However, the study findings are questionable due to the sampling strategy used and because of the lack of definition and control of the independent variable.

Velasco *et al.* (1996) tested the impact of a care pathway and case manager for coronary bypass surgery ($n=114$) against a historical group of patients ($n=383$) for 6 months. Although LOS had been decreasing for some years, the impact of the care pathway significantly decreased LOS ($p<0.0001$) and costs of care reduced by 14% ($p=0.0001$). However, the study does not indicate if the reduced LOS occurred evenly across the care pathway implementation period. From this study it is impossible to determine the effects of the developmental process on the experimental ward staff. Moreover, the study does not consider the exact experimental effects of either the care pathway or the case manager, the convenience nature of the historical control group or the selection effect of the experimental ward.

To offset some of these methodological flaws, Gregor *et al.* (1996) tested the impact of a care pathway for total knee / hip arthroplasty comparing a pre-intervention group ($n = 77$) and post-intervention groups at 1-4 months ($n=75$), 9-10 months ($n=38$) and 25-27 ($n=84$) months. LOS did not reach significance levels until 9 months after implementation ($p<0.0001$), although this level of significance extended to 27 months post-intervention. This study indicates that some time is required for the care pathway to be effective following introduction to clinical practice.

Morris *et al.* (1997) tested the impact of a gynaecologic oncology care pathway using a before ($n=73$) and after ($n=30$) matched trial controlling for the effects of the developmental period ($n=29$) and the implementation phase. LOS ($p<0.001$) and costs ($p<0.002$) decreased following the three-month intervention period. However, LOS also decreased in the development phase suggestive of a 'ripple effect' on care provider behaviour (Gottlieb *et al.* 1996). There was no control for the effects of extraneous variables during the implementation phase and no random selection of patients to serve within the three groups.

Falconer *et al.* (1993) tested the impact of a stroke care pathway using a RCT. Upon admission, patients were randomly allocated to either a control group ($n=68$) or experimental group ($n=53$) over a four year period. The study found no significant differences in LOS, costs of care or motor / cognitive function. However, there were similar methodological flaws within

this design such as the selective bias of the experimental ward over the control ward and the possible contamination of the experimental effect onto the control ward subjects (close proximity of wards). Within this design, the care pathway was computer generated for each individual patient at the first case conference and changed thereafter in response to patient need. This makes generalising the findings impossible due to the care pathway technique employed. However, Falconer *et al.* (1993) offers an alternative reason such as the conflict between individuals aligning themselves to professional disciplines as opposed to the consensus of the team.

Ogilvie-Harris *et al.* (1993) conducted a before ($n=51$) and after ($n=55$) trial comparing a care pathway for hip fractures against usual care planning processes. A 6-month time lag was given for the experimental group to customise to the care pathway structure prior to implementation and outcomes were recorded 6-months post discharge. Results from the study show that patients on the care pathway recorded fewer post-operative complications ($p=0.01$) and reduced LOS ($p=0.047$). Further, there were a statistically significant number of patients who regained pre-fracture ambulation and accommodation status in the experimental group compared to the control group ($p=0.036$). The most striking methodological flaws however, included the lack of control over the possible effect of increased motivation levels for new interventions and the convenience sampling within the populations studied. Using a blind rating of the sample groups may have strengthened the findings.

Ireson (1997) compared a care pathway for a total knee / hip replacement with traditional care planning processes using a before ($n=64$) and after ($n=64$) design. The Quality Audit Marker (QAM) (Holzemer *et al.* 1991) was used to rate the quality of clinical care performed during the first post-operative evening and at discharge. Data collection for the care pathway was started 6 months after implementation for training purposes. The QAM increased significantly from the first post-operative reading ($p<.05$) and registered higher levels at discharge for the experimental group. On the QAM, the ambulatory component contributed the largest score over the total score. LOS for the experimental group decreased significantly ($p=.0001$), although cost reduction was insignificant. Ireson (1997) suggests those patients on care pathway achieved significantly improved quality and discharge outcomes because of the type of clinician activity (daily sub-goals for planning, implementing and evaluating care).

Cohen *et al.* (1997) developed four care pathways for head and neck surgery (chemotherapy; clean head and neck surgery; clean contaminated head and neck surgery; clean contaminated head and neck surgery with reconstructive flap) and tested their impact against LOS and hospital costs using a before and after trial. The experimental sample ($n=68$) were admitted onto the care pathway over 5 months and compared with the control group ($n=30$) collected over the previous year. Two of the care pathways (clean

contaminated group with/without flap reconstruction) resulted in decreased costs and LOS.

Many studies have been completed using DRG's that have predictable responses to treatment. Uzark *et al.* (1998) developed and tested a care pathway for children with heart disease, which is considered more heterogeneous than other conditions. The care pathway was designed to incorporate many sets of problems (atrial / ventricular septal defect, patent ductus arteriosus, transposition of arteries). The study used a before ($n=69$) and after ($n=173$) design using consecutively admitted patients to the unit. Levels of significance were not reached in all infants following the care pathway for hospital LOS, although this did occur for infants requiring ventricular septal defect repair ($p=0.03$) and a concomitant 28% reduction in care costs ($p<0.001$). An important inclusion within this study was an analysis of the reasons for patient variation. Correlations between LOS and costs were associated with some variances from the care pathway. Similar to other reported studies, the design did not incorporate a randomised control group to measure the effects of usual care.

Cook (1998) undertook a meta-analysis of 18 North American outcomes based studies (1988-1995) testing the impact of care pathway models. This examination found no conclusive evidence for positive effect on patient / provider satisfaction, quality of patient care or costs of care. Although reduced LOS was found to be significant in most studies, Cook (1998) suggests this be

due to bias in the sample population and construction of the research design. Future research studies need to test with comparable randomised control groups using valid and reliable rating scales. Hale (1997) identifies other problematic areas such as the need to define the exact nature and effect of the independent variable, difficulty in comparing differing patient populations, relatively small sample sizes determining statistical significance, and limited site specific research studies. However, the problems of conducting a controlled trial may be difficult to reverse due to the practical problems of control group contamination and randomisation of staff / patients to deliver the experimental effect. Vigorous testing of the structure of a care pathway for in-patient services against outcome variables such as LOS, quality of care, and staff / patient satisfaction is required (Hale 1995c).

The evaluation studies suggest the framework may decrease the lengths of hospital admission and reduce resource utilisation by the effective co-ordination of the MDT. However, effects on staff morale, burnout and attrition rates are relatively untested within these designs. Hale *et al.* (1999) suggests that research and development should focus on how care pathway systems are put into practice and how a care pathway impacts on the role of nursing staff.

Critical issues

Legal implications

The uses of care pathways have also been examined from a medico-legal perspective (Cheah 1998). It is argued that the use of a care pathway may demonstrate to the courts detailed management systems that have attempted to define and reflect on the problems and outcomes of the patients care (Tingle 1995). If the clinician deviated from the care pathway, this would be documented and if correct, explained to the courts. Hyams *et al.* (1995) reviewed malpractice claims of two US insurance companies and found both plaintiffs and defendants used clinical guidelines for case law. The review also pointed towards increasing use of clinical guidelines in both preventing and pursuing litigation and this varied across specialities. For example, in anaesthesia (clear guidelines), physicians who comply with guidelines were less likely to have a case brought against them as opposed to their colleagues in obstetrics (ambiguous guidelines). Cases of litigation were also less likely to be brought where clinicians followed clinical guidelines, which may lead to increased compliance (Hyams *et al.* 1995).

Using length of stay as a quality indicator

Reducing the LOS for psychiatric patients has benefits for both cost and therapeutic reasons (Lieberman *et al.* 1998). The US measures hospital performance by examining LOS and costs of care provision (Jayaram *et al.* 1996). Jayaram *et al.* (1996) reported an exercise in admitting psychiatric patients into a short stay unit. Structures and changes associated with the

unit included daily ward rounds between the team (increased communication about patient management amongst the team), quick referrals to agencies such as housing, rapid parenteral tranquillisation for violent patients and symptom control, increasing response instigated by nursing staff without the consultation of psychiatrists. Factors associated with a prolonged LOS were non-compliance with medication, patient violence, and the level of patient disability.

Some commentators have associated lower LOS with higher levels of personnel resources. Shamian *et al.* (1994) studied the relationship between LOS and nursing hours per patient day across 11 areas of clinical speciality in 58 US hospitals using the Grasp Workload Measurement System. The study examined 137 psychiatric wards and found that average LOS was 12.5 days with an average hour per patient day at 8.0. With a 1-day decrease in LOS, there was a concomitant increase in nursing hours per day ($p=0.01$).

Lieberman *et al.* (1998) studied the effect of treating depressed patients within a short stay admission programme (8.3 days) compared to longer stay programmes (26.5 days). The study found that patients in the short stay programme were discharged with higher levels of depressive symptoms and lower levels of global functioning. Drawing on a study conducted in the UK, Stilwell & Hawley (1993) suggest that for some types of patients, the financial incentive to reduce LOS can be over valued. Other commentaries suggest that the cost benefit reduction in LOS should be examined within the context and

resultant effect on non-psychiatric sectors such as the criminal justice system (Sharfstein 1997a).

Although awareness is increasing about the factors contributing towards LOS, it is difficult to predict for mental health patients (Sherman & Flatley 1980). The stage model (admission-treatment-discharge) has been used to provide a guiding framework (Hughes & Kennedy 1983). Rittman's (1993) study of a psychiatric unit found that LOS was influenced by a series of social processes. He found the stage model to be the ideal rather than a true representation of the social reality of a hospital stay. Both the patients and staff in his study used benchmarks, such as leaving the ward unescorted, attending activities and weekend leave to legitimise continued leave or hospital discharge. However, these privileges were not always predictive of hospital LOS and were complicated by complex factors such as problems securing accommodation. Rittman (1993) found LOS to be a continual process of negotiation whilst the patient remains in hospital. Other types of studies have attempted to identify specific variables predicting LOS. Horn *et al.* (1989) found that diagnosis accounted for about 6% of the variation in hospital stay, whilst Creed *et al.* (1997b) identified other variables such as social behaviour on admission, levels of housing and specific psychiatric symptoms and the predictive value rose to 36.6%. In Creed *et al.*'s (1997b) study, diagnosis was found to account for a larger variance (14.6%). The conclusion being that diagnosis alone can only predict a small percentage of the LOS, which has

implications for DRG's and prospective resource packages.

A common criticism with managed care programmes is that the patient is discharged prematurely, although a recent study has found this not to be the case. Lyons *et al.* (1997) followed 255 patients with predominant mood disorders admitted to managed care programmes in the US and found rates of re-admission to be unrelated to early discharge. To prevent relapse and provide support, it was proposed that the community team should be more intensive when the patient was discharged from hospital. In a sense, the location of support has changed from a hospital environment to a community setting.

A reduced LOS for an illness episode may represent only a temporary and misleading outcome along the service continuum (Webster 1995, Hale 1995c, Hale 1997). For example, a patient may have recovered from the initial relapse of the illness but the ongoing recuperative aspects of the condition that may still require hospital treatment would be managed by another part of the service such as a community team. Although the care pathway may reduce hospital episodes, it is at the expense of increased demand on other services along the care continuum. Arguably, the patient is the most appropriate person to decide the type and duration of hospital stay and to some extent, this has been borne out by Rittman's (1993) study. The views of the patient remain central to care provision, although this fundamental aspect of a quality 'user responsive' service appears to be jeopardised by the

managed care strategy. To some, a more preferable and valid outcome would be the users' subjective experiences of the hospital care and treatment (Olsen 1995).

Ethical & ideological concerns

The guiding philosophy of managed care is of a cost control strategy (Shore & Beigel 1996, Barnette & Clendenen 1996, Wurzbach 1998). Managed care aims to control access to and consumption of health care resources for specific client groups (Benton 1995). It is therefore imperative for its practices to become the subject of ethical scrutiny. Quite possibly, care pathways disempower the patient's level of autonomy in health care environments (Olsen 1994). Care is preformulated within the care pathway that aims to treat the illness episode with maximum efficiency and effectiveness. Little consideration is given to the recipient and the overall goal is to reduce the need for hospital stay. Geraty *et al.* (1992) believes that the emphasis on financial considerations ultimately contaminates clinical judgement thus diminishing the altruistic nature of the practitioner-client relationship. The practice of care pathways attempts to re-shape the role of health care workers and the nature of illness and disease (Olsen 1994). The market economy of health care provides an incentive to deliver health care at the lowest possible cost (Wurzbach 1998).

The care pathway movement follows on from primary nursing (Zander 1988a) and the nursing process (Faherty 1990) although the approach could be

perceived as a cost containment strategy and may be incompatible with the views of the health care workers. The case manager becomes accountable to effective outcomes for both the patient and the organisation (Zander 1988b, Fralic 1992). The outcome variable, LOS, becomes a product rather than a service. This change in emphasis places the need for care secondary to the 'corporate responsibility' towards the organisation (Shore & Beigel 1996). Wurzbach (1998) suggests that this position may create distrust in the provider-consumer relationship. The NHS continues to pursue policies of cost containment and effective resource utilisation, although there is little evidence to suggest that health professionals are willing to accept such a fiscally motivated health care strategy (see chapter one).

There is mounting evidence of a lack of faith in community care (Mental Health Foundation 1994), and in the adequate provision of resources for mental health generally (Morris 1996). Ethical considerations revolve around ensuring that resources are targeted in a cost-effective and equitable way for those patients deemed to be more severely affected and disempowered by their illness (Wurzbach 1998). Given these issues, further research is required to examine the attitudes to managed care and the perceptions of a care pathway in shaping health care delivery.

Compromising professional autonomy

For some a care pathway exerts a form of control over nursing practice (Gibson & Heartfield 1996). Principally this is due to the influence of the

medical model on the development of the care pathway. This can be seen for example in designing a care pathway for people with schizophrenia and focusing on medically defined symptoms of the disorder such as hallucinations and delusions. Less attention may be paid to the hidden skills required in the care and treatment of schizophrenia such as developing relationships. This delineation may serve to undermine certain professions such as nursing which place high regard on these interpersonal interventions (Barker 1989). Furthermore, pre-determined treatment plans may deny access to other services and so place limits on what can and cannot be treated (Krauss 1994). Indeed, it has often been mentioned that care pathways will reduce the patient episode to 'cook-book' medicine (Heyman 1994). On the other hand, in a study of contemporary note keeping in psychiatric hospitals, Mohr (1999) found that nurses described the patients' care according to a set pattern of nine coded entries. Over half of the entries were of the descriptive category that detailed 'simple observations of patient behaviour'. It could be argued that a care pathway would make these categories more explicit for mental health professionals to follow.

Psychiatrists in the US have expressed discontent about managed care programmes and their thrust to cut health care costs by using cheaper occupational groups to deliver their role (Sharfstein 1997b). Some studies have found that psychiatrists feel compromised by managed care systems, particularly the length of time patients remain in hospital (Schlesinger *et al.* 1996). Other health care professionals, such as nurses are controlling access

to these specialist services, thus relegating and reducing consultation to a specialist field. With increasing drives for non-medical personnel to prescribe medication, coupled with the fact that all typical neuroleptics are non-specific in action, nurse practitioners could follow research-based protocols (Detre & McDonald 1997). Olfson *et al.* (1997) reject this position and proclaim that psychiatrists are the most qualified professional group to integrate and apply biopsychosocial interventions to manage complex psychiatric disorders.

Care pathways proclaim the inclusion of EBP. For example, the use of anti-psychotic medication remains the core treatment in the psychiatric management of people with schizophrenia. Reliance on the effects of medication may reduce care to a medically dominated perspective (Shera 1996), thus altering the autonomy of other health care professionals involved in the care pathway. Others have considered that the development of a care pathway may stifle innovation and creativity in the care and treatment of health conditions (Hunter 1995).

Applicability to schizophrenic disorders

Schizophrenia is a debilitating mental illness leading to impaired cognitive functioning and for some patients, social and occupational disability (Fenton 1997). The illness most often starts during adolescence although 75-80% of sufferers will have suffered their first episode before age 45 (Bland *et al.* 1976). The general population has a 1% risk of developing the condition (Klerman 1986, Birchwood *et al.* 1989). The exact cause is unknown although

there are many predisposing factors (Jenner *et al.* 1993). Much evidence points towards genetic factors that trigger neuro-developmental problems in the brain. However, the location of a specific genetic transmission remains unclear (Cardno & McGuffin 1996). Zubin & Spring (1977) developed the 'stress vulnerability' model of schizophrenia, suggesting the disease has an underlying genetic vulnerability and that onset is precipitated by certain environmental factors. More contemporary findings are linking neuro-anatomical changes with particular groups of symptoms. For example, Chua *et al.* (1997) has found a possible correlation with a decreased grey matter volume in the left prefrontal cortex and negative symptoms (psychomotor retardation) for patients diagnosed with schizophrenia.

Treatment & outcome: measurement & prediction

Schizophrenia is far less amenable to treatment and prediction than the medical-surgical conditions that have been the focus of care pathways so far. The presenting course and progression of schizophrenia is complex and multifaceted (Jenner *et al.* 1993). Davidson & McGlashan (1997) identify the positive effects of anti-psychotic medication, family interventions, psychiatric rehabilitation and psychological interventions for the treatment and management of patients with schizophrenia. Sharma & Kerwin (1996) concluded that there are no specific structural brain abnormalities or biochemical markers that predict response to treatment. However, Lindstrom (1996) has found that those patients who present with cerebrospinal fluid abnormalities were predictive of poor outcomes such as increased

hospitalisation and poor socialisation skills. It is known that many sufferers do not recover to their premorbid levels of functioning. Deterioration is not always progressive although the relationship between relapse and further deterioration is unclear (Johnstone & Lang 1994). There are no reliable prognostic criteria to assess the disease progression and recovery for this illness. However certain factors such as age of onset (Delisi 1992, Mayer *et al.* 1995), psychopathology at discharge (Hwu *et al.* 1995), response to medication (Ribeiro *et al.* 1992), gender related differences (Goldstein 1993), length of untreated psychosis (McEvoy *et al.* 1991) and cultural differences (van Os *et al.* 1997) are known to be important. The picture is further complicated by the presence of positive and negative symptoms at different stages during the patient's illness trajectory. Some studies have questioned the homogeneity of the positive-negative syndrome (Carpenter *et al.* 1988). Palacios-Araus *et al.* (1995) studied 67 out-patients with chronic schizophrenia and found that the traditional positive symptom cluster could be separated into a formal thought disorder / bizarre behaviour cluster and hallucination / delusion cluster.

Negative symptoms appear to predominate towards the latter end of the illness process (McGlashan & Fenton 1993) and following repeated relapse, these symptoms become increasingly less responsive to conventional neuroleptic treatment (Johnstone & Lang 1994). However, not all studies proclaim a progressive decline for schizophrenic patients. Wieselgren & Lindstrom (1996) performed a 5-year outcome study on 120 patients

diagnosed with schizophrenia using the Strauss & Carpenter scale (1972).

Following the first year, only 20% of the sample was scored as having a good outcome, although by the fifth year, this score had increased to 30%. There was little difference between first admitted patients compared to chronic readmitted patients in outcome areas apart from work functioning. The study found certain predictor variables of poor outcome at 5 years such as education level and problems at school.

The variability and unpredictability of the disease process of schizophrenia makes it very difficult to develop a care pathway that is sufficiently valid for a relatively high proportion of sufferers. Following conventional neuroleptic treatment, a significant number (5%-25%) of patients with schizophrenia will continue to experience disabling psychotic symptoms (Brenner *et al.* 1990, Conley & Buchanan 1997); become increasingly less responsive to treatment (Tarrier *et al.* 1993); require unpredictable and extensive periods of hospital admission (McGlashan 1988). Kane (1996) has identified factors such as treatment refractory states, adverse effects of medication, non-compliance, and co-morbid conditions such as drug abuse, which contribute towards the process of patients being difficult to treat. Other factors may be insufficient bioavailability or excessive deposits of the drug (Osser 1990), or the effect of staff attitudes or system rigidity towards the patient (Kuipers 1996). This has led to the development of psychological approaches such as teaching patients and their carers to monitor prodromal symptoms (Birchwood *et al.* 1989, Clare & Singh 1994), strategies to increase compliance (Eckman & Liberman 1990)

and interventions to reduce intensity of drug resistant symptoms (Chadwick & Lowe 1990).

Clare & Singh (1994) implemented an 8-week group programme with 11 patients diagnosed with a psychotic disorder in an attempt to increase coping strategies with their illness and recognise early signs of relapse. Findings suggest some degree of efficacy for patients who are in remission as opposed to those patients with florid symptoms. A later randomised study tested the effect of cognitive therapy ($n=20$) versus recreation and support ($n=20$) on in-patients suffering from psychosis and found a significant reduction in acute phase positive symptoms using CBT as an adjunct to medication and this effect lasted for 9 months post trial period. However, this effect was insignificant for negative symptoms (Drury *et al.* 1996a). The patients in the CBT group were also discharged more quickly compared to their controls with quicker resolution of symptoms (Drury *et al.* 1996b). Each allocated patient was given 8 hours of therapy per week. A problem with the study however is the relatively small sample and the inclusion of only medication compliant subjects. Although there appears to be increasing evidence for these types of individual interventions for people with schizophrenia (Haddock & Lewis 1996), the long-term effects remain untested (Johnstone & Lang 1994). A later study by Tarrier *et al.* (1998) tested the impact of CBT versus supportive counselling and usual care in a controlled trial. The study design evaluated the 10-week package of interventions both before and after the interventions using the Present State Examination and the Brief Psychiatric Rating Scale.

Following the interventions, the CBT group showed significant differences in reducing the number ($p=0.009$) and severity ($p=0.006$) of positive symptoms compared to the supportive counselling group. However, the trial failed to test the permanency of change following the interventions or the overall effect on relapse and admission to hospital some time following the trial. Moreover, the trial excluded patients who were in a relapsed state and concentrated on those patients who exhibited positive symptoms. Arguably, the most difficult patients to treat would be those patients who have relapsed, who are non-compliant and who exhibit negative symptoms (i.e. the presence of negative symptoms may indicate a more severe form of schizophrenia and so more difficult to treat). Other types of interventions to prevent relapse have been performed in community settings. O'Connor (1991) discusses the role of the nurse in symptom monitoring, particularly 'target symptoms' as an aid to early intervention.

Although some reviewers of psychological interventions give the impression that these interventions 'work' (see Birchwood 1999 for review of different types of PSI), the problems of psychological interventions such as CBT may not necessarily bring benefit to all concerned. Jakes *et al.* (1999) found that CBT for patients ($n=18$) with a delusional disorder was only successful for one third of patients. This study suggests that a particular sub-group may respond to CBT as opposed to the larger group of people with schizophrenia. The problem with this evidence however, was the small number of patients

entered into the trial, no control group and the subjective interpretations of effect within the sample group.

Issues such as skills training for specialised personnel, disputable claims to effectiveness, ability to separate the effect of the therapist from the active ingredient of the intervention (Kuipers 1996) and securing peer support for performing PSI are evident (Harrison & Eaton 1997). A further problem lies in being unable to predict how patients will respond to CBT (Haddock & Lewis 1996), which raises questions about the validity of a projected care pathway sequence. Jones *et al.* (1999) carried out a Cochrane review of CBT for patients with schizophrenia and noted the small number of robust studies. Moreover, the effects of CBT were no more likely to maintain people in contact with the service or comply with medication than standard care. Although CBT was able to reduce the rates of relapse, highly skilled practitioners carried out the intervention and it remains untested whether this effect could be reproduced with a lesser skilled personnel.

For patients diagnosed with schizophrenia, compliance with medication becomes central to achieve the most effective and efficient treatment response. Non-compliance is high within this group of patients with upto 50% of outpatients defaulting on medication (Bebbington 1995). Kasper *et al.* (1997) found a non-compliance rate of 12.9% and compared the outcomes of in-patients who refused neuroleptic medication ($n = 33$) to those that were compliant ($n = 41$) over a 6-month period. The study found that patients who

refused treatment incurred a greater LOS ($p < 0.01$) (unrelated to the length of non-refusal), higher levels of restraint ($p < 0.02$) and higher levels of assaultive behaviour ($p < 0.05$). There were significant attitude differences between the two groups with non-compliant patients expressing negative attitudes towards past, present and future psychiatric services. However, these findings may be due to the higher levels of psychopathology registered amongst the non-compliant group on admission. Employing CBT with the patient to address the objective status of their symptoms has been advocated to improve compliance (Barnes *et al.* 1996). Kemp *et al.* (1996) found that in-patient compliance and attitudes to medication improved with 4-6 contact sessions (motivational interviewing) compared to a control group and this effect lasted for 6 months post treatment. In a later study, Kemp *et al.* (1998) studied the effect of compliance therapy ($n=39$) versus non-specific counselling ($n=35$) in an 18-month follow-up period. Patients in the compliance group were less likely to be admitted to hospital compared to those in the control group. Reporting from the same trial, Healey *et al.* (1998) found that as compliance increased, so did the uptake of services, although there was no difference in costs between the two groups. Other types of interventions found to improve compliance and reduce relapse have been family work. A Cochrane review conducted by Mari & Streiner (1999) found that those patients who received family interventions were less likely to suffer relapse or spend periods of time in hospital, although the levels of expressed emotion and risk of suicide were not decreased. Moreover, the high cost of providing family interventions may lead to this intervention being used

sparingly for patients and their families. The difficulty however, is reformulating these sophisticated types of interventions onto a care pathway and providing the skilled personnel to deliver them for all patients who present with these problems.

Further developments in the management of treatment resistant schizophrenia have been the advent of atypical anti-psychotic medication (Morrison 1996). It is widely accepted that all classical neuroleptics are equipotent in their effect on positive symptoms (Morrison 1996). Some trials have shown atypical neuroleptics to be more effective in the treatment of negative symptoms (see Kane *et al.* 1988 trial comparing clozapine and chlorpromazine), although not all trials have replicated this finding (see Conley *et al.* (1998) trial comparing olanzapine and chlorpromazine). Other studies have tested the effect of atypical neuroleptics (respiridone) on negative symptoms and correlated these with fewer cognitive deficits (Rossi *et al.* 1997).

A further problem for managed care is the relatively low level of agreement between mental health care professionals on care and treatment. On occasions, psychiatric treatment may be governed by clinical anecdote, whereby if the treatment is successful the diagnosis is confirmed. This raises the issue of clinical freedom and concern amongst health care professionals that standardised care pathways may stifle creativity and innovation, transform professionals into technicians (Hunter 1995) and erode the power

base of professional health care workers. These concerns are relevant to managed care in all specialities, but are heightened in relation to schizophrenia because of the incomplete evidence base supporting the interventions. A practical consequence is those health care workers whose interventions and procedures will be subject to variance analysis and critical review may resist the development of a care pathway. Possibly, a locally developed care pathway may be accepted more than one developed through reviews of past literature.

Care pathway development

Care pathways have been developed for high volume / cost DRG's which exhibit extreme variations in the management of the disorder (Ethridge & Lamb 1989, Wilson 1997a). The care of some DRG's is less amenable to translation into care pathways due to heterogeneity in the disorder or problems that may co-exist when the disorder is present. There are very few reported accounts detailing the development of mental health care pathways, and in the main they focus on medical / surgical conditions, vary from hospital to hospital and lack the controlled ability to determine the most effective development processes (Pearson *et al.* 1995). Care pathways have been developed to structure care delivery for medical and surgical conditions (Ireson 1997, Hainsworth *et al.* 1997, Velasco *et al.* 1996, Farley 1995, Abreu *et al.* 1996, Baldry & Deborah 1995, Gottlieb *et al.* 1996, Cohen 1991), neonatal complications (Kimberlin & Bregman 1996, Tobin *et al.* 1998), child preanesthesia screening programmes (Voepel-Lewis & Malviya 1997),

pediatric day surgery (Lawson *et al.* 1997) and childhood asthma (Morris & Mylotte 1995), and mental health conditions such as schizophrenia (Andolina 1995, Anders *et al.* 1997, Chan & Wong 1999), depression (Smith 1997), cancer related depression (Lovejoy & Matteis 1997) and adult / child substance abuse (Barnette & Clendenen 1996).

There has been little qualitative research into engaging support, development and implementation of care pathways for specific types of diseases and even less so for mental health conditions such as schizophrenia. This section of the chapter discusses some pertinent factors impacting upon the potential development of care pathways. Due to the scarcity of mental health literature, mainly sources outside that of mental health are reviewed.

Professional consultation

The majority of studies stress the importance of developing care pathways through meetings and consultation between key members within individual disciplines, administration officials, finance directors and priority service managers (Clark *et al.* 1994, Velasco *et al.* 1996). Some authorities place importance in the medical staff being involved and committed to the concepts within managed care if the care pathway is to be workable (Heacock & Brobst 1994). Each discipline group collects information on what they do within the care continuum and attempts to place these interventions along a time-line from admission to discharge (Ignatavicius & Hausman 1995). The challenge is gaining consensus between health professionals on what constitutes an

intervention, when it should be delivered and who should be responsible for initiating it (Heacock & Brobst 1994). The benefits, disadvantages and tested examples of care pathways need to be presented to health care professionals in a clear format allowing time to examine and explain the problems (Tahan & Cesta 1994). Ramos & Ratcliff (1997) noted many difficulties in the development of care pathways for cystectomy patients. They suggest that the development of care pathways requires the clear identification and active involvement of stakeholder groups and illustration of tacit care processes. Velasco *et al.* (1996) visited other sites and observed the use of care pathways to inform their developmental process.

Hainsworth *et al.* (1997) described the process of developing and implementing a care pathway for stroke patients between three different hospitals in a metropolitan area of New York. All hospitals shared a desire to reduce the LOS. Although separate care pathways were developed, some were unique to the particular hospitals, whilst all agreed on a set LOS, resource consumption and quality standard. The distinguishing feature of this study was the shared use of information between the three hospitals. An important requirement was the need for medical commitment to the development and implementation process and to educate staff on the components of care pathways for them to be implemented.

Wieczorek (1995) described a development process for a coronary artery bypass surgery critical pathway. The first two steps were to establish a DRG

amenable to a care pathway structure (high volume predictable course) and to aggregate the different members of the team who play a part in managing the disorder into a consulting committee. The care process was then split into a time frame and care sequences and outcomes determined. This information was then assembled into a care pathway. The care pathway was then reviewed and modified prior to the implementation test phase. Wieczorek (1995) advises three months for a test phase and review. This anecdotal developmental review gives some useful structure but little idea of the dynamics operating between professional groups and willingness to have their interventions placed on a care pathway.

In contrast to using a predictable disease course, Cohen *et al.* (1997) describes the development of a care pathway for head and neck surgery that entails complicated surgical procedures, complex multi-disciplinary care and discharge planning and variations in LOS. This development phase entailed examining the current practices within this area and selecting possible care pathway routes. The organising team used a generic pathway structure to import the care processes and outcomes for the MDT. Following completion, the care pathway was reviewed and alterations made as necessary. As with previous accounts, little commentary was given to the problems in undergoing such a process of development.

Latini & Foote (1992) attempted to develop a care pathway for trauma patients who did not fit the single disease processes found most commonly in

the care pathway literature. They took the traditional route to care pathway development by reviewing existing standards of trauma care and retrospective review of patient care documentation. A 72-hour multiple injury care pathway for an Intensive Care Unit was developed and implemented by the team members leading to positive expressions of commitment from nurses and doctors.

Research on the development of care pathways for mental health problems is very limited. Dunn *et al.* (1994) describes an unspecified mental health care pathway. These authors emphasise the importance of ensuring collaboration of key players within the MDT (consultant psychiatrist, mental health nurse, social worker, psychologist). A member of each discipline represented their role and interventions along a care continuum for a specific DRG. The emphasis was on quality audit instruments, problem statements, outcomes criteria and research based interventions. Dunn *et al.* (1994) identifies that commitment by all members of the MDT was crucial to the successful development of the pathway. Important too was clear and compatible role boundaries between health care professionals and a common language between the various professional groups to ensure that MDT documentation was relevant to all.

Barnette & Clendenen (1996) describe their approach to developing mental health care pathways to be focused towards standardising quality of care and treatment and reducing costs. A team was commissioned (senior leaders and

two full time staff members) to undertake a review of the literature and established care pathways. Focus groups were developed to gather 'best practice' interventions and the developing pathway was under constant critique by the participants. The findings of this anecdotal discussion provide no outcomes based data on the effectiveness of the care pathways or any qualitative data on the problems of development.

Facilitation & training

The process of developing critical pathways has been reported widely in the nursing literature and most accounts (Zander 1988b, Olivas *et al.* 1989b, Holle *et al.* 1995) identify the nurse taking on the main co-ordinating role for the team, although Tahan & Cesta (1994) advocate physician facilitators. In the medical literature, commentators suggest that the co-ordinator should be a physician and argue that this professional would provide credibility to the process and engender support to medical and other disciplines (Pearson *et al.* 1995, Gottlieb *et al.* 1996). Lagoe & Aspling (1996) suggest that facilitators need to understand the perspectives of doctors on issues such as quality of care and care delivery for medical support to be gained. Gadacz *et al.* (1997) are critical of the development of surgical care pathways by non-specialised personnel and argue for the centrality of practising surgeons in developing and disseminating surgical care pathways. Other development projects have enrolled facilitators (physicians) external to the organisation to assist in the development of the care pathway (Gottlieb *et al.* 1996). Some commentators report on the need for support from senior personnel within the organisation

to empower the facilitator to engage effectively with the participants (Wilson 1997a).

Some clinicians may obstruct the development process when they realise that variances from the care pathway may reflect negatively upon practice (Hall 2001). Strategies to overcome this may include giving time to professionals to absorb the potential impact of care pathways and the effect they will have on their practice (Ignatavicius & Hausman 1995). Second, to provide professionals with clear reasons for the consideration of care pathways such as a break down of the costs of care for managing the disorder and how resources could be more efficiently organised to reduce LOS (Pearson *et al.* 1995).

A further obstacle to development may be the preparation required by a staff member who is expected to implement the care pathway (Biller 1992).

Matrone (1990) conducted a study where 45 registered nurses were prepared for a case manager role within an acute care environment. The case types included myocardial infarction, coronary artery bypass graft and chemotherapy. The experimental group received a 16-hour staff development programme and three areas of competency were assessed: making inferences about care and nursing diagnosis, the effectiveness of communication, and management of care. The experimental group scored higher on the competency scale on the management of care and in communicating aspects of care. Aronson & Maljanian (1996) found that both self-learning packs and

case study were effective strategies to aid nurses to develop and implement care pathways. Care pathways can also be used to teach and train medical (Pearson *et al.* 1995) and nursing personnel (Ireson 1997).

Retrospective review of practice and literature review

In many studies, the need to draw on evidence from controlled trials and local expert opinion has been seen as central to the development process (Morris *et al.* 1997). Other studies review past care and treatment (Neidig *et al.* 1992, Tahan & Cesta 1994). Schoenenberger *et al.* (1996) conducted a study to compare a theoretical critical pathway for the management of deep vein thrombosis (DVT) with a retrospective record review of past patients ($n=92$). The development of the pathway (cardiologists, radiologists, internists, nurses) identified 6 key steps and processes to manage the condition with a prospective discharge date set at 5.5 days. The retrospective review was performed blindly to the targets set within the care pathway. For the 92 patients, only 12% achieved the LOS goal (mean LOS 7.4 days \pm 2.7). The timely administration of warfarin therapy was achieved in 51% of cases. Only 18% of cases were discharged within 12 hours after the standard of 96 hours of heparin. The conclusions from this study indicate large clinical variability from theoretical standards in the care of DVT patients. Clinicians were not consciously working towards explicit clinical guidelines. Schoenenberger *et al.* (1996) suggests that discharge planning should commence upon admission, plus staff education on aspects of the DVT management process and points to

the probability that a care pathway may decrease the LOS for this client group.

Pearson *et al.* (1995) has commented on the limitations of reviewing evidence in the literature to inform the development of a care pathway. Questions relating to cost effective interventions have not been subjected to controlled trials. They advocate other strategies such as reviewing expert evidence, discussions with colleagues in other institutions, and reviews of existing care pathways.

Research agenda

The Center for Case Management in the US has developed mental health care pathways such as schizophrenia (Andolina 1995), although these commercial products remain untested. Purchasing 'of-the-shelf' care pathways may enable researchers to customise the framework to match UK health care policy and practice. These pathways could then be implemented and tested against carefully selected measures of patient and staff outcome. However, research designs would need to move beyond the commonly used pre-test / post-test comparison design and use more controlled research designs. Other areas of research need to be conducted into examining the content of the developed care pathway and how they compare with practice. The studies reviewed indicate little consideration of this point. Different methods of developing the care pathway may lead to a variation in their content.

The process of developing a care pathway requires a series of exploratory studies to focus on delineating professional boundaries and interventions, and to examine the gulf between EBP and usual standards of care. The problems, interventions and outcomes of care pathways should attempt to represent 70-75% of patients within the selected group (McKenzie *et al.* 1989), however this may be difficult to achieve in all cases. Anders *et al.* (1997) developed a care pathway for in-patients with schizophrenia using the MDT over a 7-month period. In an attempt to establish external validity of the care pathway, local ($n=4$) and national ($n=4$) experts rated each of the care pathway components using a four point ordinal scale. Of the 161 items on the care pathway, 151 were validated giving a total validation score of 0.98. Elements that were considered to be invalid were then referred back to the development group for further analysis. Using a larger and random sample of experts to rate the care pathway may have enhanced the findings of this study. The study also omitted the differences, if any, between the local and national experts.

Process evaluation needs to take place that explores the development of a care pathway for people with schizophrenia. This may provide knowledge on how complex MDT's work together to form mutually agreed problems, interventions and outcomes. The literature assumes that professional teams will readily discuss the role they play or deliver their interventions via a care pathway, and this needs to be rigorously evaluated. Secondly, little is known about how in-patients with schizophrenia will progress along a care pathway,

if outcomes will be achievable, or if community resources such as suitable supported housing could be effectively mobilised. Thirdly, the principles of action research could be used to allow the various disciplines and user groups to decide which aspects of managed care pathways would be more suitable to the UK health care context. This type of exploratory research appears more suitable given the relatively unknown factors surrounding the development of care pathways for mental illness categories.

Conclusion

The principles of care pathways appear to rest on three basic assumptions; illnesses such as schizophrenia have a predictable economic course; pathways can be constructed to standardise this process; resources can be mobilised to match pathway requirements. How these assumptions can be met ultimately determines the nature and success of the care pathway. Models of hospital case management and in particular care pathways have been extensively developed in the US for over a decade. Care pathways are beginning to enter the UK health care system but research is limited, quantitative, and almost wholly devoted to medical and surgical disease conditions.

The potential impact of care pathways for mentally ill people, particularly those with serious and enduring conditions such as schizophrenia requires evaluation. Issues relating to the unpredictable nature of the illness, challenges of measuring mental health care outcomes, problems relating to the current organisation of mental health care, implicit and ill-defined care

processes are particularly contentious. Changes to LOS parameters may impact on other professionals and services further along the treatment trajectory.

Qualitative research therefore needs to focus on the development process of care pathways for in-patients diagnosed with schizophrenia. However, the majority of the literature detailing the development of the care pathway is American and almost exclusively concerned with general adult conditions. Studies detailing the advantages and development of mental health care pathways are anecdotal and provide little guidance on the most effective ways of to develop a care pathway that is acceptable to the clinical team and complements research based literature. There appear to be many factors in the successful development of the care pathway including: team building and professional relationships; role and skills of the facilitator; ability to define the problems, interventions and outcomes for patients with schizophrenia; access to credible research findings. Possibly, the most difficult aspect would be the ability of professional groups to articulate their skills and role to complement the confines of a care pathway.

Chapter Three

Methodology

Introduction

This research study was designed to explore the development of a care pathway for in-patients with schizophrenia. It was necessary to devise a method, which sought to uncover the problems and difficulties in this exercise. Various methods were chosen to conduct this enquiry, although a predominantly ethnographic tradition was followed. The majority of studies investigating the development of a care pathway have used experimental designs to test the impact of it upon many service indicators (see chapter two). Very little qualitative research has been undertaken to determine how the development of a care pathway affects the functioning of inter-professional relationships or the conceptions of psychiatric care.

The process of implementing an action orientated ethnographic account as applied to the study context is described. How the study findings were collected and analysed from the members of psychiatric staff working in one ward and community team attached to a District General Hospital (DGH) are also discussed.

The researcher carried out the study with a unique personal background having worked in the hospital at various levels prior to carrying out this study.

This proved to have both negative and positive benefits. For example, the

position hampered gaining data from some respondents but allowed the researcher to form close relationships with other respondents over a very short time. How the researcher was able to overcome this methodological and practical problem form part of the engagement approach and data analysis and are discussed in detail. Issues of power in health care evaluation and the importance of collecting data from a range of data sources are reviewed.

Philosophical orientation to research

Positivist and interpretist ways of thinking are two governing paradigms of thought in social science research (Kim 1993). Positivism concerns itself with social structure and facts using hypothesis-testing methods. Interpretism focuses on social meanings and uses hypothesis-generating methods (Silverman 1993). Some commentators suggest that research methods are derived from fundamental epistemological positions, thus giving rise to different conceptions of what constitutes social knowledge and how social phenomena can be studied (Cassell & Symon 1994). Miles & Huberman (1994) suggest that it is necessary for researchers to state their positions on the nature and discovery of reality, whilst other scholars are more pragmatic. For Silverman (1993), 'there are no principled grounds to be either qualitative or quantitative in approach...it all depends upon what you are trying to do' (Silverman 1993: 22). Coffey & Atkinson (1996: 190) echo similar versions of this argument by calling it a 'paradigm mentality' and Bryman (1989) calls for the researcher to be diverse in considering and employing data collection and analytic strategies.

Some scholars have argued that post-positivist worldviews are philosophically opposed to understanding complex human processes (Lincoln 1992). Given some treatment in the literature is the constructivist movement, which construes reality as being constructed in people's minds. For Stake (1995), people use experience as opposed to a process of discovery to construct the 'world'. People experience external stimuli and place personal meaning to these experiences. Only the inner world can be known as opposed to the outer world. Guba & Lincoln (1989) propose a methodology to expose these constructions called fourth generation evaluation. The focus of the enquiry follows a hermeneutic-dialectic process. The hermeneutic part is collecting individual constructions and describing them as accurately as possible. The dialectic part is comparing and contrasting the constructions (enquired and enquired into) to produce a shared view. These scholars would assert that the process of enquiry must uncover the constructions held by all interested parties or 'stake-holders'. This form of enquiry would be different to an interview style because greater importance is given to developing a shared interpretation of the data. It would also offer the researcher a flexible approach to collecting and analysing data.

Traditional qualitative research

Qualitative research applies to a whole range of strategies, although there are some core features such as participation in the community under study; observing real-life-situations; focus on insider and outsider perspectives; rich

description of events; focus on organisational change over time; socially constructed perceptions (Bryman 1989, Burgess 1991). Silverman (1993) rejects the notion in qualitative research that 'anything goes' and advocates a theoretically driven framework to define the focus of the research. He describes 'some qualitative research as a disorganised stumble through a mass of data, full of insightful observations of a mainly anecdotal nature' (Silverman 1993: 43). Alternatively, Schatzman & Strauss (1973) suggest that research problems may not emerge until sometime into the process. For field research focusing on process, the researcher utilises the methods to best collect data in response to field changes (Patton 1980). In line with Burgess (1991), this research study did not follow any predetermined mechanisms to employ field research strategies but was rather determined by the researcher, participants and the data collected. Moreover, there was no desire to develop or extend theory, but rather an attempt to describe and explore the reactions to the development of a care pathway. In this sense, the research study used features of ethnography and action research to reveal and explain the issues in developing and implementing a care pathway.

An action orientated ethnographic perspective

Although ethnography is a type of qualitative research (Hammersley & Atkinson 1995), there are defining attributes: close and extended contact with study setting and people; focus on both usual and unusual daily events; emphasis on respondents' views; participation in daily events (Bowers 1996). Ethnographers are concerned in the explication of rules and patterns of

behaviour within a reflexive process. In effect, the researcher participates in daily activities thus impacting on the types and form of data to answer the research question (Hammersley & Atkinson 1995). However, this researcher approached the research site with particular questions such as 'do psychiatric professionals wish to change practice', 'what is psychiatric practice' and 'how can psychiatric practice be represented within a care pathway'. In order to answer these questions, the researcher needed to engage the participants in a critical action orientated dialogue of psychiatric practice and in effect, departed from a traditional ethnographic approach.

Aims of the study

The researcher first considered a research proposal that would develop a care pathway and following implementation, test the effect of this care pathway on a range of outcomes such as length of hospital stay, quality of life of the patient and staff satisfaction. However, it quickly became evident to the researcher that a care pathway could not simply be developed without some understanding of the mechanics of development. Moreover, when the researcher started to engage professions on their role, it became apparent that the researcher had underestimated some of the professional issues in having a care pathway display their practice. A particular feature of this study was exploring professional viewpoints on the nature of their work and other clinicians work with people diagnosed with schizophrenia.

The researcher had gained an interest in care pathways for relatively predictable conditions such as total hip replacements and had assumed that a care pathway could be developed for people with schizophrenia. Preliminary investigation of the literature however demonstrated that the course and progression of the illness of schizophrenia was far from certain. Moreover, clinicians vary considerably on what they think should be done to treat and care for people with this condition. The aim of the study changed to understanding how clinicians were able to identify what they do for people with schizophrenia and how this could be conceptualised within a care pathway structure.

The research started out with a programme of working groups to develop and implement the care pathway and to explore how professions came together to develop the care pathway. However, it transpired that clinicians were not always willing to engage in a critical dialogue over what they do, especially within a working group setting. The researcher needed to adapt the study to carry out intensive interviews with respondents outside of the working groups.

The research project did need to change from its original set of objectives and a completely different set of research methods was eventually adopted. The modified aims of the project were to develop and implement a care pathway for people admitted into a psychiatric hospital with a diagnosis of schizophrenia and to explore some of the ideological and professional factors

in such a programme. Moreover, a further aim of the study was to understand the contextual issues that may effect the development and implementation of the care pathway.

Action research

Action research is a type of research design where the researcher and members of the organisation work on devising new ways of working to deal with a mutually established problem. The point of analysis is where the researcher notes the impact of these new methods of working on the workforce and environment (Banister *et al.* 1995). Different research designs and methods can be used within action research and in some respects, it can be conceptualised as a type of research design in and of itself. The distinction therefore between this approach and other qualitative approaches would be the participative relationship between the researcher and the respondents and the focus of the research question. However, Bryman (1989) does not feel that the element of participation or collaboration is a definitive component of action research. Rather the approach should be seen where strategies are used in response to experiences in the field.

Action oriented research has proved to be a popular type of research for changing psychiatric (Towell & Harries 1979) and elderly nursing practice (Nolan & Grant 1993). It enables all concerned to 'problem solve' and place certain agreed upon strategies into practice (Webb 1989). Holter & Schwartz-Barcott (1993) have suggested various approaches such as a 'technical

collaborative' approach or an 'enhancement approach'. The core elements of these designs are to value individual judgements, decisions and actions; to facilitate 'unconstrained communication'; expose hidden agenda's; neutralise power imbalances (Allen 1985) and to develop and apply social knowledge (Bryman 1989). Fawcett (1998) has developed a four-stage model of action research. The first and second stage of the process is to identify the problem and collect information with participants. The final stages are to change and re-evaluate the impact of the change. In general, the process opposes a 'top-down' management style and actively empowers the less vocal members of the organisation to 'air their views' to other group members (Hart 1996). However, the intention of action research to empower staff may be limited given the status of certain professional groups in the wider organisational team and hierarchy.

Action research was used so that the researcher could engage with participants in developing and implementing the care pathway. Understanding the development of a care pathway is also new for delivering care for people with schizophrenia and so the researcher required a method that would uncover the possible cycles of development. For example, when the researcher first started to develop the care pathway, respondents found it difficult to describe the structure of hospital care for people with schizophrenia. Respondents were unable to illustrate the possible categories of intervention such as assessment and planning for discharge. The researcher was able to illustrate to respondents the need to use a structure

for defining what they did and respondents were keen to develop a care pathway similar in type to one purchased by the researcher. As in Fawcett's (1998) cycle, both the researcher and respondents identified and agreed upon a way forward to structure psychiatric care prior to implementing the care pathway.

Within the action research cycle described here, the researcher was an active participant both in the development of the care pathway and in its final implementation. For example, the researcher would conduct the meetings and provide material for discussion in the working groups. The researcher also conducted many of the working groups, and carried out all the interviews and observations on the study ward and community team. The researcher was thus highly visible to both those staff engaged in the study and those who were not. However, for those respondents who were engaged with the study, the researcher did endeavour to consult on the process of development and implementation as far as possible. Some respondents, for example one nurse, commented to the researcher that a serious attempt had been made to involve as many stakeholders as possible in the project.

This research study would best be described as a modified single cycle piece of action research that was slow in duration. Most attention was directed towards looking at the process of development and the professions' role within it, with a later evaluation of implementation. The group of participants was changing and the role of the researcher was to ensure that a

representative of all the disciplines was available to give their view on their professional role in the care pathway. The researcher was not actually feeding back information as it was being collected because he was facilitating their agreement on the content of the care pathway. Moreover, the researcher was facilitating communication between the different disciplines because they did not always attend, whilst, on other occasions staff were leaving and disengaging from the group. Information was new to some participants due to the stage of their involvement, and this resulted in some respondents being less informed than others. This sometimes left respondents feeling that more attention was being given to certain professions, or that the researcher was developing a care pathway in a particular way to suit a managerial agenda. The main forum for giving information was the working group meeting, and, in all, there were fifteen meetings over the duration of the study. The researcher also endeavoured to pass on information when carrying out intensive interviews or when he met with respondents on an individual basis to further develop the care pathway.

The action research cycle was complete when both the facilitator and participants implemented the care pathway. Respondents were able to give their views on some of the difficulties of implementation, and the effects on their relationships within the team. For example, some respondents, including an occupational therapist, felt that a greater understanding of their role had been achieved across the team as a result of completion of the study. The researcher was active in the implementation of the care pathway, carefully

ensuring that patients were started on it, and that care was being delivered within safe limits. It was through this explicit monitoring process that the implementation phase of the study was prematurely terminated due to the difficulties of implementation.

It was always difficult to know how the researcher was perceived through the course of the study. Judging from participant responses, some accepted the role of the researcher, sometimes grudgingly, whilst others avoided being part of the project. It was difficult to disentangle the response to the researcher from their response to the development of the care pathway itself. The researcher did accept however that the process of action research had influenced the respondents, a finding that has been identified in similar studies (Searson 2001). Respondents also perceived the researcher as being a stooge of management. In some respects this was correct, given the objective of developing a care pathway for the organisation.

The benefits of close proximity to the study site plus the participative nature of action research enabled the researcher to engage mental health workers in the development of the care pathway. Development of the researcher-participant relationship also led to participants and respondents identifying other potential people who might have been willing to engage with the study. Selection of events, respondents and participants was both planned and opportunistic, but largely governed by events happening at the time of the study as so often is the case with action research.

Many sources dismiss the notion that researchers are devoid of preconceptions when they enter the setting, arguing that researchers have a particular perspective or motive guiding research questions and data collection (Miles & Huberman 1994, Foster 1996). Lofland & Lofland (1984) consider the use of 'current' or 'remote' biography or circumstance as the stimulus for the researcher to carry out a piece of research (Miles & Huberman 1994). Pertinent factors for this researcher were the genuine interest into the development of psychiatric care pathways and how health care resources should be managed for effective hospital care. For Lofland & Lofland (1984), research activity requires a profound degree of interest to sustain commitment through the research study. They feel that the methodological and ethical problems associated with 'starting where you are' are small when compared to the larger products of such an enquiry.

Ethical issues

The researcher applied and was granted ethical approval from the Trust medical ethics committee before starting the study. The original intention of the research proposal was to test the impact of a care pathway on a range of outcomes. The qualitative process of observation, interviewing technique and method of developing and implementing the care pathway was outlined in the proposal.

Prior to starting the interview and observation process, the researcher informed respondents that the data collected would be used for the purposes of a research study. Respondents were asked to sign a consent form detailing the aims of the study, and were assured that their identity would be anonymised in the production of a report for the hospital and any research thesis. The majority of respondents agreed to interview data being recorded by tape. Prior to starting the interview, respondents were again reminded of the voluntary nature of their participation.

The researcher interviewed respondents whom he had formed a relationship with over a number of years, for example two nurses, whilst some respondents such as a clinical psychologist, were new to the research setting. It could be argued that the nature of a close relationship introduced bias in the collection of information or in how the care pathway was developed. Some respondents did perceive the researcher as being antagonistic towards the occupational therapist respondents. The researcher guarded against this tension by routinely maintaining a reflective log on his relationships with respondents in the field. It was sometimes difficult for the researcher to separate out his personal opinions on the role of occupational groups. It could be that respondents observed this particular reaction in working group discussions although the researcher was not consciously aware of displaying these opinions.

Depending on the nature of the relationship, the researcher needed to adapt the technique of engagement. This was evident, for example, when attempting to gain interview data from the occupational therapist and psychologist. The researcher needed to hold a number of meetings with them individually to persuade them of the intentions of the research study. It was necessary for the researcher to minimise the organisational objectives in order to gain interview data. The researcher needed to persuade them that the information given to him would not prejudice their position within the hospital.

The researcher occupied a dual role in needing to meet organisational objectives to develop and implement a care pathway as well as collecting research data. This issue gave rise to an ethical concern, as the researcher could have been perceived as exerting pressure on respondents to engage with the research study and may have led to people responding differently because of this role. For example, respondents may have put themselves forward in a favourable light especially given the sensitivities in the perceptions held by some respondents towards standardising care. The researcher was worried that the project might not succeed, and required close and frequent supervision to disentangle the two roles. It could be argued that the project could have succeeded in full implementation if the researcher was not dependent on consent for collecting research data for a PhD. Indeed, one respondent perceived the researcher to be carrying out the project in order to gain a PhD.

Although the researcher was known by many working in the hospital and community team, he was able to approach the ward with an open mind because it was a new ward, which he had not worked on before. The researcher needed to build a relationship with the staff group so that he could begin the process of care pathway development. The researcher maintained a daily reflective log detailing his relationship with all respondents and this helped him to guard against possible bias in the collection and interpretation of data. Ethical dilemmas encountered in this study were numerous and varied but ones which were not insurmountable and on reflection ethical standards for conducting the research were upheld.

Structure & process of field work

The first 8 months of the research study was spent developing the care pathway. The remaining 6 months of the research study was concerned with implementing the care pathway. The research study commenced in June 1996 and ended in September 1997 (15mths). From June 1996 to September 1996 (3mths), the researcher carried out discussions with hospital and community staff about the research study alongside a review of the on-going literature. From October 1996 to March 1997 (6mths), 15 scheduled working group meetings took place on the study ward to develop the care pathway. These working groups were attended by disciplines named below, but also included others such as the general manager and senior nurse for adult mental health. There were varying degrees of participation and attendance.

Between August 1996 to September 1997 (6mths), 29 in-depth interviews took place with 18 key informants to collect data on the development and implementation of a care pathway. Repeated interviews occurred with 7 of the informants (George: 4; Peter, Mike: 3; Tina, Steve, Simon, Giles: 2). Interviews were collected from 10 nurses (2 community psychiatric nurses; 1 team leader; 1 ward manager; 1 charge nurse; 5 staff nurses), 2 social workers (1 team leader, 1 locality manager), 1 mental health purchaser, 2 occupational therapists (OT) (1 head of department, 1 ward based), 1 psychologist, 1 consultant psychiatrist, 1 senior house officer.

Between April 1997 to September 1997, participant observation and loosely structured interviews were used to collect data on the implementation of the care pathway. From June 1996 to September 1997, observations of events and conversations were recorded in the researchers' field notes (overt and covert data collection). These notes included meetings and conversations with informants identified above, and others where it was not practicable or permitted to use taped recording procedures.

Context of the study

The study took place in a purpose built psychiatric unit attached to a DGH in London. The locality experienced severe social and economic deprivation and had a population of 181,000 people. Approximately one third of the population came from an ethnic minority background. The hospital

experienced severe shortages and retention of staff. On the study ward, the nursing staff turnover rate was 65% over the course of the research study. The numbers of permanent staff employed on the ward and community team plus a recommendation from the clinical director and general manager led to the study ward being chosen.

The researcher had been working in the psychiatric unit part of the hospital since it was open in 1995, and prior, to this, in the old part of the hospital since 1991. The hospital was chosen because the researcher was employed by the organisation. The study ward was selected because it employed a larger number of permanent staff compared to other wards in the hospital. The researcher was aware of other wards in the hospital, which relied on high numbers of agency staff, and this was deemed to be problematic for engagement with the study objectives. Moreover, the researcher had been employed as a charge nurse on one of the wards and this ward was discounted as an option due to possible ethical dilemmas.

There were four wards within the psychiatric unit plus an intensive care unit, a rehabilitation ward and a day hospital. The study ward was similar in geographical layout to the other acute wards. The study ward was a mixed 16-bedded acute unit catering for adults (18-65) with a mental illness. Bed occupancy rates remained high by as much as 115.8%, but averaging 104.8%. Average mean hospital stay for all admissions was 49.20 days, although almost a third were discharged within 10 days of admission for the

duration of the study. The study ward / community team had a designated occupational therapist, psychologist, junior doctor, consultant psychiatrist, nursing team, community psychiatric nurses, social workers and community support specialists. The community team was designated to the ward and all efforts were made to relocate patients if they were admitted onto other wards. Discharge planning for patients works best when patients are discharged from a ward that directly links into the community team. The team was situated five miles away from the hospital and located above an office block. Throughout the week, members of staff from both the ward and community team spent time in each location, in order to share information on referrals and hospital progress of patients admitted. The locality manager coordinated the activity of both the ward and the community team to provide greater accountability for the admission and discharge of patients within their sector.

The researcher had developed a keen interest in care pathways for general adult conditions since 1992. When the researcher started working in the hospital in 1995, he became interested in learning about the application of care pathways to mental health conditions. The researcher had been interested in designing a study to test a care pathway on length of hospital stay. It became apparent, however, that a qualitative study which would uncover some of the challenges in designing a care pathway for people with schizophrenia was needed. Particularly, the researcher was aware that many people with schizophrenia were admitted into hospital on a frequent basis.

The researcher was keen to explore how hospital care could be changed to deliver a more effective and efficient service. To this end, the researcher was interested in designing a care pathway for people with schizophrenia who had been admitted into hospital three times in three years. Frequent re-admission for people with schizophrenia was a problem for the hospital, but also for the patient, with respect to community integration and quality of life.

The study began by the researcher approaching the general manager of the Trust to develop a care pathway for people with schizophrenia. Aspects of this role would be to investigate the development and implementation of the care pathway as part of a research programme. In effect the researchers charge nurse post was seconded into a facilitation post for a 15-month period.

However, this newly developed post impacted on the nature of the relationships with study respondents and possibly resulted in difficulties in securing research access, development of the care pathway and data collection. For example, some respondents would only agree to a tape-recorded interview towards the end of the research study. One possible explanation could be the level of suspicion about the researcher's position within the organisation. The researcher was only able to undertake this interview by prolonged but sensitive development of rapport with respondents.

The researcher occupied a dual role in both being a project manager to carry out the project to implement a care pathway but also as a researcher in

studying the process of development. The researcher played a central role in both developing the care pathway and ensuring that the care pathway was able to be implemented. The researcher established a series of working groups for the care pathway to be developed and worked to ensure that staff attended. The researcher was active in supporting the chair of the group

Morse & Field (1996) suggest that researchers spend a short time in the study area prior to the formal data collection period to 'acclimatise' participants to the study aims. The first part of the research study was spent observing care practices in the study area and the aims of the research study were explained to participants who worked on the ward and locality team with the aim of encouraging support and involvement. An important part of the action research process is the recognition by workers that a problem exists within their clinical practice (Lauri 1982). The first phase of action research asks the clinicians to inspect their working practices for any problems. Taking the time to be-friend the different disciplines and listening to their problems with the service becomes essential. Many critical and supportive discussions took place with staff and many opposing and supportive reasons identified for and against care pathways as a way forward. This period of reflection upon practice was essential to the spirit of action research and the freedom to challenge present service provision.

Official letters were sent to all disciplines at all clinical levels inviting staff to be part of a working group to develop a care pathway for people with

schizophrenia. To supplement these letters, the researcher spent time in individual sessions explaining the purpose of the research with all disciplines. These conversations were met with varying degrees of hostility and acceptance.

Staff members working on the study ward and community team were especially targeted for engagement. The researcher was able to personally approach members of staff involved to inform them of the study. The researcher did this by examining the off-duty for the ward, and maintaining a diary log of his conversations. The researcher supplemented this strategy by asking people whom he had met if they knew of clinicians who would be interested in being part of the study. This form of sampling is known as 'snow balling' and is used when researchers search for people who can give usual but also polar views on the selected topic (Tremblay 1991). The researcher needs to be aware, however, of respondents giving the names of people who would support a particular view, or offering similar views.

Working group process

The process of developing the care pathway proved to be a time consuming and labour intensive activity requiring much participation from the staff groups. In total, 15 working group meetings took place on the study ward over 8 months to develop the care pathway. The researcher invited clinicians and managers to this first meeting by placing posters around the hospital, study ward and community team offices. Not all members of staff were

interested in being part of the project occurring on their ward or community team and the researcher endeavoured to work around them but casually informing them of the project. The researcher was not aware of any antagonism from respondents who did not wish to engage with the study at the start, but this was apparent when changes took place to the staffing levels of the ward. Nurses, for example, would comment that they had more important priorities than participating in a research project. Attendance to the working groups did need to be encouraged by the researcher and the general manager. It is quite possible that respondents were reluctant to attend the working groups because they perceived the project to be directed by the management staff in charge of the hospital.

Average duration was between 1-2 hours. The first session asked participants to engage in discussions about the common elements of care and treatment for in-patients with schizophrenia, individual professional roles, perceptions of other discipline's roles and the complexity of decision-making and action along the care trajectory. A voluminous amount of information was generated from these discussions. Often it was difficult to order this information into a meaningful framework. Progress was made by using the structure of a United States (US) based purchased care pathway for acute episode schizophrenia. Although much of the information contained within this care pathway was incompatible with United Kingdom (UK) services, the working group began to structure their input and care expectations into problems addressed,

interventions used and outcomes achieved. The interventions and outcomes parts were indexed on a time frame.

The working group process provided the vehicle to develop and implement the care pathway but also an avenue to uncover the many problems within clinical practice. For example there was a major difficulty in identifying the role and function of professional groups within the format of a care pathway. Discipline groups were asked to identify roles and functions by drawing on evidence based practice. There was little reference to empirical research in in-patient settings. The working groups also supplied a rich supply of data on the reluctance of participants to engage with the research study. Similar to the observation by Alty & Rodham (1998) the researcher had over-estimated the enthusiasm and support for conducting the study and involvement of the MDT in the working groups was sporadic. Meetings were scheduled outside working group time where some progress could be attained, but beyond the critical discussions of the group, progress was slow. At times, impasses were reached and these hurdles were relayed to the service manager to intervene. On some occasions, progress continued within individual sessions, whilst in others, discussions reverted back to a working group forum.

At times during working groups, co-operation was stifled and it became difficult to obtain access to information or opinions on service requirements and provision for professional groups. Professional groups attempted to construct time delays into the process of care. Respondents felt unsure when

actions could be achieved and anxious to remain within agreed targets. A considerable amount of working group activity was spent discussing these time delays. Constant re-negotiation on what professional groups were prepared to do was a perpetual feature of care pathway development. Burgess (1984) found negotiation with gatekeepers and respondents to be a continual process in his experiences with a school project. The teachers would only sanction entry to observe classroom situations upon their terms. Burgess (1984) was urged to perform joint teaching sessions to access pupils for interview. The researcher found similar access problems and one particular key-informant called Steve suggested that the care pathway process should follow a 'twin track' approach. The care pathway was both developed in working groups and in individual discussions.

Access into organisational structure

Research into organisational teams requires access and begins with the participants granting the researcher approval for conducting the study (Lee 1993). Access however is not a smooth process and requires a sustained approach by the researcher. The researcher may be at an advantage if they are already employed by the organisation (Lofland & Lofland 1984). In this research study, the researcher had worked both part time and full time in the hospital for five years before the commencement of the study, although this did not extend to the study ward. In some respects, the researcher was both an insider and outsider to the site participants. In this position, the researcher needs to seek entry permission and Lofland & Lofland (1984) identify some

strategies such as for the researcher to create and capitalise on people who may have influence over the site and its participants. For this researcher, entry conditions defined the research process and engagement with the respondents (Johnson 1975).

Schatzman & Strauss (1973) suggests that the researcher 'case the joint' to determine the suitability of the site and collect information about the people to arrange on-going tactics for entry. Issues such as the people who work in the site, power lines and disparities and relationships towards one another and favoured use of expression are collected. In ethnographic presentations, 'participants' are either 'informants' (Spradley 1979) who provide in-depth knowledge to carry out the study or 'key-actors' (Fetterman 1989) whom have been central members of the organisation. Davis (1986) suggests that the researcher form a link with 'sponsors' or 'gate-keepers' (Lofland & Lofland 1984; Tremblay 1991) who are intimately involved with the group and who sanction entry with other key-actors. This entry strategy occurred with key-individuals in the professional groups studied. For example, Tina was the ward manager and exercised control and influence over junior colleagues. On many occasions, informants who were junior within the profession requested to know if the researcher had spoken to their superiors and if they agreed with the research study. Fortunately, the researcher had established strong friendships with a number of people on the study ward and community locality team. On the advice of these gatekeepers, the researcher was able to capitalise on individuals who may be willing to engage with the project.

Lofland & Lofland (1984) also suggest using allies to counter negative reactions from unwilling participants. The researcher was able to persuade Steve and George to engage further support from other members of staff for the project. More importantly, these key-informants informed the researcher of people who were undermining the research project. For example, Wyn informed the researcher that Simon (psychologist) was attempting to destabilise the project by refusing to take part in the working groups.

It is not uncommon for problems of access to remain throughout the study. For example, respondents voiced suspicions about the motive for the research and thought that the care pathway might be used to rationalise the work force. The researcher attempted to minimise these problems by being opportunistic in the use of 'friends' to gain useful insights into the organisation and seeking access at higher levels of the organisation.

Schatzman & Strauss (1973) suggest a range of responses upon gaining entry such as outright acceptance; rejection through fear of exposing hidden agenda's, disinterest with the study focus; dissatisfaction with the status or affiliation of the researcher. The process of gaining access, reasons for rebuttal and subsequent data collection strategies have been documented and used in data analysis. For example the researcher found respondents to be disapproving of the research design, suggesting it was '*not proper research*' when they realised the researcher was taking a qualitative approach.

Hammersley & Atkinson (1995) remind the researcher to be aware of gatekeepers and their sanction to obstruct access. In such circumstances, covert levels of enquiry may have to take place (Foster 1996). This research study included both planned and opportunistic meetings with management and clinical staff both on and off the ward in conference rooms, the locality mental health team, corridors, the canteen of the hospital and any available social contact with respondents.

One strategy used in the research study was a progressive entry procedure (Schatzman & Strauss 1973). By this the researcher agrees to superficial access and then re-negotiates further access. For example, Ingrid would only speak to the researcher about care pathways in a working group. However, with constant approaches, towards the end of the project, Ingrid agreed to a taped interview. Johnson (1975) notes that most initial entry strategies give the impression of scientific authority to conduct the study. This was the case with the researcher's initial research proposal, which detailed a quasi-experimental design. When the research design became qualitative, some respondents such as Helen and Peter questioned the so-called validity of the approach to produce scientific generalisations. The researcher was accused of becoming too involved in the collection of data from the respondents and being too proactive in the development of the care pathway. To overcome some of these problems Johnson (1975) introduces the idea of defocusing the intent of the research study from the host organisation by presenting a wide and loose agenda. By this, the researcher can renegotiate levels of access as

and when the field requires. For example the researcher would outline the nature of the research study if it were thought to be advantageous to obtain access. In other cases the researcher would offer a brief overview to those respondents who may be threatened by a research process.

When the researcher has been granted access, they should attain an impartial relationship with the organisation (Davis 1986) such as withholding findings until completion of the study. This was not the case within this research project. For the study to remain viable, it was necessary to report some findings to tiers of management. This has the beneficial effect of validating and refuting issues (Silverman 1985). For example the researcher would take data and ask Wyn to offer his views or suggest other alternative explanations. The researcher also used this relationship to secure compliance with the study objectives and to gain insights into the motives of the organisation to rationalise professional groups. In one exchange, Wyn confided in the researcher that he wanted to dismantle the OT hierarchy and so have them managed by ward managers. During the time of the research study, the researcher was unable to negotiate a totally impartial role within the organisation.

Schatzman & Strauss (1973) suggest presenting oneself for informal discussions to briefly display themselves and interests of the research and this should be on going to ensure close relations with the informants throughout the study. In this study the researcher also made contact with the less central

parts of the organisation such as the rehabilitation services. This had the effect of making respondents feel important within the organisation.

A stylistic factor that needs to be borne in mind is the possible threat perceived by the respondents from the researcher. A strategy to minimise this may be for the researcher to be perceived as 'socially acceptable incompetent' (Lofland & Lofland 1984: 38). However, the researcher had many years of experience in psychiatric settings and working with a wide range of professional groups. This had the effect of making the researcher appear too knowledgeable about psychiatric care and fuelled a suspicion that the research study was concerned with reducing resources.

Lofland & Lofland (1984) identify that research performed in organisations contains factions and the problem for the researcher is to remain neutral in the strategy and collection of data. This particular problem occurred during the research study because the researcher belonged to a nursing background. Non-nursing groups perceived the research study with suspicion and it took many months to gain access to the issues important to the respondents. Lofland & Lofland (1984) advise the researcher to be 'mainstream' in their allegiance to internal problems and to ensure confidential handling of information gleaned from each side. The problem with the final part is that some research texts (Schatzman & Strauss 1973) advise the researcher to use competing perspectives to prompt other respondents into giving information. The researcher did this by suggesting that a care pathway would provide

improved management of resources. The respondents would then respond to this particular perspective and provide a variety of responses. For example, Ingrid who was an OT argued that the importance of a care pathway should be focused on the quality of care as opposed to the efficiency of the organisation.

Johnson (1975) notes the assumption regarding access is that the procedure is devoid of any intransigent problems. Of interest is the consideration that published accounts omit if the researcher used coercive strategies to get access to respondents (Silverman 1987). A persistent feature of the research study was the feeling of being denied access to people's thoughts and actions from one day to the next. Some parts of the development phase of the care pathway became very intense where the discipline groups of OT and psychology refused to take part in the full number of working group sessions.

In Johnson's (1975) entry negotiations into a public welfare department, access was gained by following his theoretical and practical understanding of how the organisation operated. Johnson (1975) also capitalised on people he knew or had close relationships with within the site (one was his wife).

Johnson (1975) discusses strategies to manage those individuals (freeze-outs) in the field who refuse to engage with the research. With one freeze-out, the respondents stated that he did not trust the researcher and that he began to influence other respondents to avoid engaging with the researcher. Johnson (1975) later became proactive in neutralising the freeze-out's comments by

verbal interactions with other respondents. 'Freeze-out' situations occurred during this research study, where respondents refused to speak to the researcher, answer letters or return phone calls. Meetings were arranged many weeks in advance, only for them to be cancelled. Likewise, for Johnson (1975) the field research occurred in a stressful environment. This made relationships with respondent's fluid and determined by the conditions of the day and person. Rather, the researcher negotiates with the respondent for their willingness to engage, and he called this process 'the mini-dialectic of personal relations in the field' (Johnson 1975: 134).

Lofland & Lofland (1984) discuss the legitimate issue of 'trade-offs' and 'closed doors' in qualitative research where the researcher is a known participant. In this research study, a trade-off was accepted from Simon who was the psychologist to stop circulating the working group minutes to the Health Authority. Agreeing to this request was dependent on their continued involvement. In one working group, Simon disclosed that many of the interventions used by a psychologist were 'hit and miss' and he was uncertain of the effectiveness of the interventions for people suffering from schizophrenia. When the minutes were circulated, Simon approached the researcher and expressed his concern that information would be used by the Health Authority to reduce the level of funding for psychological interventions.

Choosing participants: informants and key actors

The researcher can employ different sampling strategies to collect data, although Bryman (1989) suggests that qualitative research sampling is dependent on the degree of participation encountered by the researcher within the organisation. The researcher adopted a range of strategies to choose respondents for the study but this was largely determined by the location of the study being on one ward and a community team. The researcher also needed to be flexible to meet respondents at a time, which was suitable for them, and to continually seek engagement for the project to start. The researcher would approach potential respondents by firstly informing them about the aims of the project, which was to develop a care pathway. Following initial engagement the researcher would then inform them about the research study and a general enquiry if they would be interested in being part of it. Not all members of staff wished to engage with the research part of the study but were agreeable to helping in the implementation of the care pathway. However, there were occasions when they identified other people that did agree to be part of the study.

Random or representative sampling (people, events or situations) could be employed in order to generalise from the study findings (Patton 1980), but this research study was unable to overcome the pragmatic considerations such as having sufficient access to people in the organisation. As an alternative, snowball sampling was used where informants tell the researcher of people who may co-operate with the research study and provide diversity

of accounts (Tremblay 1991). For example, Wyn informed the researcher about contacting Zac who was a mental health purchaser. This contact led to Zac being part of the working group. However, Lee (1993) notes the potential for co-respondents to select those people who will offer similar views, leading to studies offering limited cross case analysis.

The research study also used a multiple location strategy, allowing the researcher to gain insights into how informants relate to others within their own or other departments (Schatzman & Strauss 1973). Using this strategy, the researcher is less interested in sampling random occurrences, but concentrates on those aspects that are informative to the research enquiry. Informants in this research study worked and functioned in different positions within the organisation and provided the researcher with competing interpretations for interviews and observation.

Miles & Huberman (1994) propose conceptually driven sequential sampling. In this, the researcher seeks out respondents to offer competing perspectives on the chosen concepts. Miles & Huberman (1994) acknowledge the field practicalities of sampling such as time permitted both from the research study and respondents. A further way of gaining data is that from peripheral sampling. The researcher questions people who are not directly involved with the research study, but are able to offer interpretations, such as dissidents created by the organisation (Lee 1993). Patton (1980: 101) labels these informants and key-actors, the 'extreme cases' where by the impact of

program evaluations would be understood from a wider perspective. For example, Howard who was a nurse psychotherapist, working in a office detached from the main hospital building commented that Wyn was a '*control freak*' who would use care pathways to better manage the work force.

The entry strategy for the researcher was an opportunistic and theoretically selective method. As the research process uncovers new interests and foci, the researcher deliberately searches out those informants to provide information on these new directions. It was for this reason that the researcher limited the number of observations and interviews to match the available resources and time and so subordinate breadth with depth of focus. In this way the recording of information become more select, concrete and detailed (Patton 1980).

Observation strategies

When the researcher enters the field, initial observations are shaped and modified by experiences to form and test theoretical leads (Foster 1996). In structured observation, the researcher employs direct observation in the field. The types and frequency of observation are computed onto a schedule (Bryman 1989). Observation strategies that incorporate degrees of structure attempt to place an objective edge to the collection of data and so emulate the traditions of positivist science to produce quantitative data such as frequency counts (Foster 1996). Silverman's (1987) study of a paediatric cardiology unit examines how he limited his categories of observations to a

coding sheet, which then described patterns of communication between doctors and parents. Miles & Huberman (1994) note that if the context is well known and the research questions are unambiguous standardised instruments would provide data that could lend generality to other research settings.

Observation strategies that use less structure originate from the Chicago School of Sociology and are more closely aligned with ethnographic research. Proponents of unstructured observation reject the notions of positivism and work on the principle that to understand behaviour and action, you need to understand meanings held by people studied in context. Unstructured observation requires that the research site accept the researcher for long periods of time and for trust to develop amongst the participants and researcher (Foster 1996). Due to the lack of knowledge about the development of care pathways, unstructured observation was most appropriate for this study.

Schatzman & Strauss (1973) lists the main types of observation which the researcher may progress through as the research process unfolds; watching from outside; passive presence; limited interaction; active control; observer as participant; participant with hidden identity. Within this research study, problems were experienced in initiating and sustaining trust with respondents, thus impacting on levels of participant observation. It was only towards the end of the research study that a degree of trust had been established to collect participatory observation data. Johnson (1975) found that his

relationships with social workers was a developmental process, always open to subjective reinterpretation as the aims of the researcher and research study impacted upon the respondent. Johnson (1975) used the identity as the 'humble' researcher to match those of the respondents. Johnson (1975) normalised respondents accounts of deviant practice i.e. when respondents went beyond the 'fronts' of their role to tell about going home early, he informed them that his wife was in the practice of doing the same.

Within participant observation, the researcher is 'immersed' with the study site (Lofland & Lofland 1984) and the goal is to collect information on people's day-to-day activities and routines within the context of study (Hammersley & Atkinson 1995). The main data collection technique for participant observation is unstructured observation and interviewing strategies (Foster 1996). The method also entails listening to what people say and engaging them as informants to find out less visible things about the organisation (Bryman 1989). Silverman (1993) is critical of this emphasis, believing that information will take on a 'psychologistic perspective'. Sandelowski (1986: 31) notes that as the researcher becomes close to the participants, this may in effect colour the 'truth value of a qualitative study'. However, this researcher found other pragmatic difficulties in securing close relationships with all respondents and activities within the study site. Participant observation is dependent on close relationships with respondents but this was limited for the researcher by the nature of the relationship with the managerial levels of the organisation.

Bryman (1989) identifies three types of role: covert, full and indirect. Within covert observation, the researcher gains entry and observes the processes of an organisation through a concealed identity. For example, Rosenhan's (1992) study asked people to be admitted to a psychiatric hospital with no previous psychiatric disorder and pose as patients. Rosenhan (1992) acknowledges the breach of ethical standards and argues that this form of observation was necessary to collect data for his research question. The advantages however, are the removal of the problems in gaining access to the organisation and less chance of the usual occurrences being undisturbed, or stage-managed for the researcher. Conversely, the full participant has a work role within the organisation and the identity of the researcher is known. Although the researcher occupied a full participant role within the organisation, some forms of data were collected through a covert form. For example, the researcher concealed his close relationship with Wyn who was the general manager, which if known would have hampered further his relationships with participants in the field. In other ways the researcher 'eaves-dropped' on conversations in the nursing office.

This research study used variants of unstructured observation and this was principally determined by the relationships with the participants. In some examples less structured observation produced descriptive qualitative data and this was usually recorded in the form of field notes such as conversations, interviews or direct observations. Field notes serve as a precise record of social situations and enable the researcher to place these data into a

meaningful context (Hammersley & Atkinson 1995). As the collection of data becomes more meaningful, theoretical leads are formulated and the strategy becomes more focused to support or refute emergent themes. For example the researcher attempted to observe 'usual care' on psychiatric wards but this became more focused to observe the features of individualised care, which is more central to the study. Foster (1996) notes the importance of remaining true to the types and variety of language used by the respondents and recording this with the specific location of the observed behaviour. However, it must be acknowledged that some descriptions may be the product of interpretation and selection or the possibility of the researcher manipulating respondent's accounts and accuracy of reporting the data. Chenitz (1986) discusses the practicalities of writing up these field observations and the researcher performed this necessary function when the field had 'closed down' such as at the end of a working day for the ward or members of the team.

Interviewing strategies

Qualitative interviewing is generally a loosely structured method of collecting information, although they can be structured in the form of a survey or totally unstructured in the form of a conversation (Bryman 1989). The specific interviewing strategy adopted is dependent on the nature of the research question. Wilson (1996) discusses two types of structured methods such as the interview schedule and the questionnaire, although these methods assume the researcher already understands the topic of interest (May 1989).

These formal types of asking questions may lead to reactivity and restrictive answering of questions. To overcome these problems the researcher used intensive interviewing as a strategy to gather rich data about the participants' experiences surrounding a particular topic or context. This strategy differs from structured interviewing in that the emphasis is placed upon finding diversity of cases as opposed to frequency of cases (Lofland & Lofland 1984).

The researcher also used unstructured interviewing, or the informal interview, which encompasses the use of ordinary conversation to collect data. Chenitz (1986) notes that the informal interview may lead to less procedural reactivity, thus taking account of the norms of social discourse in natural settings and so is less constrained by the formal methods of structured interviews. Silverman (1993) criticises the reliability issues of this type of interview and the sampling procedure adopted. However, Hammersley & Atkinson (1995: 156) write that '*accounts produced by people must neither be treated as valid in their own terms, nor epiphenomena or ideological distortions*'. The researcher was careful not to locate unstructured data strips as having any more or less validity than other data sources. This position is even more important because the views of respondents changed as the care pathway was developed and then implemented in practice.

Schatzman & Strauss (1973) discuss '*eavesdropping*' as a particular strategy of collecting unsolicited data. The researcher used this strategy at the start of the study with information recorded in field notes. For example many nurses

expressed anxiety about forming a working group and the researcher used this information to persuade those reluctant nurses to attend or gather their views for inclusion within the working groups.

Swanson (1986) suggests that the researcher follow a loosely ordered list of questions or themes to ask the informant, continually probing for elaboration within the replies that are interesting and different to the accounts provided by others. Lofland & Lofland (1984) note that probe questions can be used when respondents have not discussed issues in full detail or discussed differently to other respondents. In situational conversation, the researcher asks questions 'on the spot' to enquire further about confounding observations or eavesdropping conversation. The researcher used these strategies to both collect information and to approach participants for an extended formal interview.

The interview may be non-directive or confrontative in the collection of data. Hammersley & Atkinson (1995) suggest that leading questions can be used to test hypotheses or take down respondent 'fronts'. Posing the question in a negative way to how the informant is expected to respond can reverse bias. This research study used 'hypothetical questioning', 'presenting the ideal', 'presenting interpretations' and 'devil's advocate questions' such as 'do care pathways take away the individual nature of care' in response to a positive opinion about care pathways.

Bowers (1996) notes that interviews performed at the start of the research study may be less informative compared to interviews performed towards the end of the study. This is mainly because the researcher is uncertain on the types of information required to answer the research question. Secondly, it may take some time for the researcher to understand what particular issues the respondent is attempting to discuss. Particularly in this study, there was little standardisation of interview style leading to the researcher collecting more information than necessary (Morse & Field 1996). In order to uncover the various issues, Spradley (1979) suggests different types of questions to ask of informants based on the observations of the researcher. This proved to be a feature in this research study where the researcher used 'grand tour' descriptive questions at the start such as 'what is usual care'. More focused interviews asked structural questions such as 'in what ways do care pathways lead to standardised care' or 'in what context do care pathways lead to integrated working'. Data generated from these interviews led to different sets of terminology being used to describe the impressions of care pathways. For example, the issue and meaning of individualised care in psychiatric practice. In order to establish a meaning to these terms, informants were asked contrast questions such as 'in what ways would you individualise care' or 'in what way could standardised care be represented on a care pathway'.

The benefits of unstructured observation, eavesdropping and casual conversation have developed insightful interview questions. For example, the researcher would pass from being a covert observer, but also adjust to an

active interview role (Chenitz 1986). This enabled the researcher to interview numerous key actors, which created a list of questions leading to a more formal type of interview, thus focusing on similar types of questions to key informants (May 1989). In this respect, the researcher used an interview guide to log intensive interview sessions and this included biographical information, feelings and thoughts (Lofland & Lofland 1984).

As the research study unfolds, respondents may approach the researcher and divulge information not specifically requested by the researcher. Schatzman & Strauss (1973) suggest this situation may arise from host respondents who may want to ensure that their perspective is counted alongside others (especially those views which may be dialectically opposed). In some circumstances, the researcher may act as a catalyst for discussions to take place. The researcher maximised these opportunities to collect data to better understand the reality of the phenomena under study. The researcher also searched for leaflets and documents that described the study context such as census material, and other sources of data such as biographical details about the people involved with the research study. These peripheral sources and forms of data added to the diversity and breadth of cases in the final analysis.

Lofland & Lofland (1984) identify the need to transcribe interview material as quickly as possible following the event. This serves as itself a form of analysis, but there is no need to be meticulous in the recording of every exclamation or word. They provide a general rule of thumb that because qualitative

Interviewing produces vast amounts of data, studies usually use between 20-50 interviews. However, one could argue that the researcher should search for cases that would adequately provide a rich supply of data able to provide understanding and depth to the area of study (Sandelowski 1995). This researcher attempted to transcribe interview data the following day but was limited by the amount of time. However, there was not a huge delay and each interview yielded further types of questions to be asked to secure the depth of analysis required.

Analysis of qualitative research

A process of collecting data, formulating codes and subsequent testing of these codes, ideas and hunches has become a hallmark of qualitative research. Bryman (1989) suggests that when qualitative researchers have a preconceived structure, the data can be analysed by following this focus.

Alternatively, researchers can choose not to have delimited areas of focus and 'wait for interesting themes to emerge' (Bryman 1989: 166). However, this researcher was influenced by compiling a literature review on care pathways and some of the inherent problems and solutions for their use in practice. This gave way to a more focused collection of data around emergent themes such as the nature of individualised care or the impact of a management inspired changes in health care.

Coffey & Atkinson (1996) characterise the process of analysis as iterative with other stages of the research process. Preliminary analysis thus begins with

the synthesis of theoretical notes. Hammersley & Atkinson (1995) note that the relationship between data collection and analysis is not as wide spread in ethnographic accounts because of the researcher not taking sufficient time to be reflexive with the data collected. They insist that reflexive processes must occur to ensure that well developed analyses take place. In other words the researcher must make some evaluation of their part in shaping the way data was collected and the impact of the researcher on the study participants.

Schatzman & Strauss (1973) suggest that the researcher should search for certain classes of data and their properties such as common or theoretical codes. Common codes are types that lay people would use to classify varieties. Theoretical classes are those constructed by the researcher from their observations. Hammersley & Atkinson (1995) suggest using Glaser & Strauss's (1967) constant comparative method where the ethnographer notes the differences and similarities to bits of coded data within and across categories. This may lead to some categories becoming split and differentiated, thus identifying the internal structures of the categories.

Hammersley & Atkinson (1995) believe that the inductive nature of grounded theory is far fetched and in practice, common sense and alternative theoretical frameworks displayed within the literature guide the ethnographer. Silverman (1993) criticises grounded theory for its preoccupation with theory construction rather than theory testing. However, for this researcher a range of strategies were used to order the data set into a meaningful account (see below).

For Dey (1993), the analysis of data is driven by the data collected and follows a process of describing, classifying and connecting. The meanings given to words are constructed through a social medium. The researcher collects data on people's meaning given to objects or expressions. The analysis of a meaning of a word cannot be taken apart from the context from which it arose and from how the meanings of the words were used. This is dependent on finding patterns of using the words, but signifies the importance of tracing process over time to chart how meaning does change. For example the researcher studied the use of the term 'standardised care' and how this became tempered by the need to apply 'standards in a flexible manner' for a care pathway to be accepted in practice (see chapter four).

For researchers who have not used a systematic collection and ordering of information, Schatzman & Strauss (1973) propose 'audience conjuring'. They first direct the researcher to provide a literal description of the research process and what was observed and then illustrate classes and properties of the data. A further analytic strategy is to 'interrogate' the data and so test the ideas and classes developed with affirmative and negative cases. The researcher then actively questions the integrity of this form of evidence to the concepts constructed (Silverman 1993). Schatzman & Strauss (1973) suggest two types of questions to lever the data in order to establish some form of analysis; substantive and logical. Substantive questions are those to do with the perspective of the researcher or received concepts. Logical questions look

for comparisons between the different respondent's views, and explaining polarities in the data set. For the researcher who has collected rich supplies of data, although insufficient to form grounded theories, Schatzman & Strauss (1973) direct the researcher to think back over the time of the research study and construct other possible questions to ask the data. For example, the researcher searched for how respondents interpreted the impact of a care pathway on defining psychiatric care and how respondents tended to exaggerate their role and function.

Coffey & Atkinson (1996) note the fluid nature of the use of codes to aid the analytic process. Analysis would be aided by reading all the created codes and categories comprising the research study. The codes and categories should be supplemented with negative cases and rich contextual description of the events, people and activities. Coffey & Atkinson (1996) discuss the strategy of transforming the codes and categories into 'meaningful data' to thus theorise from the data.

Miles & Huberman (1994) discuss their view on analysis of data as composing of three interdependent phases; data reduction, data display; verification and conclusion. Data are reduced into codes and summaries as the data collection period continues and comes to an end. Data display is how these codes, clusters or categories are placed into a whole in which concluding remarks can be made. Verification and final conclusions serve to analyse the findings and to ground these findings with the context of the study. This research

strategy achieved this by eliciting comparison between cases, searching for negative cases, and discovering regularities and patterns.

Boulton & Hammersley (1996) describe the process as both funnelling data into categories and simultaneously creating / altering the categories. They discuss some tactics to achieve this such as a 'close reading of the data' and selecting issues and relationships that appear significant or contrasting and comparable. The approach is one that places an iterative process between data collection and analysis as the research study proceeds through to conclusion. Categories can be created from many sources such as the starting point of the research or native tongue of the respondents. The researcher could also draw from sources far wider such as non-fictional accounts (Coffey & Atkinson 1996). The overall goal is to formulate a list of categories that somehow provide an overall description of the research study. Dey (1993) suggests looking back over the data for the decision points on why certain actions were taken. The researcher achieved this by examining the working group minutes and field notes, which set out a chronological sequence in developing the care pathway.

Coffey & Atkinson (1996) suggest that the particular style or representations of research findings be situated within the realms of how the world has been studied, or 'reconstructed'. They also identify that different theories can be developed from the data set and that ethnographic accounts could become fictionalised (such processes as anonymity) through combining and splitting

respondent's views. Schatzman & Strauss (1973) propose that the researcher analyse the cumulative properties of the findings and move away from labelling certain points as arising from any particular individual. In effect, this type of data becomes 'recycled'. For example within the research study some informants interviewed at the start of the research became disengaged from the project by leaving their place of work.

This researcher used cross sectional categorical indexing to reverse some of the weaknesses of qualitative analysis. It involves reading a selection of the data and grounding the themes from the data to create categories. When a sufficient number of categories have been assembled, partially tested and modified with some further data, the whole of the data set is coded and retrieved into the categories. Mason (1997) identifies that this process entails a value-orientated position in the selection of data to be viewed as potentially meaningful to the overall analysis. The researcher thus needs to be explicit in the reflexive action in how and why he has generated certain data and themes. This type of sorting and indexing the data offers a useful strategy to provide a systematic perspective of all of the selected data as opposed to discrete units of data. It also allows the researcher to provide an account of the themes that do not appear as orderly in the collected data. The method provides a medium of getting close to the data for further analytical processes to occur at a later stage following retrieval and allows the researcher to reject the method of variable analysis. The disadvantage is that the researcher eventually stops creating categories for application across the data set.

Arguably, the list of categories may change as further analytic processes come to develop (Mason 1994). Moreover, there may be a tendency to de-contextualise the slices of data; a problem noted in many research texts (Sandelowski 1997).

A consideration for all qualitative analysis is the use of computer software packages such as Ethnograph and QUALPRO. Unlike some (Morse & Field 1996), there was no strong philosophical urge to reject software packages but rather an understanding of their use in qualitative analysis (Mason 1994). The researcher attempted to use NUD*IST but found a greater grasp of the issues by using simple 'cut and paste' functions on the computer. There are disadvantages to not using software packages such as the inability to quickly check the various codes and categories across the data set (Pateman 1998). This was a problem given the vast amount of interview and observational data.

Interpretation of data

A common criticism of ethnographic presentations is the biased selection of cases to support the points made by the researcher (Silverman 1993).

Therefore, it is important for the researcher to critically examine the plausibility and credibility of data forms and analysis (Lofland & Lofland 1984). The researcher attempted to achieve this by undertaking a reflexive analysis of the role of self in the design, collection and analysis of the data. This can be achieved by leaving a decision trail for others to judge the validity of the

claims (Boulton & Hammersley 1996, Koch 1996, Coffey & Atkinson 1996). However, Sandelowski (1997) feels that researchers should celebrate the subjective art of qualitative research and not be constrained by the tests of validity and supposed objectivity. To a certain extent this was carried out, because the researcher did not become too constrained at following rigid rules of collecting data in a consistent way with all respondents. The researcher altered the nature of questions throughout the research process, often prompting respondents with 'half truths' to gather rich sources of data. For example, the researcher would suggest that some respondents offered various opinions on care pathways even if not strictly true.

The reading of text and allocation of codes are part of an interpretation exercise although there is the potential for the process to lose information contained within the text. To reverse this the researcher continually referred the selected codes back to the whole of the data set. However, data loss is more pronounced when the analyst does not move beyond into dense coding and linking between and within the categories (Coffey & Atkinson 1996).

Lofland & Lofland (1984) urge the researcher to question their own perceptions and secondly that of the respondents. The products of analysis need to be seen as a particular perspective and that re-analysis may produce other interpretations (Atkinson 1992). Some questions to ask of these perceptions are to do with 'spatial location of the researcher', 'self serving error', 'possible skewing effect of researcher-respondent relationship', and 'internal and external consistency of accounts'. Even when these questions

are asked of the data, the data may still be no more or less true (Lofland & Lofland 1984). Atkinson (1992) provided an example of this in re-reading his field notes of an ethnographic study performed on the medical training of students in Edinburgh. He considers the advent of new areas of knowledge on his past method of recording and analysis of his field notes and suggested different interpretations of the findings. Bryman (1989: 163) questions how researchers are able to correctly interpret the social world 'through the eyes of respondents' and that the researcher and respondent may arrive at different perspectives. These different perspectives would serve to provide greater insights on the observed phenomena (see emic & etic perspectives below).

The researcher needs to show how their presence has shaped the data and this is referred to as reactivity (Hammersley & Atkinson 1995). One of the important considerations is that of context. Threats to the validity and reliability of observational data may be through personal or procedural reactivity. Other threats may be observer bias and subjective interpretation and selection of what to observe. This is poignant given that observation and interview questions are not pre-formulated at the start of the research study and those interpretations of the data are the product of a lone researcher. Misinterpretation of behaviour may occur because the researcher may be unable to understand the observed behaviour due to lack of knowledge about the field or the respondents involved (Foster 1996). Other factors that need to

be accounted for are 'fronts' and how the audience will deliberately present an altered image to the researcher (Hammersley & Atkinson 1995).

Emic & etic perspectives

In ethnographic research, questions of validity are relegated in favour of acknowledging the role of the researcher in shaping the collected data typically described as an emic perspective (Hammersley & Atkinson 1995). To complement this the researcher should attempt to analyse the perspective of those observed and how this compare with the views held by the researcher (etic) (Schatzman & Strauss 1973). This researcher found that the etic perspective was more sensitive to issues that possibly an insider perspective would discount or find unrelated to a wider theory. This outer perspective would strive to maintain a sense of sensitivity and influence on the data collection, searching for shades of difference from the seemingly regular. Schatzman & Strauss (1973) state that people will view phenomena from diverse perspectives and in a sense, each and all have their own biases. They adopt a perspective, which accepts this bias in an attempt to understand the view of each particular informant, and how they vary in relation to the given phenomena.

However, Lofland & Lofland (1984) discuss the importance of respondents' causal theories to inform those developed by the researcher. Some respondents are aware of their own setting and notice variations to a similar degree as the researcher. Within this research, Simon who was a clinical

psychologist readily discussed theoretical points about care pathways. In one exchange, Simon spoke about the impact of wider Government policy and professional behaviour towards care pathway structures and this was later to become a major theme (see chapter seven).

Burgess (1991) believes that for a researcher to produce a valid outsider perspective, they must be both involved and detached from those being studied. The position of this research study is at odds with this requirement. The researcher both worked and designed the study in the hospital under investigation and knew some of the informants at various levels of friendship and professional acquaintance and remained entrenched within the culture during fieldwork stage. The researcher only became detached from the study location following a work opportunity in a different hospital. Foster (1996) notes a problem for the researcher in being able to balance the emic and etic perspectives within ethnographic work. For example, the researcher may become too engrossed with particular issues, thus distorting interpretation and subsequent data selectivity. Furthermore, by becoming too friendly with some respondents, this may bias the researcher from studying other groups of people or other locations. The check is that of adopting a detached outsider perspective, although the researcher acknowledges the inherent biases in selecting respondents and interpreting their views.

Respondent validation & triangulation

Respondent validation entails asking respondents to comment on researchers' interpretations, comparing respondent's accounts with that of the researcher and iterative modification of interpretation (Foster 1996). The advantages of respondent validation are that the informants can present contestable issues adding further information undisclosed at interview. However, the limitations of such an approach are a potential threat to the validity of the data. For example, some social action takes place unconsciously and people may not remember what they did or thought about the action. Important too is that informants may view the account from a different perspective from that of the researcher. However, there are cautions to be considered with respondent validation such as manipulation of accounts by respondents to suit particular motives, impressions, interests and errors in memory (Foster 1996).

Respondent validation accounts must be treated with the same caution to inference as any other type of data (Hammersley & Atkinson 1995).

Triangulation methods are various and aim to check the validity of accounts.

The process of triangulation has been proposed as a research style to counteract the weaknesses of single research approaches (Morse 1991), increase the confirmation of results (Redfern & Norman 1994), discover negative cases (Duffy 1987) and produces common forms of reference for validity criteria (Cowman 1993). Coffey & Atkinson (1996) suggest that triangulation strategies should be viewed as a method to enhance understanding of the complexity of social phenomena. However, the various

checks of triangulation appear to balance the contextual nature of qualitative data. For example, the researcher searched for data supported by interview and observation data. An example of this was the theme of exaggerated view of work skills (see chapter six). The researcher triangulated the data from interviews and by checking the care pathway completed by the respondents.

Hammersley & Atkinson (1995) point out that some informants become too sophisticated in what they say as they become analytical, rather than descriptive. The researcher can check and compare descriptions given by other informants and also take account of this effect in the analysis and production of the ethnographic account. Within this research study, the researcher constantly attempted to verify observations such as negative cases, which did not fit with the conceptual framework, and this served as an effective check against the validity of the account. Moreover, the researcher triangulated unstructured and intensive interview data to develop further research questions and validate findings.

Johnson (1975) discusses the level of trust between the respondent and researcher and the subsequent collection of data. He typifies responses according to certain factors such as practical factors and respondent's attitude at time of questioning. Johnson (1975) presents the argument that a trusting relationship between the researcher and respondent would penetrate past the 'front'. Johnson (1975) directs the researcher to evaluate the impact of these different forms of relationship on the collected data. This researcher found

differences in the types of relationships held with respondents and this impacted on the ability to gain interview data that could be recorded on tape.

Issues of power in health care evaluation

This research study has examined the reaction of the major professional groups to the development of a care pathway. Engagement has been problematic, although this is common where the evaluation procedure is politically sensitive, or when accesses to the research site and respondent's views are deemed problematic (Lee 1993). In some circumstances, it may be inconceivable for professional groups to identify themselves for public scrutiny, share power over decisions, allow an inspection of records and documents concerning the evaluation intent, or change views to compromise the views of other less powerful occupations (Johnson 1972).

Professional power and autonomy may dictate the level of engagement in service evaluation. Disciplines exert a form of occupational control over external forces to prevent evaluations that may potentially de-skill and so de-professionalise aspects of their work (Turner 1987). Discipline groups may view this evaluation procedure as a process of fragmenting the professional base by other occupational groups 'where it will struggle against competing occupations in terms of maintaining its privileged access to knowledge and to educational systems...to ensure the continuing ignorance of its clients' (Turner 1987: 140). Resistance to occupational disclosure and possible erosion of power may forestall the research gaze and freedom of access.

Confidentiality would be practically impossible to secure within small organisations (Koch 1994a). Although stakeholders may have foresight to know this position before they enter the study, this may only produce data from the most confident of respondents or those who have little to lose from having their accounts made public. Moreover, the researcher is embedded within the political agenda of the sponsoring organisation (Silverman 1993). Within this study, the researcher offered an extension of the political motives of the organisation to develop standardised care processes and so control work methods.

Position and purpose of the evaluator

This research strategy deliberately engaged stakeholder groups and individuals in designing and implementing the care pathway. The role of the researcher within this action research process could be criticised for manipulating the group to develop the care pathway. Koch (1994b) described the role of the facilitator as leading the group, producing agenda's for negotiation, and comparing / contrasting stakeholder perspectives. This forum relies on the stakeholders to accept the accounts of others given the relative power imbalances in health care. However, the approach gives the impression that the researcher lies on an equal power relationship with the informants to evaluate the change process. The approach is also reliant on the researcher consciously engaging with informants to gather their views and those of others. Second, there is the implicit assumption that the interviewer and respondent will automatically develop a level of rapport ready for the

divulging of truthful information (Chenitz 1986). This researcher found great difficulty in forming relationships with all participants to gain engagement with the study. This may be due to the role of the researcher in promoting the use of care pathways and so undermining the facilitation aspect of the role that some respondents may well have preferred.

Issues relating to reactivity in the field and certain techniques that the researcher can use to become unobtrusive with those being studied are important (Foster 1996). Of significance is of building trusting relationships with respondents by spending time in the site. The researcher negotiates his 'front' identity with the respondents and controls the amount and delivery of information. Foster (1996) suggests that if the research study and the identity of the researcher are known, the researcher could discuss biographical experience and knowledge of the area under investigation to imply a sense of common goal as opposed to an 'expert or critic' (Foster 1996: 71). The information and presentation of self may change towards respondents as and when the needs of the research study change. Foster (1996) limits the positive elements of ascribed characteristics (race, sex), although adds that certain impression management techniques could be used to reduce these problems.

Conclusion

For the most part, research studies have taken a positivistic approach to exploring the impact of care pathways. The studies have not appreciated the

impact of care pathways on professional conceptions of psychiatric work. It is maintained that by using a qualitative approach, the researcher is more likely to reveal multi-dimensional views and experiences about the development and implementation of care pathways. The focus of this chapter has been to outline the key methods used within this research study. Engagement was a particular problem and strategies were required that would allow the researcher to get close to the respondents in a revealing way without the limitations of more structured research methods. Predominantly emic and etic perspectives were generated and various checks used to analyse the authenticity of accounts. The data has been coded and analysed by searching for how themes are used within and across the many and varied perspectives. The specific method of creating the care pathway has been charted, alongside the restraints and challenges within such a process.

The researcher had been employed by the hospital as a psychiatric nurse and subsequently granted the approval, financial backing and project manager status to carry out the research study. It was difficult for the researcher to maintain an independent position to conduct the study. Action research processes were selected to work on the strengths of this position and the organisation was asked to diagnose the problems and solutions in improving psychiatric care. The researcher became part of this ethnographic process and collected data from his observations, interviews and reflexive effect on the data set.

Although ethnographic accounts concentrate on the micro study of the individuals within the group, this study has also considered the impact of macro policy on the study findings. In effect, the micro and macro issues collected from the respondents are analysed concurrently, thus displaying how the issues of developing a care pathway are related to the wider Government agenda towards more standardised care.

Much has been documented about the reflexive effect of the researcher on the collected data and issues of power within organisational research. The process of carrying out the study has been carefully outlined to enable others to place interpretation over the events. It is readily accepted that data can be interpreted differently. However, there are very few evaluation studies concerning the development and implementation of care pathways and the method reported here appears most fitting for the current research enquiry.

Chapter Four

Constructions of psychiatric work

Introduction

The process of developing and implementing the care pathway centred on respondents discussing their role and function to set problems, interventions and outcomes for in-patients with schizophrenia. The first major theme to evolve from this process was the conception of standardised care and individualised care. Some respondents described care to follow a standardised pattern whilst for others it was described as being individualised to the patient in their care. In this analysis attempts are made to show how respondents placed these views into a differentiated structure towards or away from standardised work. The various descriptions are analysed by drawing on the participants' experiences of being part of this research study. The analysis has also taken account of the various positions the participants held within the team and how this shaped their spoken views. Respondents have all been given pseudonyms to protect their anonymity.

Standardised work

Standardised 'process' care

One of the major aims of this study was to explore how the multi-disciplinary team (MDT) developed and implemented a care pathway. A central theme throughout the study was why participants were able or unable to represent

care within a care pathway, which has as its aim, the standardisation of psychiatric care. This chapter will aim to display evidence of this theme and its significance for the following chapters.

The care pathway literature assumes that care and treatment can be standardised (Wigfield & Boon 1996). Many examples of standardised procedures have been published such as medication protocols (American Psychiatric Association 1997) and specific care pathways (Andolina 1995). On a wider level, the NHS has developed health-related groups that consume similar levels of resources for various clinical problems (Lees & Stafford 1996). However, the process of detailing standardised care is less clear.

For some respondents, there was an unmoveable assertion that care can only be conceived as an individualised entity. Whilst for others, some aspects of process related activities could be conceptualised as standardised care. When respondents were asked for a description of usual care most identified with the individual aspects, but also drew upon a core process. For example, Pat who was a team leader in the locality team acknowledged the difficulties in describing '*usual care*' but highlighted the need for assessment:

If we take a relapsing schizophrenic, usual care would be a thorough assessment of mental state on admission.

Similarly for George, although patients were admitted with unique personal histories there was a '*general pathway of care*' through a hospital stay such as

the completion of a 72-hour assessment period by nursing staff. Within this period, a patient's social needs and mental health symptoms were assessed within a preformatted booklet. Contained within this booklet were specified areas to be completed such as accommodation needs, welfare benefits and symptoms of mental disorder to be assessed.

Derrin felt that some aspects of standardised occupational therapy (OT) care could be formulated into a care pathway such as the assessment procedure, but this was tempered by the individuality of the patient. When Derrin was pressed to become more specific about the types of group work for people with schizophrenia, the individualised nature of OT work was maintained.

Derrin felt that her work could not be predetermined to the extent that a patient went into particular types of groups and what the outcomes would be of these groups:

You can standardise the general direction of care such as standardised assessments but you can't use them for all people, you can write broad statements about the kind of treatment you are offering, but you can't say, they'll go to art groups and then go to ADL groups.

This statement is similar to one identified in the literature. For example when Parker (2001) described a typical treatment programme for people with a mental illness into moving independent living she identified 'typical' activities such as cooking, shopping and leisure. However, implementation of these activities would be determined by the individual needs of the patient.

The need to assess the patient has become a 'hall mark' of psychiatric care. In Wilson's (1986) study of usual hospital treatment, respondents used the assessment process as a standard mechanism for all psychiatric patients entering the hospital system. Wilson (1986: 186) described how the admission system was characterised by *'standard operating procedures where there was no pretence at keeping up the individualised rhetoric'*. Porter & Ryan (1996) observed that nurses followed admission checklists with little attention to the individual needs of the client. The care plan was constructed from these assessment notes but was not used to guide patient care or communicated to the wider team. Patient care was standardised by default but without the benefits of a more co-ordinated plan of care.

George suggested that if an inspection of past nursing notes were to take place, a huge degree of similarity in the process of care would be found.

George used the example of planning for discharge:

If you look at preparing for discharge, it's all going to be very similar cases of ever extending periods of leave to see how you cope, over night leaves on to weekend leaves to discharge all together, it's rare to be looking at someone's symptoms at that time.

Mike suggested that the overall framework of care should be standardised but that the micro aspects of nursing care should remain individualised. Parts of this process were the assessment procedures, the care programme approach (CPA), monitoring medication side effects and referrals to other departments:

All care should be individualised but the structure of care should be standardised and all care should be within a standardised framework.

There may well be differences between what people claim to be individualised care and that of the realities of psychiatric care. Alty & Rodham (1998) suggested this could be attributed to the questions placed by the researcher or to the different interpretations made of the terms. For this reason, the researcher searched for how terms were used across the data set (Dey 1993). For example, aspects of standardised care were used to describe how patients were admitted onto a psychiatric ward and discharged within the care programme approach (CPA) framework.

Other respondents observed care practices to follow an individualised pathway, particularly in relation to occupational therapy. For example Ingrid felt that for different hospital episodes, you would need to have a different care pathway process. In other words, for each patient to be offered an individual care pathway:

You need different kind of avenues that you could go down for each particular client because everyone is different, people respond at different times to the intervention, however it's not really feasible to have individual pathways.

It was very difficult for the researcher to collect this piece of data because Ingrid who was an OT linked to the study ward refused to have a taped interview until the end of the research study. Many informal impromptu conversations with this informant were recorded and the researchers' field

notes charted a low engagement record with the research study. This begins to illustrate the potential difficulties in approaching a research site and asking for views on the development of a care pathway.

George on the other hand offered a bridge between the theoretical thrust of the care pathway to have a standard package of care to the realities of patient care and illness progression. George argued that the care pathway had taken account of both the standardised and individualised components of care, but placed the failings of the pathway with the clinicians involved with the research study. Primarily George felt that the care pathway placed care into a series of tasks that would lend themselves more amenable to audit:

A series of actions common to all patients and if you group together the diagnosis, you will find even more in common because it tried to show what tasks should be done for patients. If you look back on the care pathway documentation that was completed, you can still say yes, that thing should have been done for that patient.

Zeb who was a social work team leader from the locality team also spoke about a standardised process of care and used the way in which a patient was referred to the locality team as an example. This begins to illustrate how some respondent's currently conceptualised care to follow a standardised process and their readiness to accept a possible care pathway structure. Although the process was not written down, there was an explicit standardised practice:

If you're the admitting nurse, you know what you need to do to admit somebody, the admission procedure but also that you automatically refer someone to the locality, it's routine and effective but it's not written down.

Some respondents felt that care could be standardised beyond looking at the process of care. Tina felt that care pathways would define care more clearly by placing care into boundaries. In other words, Tina felt that patient care could be placed into achievable predictable sequences and that the work of the clinician could be matched to meet these goals. Moreover, that care could be standardised to meet different sets of objectives depending on the clinical progress of the patient.

The researcher held a meeting with Jean who was a psychiatrist working within the Trust but also chairperson of the Hospital Drugs Committee. For Jean, both the process and outcomes of the medication part of the care pathway was too simplistic to be of value in clinical practice. The researchers' field notes record this view collected from a psychiatrist on the standardised nature of treatment for schizophrenic conditions:

How do you expect to treat the patient with so little guidance when there is so much out there, although there are no overall accounts of prescribing guidelines which have been tested, there are bits which can be put together to form our opinions, I think that there is enough mileage to go further and we have enough evidence to make informed judgements and they can be placed into standardised guidelines, in 10 years time we'll all be following medication outcomes and we won't think anything wrong with it.

Others described a process by which the professionals' role was individualised but argued that sufficient scope was available for this to be standardised in some way, particularly the advantages of a more outcomes focused service. Rob attributed the variation in care outputs to particular clinicians, regardless of practice guidelines and informal managerial team structures:

There is a general way of working that we expect people to follow and there are individual variations...the advantage of care pathways is that all workers should perform in the same way, which they don't...it would be easier to monitor the outputs which is not so easy for us to do at the moment because we haven't sophisticated ways.

Peter noted further organisational elements which could be standardised such as assessing mental states, daily living skills, co-ordinating care, but stopped short for some areas such as '*getting better*' which could be described as more difficult to define. In other words, Peter was suggesting that a patient's subjective impressions of their progress remained individual.

Similar to other respondents, Simon conceded that the overall process of psychological care could be standardised and then individualised for personal interventions. For Simon, the difficulty in standardising care was the variability of the human condition and he drew comparisons with the ease of physical medicine, which is arguably more predictable:

All that should be standardised is to engage the patient, how one actually does it is an extremely difficult thing, impossible to verbalise, apart from an extremely crude descriptive level because there's so many human variables in mental health that are not there in surgical care.

Mirren straddles both sides by suggesting that some parts of the care process can be standardised whilst others remain individualised. Drawing on her experiences of using the care pathway in practice, Mirren felt that schizophrenic conditions could be predicted and that variations could be accounted for by variance coding. However, this view is at odds with some of the medical and psychological literature depicting the course of schizophrenia as unpredictable (Boyle 1990).

George felt that acceptance of standardised care would arise through the working group process. However, not all respondents needed to go through this process to advocate standardised care and some respondents went through the entire process and still advocated individualised care. Barker (2000) has suggested that a standardised approach to care works against the caring role of the nurse and the individualised needs of the client. This ideological stance may account for differences in opinion:

People who weren't involved in the working party are still working from the point of view that nursing is an individualised activity and that you can't define it...they weren't there to listen to how we managed to define parts of it without losing the individuality of patient care.

Instead of using process orientated language, Mike preferred to look at the more '*tangible and scientific*' parts of nursing that he could identify as being amenable to standardisation such as knowledge and administration of medication, measurement of side effects, mental health assessments, social

functioning measurements. As other writers have noted (Bracken & Thomas 1998), the means of gaining consensus was not easily achieved due to the lack of evidence supporting psychiatric practice:

Assessment and teaching components are clear-cut. You can measure whether somebody is hallucinating. It is the interventions, which are more difficult to measure because there is little consensus. Discharge planning is more mechanical because you have a guide what a client needs when they're discharged, housing, finance, social support, medication.

Giles identified that although some aspects of care can be standardised, the clinicians within the environment were so varied in skill base that the exercise became compromised. Giles described a situation of a patient being managed by a care pathway but with differently talented staff. Giles used this rationale to undermine the necessity to standardise care:

If you are going to start standardising care, you need to standardise the quality of the nursing staff, which particular domestic they talk to that morning. To achieve the utopian situation described in the care pathway you need to provide a 'rolls royce' psychiatric service to live up to it.

Edwards (1999) also identified this problem in discussing the potential use of care pathways to bridge the referral route from primary to secondary care services. Although Edwards (1999) focused on the different types of practitioners sending referrals to hospital, the inference, similar to Giles is the variable quality of staff in using the care pathway. Alongside the individuality of the client, the variable quality of staff becomes a second major factor. Advocates of care pathways note that it leads to a greater quality of care by

staff groups (Kitchiner *et al.* 1996) although respondents in this study did not observe this.

Giles suggested that the priority of a care pathway needed to '*down grade*' from that of standardising care to one of a general description of what clinicians did and this was largely due to the nature of schizophrenia:

You've got to drop your eyes about what care pathways are all about, and not think about predicting, that's far too grandiose, God does that, have a care pathways regularising 60 to 70% of care.

Similar to Tina and Rob, Steve also postulated that nursing care could be standardised to complement some parts of the disease process of schizophrenia. Steve discussed how he would use similar behavioural approaches for patients that were aggressive or who had paranoid ideas:

For paranoia, there are standard ways of working and you would mould it in a certain way to suit the individual and the kind of behaviour and your relationship with them.

In a later interview, Steve identified that both process and outcomes related items of care could be standardised. However, there has been little consensus on these outcomes beyond the working group in the wider theoretical / practice literature (Lelliott 2000). Further, there was less readiness to predict social outcomes such as housing, social support and welfare benefits in treating people with schizophrenia:

Responding to medication, forming relationships with nurses, attending groups, risk assessment mile-stones such as staying on the ward for the first 24-hours, first CPA, accepting the need for medication, understands their illness, these are all outcomes that could be set although accommodation and benefit needs will be reached differently.

Although Simon remained firmly committed to individualised care, for the purposes of the care pathway, he did agree to see the patients for between 1 and 20 sessions of psychological therapy. This could be a step towards standardising outcomes, although he did admit to this being a '*very crude rule of thumb*' but also influenced by organisational pressures and research findings that therapy works in early sessions.

Patton (1980) notes that the impact of individualisation has been profound on the delivery of social and educational services in the 1970's. The nature of individualised care thus warrants qualitative measures as opposed to quantitative indices. Patton (1980: 62) argues that '*program staff are justifiably reluctant to generate standardised criteria*'. Simon's personal background as an educational psychologist may have contributed to the impression that the outcomes of psychological care could not be represented in quantified forms, applicable to all patients. Patton (1980) suggests that descriptive information such as client experiences would be more appropriate for individual programs.

Ingrid likened the process of a care pathway to a machine and the actions of a clinician as a robot. Ingrid was very reluctant to give a standardised

package of interventions and attributed this to the unpredictability of the human state:

People haven't got a set pattern, your working day isn't a set natural pattern, we are not robots, we might have things planned but they don't always work out that way unless you're working with a computer.

Young (1996) suggests that clinicians prefer to work as 'individuals', although often unaware that it leads to inefficient working practices. Alternatively, Ingrid could be implying that the tasks of an OT could be susceptible to 'routinisation' and so taken on by other professional groups, or lesser skilled occupational groups. Ingrid may be using the idea that people are unpredictable to prevent a routine from occurring and this could have application for most of the occupational groups studied. In Johnson's (1972) critique of power and the professions, the professions allied to medicine may be vulnerable to fragmentation because they have little perceived control over the scope of professional practice. This could be one reason why professions such as OT were reluctant to standardise patient care.

In this section, various perspectives about process related standardised care have been illustrated. Many participants from all disciplines were able to provide examples of process related activities that could be placed into a predictable sequence. The findings bear similarity to Wilson's (1986) study where the care of the patients was partitioned into regular parts that could be neatly put together into a standardised sequence. Presenting care as a

standardised pattern does appear to work against an individualised approach to care.

Respondents have also identified some aspects of outcomes based practice for people with schizophrenia. The nature of the research study found it difficult to gain a greater variety of cases, principally due to the difficulty of the case type in predicting care into outcomes, but also because of the relationship between the researcher and participants. Participants were reluctant to give examples of predictable outcomes focused care sequences. Similar to the advocates of individualised care (Redfern 1996), respondents possibly felt reluctant to give many examples of standardised care because of the constraints placed upon it in clinical practice. Alternatively, this may be due to a preference for role autonomy.

It is questionable whether it is possible to standardise what a clinician does given the complexities of psychiatric practice. Only certain elements of psychiatric work could be standardised and some disciplines were able to standardise greater parts of their perceived care delivery compared to others. As will be illustrated in a later part of this chapter, respondents highlighted the interpersonal and less visible nature of psychiatric work such as building up and maintaining therapeutic relationships.

'But with flexibility'

Geddes & Wessely (2000) suggest that few areas of practice can be subjected to protocols without some degree of flexibility although some respondents were able to set outcomes for patients with schizophrenia. Other respondents felt that in doing so, the artistic aspect of practice may be compromised. This has been found in other commentaries in the care pathway literature (Hunter 1995).

Kerry recognised that you need a care pathway structure but one which was not *'fixed in stone and making the role of the SHO akin to a computer'*. The effect of standardising care serves to make the role routine in nature with a perception that autonomy for carrying out the role was being stripped away. In many respects, this has been the intention of a management-orientated agenda (Elston 1991). An acceptable compromise for Kerry was the use of a care pathway to guide patient care but one that could be adapted to suit particular clinical circumstances.

Peter concurred with this perspective by suggesting that professions such as nursing would be more sceptical of care pathways because of their allegiance and training in individual relationships with patients. De La Cuesta (1983) noted that the individualised care ethic was introduced into educational training of nurses and later practised through the 'named nurse' concept within the patient's charter (Department of Health 1991b). Great emphasis has also been placed on the 'art' of nursing which has been celebrated in

nurse education for some time (Barker 1989). Peter suggested that professions who are led more towards the artistic side of practice would be threatened by care pathway systems.

Mirren supported the use of a care pathway to both underpin the more artistic forms of care and those parts of care that it was possible to standardise. The researcher's field notes recorded a conversation with Mirren about how a patient diagnosed with schizophrenia was admitted onto the care pathway, but ultimately transferred to the intensive care ward when he became aggressive. For Mirren, this demonstrated the level of flexibility that could be built into a care pathway structure, but also touched on predictability of the illness:

The care pathway was working up until Jacob became aggressive went to Florence ward but just because he went to Florence doesn't mean the care pathway was wrong, we can still account for that variance which is usual for psychiatric care. I think Jacob presented as a standard case up until his transfer.

Incidents of violence are not unusual for people in acute or chronic psychotic states (Taylor 1995) and these people may be transferred back and forth between the open ward and a locked facility. Care pathways are designed for application in one care setting and the control over that care diminishes as the number of care settings increase and also as the number of people delivering support and making decisions rises. A care pathway is required that is sufficiently flexible to account for both clinical variation and the hospital structure.

Steve positively embraced the need for structured care balanced with flexibility. The main reason for flexibility was the need to reflect the changing needs of the patient and to make the care process more explicit with a refocusing on time frames and outcomes:

It's a play off between creativity and a closer monitoring of someone's care. I'd rather see more focused interventions and less haphazard creativity but you need some discussion for a changing of opinions. You might do something for a week and decide, you don't like working like that anymore, or its not working, I need to change the care pathway and clinicians need to know that it's acceptable.

Both Steve and Rob wanted to build in assurances that if clinicians agreed to standardise care that it would be sufficiently flexible to match the patient type. In this sense, both respondents held regard to the uniqueness of the client, which has been identified as a guiding principle of individualised care (Redfern 1996). This position may also be one of compromise where some clinicians have permitted themselves to work away from the position of individualised care to fit in with the needs of the care pathway. The crucial factor was the degree to which care was to be standardised and how much flexibility was built into the care system to accommodate the diverse array of mental health practice.

Giles added that the care pathway needed to be more flexible, but to include all psychiatric possibilities in care. Giles drew on his experience of using the care pathway in his medical practice and argued that the content of the care

pathway needed to remain individualised and to account for every conceivable possibility. This example represented a total rejection of standardised care and urged ultimate flexibility:

Just when you think that the area of change needs to be on the lines of medication, then suddenly the patients' long lost granny turns up, and all of the care planning is focused around granny and medication.

Linda suggested that care processes needed to be flexible to accommodate individual variations to both system and patient outcomes such as housing, compliance with medication and relationship building skills. Simon who was a clinical psychologist provided a clearer view on the individual response to care and treatment offered by some respondents. This revolved around the need for unbounded flexibility:

The care process isn't a deep mysterious and intuitive thing, but when we're dealing with individuals the clinician requires extreme flexibility even in ways we can't foresee.

In support of this point, Simon used the following example with a client suffering from schizophrenia and how reluctant he would be to provide any detail to his role. Simon illustrated a predicted sequence of events but then the patients' presentation changed dramatically within his delusional treatment plan:

Bart came in and said his wife's thrown him out, so I had to stop doing my standard treatment that week, because he was on the verge of a break down, this would breach my predicted number of contact sessions...it's like you're planning a journey to the North pole and when

you get there, you find it's not true, polar bears who I always thought were nice and cuddly, in fact are trying to eat me.

The point being that if a sequence of care is planned, it assumes '*you've grasped the terrain of knowledge*'. For Simon, if he were to agree to standardise his work without having recourse to flexibility, it would have placed limits on his role. Simon picked up on the metaphor above and described it as '*if you're not careful, you end up like Scott wandering out of the tent*'.

George accepted that the care pathway was unable to account for all care processes and that the acceptance of the structure revolved around its flexibility for practice. Reflecting the developmental nature of the care pathway, George suggested that the care pathway must be flexible because of its evolutionary nature:

It's not the 'be all and end all of care', there's always going to be bits attached to it, the difficulty is how flexible the pathway is going to be to the bits and pieces tagged onto the end of it, it's always going to have a couple of things running at the same time because it's in a process of continual development.

The interesting observation about these examples lies between the professions. For example, George and Steve who were both nurses expressed more certainty to the care process and patient outcome compared to respondents from medicine, OT and psychology. In a sense, they had rejected the holistic model commonly celebrated in nursing practice. Others such as Simon (psychologist) and Giles (psychiatrist) have identified that the way

patients understand their illness, or the context, from which the illness is presented, are important factors to consider when deciding how and why care should be delivered. May & Fleming (1997) have suggested that the boundaries between objective signs of disorder, which may lead one to think that care can be standardised, and the more subjective elements of the patients perspective, which may require an individualised approach, have become indistinct. This merging of viewpoints may have led to some respondents to argue for a flexible approach to standardised care.

In this final section, it has been demonstrated how some respondents tempered their acceptance of standardised care with the requirement for the care process to be flexible to match the complexity and unpredictability of psychiatric care. Many respondents, including those who gave examples of standardised care processes and outcomes, identified that the individual aspect of the patient, relationship and context steered them away from advocating total standardised care for psychiatric practice. It may well be the case that respondents interpreted standardised care as a task centred approach. Nolan & Hopper (1997) noted that the 1950's asylum type of psychiatric provision were antagonistic towards individualised care. Custom and practice was geared towards maintaining the routine of the organisation and resulted in practice becoming oppressive. Possibly, respondents may have perceived a care pathway to bring about care practices unresponsive to individual needs thus likening it to past care practices. This may be why

respondents argued for a sense of flexibility to be inserted into the care pathway.

Individualised care

Knowing the patient

There has been much documented about the characteristics of individualised care such as involvement of the patient in care plans (Cooke 1993) or as a goal of treatment (Gilloran *et al.* 1993). Others have interpreted individualised care to mean taking account of life history such as culture and custom (Abdullah 1995). However, there is still a difficulty in understanding the full meaning of individualised care (Reed 1992, Suhonen *et al.* 2000a,b), particularly for psychiatric practice. One of the main reasons for advocating individualised care was the centrality of knowing the patient within the care process.

Some studies have suggested that nurses claim to bond with patients within a '*modified social relationship*' (Ramos 1992). Walsh (1997) found conversations were laden with nurses claiming to know their patients. Linda for instance suggested she had developed such an intense level of rapport with patients through repeated admissions that she knew the illness cycles that particular patients go through. Linda described her nursing experiences of one patient and how this contributed towards her view that interventions have to remain individualised. Linda used these phases as indicative of '*knowing*' the patient along the care trajectory:

I know Jock from three previous admissions and he can be very psychotic and thought disordered and hearing voices and then he'll calm down a bit and come slightly sexually disinhibited. He's on the road to getting well because he goes through certain phases in response to types of medication.

Peter expressed acceptance for some aspects of standardised care, although for some goals of care such as insight, these would have to remain individualised to the patient. However, the meaning of insight in psychiatry is a poorly developed concept. Insight is generally understood as an awareness that a patient has of their particular illness. Markova & Berrios (1992) identify that insight is more than being present or absent. Moreover, insight should not be considered as a symptom of improved mental state (Jaspers 1959). Insight into a patient's condition has been associated as important for treatment success but also to how the patient progresses through the hospital system. Peter used a particular patient as an example to illustrate his views on insight and the importance of this for individualised care but also as a marker of knowing the patient:

One thing that's really important for John is to develop insight because he's got none and he denies he's ever ill, but when he starts to get better, his particular stage is gaining insight and that's difficult to standardise.

George also gave an example of a patient called Jane who suffered from schizophrenia and at the time was an in-patient on the ward during the project. In Jane's case, there was very little insight into her condition by her and for the care team this prevented active work in planning a community

care package. To a large extent the presence or absence of insight in a patient's condition appears to be unpredictable and therefore shapes a particular view towards the ability to know the patient or set out their care on a care pathway.

Recognising certain markers or signs of relapse for people with schizophrenia has become an important part of practice (Birchwood *et al.* 1989). Zeb also agreed that over time, clinicians became acquainted with patients, their illness scripts and response to treatment. However, Zeb used this experience of knowing the patient as a lever to standardise care for patients in the community:

With experience and knowing the patients, you have a good indicator of how long they go long before defaulting on medication or keeping appointments with their key-worker or the out-patient department...its not difficult to predict for people that you know.

Kerry described her interpretation of how Giles prescribed medication and emphasises the process of '*knowing the patient*' through time and experiences of working with the client. The effect of knowing the patient transcended a linear projected sequence within a care pathway:

Prescribing medication is more personalised than it is on a pathway. You go through a process of bartering with the patient and if they take medication, it's always how much, for how long and in what circumstances.

Perry (2000) suggested that the amount of time in knowing the patient was imperative to identify individual needs. Individualised nursing care is also where the nurse changes the response to take account of different patients (Giger & Davidhizar 1990). Bill posited that the determining factor in knowing the patient was the amount of time spent working with the patient and this was crucial to determine housing needs on a care pathway. Moreover, the assessment process would need to change to reflect individual patient circumstances:

You have to know your client to determine housing needs...If I work with someone for a year, I will be in better position to tell you exactly what there accommodation needs are, if not I will need a period of assessment built up over a number of visits.

In other words, the clinician's understanding of the patient enables the nurse to best select the appropriate intervention (Radwin 1996). Jenny & Logan (1992) suggest that nurses gain knowledge of the clients 'needs' over a number of interactions and contact sessions and this appears to confirm the findings of this study.

Rob offered a contrasting perspective and argued that community workers operated in a predictable manner largely because they knew the types of patients that presented to the service. People were unable to articulate what they knew about patients into a structured pattern. However, Rob assumed that clinicians operated in an organised way without realising it:

They've been working with them for four years and every three months post discharge he's defaulted on his medication...when you probe people's way of working, you do get this structured pattern.

Rob suggested that people will claim to be individual in their work but when asked to account for what they do, clinicians described a very predictable sequence. For example the care pathway was designed for people who had been admitted to hospital on three admissions in two years and currently known by the community team. The frequency of admission and discharge would lead clinicians to develop a working knowledge of these patients.

In this section, knowing the patient has been seen as influential in determining an attitude towards clinicians valuing individualised care. Previous research has explored the process of forming relationships between nurses and patients (Peplau 1952). Nurses claim to 'know' their patients within this relationship (Tanner *et al.* 1993, May 1992). Others have suggested that individualised care is co-dependent on knowing the patient (Radwin 1996). Some respondents claim to know their patients by phases of the illness or specific symptoms that the patient displays. Other respondents use this aspect to argue for the centrality of individualised care, whilst others claim in that knowing the patient, they can predict care sequences for particular types of patients. A related but distinct aspect is the process of developing a relationship between the clinician and patient.

Developing a relationship

The relationship between the patient and the clinician has been considered central to the art of nursing practice (Chinn & Kramer 1991). The use of interpersonal skills has been identified as the key to developing nurse-patient relationships (Morrison & Burnard 1991). In this study, respondents discussed the relationship between the clinician and the patient as a central part of the care process. Indeed, for respondents such as Linda, it was the main intervention. The central issue for developing a relationship was the level of trust and intimacy between the nurse and patient. These characteristics have also been considered foundational from the view of the psychiatric patient (Forchuk & Reynolds 2001).

Steve discussed the nature of this interpersonal process as a relationship building process and identified that the issues of 'trust' and 'intimacy' within the relationship as important factors. However, it remained an individual process and he described why:

Even when patients are at they're most disturbed that underlying trust is paramount. Spending time with them, listening to them, giving them opportunities to talk about their situation and medication and some people can build it easily and clients get to a stage where they trust the nurses fairly well and you've got a good rapport, others take a bit longer...it might be the severity of their illness or the willingness to engage in a relationship.

Mike firmly placed the 'humanistic' nurse-patient relationship as the core function of psychiatric practice and used this perspective to displace the importance of evidence-based practice. Again similar to Linda and Steve, Mike

discussed the element of trust and identified that this intimacy was essential to develop but difficult to measure. Reflective of Peplau's (1952) psychodynamic theory, Mike described the relationship as the '*central vehicle towards change within the client*' emphasising the need to develop trust and listen to individual patient needs:

Mental illness is a psychologically traumatic illness for people to go through and we can't just stick to symptoms as if it's the flu because all people are different and we should be there to cushion that pain and that's very difficult to measure.

There were some respondents who have identified that the way patients recover from their illness would be impossible to standardise. George for example has contrasted a feeling of '*getting better*' with the traction procedure of an orthopaedic care pathway, which is relatively standardised:

Building a relationship is an individual part which we haven't tried to narrow down on the care pathway...the actual therapeutic work isn't very defined because you get too heavy on the grounds on individualisation, but improvements in care can be difficult to spot, you can't see it on an x-ray like it was a broken leg.

Mike suggested that the skills of humanistic counselling could be standardised, but the actual '*use of self and using one's life experience would be unique to the particular clinician*'. He describes this as the '*qualitative*' aspects of work such as relationship building and engagement tactics. However, problems in identifying the procedures of developing the relationship may be part of the wider problem in recognising the importance of this task for inclusion within policy (Porter 1993). One could argue that the

emphasis on the hospital stay, effectiveness and efficiency has displaced the more humanistic and therapeutic role, which is so vital for clinical progress to be maintained.

Respondents in this study celebrated using interpersonal skills and spending therapeutic time with psychiatric patients on hospital wards. However, the researcher found nurses to congregate in the nursing office pursuing administrative activities and only to approach patients to carry out specific tasks such as administering medication. This has been noted in other studies such as Walton (2000) who found therapeutic relationships were characterised by nurses '*watching patients rather than engaging with them*'. It does question the importance placed on developing therapeutic relationships and it seems possible this was used as a barrier stalling the development of a care pathway. A more probable conclusion may be that clinicians have few skills in developing relationships and this has been demonstrated in many studies (Sainsbury Centre 1997). Alternatively, clinicians may choose not to engage with patients and prefer a more detached relationship (Menzies 1970). However, to admit this openly may be to conflict with the cherished view of the altruistic nurse-patient relationship.

In a further example justifying the need for an individualised approach Steve argued that certain '*micro-structures*' within the care process would need to be individualised and included examples additional to the frontiers of the nurse-patient relationship such as conducting an interview, performing

assessments and educational interventions. Steve underpinned this by drawing on the individual nature of people in the way that they work:

Micro-structures would always be individualised because you use different techniques, people will prefer to relate in different ways to people, processing information differently and under different levels of reinforcement to achieve goals.

Peter added that although the process by which you would engage a patient could be standardised, the content of the conversation would be individually tailored:

You can't standardise talking to somebody, you can say you're going to talk to them five times a week, but you can't standardise the content, unless you get people reading from cue cards, 'how do you feel today Mr. Arthur'.

Simon differentiated this dimension further by suggesting that a care pathway would not be able to instruct the clinician to work in a predefined 'humanistic' manner in forming relationships:

You can have guidelines on how you educate and support the family on schizophrenia, the subtler sides of promoting trust in the client with paranoia isn't easily definable and some people are better at it than others.

Derrin noted the difficulty in attempting to standardise the human relationship element within care and argued that these skills must be individual. For Derrin, the nature of the relationship was the end point in which a care pathway could not intrude. She felt that these personal elements were what

made the human encounter meaningful. Similar to Ingrid and Giles, Derrin likened the opposite to the function of a 'robot':

How you converse with patients is about professional judgement, the knowledge you've built up with them in the relationship, otherwise a robot could do it. You can't quantify how you use your self as a therapist, those things that are judgements.

Although Derrin was able to identify the importance of human relationships for psychiatry and how they occur for usual OT care, the care pathway did not allow for this activity. For example, Derrin questioned whether this was even an aspect worth considering and argued that it was impossible to standardise how you would plan to meet and work with a patient.

To demonstrate this point further Simon provided two clinical examples where care processes were unable to be standardised in relation to therapeutic alliance and delivering psychological interventions:

I met Mary this week and she walked out, she isn't anymore difficult than other people and I've got Michael who you would predict wouldn't comply but who turns up all the time.

Drawing on the case example of the uniqueness of the individual, Simon linked both the level of abstraction and lack of generality of evidence to ground his conception of individualised care:

The ideas have to be unique to that individual and they might have some commonalties, but at such a level of abstraction, it's not very interesting. You can always find some commonality if you look at 20

interventions. But we're most likely to find that each one works best for certain kinds of combinations of personal problem situations and it couldn't be generalised.

In this section, some facets of the nature of patient-clinician relationships have been explored. It has included developing and maintaining the relationship, ways in which both patients and clinicians enter in to a relationship and the difficulties in measuring these components. It has also been suggested that relationship-building skills can be gained through life experience through professional work and training. Respondents remarked on the centrality of patient relationships and used this to argue against the role of care pathways. A recurrent theme was the development of trust within this relationship. The centrality of patient relationships has been embedded in the philosophy of nursing education (Peplau 1952) and individualised care has been a central aspect of practice, heralded within many studies of psychiatric theory (King 1981). Other studies have indicated that psychiatric nurses spend little therapeutic time with patients (Cormack 1976, Ford *et al.* 1998) and increasing amounts of time are spent on management issues (Higgins *et al.* 1999). This in some senses contradicts the notion of nurses celebrating individualised care. Other professions such as psychology and OT highlighted the need for the relationship building process to be individualised and ground this principle to the art of psychiatric practice.

Values of the clinician

Although clinicians claimed to be using an individualised approach for the best interests of the client, some respondents criticised this perspective. One

example was from Zeb, a social worker in the locality team with regards to the allocation of housing for patients. One of the problems of individualised care is that it is subject to people's individual styles and decisions about what is important for the patient. Zeb observed that a standardised format would remove some of these value-based problems:

Have you thought about this and they say I don't like that hostel, well nobody asked you if you liked it or not but was it appropriate for your client as opposed to your value system.

In another example, Giles celebrated the position that he works in an individual way guided by his own experiences:

The only thing that guarantee's the standard is that they all see me in my clinic. I use my global impression of the patient's progress because I ain't got time to use standardised outcomes scores, they will tell me what I already know.

Giles adds depth to this view in that the way the care is delivered to one group of schizophrenics may differ to another depending on the point of view of the psychiatrist. Giles described a situation where some doctors were 'pill heavy' whilst others would try different techniques alongside lower doses of medication. This was to lead to variation in the treatment plans:

Some doctors like patients more and interested in the human side, others for example like me would not want to keep them on the ward for very long, they're more responsive to the pressure on beds. Others are more experienced and simply time weary, 'oh here we go again, all schizophrenics look the same to me'.

The suggestion that individualised care follows a value system has been supported by a study completed by Hall (2001). In Hall's (2001) qualitative study exploring clinician's perceptions towards a dementia care pathway, individuality of the patient was regarded as a '*personal philosophy*' and the care pathway was not allowed to compromise on this ideal. Hall (2001) also identified that the '*beliefs of the sceptics had not been realised and that variances did allow individualisation*'. Findings of this study add support to the intensity of feelings for individualised care and the threat that a care pathway presents to psychiatric practice.

Many respondents asserted that people have individual needs. However, Zeb observes that '*clinicians do this as a good excuse to say people are people and they always do weird things but 80% of patients are known to the service*'. In a sense, the claim that people present with individual problems that require a protracted individualised assessment has been based on a particular value system. It could be argued that clinicians think that patients require an individual assessment but the reality may be the opposite. Clinicians may present the case for individual assessments to support the professional stature of clinical decision making. Alternatively, it may take place to make the clinician feel better about the role they perform. Either way, the value system of staff would distort the perceptions of individualised work and its necessity for psychiatric care.

George spoke about how ideological conflict emerged when clinicians were drawn on individualised care and as such they focused on the micro processes of care as their examples. For example, the first two working group sessions were dominated by nursing staff citing individual nursing interventions based on particular client experiences. George recalls that it was a case of *'oh no, we can't possibly define set standard things because we work from an individual point of view'*. The researcher also recalled this *'individualised care ethic'* when he organised a discussion exercise to determine some early reaction to the concept of mental health care pathways.

Steve argued that if clinicians elected to work on individual needs it led to care being disorganised and in effect, resistive of a more ordered approach to care. Moreover, it also led to an impression that individualised care was representative of an idealised version of psychiatric practice:

It's very difficult to standardise care because people have been very keen to hold onto that individuality in every intervention and it's been difficult to separate the individuality and work on some sort of standardisation, for example someone comes in with a history of paranoid schizophrenia, you try and get that person on depot, look at options like clozapine if their treatment resistant, but theirs only so much individuality you go with, people pay lip-service to individuality, it doesn't really happen when it comes down to brass tacks of psychiatric care.

These illustrations mirror that of the literature where clinicians believe they deliver individualised care, but on inspection fail to take account of the patients needs (Kenny 1990). Porter & Ryan (1996: 417) found that nurses referred to individualised care planning but *'once completed filed away'*.

Gerrish (2000) examined the provision of individualised care by district nurses and discovered that nurses interpreted individualised care to suit their own needs and practice parameters. Moreover, although nurses celebrated the holistic focus of care, this was not evidenced within their work.

Zac who represented a view from the Health Authority questioned whether nurses and other professional groups who aspired to use individualised care were aware of the implications for their own role and function. In the working groups, Zac observed nurses to describe individualised care *'as though it was a mystical construction special to the task of nursing'*. In all he questioned whether nurses were clear about what they meant by individualised care.

Nurses may have been discouraged from standardising care due to the nature of the nurse-patient relationship. For example, Linda suggested that the language of standardised care would *'ring alarms straight away because it's been an aspect that nurses hold very dear to, more so than any other profession'*. Linda claims that the domain of client-clinician relationships is more highly valued by nurses than other professions and supports this by suggesting that nurses have in-depth knowledge on building relationships. However this position contradicts findings from the Standing Nursing and Midwifery Committee (1999) who found problems with in-patient services, particularly the lack of therapeutic contact and interventions from nursing staff.

It could be argued that clinicians are less likely to standardise care given the relative dearth of knowledge about the psychopathology of the illness and the belief that people respond in different ways to the effects of hospitalisation. However, Zeb agreed that the realities of psychiatric practice only afforded so many options:

Clients are very individual in coping with their prodromal symptoms and residual hallucinations, but that's not to say it can't be a milestone. There's only so many support systems in the community, you go to your depot clinic, key-worker, the emergency clinic, for me it's like an attitude to care planning as opposed to the practicalities of it.

Clinician groups have held onto a perception of individualised care and the importance of this principle for psychiatric care. One could argue that this has gone beyond the frontiers of professional ideology and has become part of a clinicians individual value system. It is further asserted that this individualised conception of care is rhetorical and may not be routinely practised on a psychiatric ward. Steve suggested that nursing staff referred to the application of individualised care because it was easier to apply than standardised practices:

There isn't a conscious nursing effort to cling onto individualised care to avoid a more thorough auditing of what they do. It's easier for people to work that way, rather than consciously set outcomes, they don't have the time, expertise or support to do that.

This drive towards standardising community care was also echoed by a locality manager who criticised those workers who held onto the conception that care has to remain individualised. For Rob, community care work was

disorganised, but with proactive planning, a process that could be standardised, predictable and ultimately subjected to measurement and audit:

Some key-workers provide a very good service because they're aware of what the needs are, others are less good and they tend to miss out areas that other workers would naturally attend to...something which is standardised would be useful to ensure people followed the usual path of care.

Mental health practice is so diverse and without fixed directions that people choose to work according to set beliefs. Individualised working has been described and celebrated by some respondents such as the unique personal relationships with patients and individual patient presentations. Others have questioned the depth of understanding and applicability of individualised work for psychiatric care pathways. Without clear ways of working, it has enabled clinicians to practice psychiatric care according to particular value systems and these may be inconsistent with other members of staff or to the priorities of the organisation. Factors that may have formed these opinions could be the past methods of training or current practice trends.

Conclusion

In this chapter, the various views on the nature of psychiatric work have been described. Some respondents have noted that large parts of the process of psychiatric work can be standardised such as the assessment process, CPA and referrals to housing and social security departments. Others have retreated slightly from this perspective by arguing that the care pathway

would need to be sufficiently flexible to account for individual variations. The importance of individualised care has been strongly advocated across all professions and also by respondents who were in favour of standardised care. Knowing the patient and developing a relationship have been pivotal in shaping and supporting views towards individualised care. It could be argued that the importance of individualised care originates from a core value system and many respondents alluded to this. Possibly the determining factor to both perspectives is the degree to which a clinician believes a patient's care can be predicted.

The various positions on standardised and individualised care have been collected in a highly political context where participation with the research objectives was not always possible. Securing access to respondents was a limiting factor. The approach taken by the researcher in action research makes the assumption that people want to change practice. Presenting the view of a care pathway and asking for a clinician's response may have acted as a stimulus to produce these polar views on care. It is also apparent that the researcher did not develop relationships evenly across all the professions and so the depth given to all the categories is incomplete.

Respondents did not always recognise they were talking about standardised or individualised care at the start of the research study. There were some instances where respondents identified and agreed with both standardised and individualised care, whilst other respondents occupied a certain position from

the outset. For some respondents aligned to individualised care, the process of development and implementation did not alter their opinions on individualised care. Supporting the conclusion of Gerrish (2001), respondents spoke highly of the rhetoric of individualised care but the realities may be somewhat different. Alternatively, the resistance to standardised care within a care pathway may have arisen through the profession's history of working towards and retaining clinical freedom.

Chapter Five

Occupational functioning: collaboration & conflict

Introduction

One of the proclaimed benefits of a care pathway is to draw discipline groups together (Andolina 1995) and this pivotal assertion will be explored in this chapter. The first issue to be addressed is how professional groups discussed their perceptions of feeling threatened by the care pathway process. Clinicians aimed to defend their role by asserting role boundaries and functions. A related but separate theme explores how clinician groups engaged in professional degradation. Professional degradation was found in many forms and involved a critique of another professions research base, contributions within the team and the perceived effect on health care outcomes and efficiency.

How the care pathway affected the functioning of the multi-disciplinary team (MDT) will be discussed. Areas to be explored will be the understanding of role, group cohesion and focus, commonality and diversity of role within the MDT. A greater understanding of these issues is important for the development of care pathways.

MDT working

The development and implementation of a care pathway served to demarcate areas of practice specific to discipline groups. The motive to do this came from the pressure of finding the most appropriate professional group to carry out an intervention. In the following section, a clinician's general feelings of being threatened when discussing their role and function will be discussed.

'Let the sparks fly and open up a degree of competition'

The motivating factors for some people to engage with the project came from ideas of reducing the length of hospital stay. For Tina, this was the desire to improve care processes for both herself and other members of the nursing team. Although the ward had been operating for 12-months there was a willingness from the ward manager to *'totally re-evaluating'* how the ward functioned. Tina felt that nurses who had been qualified longer would feel threatened with a care pathway process although this did not include herself. The important aspect was to be able to *'sell it'* and she planned to do this by emphasising the clinical objectives of the care pathway to reduce length of stay and improve care.

Similar to Tina, George felt that the process of examining the role of the nurse would be beneficial to reduce an *'air of apathy over the process of care'*. This point is very important because it was maintained at an early stage of the research process that the ward was very motivated and open to

change. It was expected that clinicians would be receptive to questioning their role and function in order to improve the care process.

At the start of the project, nurses were positive about their role in developing the care pathway. George suggested that the process would rekindle the debate on who should provide certain interventions:

There's conflict between nursing staff and OT's as to who runs the groups, people saying 'yes we do such and such' with this client group otherwise we can go off and say to the purchaser that they're not required because nurses can say we do that with the patients.

Respondents were quick to criticise colleagues such as Tina who suggested that the process would *'let the sparks fly and open up a degree of competition'*. Some have argued that the emphasis on improving quality of care and delivering *'value for money'* health care has made clinicians extremely competitive (Lydeard & George 1999: 75). Hummelvoll & Severinsson (2001) also asserted that when 'treatment effectiveness' and pressure to reduce length of hospital stay become dominant within acute psychiatric care, certain clinician groups experience a feeling of being a 'scapegoat'. The researcher observed respondents to feel responsible for the treatment plan. Respondents had internalised the concepts of efficiency and effectiveness and spoke of the need for clinicians to subscribe to these maxims. It seems clear that the care pathway process has ignited these particular tensions by asking respondents to comment on the value of their own role and that of others.

Meyer's (1993) action research study of a general medical ward and the process of introducing a patient-centred orientation to care found the project to reveal tensions between the ward staff. Moreover, some respondents experienced a sense of vulnerability in relation to senior management and colleagues. Aspects of Meyer's study are relevant to this research context because the care pathway was created in an environment where a clinician's reluctance to engage with the project was visible and open for debate. In this study, this resulted in respondents expressing a feeling of their role and function being threatened. Some respondents interpreted a clinician's reluctance to engage with the project as a marker of '*something going on*'. Tina felt it was due to not having confidence in their skills and role, and being unable to state publicly what they do. During the research study, Tina maintained that she was perfectly comfortable outlining her role and function but questioned the reasons when other clinicians were unwilling or unable to do so.

It seemed to be the case, as evidenced by Peter and Tina, that if you felt confident in your role and were able to articulate this to a working group, then you felt less defensive. However, some nurses such as Linda admitted that the nurse's role and function was ambiguous to both themselves and to the patients they were treating and attributed this to the conflicting nature of professional work:

Patients and ourselves don't know what we do but a lot of things that we used to do is done by other disciplines and this has caused much of the confusion.

Other reasons for lack of clarity were to do with the changing managerial focus of the nurse. Linda was voicing dissatisfaction with the current role of the nurse and how this model of nursing care has been changed by the presence of other professional groups, most notably OT. Altogether, this change in role created a feeling of being threatened and the care pathway process served to accentuate this perception:

We're still sorting out the bed-state, managing the ward problems that distract you from your patients...other people will be doing therapeutic things with patients rather than you, we should be doing groups with patients, not OT's.

The perception that non-nursing disciplines and personnel were undertaking more therapeutic individualised work is unique to this study. However, this finding is unsurprising given that the role of the nurse is seen more as a manager and administrator of care (Gibjels 1995). This has been brought about by the need for nurses to co-ordinate the care package within budgetary limits (Porter & Ryan 1996). It seems possible that professional groups would occupy work tasks undertaken by nurses. Nurse managers in this study would argue however that the individualised ethic was an important and valued principle in care and might have led to respondents offering negative views on professions that were perceived to undertake therapeutic work.

Other respondents spoke about past training and how this encouraged a 'protectionist mentality' and professional identity. For George this factor seems to have built a defensive reaction to non-nursing disciplines and their role and function:

The huge fear was that OT's were coming to take your job and this was drummed into our heads at nursing college and to safe guard your role you have to be able to define what you do and you get 101 different theories thrown at you.

Respondents noted situations where clinicians have not felt confident in themselves in what they do. The working group served to confront clinicians with the supposed realities of psychiatric care and this dynamic challenged professional security and for Mike, this resulted in poor engagement with the research study:

If they're confronted with 'what do I do' and they haven't got the security and conviction of this is what I do, then I can see why nurses haven't come to the groups...nursing work is unquantifiable and around humanistic principles and it's led nurses to looking at their role and function and being threatened.

Mike again expressed his view that much of psychiatric work was difficult to quantify. This may be a factor in why people have felt less confident in their role. The working group asked all professional groups to define their interventions but for the most part, clinicians were reluctant to do this and this served to propagate professional defensiveness.

Nurses may have been reluctant to discuss openly about their role and function because in so doing, it leads onto identifying the outcomes of practice. It is the lack of evidence supporting the outcomes of psychiatric practice that has led Steve to perceive professionals to advocate certain interventions over others:

It opens you up to having to talk about the efficacy of what you do and this has made us move towards certain things like compliance with medication, reduction in certain overt symptoms to overcome this ambiguity where its easier to set outcomes and you tend to forget about other areas of your job.

In order to discuss role and function, respondents identified medically defined parts of practice. Nurse respondents may have done this because of the support and legitimacy given to these interventions by the team. When clinicians were unable or unwilling to state their role and function, according to these medically defined parts of practice, this was interpreted as a weakness to their professional base. Such vulnerability led to professions feeling threatened by the process.

Most respondents identified that the care pathway more clearly defined what professionals do by setting milestones for a client group. However, trade-offs were observed following the process such as a feeling of exposure and vulnerability in their positions relative to other professions. Upon inspection of his field notes, the researcher also found that more work was being carried out in practice than that described on the care pathway. For example, nursing staff interacted more with the patient about their symptoms than detailed on

the care pathway. This could indicate that respondents were less than open about detailing their role for the care pathway.

Simon noted some reasons for role ambiguity and defensive posturing as to do with the occupation of psychology itself. For Simon, there did not appear to be a unified and clear direction within clinical psychology for adults with mental health problems. Simon argued that care pathways were particularly effective at exposing these inadequacies when he drew on his experience as an educational psychologist with children. Simon suggested that psychiatry was more problematic due to the conflict between psychologists and the rest of the professions and amongst themselves. The development of a care pathway served to draw out this perspective:

I used to work with kids, teachers, social workers, and psychiatrists and they all had a definitive job despite overlap in the jobs...in psychiatric care pathways there's such conflict and confusion in roles and besides what is psychology, it's such an unexplored science.

However, Simon's perception is different to that of Spitzer & Mundt (1994) who have noted the close relationships and origins of medical psychiatry and psychological practice. They recall that many psychological theories have guided early psychiatric practice. Moreover the influence of psychosocial interventions within post-basic nurse training programmes can largely be attributable to clinical psychology.

It could be argued that nurses find it less difficult to discuss their role and function because of the amount of contact, location and high visible tasks of the role compared to other professions. This may have led to nurses such as Steve to feel more secure in their role and added confidence to confront other professional groups:

Nurses can fill up sides and sides of foolscap talking about mundane things they do...nurses swan into work and not set objectives of what they do for a client. It's not as focused compared to an OT or a psychologist because they see a client for a limited period.

Although studies have found sufficient evidence for some aspects of care to follow a standardised format (e.g. Lehman & Steinwachs 1998), there was reluctance from some respondents to fully endorse such a conception of care. Kerry illustrates this with her view on medication protocols and her practice as a Senior House Officer. Medication protocols have been found to improve prescribing habits (Taylor *et al.* 2000), although for Kerry, the way she was trained mitigated against using standardised protocols and in some sense, served to undermine her own training, working practice and confidence in role:

It feels threatening to have guidelines for medication and put in such a prescriptive fashion but I'm trained to look at the underlying principles and facts and then apply them to each individual case.

However, Kerry may have experienced this threat due to a lack of experience and confidence in performing the role and articulating this within a group setting. Other factors may be poor awareness of a research base to guide

evidence-based practice and this has been demonstrated within the literature (see chapter two).

Schatzman & Strauss (1973) identify that the researcher be aware of the tendency for respondents to shape the process of the interview. The researcher was acutely aware of his identity and the possibility of fuelling resentment with the study. For example Peter noted the effects of non-nursing disciplines being examined by a nurse and the political environment in which this professional scrutiny took place, namely an attempt by the nursing directorate to control the management of psychologists and OT's. Specifically, Peter questioned the nursing background of the researcher and the perceived managerial support for the project from the directorate within the Trust:

People felt threatened because they were being examined by somebody who wasn't one of them, you were certainly seen as someone who was undermining what people were doing.

Some respondents have described the process of the working group as a stressful experience, whilst others such as George and Steve have embraced the process. Derrin who was a senior OT described the influence of skilled time in the job and confidence in role as a determining factor. Information disclosure within the group was seen as an important point:

Ingrid felt she might give something away as though she had to defend herself. I've got a clearer idea about what's important to keep. When you're more junior, it's harder to know what's OK to give up.

In examining the points made by the respondents it is important to look at the nature of the working groups and who attended for the sessions. By far, the most dominant professional group was nursing and for Derrin, this made it difficult for her and Ingrid to assert and defend the role and function of an OT:

You're always going into meetings with a big group of nurses and a few doctors...OT's are seen as uncompromising...it's from being on your own against what feels like a powerful force forcing you to fight your corner.

Professional dominance has been found in other studies. Sanson-Fisher *et al.* (1979) examined the content of psychiatric ward rounds and found that OT staff commented least about patient care compared to nurses and medical staff. Although some respondents in this study recognised the importance of MDT working there was an overt sense of a '*power complex*' within the group, particularly that many people from one discipline group displaced the '*voice*' from a lesser represented profession. Ingrid described this feeling as '*being out-numbered*' and argued for a case where only a single representative from a profession would be in attendance and who then disseminated back to the wider group.

Similar to Derrin, Simon noted the influence of experience in enhancing confidence in role and function during the research study:

Phil and me are very confident people and so we aren't threatened, but some people might be who are fresh from college, and you get more

confidence as you get older, you just don't get paranoid about having to prove yourself.

The analysis so far has covered professions allied to medicine. However, medical psychiatry and disciplines aligning themselves to medical interventions feel less defensive in working group meetings and individual discussions. Similar to Peter and Linda, Steve perceived the strength of the medical model in making psychiatrists feel less defensive about their role and function. Moreover, Steve observed that psychiatrists were not placed under the same degree of pressure. This observation adds support to other studies (Stein 1967) where nurses have perceived doctors to be superior in their level of knowledge and relative power:

Psychiatrists are the power base, they play the main role in prescribing and diagnosing and the nurse follows that medical model, so compared to those two central aspects of care, other elements of care are on the periphery...it's explicit what the medics do and its well documented, formalised, researched...the majority of what they do has got some evidence and so it's just easier for them.

It has been accepted that doctors are not fully aware of why they use interventions in a certain way (Geddes & Wessely 2000) and medical respondents in this study were open about the lack of evidence supporting practice. However, non-medical staff perceived medical treatment to be guided by a clear scientific judgement and this somehow led them to feel inferior when discussing their own practice. For other professions who have been less candid about the evidence supporting practice, such as OT, the working groups may have had a detrimental effect on professional disclosure

by causing a 'stiffening up' of professional barriers and defensive posturing. Some respondents identified that they and others were immune to this process by the very nature of their profession and in this case the larger number of nurses compared to other professions. Steve, who was a nurse, offered this observation:

Nurses have the luxury of straddling both the medical, social, psychological elements of care, nurses are in an enviable position, and although we haven't a lot of evidence for what we do we know we're important and essential to run the wards.

Other respondents identified the problems and strategies of getting discipline groups involved with the project. One could argue that the study acted as a surveillance procedure to make explicit the procedure of psychiatric care and made people feel very threatened about their role and function. Some clinicians refused to attend the working group and Wyn who was a general manager was asked to secure their involvement. Steve suggested that for each discipline to develop a separate care pathway specific to each discipline and later be amalgamated so that a complete care pathway can be put into practice. However, participants in the working groups continued to develop the care pathway as a complete package.

Respondents interpreted the structure of the way the groups were implemented as a pressure to modify their interventions and working practices to complement the structure of a care pathway. This was evident for some respondents at a very early stage of the working group meetings.

Moreover during this early start to the working groups the researcher asked participants to examine a previously developed care pathway for schizophrenia (purchased from Boston USA). The researcher documented the concerns expressed about this care pathway in his field notes, these being the '*medicalised*' nature of the interventions and the omission of psychological and OT professions from the care pathway. The working groups were also perceived as a vehicle to exclude professional viewpoints and this was exercised through those who attended the groups and the perceived power they held in shaping care delivery.

Clinicians felt threatened by exposing their role to other clinicians and this appears to be mediated by the amount of contact with the patient, particular theoretical view of care and treatment and time spent in practice. To protect their role, clinicians attempted to protect role boundaries and function. This has also been described by Davies (2000) who found both medical and nursing staff intransigent in working towards collaborative ways of working. Others have suggested that when role conflict, burnout (Maslach & Jackson 1982) and ineffective social support from colleagues (Janssen *et al.* 1999) combine, it may lead to a decreased sense of work satisfaction. These factors may have been instrumental given the poor levels of morale recorded during the time of the project (see chapter seven). The following section will explore how clinicians served to assert their own professional boundaries by, for example creating a professional signature in their psychiatric work.

Asserting professional boundaries

The delivery of mental health care comes from a variety of discipline groups, each pertaining to work on particular parts of the patient's condition. In reality, this difference is small leading to the potential for shared role boundaries (Mangen 1982). However, clinicians defend their professional training and practice and this is usually articulated through language and rituals (Pietroni 1991, 1997). In this research study, much dialogue took place around the need for discipline groups to carry out their own assessments. This appeared to be a professional signature, which was defended rigorously in most exchanges.

For some respondents, it was observed that each profession holds the view that their remit was unique, each having specific experience pertaining to patients that other professions were unable to match. Steve identified the process of assessment and how professional groups carried this out differently where *'all were claiming to identify needs and work on their stake of health care'*. This may have been a strategy to resist the intention of the working group to standardise care because in maintaining a need for each profession to assess the patient, this protected professional autonomy.

It has already been noted in other sections that the role of the nurse has changed for some respondents. However, this did not deter some participants such as Pat from identifying tasks, particular to nursing such as mental health assessment or spending therapeutic time with the patient. It appeared to be

the case that if nurses within the working group did not discuss the process of assessment that it would be taken from them by other disciplines:

You defend your professional status because you know you're a useful professional, and we have a particular claim over patient care.

The reality of this statement may be somewhat different. For example, George acknowledged that nurses were inconsistent in using nursing assessments and attributed this to the administrative demands of the job such as completing paperwork and the process of bed management.

A care pathway has been noted as a strategy to increase 'team professionalism' (Hall 2001) and although this has been perceived as a positive outcome for some (Zacharias *et al.* 1998), in this study it was seen as a negative consequence. Clinicians, particularly nurses, felt their role had been eroded and changed, driven in part, by the need to add greater '*professional status*'. George argued that certain roles were not carried out due to the administrative tasks of psychiatric practice, and so displacing therapeutic activities:

We need to show that we have professional status, but everything is now so admin. based that you end up not having the staff or the time for therapeutic work and we need to say what we should be doing.

Although Derrin engaged with the project later than Ingrid as the representative from OT, she asserted professional boundaries by not allowing her work to be standardised by the working group. In this first interview,

Derrin felt that the working group had totally ignored the influence of OT in the planning of individualised patient care:

When I came in and they said standardised care pathways I felt very reluctant and in the end I became protective of my role.

Further on in the interview, Derrin described a time in the working group where she observed the nursing staff having gone too far with standardising care. Derrin perceived the group as forcing the OT to standardise care. Derrin also expressed '*amazement*' at the extent to which nursing and medical personnel had been prepared to standardise care:

Amazement that agreement had been got for that to happen and perhaps feeling, whether the nurses felt conned by this, and said that we don't individualise care and so you shouldn't, because I wasn't part of their negotiations I didn't play ball.

Derrin described the working groups as provocative and reiterated her sense of the need to protect the role integrity of the OT discipline. Steve also observed discipline groups engaging in a turf war propagated through developing the care pathway. Territorial integrity and in effect, slicing of the patients' health into portions has also been described in the theoretical literature (Beattie 1995). Each group has claimed to work with a particular aspect of the patients' illness and '*jealously guarded*' against losing any of this ground. For Steve this had led to professionals re-asserting professional boundaries by not standardising care and disengaging from the project:

A protectionist mentality undermined the process, professions more concerned with protecting their image than committing to an outcome, which they may not be, able to reach.

In this section, it has been described how clinicians asserted professional boundaries by claiming to work with particular parts of the patients' illness. This is not an unexplored area, but one that is unique to the care pathway literature. Clinicians also asserted professional boundaries by refusing to engage with the research study to develop a standardised care package. The working group process served to draw out this inter-disciplinary conflict and reaffirmed the professional boundaries of practice.

Degrading professional influence

Perceived lack of evidence

The process by which professional groups engage in depreciating activities of others in response to perceived threat has been described widely in the literature (Trist & Bamforth 1951, Beattie 1995), although not explored within the care pathway literature. There appear to be various ways by which clinicians degrade their working colleagues and these include the research base underpinning professional practice. Other issues to be considered in this section include the perceived efficiency and effectiveness of clinician interventions on the patient's health.

Evidence based practice has become widely recognised as an ideal which all disciplines should strive to achieve (Rosenburg & Donald 1995). However, not

all clinicians have been able to accomplish this objective. Mike was critical of the work undertaken by psychologists, but championed the medical model for the security it gave to the nursing profession:

Psychologists don't have standardised treatments for dealing with psychosis, they're still at the research phase and unsure sure what they're doing. The only really standardised method of dealing with psychosis is the medical model and it's worked well for nurses.

Given the superior position of the medical model over others, Steve suggests that professions were more likely to be defensive when there was a perceived lack of evidence. Steve identified that the bulk of research was based on the medical model and cited this as the reason why most nurses supported it:

Nurses don't know what OT's or psychologists do...the psychologists themselves would say that their interventions are more experimental, the medical model has provided nurses with a scientific framework.

Mike was critical of the psychologist's involvement in the project but attributed this, like other respondents to the research base underpinning their work and their perceived inability to say what they do. However, much of the literature detailing medical interventions is equally as unconvincing as the psychological literature (Geddes & Wessely 2000). George provided a further illustration of professional degradation in the delivery of care by attacking the evidence base of OT. Moreover George suggested that working in the NHS has changed with increased job insecurity and this challenged the value of what a clinician did:

To find a scientific reason why schizophrenics need to have OT pottery groups and the need to basket weave, it's quite a huge challenge...OT's have their personal beliefs, but if the purchaser says how does pottery group cure schizophrenia, they're blown right out of the water.

In a later interview, George observed that the OT discipline found it difficult to define *'therapeutic benefits in a scientific way'* but this was also the case for all discipline groups including psychiatric nurses. George's observation was that OT's were reluctant to engage with the project because they could *'end up defining themselves out of a job'*. Nurses have felt confident in assessing the relevance of particular professional involvement in hospital care and such views might support the account of OT's and psychologists feeling uncomfortable with the care pathway development process and their reluctance to fully engage with the project.

Mike commented that nurses had also been reticent about joining the working group and attributed this to the knowledge base underpinning practice:

The teaching has been unquantifiable, unmeasurable stuff like humanistic skills. Nurses trained before 1983 training syllabus have lost confidence because they think they should know this psychosocial based stuff and they were trained purely on the medical model.

Moreover, both Tina and George were critical of the individualised OT care for patients with schizophrenia and argued that these interventions were haphazard with little structure. George added that those clients in most need were given the least effective type of intervention:

Patients who require gaining the skill to care for themselves don't get it, they're not encouraged to attend the specific groups to their needs, they're happier making pottery ash trays which is great as a distraction, but when it comes to skill building, it's fairly useless.

George was critical of the individualised intention of the OT department and felt that the reality of OT was institution centred as opposed to OT programmes being tailored to the needs of psychiatric patients. George describes this as being '*pot-luck*' for patients to find the right group.

There have been many observations from respondents critiquing the research base of nursing, OT and psychology. Little has been noted for medicine. Peter supports the legitimacy of medicine by the observation that '*medics know what they're doing the medical model is domino A pushes domino B which causes reaction C, they work from the cannons of science*'. Although it could be argued that more research has been carried out for medical interventions, it certainly falls short of the domino metaphor used by Peter. Medical respondents who participated in this research programme were open about the lack of knowledge that supports their practice. The powerful effect of discipline groups upholding the scientific basis of the medical model may be in place to justify their own allegiance to the medical model, and their place within it.

Included within the working group process was a representative from the Health Authority's purchasing department. There have been many instances where respondents have referred to the surveillance of the purchaser in

determining the worth of particular interventions in the care process. Tina related the problems to the nature of 'outcomes', which has come to dominate health care. The surprising perception was that Tina felt that social workers would refuse to use outcomes in their practice, describing them as *'going for the throat'* of the researcher when this was challenged in the working groups. The reality was markedly different where both Zeb and Rob were welcoming of the need for outcomes and research based practice.

This section has covered examples of respondents critiquing the evidence base of the psychiatric team. This served to degrade the professional base but also undermine the strengths of MDT working. Many misconceptions were openly aired about the role of certain members of the team and clearly, the dominance of the medical model was upheld. However, the major weakness of this section is the number of nurses who contributed towards this theme and the absence of a counter-defence from other team members.

Efficiency and effectiveness

Alongside the critique for professional groups to be aligned with evidence-based practice, respondents also critiqued a discipline for its effectiveness and efficiency in practice. When respondents did critique their colleagues there were instances where they tried to displace them from the care process.

Even at an early stage of the research study, Tina predicted conflict with members of the social work team. However, for the most part, social workers

that participated with the research study were approachable and engaging. Tina identified the community team as the culprits for the problems in psychiatry and the prolonged length of stay. The point being that some disciplines were ineffective and inefficient:

People are in hospital who don't need to be and it's due to the social workers in the locality team not working and wasting a lot of resources, it's because of them that patients remain in hospital.

In another example, George offered a critique of OT interventions by judging on their role to provide cost efficient care. Again responsibility was placed on the OT to define reasons for OT based groups in the working groups. In previous sections it was suggested that the psychiatric medical model was dominant in organising a patients length of stay and work patterns.

Respondents also appeared to criticise the personalities of practitioners in these disciplines. For example, George castigated the role of Giles, the psychiatrist, for the lack of input, time and ability to co-ordinate care on the ward. This example serves to balance some of the previous conceptions of ineffective and inefficient practices carried out by certain professional groups:

Giles comes to his ward rounds, passes on information he thinks is going to be useful and that's it. An issue can be addressed and then crop up three weeks later. It's not good economical or effective use of consultant time.

Professional degradation also occurred by attributing the problems of the system to another professional group. For example, the ward round is the standard forum to discuss and plan a patients care. All disciplines are

supposed to be able to play a full and active part in detailing the care plan and reporting back on the effectiveness of the intervention. Recorded in the researcher's field notes, it was observed that very little time was given to the OT to feedback the views and progress on care. Following the ward round, it was observed that nurses were critical of the lack of OT involvement in the patient's care. Nurses did not attribute this to the system, but rather to the OT discipline itself. For George, an established care pathway may ensure representation from all discipline views in the ward round and re-establish a clearer perspective on the value of professional groups:

Now you get a lot of back stabbing where the OT should have done that and the psychologist should have done that and didn't. A care pathway will outline what people should be doing, it will make clear who should have done what but also allow them to do it if that is there job.

Other respondents argued that the role of a psychologist was inappropriate during a patient's admission and for this expensive resource to be delivered in a community setting. Throughout the development of the care pathway the psychologist's maintained their legitimacy to provide psychological care for in-patient psychiatry and produced a psychological treatment plan for the care pathway. In this example, Peter was displacing the role of a psychologist from the care process:

Psychologists don't do much for patients during their admission, it's a longer term thing so why are we paying out for psychology services when they don't fit in with our world view.

Pat reflected on his experience of the role of the psychologist on the ward and recalled that it was very small. The researcher also observed this point when a discussion took place between a general manager for psychiatry, Simon and the researcher to discuss some of the problems in developing the care pathway. Following the meeting Wyn confided in the researcher and admitted that the role of the psychologist was *'window dressing for the Trust'* and had little *'legitimate right'* for their contact with in-patient wards.

Similar to Peter and Pat who were both nurses, George argued that the role of some professions was inappropriate during the care process. Instead of discussing how they could be used more effectively, his view was to displace them from the care process. This was achieved by degrading their involvement. George noted that particular discipline groups engaged with the project to *'boost their profile'* within the Trust and described the input from psychology as *'a bit of a joke'*. George argued that psychologists only got involved with project when the Health Authority became part of the working party. It was suspected that staff from the Health Authority would also question the need for psychological care on psychiatric wards *'where purchasers will look at the care pathway and say that patients get better with no psychological input and so we don't need psychologists'*.

Tina expressed resentment at the OT's claim for professional status in working with the mentally ill. Tina described OT's as *'creaming off the best bits from the RMN profession'* and argued against seeing OT as a separate

profession, rather an extension of the nursing role. This position can be located to a past historical perspective where nurses worked for and under a superior medical hierarchy in the hospital. The emergence of occupational groups such as OT and social work served to displace nursing work from the care process. The position advocated by Tina and George appears to reclaim the amount of time that nurses once enjoyed over patient care.

A major finding is how some professional groups set a mandate to judge other professional groups. Tina placed the onus on particular professional groups to convince the service of its worth. George was critical of the way OT's conducted their work in relation to the functioning of the wider MDT. Similar to Tina, George located the problem within the remit of the OT profession. George spoke of an example where the nursing and OT disciplines worked with two opposing sets of intervention for one problem. There was no formal dialogue to resolve this conflict and this may provide a further reason why the OT discipline felt reluctant to engage with the research study:

Instead of sharing the views and coming up with a common plan, it was a case of working independently of each other which must have been confusing for the patient, where she'd get one discipline saying, yes you can wear pads and the other discipline saying no you can't.

However, not all respondents shared this confrontational perspective towards psychologists and OT's. During a first interview, Peter acknowledged that the agenda of in-patient nursing staff was to be as effective as possible in managing the patient's condition. In a later interview towards the end of the

project, Peter remarked on the poor involvement of the OT and psychologist and aligned himself with the views of other nurse respondents. There may be many reasons for this such as the process of having gone through the research study and the experience of actively questioning the effectiveness of professional interventions:

It's not easy to quantify what they do and obviously saw this as a threat, it may show our lords and masters that these disciplines aren't sure what they do or cost effective enough.

Mike gave an example that expressed respect for the role and function of an OT within the team and described OT's as having a positive effect on how patients function such as their occupational skills and quality of life. Mike described the OT as the most ideally trained profession to carry out these tasks and valued their role within the team. Derrin recounted that members of the working group '*attacked*' the way OT perceived their individualised work tasks:

People were saying, you've got to show us all why it's worth doing. We're going to decide if it's worth having OT and if you can't define it, then there's something wrong with you...it's hard to hang onto the idea that it's OK not to have a standard treatment.

Ingrid who was a junior OT perceived that people were urging her to standardise OT work and so legitimise her role and function. Echoing the belief by Tina that '*something was going on*', Ingrid felt a certain pressure into specifying what she did for psychiatric in-patients. If unable to do so Ingrid felt her professional contribution to care was degraded by the team:

If OT was OK as a profession, then you'd be able to tell us exactly what OT's do, you can't, and you can't be a proper OT, or you can't understand OT or the patients enough.

Many respondents used the element of cost effective care to support professional exclusion. It was argued by George that a single professional group could emerge from this type of argument, namely that of a psychiatric nurse. Further, because OT's and psychologists were perceived to do little in the care process, a psychiatric nurse would displace them:

An RMN can be just as effective and be cheaper with further training than OT's and psychologists, doctors are there to provide treatment and the nursing staff are there to carry it out and they can stake a legitimate claim on care.

In a later interview, George likened the role of an OT to an untrained nurse, this being a further example of how the nursing team degraded and readily displaced other disciplines from the care process. Discipline groups may have been critical of their colleagues depending upon how observable their role was in clinical practice. For example Mike contrasted the observable defined role of the medic to that of the OT or psychologist.

Respondents have identified that some disciplines did not have a role within psychiatry, although the basis upon which this has been suggested is not clear. One explanation may be that nurses have felt that they occupy a position of superiority towards other professional groups such as OT. This finding is important because it explains some of the difficulties in developing

the care pathway. Tina described the OT discipline as occupying a '*cosy little profession*' and she established for herself a mandate to '*force this group into a corner and say tell me what you're doing that we can't do*'. However, Tina's observation on the role of the psychologist (minimal) and the positive attitude expressed indicated some personal animosity towards OT's as opposed to an objective opinion:

Psychologists give a useful theoretical opinion on what is wrong with the patient from a different school of thought to the medics and nurses, they serve as a valuable part of the team.

In later interviews with psychologists and in their attendance in working groups, psychologists would greatly refute this observation and claim to do more than assess and provide a theoretical perspective. For example Simon commented on the great divide between people's perceptions on the role of the psychologist and his work content. Lack of understanding about the role of psychologists in MDT's has been found in other studies (Ranger 1986), often leading to poor integration and inter-professional communication within teams.

Respondents established for themselves a mandate to scrutinise and degrade other disciplines in the working groups and individual discussions and used reference points such as the research base underpinning practice, effectiveness and efficiency of interventions, inability to work with outcomes based practice and their adherence to individualised care. The observation that these groups were ineffective leaves them with an impression that they

can fulfil these roles more effectively and efficiently. Respondents, who were mainly nurses, attempted to minimise and displace the involvement of these groups from the care process although there was little evidence to substantiate how a nurse could fulfil these tasks without major training. Above all, professional conflict displays the lack of consensus over the function of in-patient psychiatric wards (Howell & West 2000) and both these factors were reaffirmed in this research study.

The major weakness of these findings is that the researcher did not collect a wider range of views from non-nursing members of the team about the effectiveness or efficiency of their practice. If a more interactive type of research method was used such as a hermeneutic approach described by Guba & Lincoln (1989), the researcher could have gained a more informed view. The intriguing finding from this analysis was a tendency to discredit colleagues although this was not the case for all respondents. The role of the researcher and his effect on the development of the care pathway would be unique to this study. However, inter-professional conflict within teams is not new, and the themes in this section merely support these findings.

MDT functioning & focus

Understanding of role

The MDT forms the bedrock of all health care, although poor integration (Onyett *et al.* 1995) and strong professional allegiances drawing clinicians away from the concept of teamwork have been noted (Firth-Cozens 2001). A

care pathway has been advocated as a tool to improve communication and understanding of the health needs for the benefit of professional groups (Rasmussen & Gengler 1994). Very little research has been conducted into how teams function on acute psychiatric admission wards. The process of developing the care pathway created a situation where disciplines were forced to converge on common goals. Many problems relating to poor understanding of professional role and function were found. In this section, the way in which respondents described the impact of developing and implementing the care pathway on MDT functioning will be explored.

It could be argued that if clinicians understand their own role and that of their colleagues then a greater level of work satisfaction may arise (Gray-Toft & Anderson 1981). Role disparity has often been linked with poor morale and burnout in many health care fields (McGrath *et al.* 1989). In some studies in general medical settings it has been suggested that care pathways produce a greater understanding of role and function (Schroeder 1993). However, it is unclear whether this would be so for mental health conditions where professional roles are less defined.

One could assume that a greater understanding of role may reduce the risks associated with health care by ensuring that disciplines adhere to set protocols (Coffey *et al.* 1992). Although Mirren observed that the care pathway led to a more risk-centred understanding of her role and function,

the dangers of clinicians following set procedures may lead to ignoring interventions not included on the care pathway:

It's on my mind that the patient is on a care pathway, I check through their notes more than a patient who wasn't on a care pathway such as care plans and risk assessments but I found that once I had done that, it was onto the next one. I'm sure I missed things in the patient's care because it wasn't on the care pathway.

In Hall's (2001) study into a dementia care pathway team performance was found to improve with enhanced role clarification and a 'common understanding' of team delivery. In this study Peter noted the positive effect on team functioning in having a more informed view of the role of the OT although this was not the case for the whole team. This suggests that some clinicians were unsure of how clinicians worked within the team. However, there were some positive observations about how demarcation highlighted a profession's role more explicitly and served to educate other professional groups. For Ingrid, less emphasis was placed on feeling threatened and more on the issue of a care pathway strengthening role definition:

On paper, you can see more clearly what individual professions do. The process listened to what we had to say about OT's and challenged people's perceptions.

Derrin felt the working groups had led to a better understanding of the role of the team, in particular that of the OT. However Derrin felt accused of not compromising on her role and function and of '*taking the high ground on individualised care*'. The process enabled Derrin to make understandable

statements about the role of OT. This would be a clear benefit for the OT profession given the difficulties identified in the literature in describing their role (Creek 1998).

Although the working groups led to a greater understanding of role, the process resulted in clinician's experiencing a degree of pressure to conform to the template of a care pathway. In the second working group meeting, a senior nurse requested that the OT change current methods of assessment procedures. The field notes of the researcher demonstrated this point:

Vicky was vocal about when the OT should perform assessments and to specify when patients should attend groups. She was becoming angry with Ingrid because Ingrid was not answering questions about what she does. Vicky wanted to control the work of the OT through a care pathway but also to influence the way Ingrid views how care should be given.

Following the working group the researcher spoke with Ingrid who felt that clarification of the role of the OT had been achieved although experienced a sense of pressure to change her role into those deemed to be non-OT tasks. The central elements being the individualised approach to patient care. However, other studies have noted that MDT working consists mainly of a medical-nursing axis with insufficient opportunity for OT or social work representation (Barker & Walker 2000). The development of a care pathway appears to have challenged this dominant medical / nursing position in the MDT although uncovered great tensions within the team.

Like other professions allied to medicine, Simon felt that the working group process had enlightened clinicians about his role as a psychologist. Simon perceived nursing staff as viewing him as a '*bit of a psycho-analyst*' confined to working with emotional problems as opposed to those patients with serious mental illness. This led to Simon outlining his role more clearly in two of the working group meetings.

Kerry found difficulties in understanding the procedures of implementing the care pathway for her medical practice. This served to counter the suggestion that a care pathway leads to greater understanding of role:

It was complicated to work out my role because it was all multi-disciplinary with all different bits and it was difficult to get around and find what I was supposed to be doing.

In a further example, Steve acknowledged that he and other team members were unaware of role and function within the team for this patient group and a care pathway tool did not reverse any of these problems:

It's easy to go ahead and not really give them any thought...people do a load of different types of interventions without clarification on structure or evaluation and the care pathway didn't really unravel this for me.

The major factor that hindered clinicians from gaining a greater understanding of role functioning was the reluctance of professional groups to inform others what they did. This could be due to professional degradation, lack of evidence based practice and confidence in role. A care pathway did not

lead to greater clarity in team function although for some respondents it served to complicate their understanding of role due to the structure and use of the care pathway. This conflicts considerably with the care pathway literature, which reports a more integrated functioning team (Newman 1995).

Group cohesion

How a team functions and integrates together has been the subject of much early research and debate (Sherif 1935). There has been little research into how teams cohere on in-patient psychiatric units within the care pathway literature although it is suggested that a care pathway may lead to a more cohesive team (Mosher *et al.* 1992). It is assumed that groups of professionals will unite behind shared interventions, outcomes and structures for people with schizophrenia. Further that a care pathway actually improves the level of team cohesion. In this section, it will be explored how the respondents viewed the ability of a care pathway to impact on the unity of the team.

Traditionally, discipline groups work in different parts of the hospital and maintain separate records of their interventions and contact with the psychiatric patient. It could be argued that a care pathway with integrated notes and shared outcomes would forge discipline groups together. However, this was not observed by all key informants and the main factor for George was the '*culture of separation*' and poor integration. The importance of sharing information was not apparent for this respondent during the research

study. This could be explained by disciplines perceiving their own contribution to the patient's treatment as being more important when it remained distinct:

OT's and psychologists will do sessional work with clients and it destroys their value and contribution to the MDT...a lot of the important information just gets missed due to lack of time and location of discipline notes because traditionally disciplines don't have access to other people's notes.

The process by which disciplines disclosed information, retained information and negotiated their involvement in the delivery of care via the pathway aroused many opinions and observations, principally being that it did not lead to a greater understanding of role. For some respondents, the care pathway did not improve team cohesion because disciplines continued to work in isolation irrespective of the rhetoric of MDT working. Steve felt that the functioning of the team was hindered by professional groups not working to the spirit of sharing information about what they do:

To observe people being so up-front about not wanting to talk about what they do is very frustrating...how can the team evaluate effectively, when perhaps the psychologist is the only person who knows what he's doing and he didn't even complete the care pathway.

One of the intentions of a care pathway is to draw all discipline groups together for the common purpose of achieving the targets set out on the care pathway. Chan & Wong (1999) carried out a study into the development of a care pathway in a Hong Kong psychiatric hospital. In this study, nurses perceived a care pathway for people with schizophrenia to improve the co-ordination and effectiveness of care. Kerry offered an alternative perspective

and felt the care pathway did not stimulate a more co-ordinated team functioning and attributed this to the poor level of cohesion and communication within the team. For example Kerry identified that she was unaware of the roles of nurses and social workers and suggested that the care pathway added a further barrier to effective communication.

The main purpose of having notes in one document is to bring the team closer together. However, respondents wanted to divide the document into chronological discipline sections although George recognised the dangers in doing this such as potential for fragmentation often seen in usual care processes:

Nurses couldn't be bothered to read through anything, which they thought applied to a doctor and vice versa. If it were discipline specific people would be more inclined to use it but the whole point of a care pathway is to defeat that.

The process of developing the care pathway acted as the vehicle to dismantle the process of care and to identify the 'nuts and bolts' of what clinicians do. Steve posited that greater patient benefits would be gained through improved '*networking across boundaries*'. However there was concern over how the MDT would form together during the implementation phase and Steve questioned whether disciplines groups would forgo their usual patterns of work and comply with the shared documentation of a care pathway. However, as a later review of the care pathway indicated, very little of it was completed

with most clinical information being documented within a disciplines own filing system.

Linda identified that although the care pathway moved towards multi-disciplinary working, the reality of the care pathway structure did not improve group cohesion. Linda drew on the location of the discipline groups and the culture of strained communication within teams:

We need better communication between disciplines because they tend to work in isolation...I don't know what the OT's or the psychologist do with my patients, its not written up in the files or handed over in ward rounds and the care pathway didn't change that.

Traditionally, individual disciplines are called to account when untoward incidents arise. This has been heightened in relation to the poor and variable quality of health care across the UK (Department of Health 1998c) and as a result, led to a 'blame' culture within the NHS (Lelliott 2000). Eastman (1996) considers the various reports into homicide in mental health (Royal College of Psychiatrists 1996) and notes the devastating effect this has on team unity and function. Bill identified that the process of developing the care pathway would lead to both cohesive and accountable team approaches, particularly in relation to untoward serious incidents:

The project will reveal how we relate to each other, how the team is responsible for patient outcomes as opposed to single disciplines and place a greater awareness of the role of the multi-disciplinary team when problems occur such as suicides and homicides.

However, Bill's observation seems unlikely given the resistive attempts to integrate the team more fully. It seems more probable that a care pathway would expose professionals and the organisation to increased litigation given the teams disunity around patient care. A care pathway would display a greater degree of transparency and show whether the care and treatment has been either provided or not documented.

Cotton & Sullivan (1999) also found that hospital nurses were conscious of the heightened risk of litigation with the use of clinical guidelines. However, Mirren noted that the care pathway provided a greater overview of team functioning and this led to a greater sense of group cohesion. This perspective illustrated the shared view on health care risk:

It contains all the discipline notes so you can get a much clearer focus of exactly what's going on within the team rather than just looking at the nursing notes which is what happens now.

For George, the actual structure of the care process worked against the care pathway, so leading to a breakdown in communication and group cohesion. George discussed the necessity for discipline groups to attend the ward rounds as required on the care pathway:

If they didn't attend the ward round that week it may be two weeks before they find out if somebody is on the care pathway by which time they should have become active.

Care pathway development claims to unify the team to approach common problems, interventions and outcomes (Zander 1993). Respondents in the research study did not feel as though they worked within a cohesive team. This could have been due to a lack of understanding about one another's roles, as previously described. Of most significance, respondents perceived the philosophy and practice of MDT work as rhetorical and unrealistic. Effective MDT working is crucial for care pathway implementation and so a fault in this area would undermine the success of a care pathway for practice. Traditionally, discipline groups work in isolation, often in different parts of the organisation and this led to the problems of accessing notes, sharing information and poor communication. However, other respondents noted that the care pathway united the team by working across the traditional demarcations of health care. Of particular interest was the observation that a care pathway may reduce individual professional accountability and team unity.

Commonality & diversification of roles

There has been a drive to find the most appropriate professional to carry out certain health care tasks in order to minimise costs (Gibbs *et al.* 1991). In this sub-theme the roles and functions of the mental health team will be uncovered to display commonality and diversification of tasks. The aim of a care pathway is to attempt to reduce role duplication and this factor, coupled with the analysis above serves to create a potential backlash to defend one's

role, to professionally degrade a colleague and to create a conflicting team spirit.

Professional groups follow their own styles of training although there has been some desire to produce generic working for mental health problems (Sainsbury Centre 1997) and shared education programmes for mental health teams (Couchman 1995). Norman (1998) found that clinicians prefer to take a specialised approach to their work and may lead professional groups to approach the patient in distinct ways. For example, Tina differentiated the role of the medic from the nurse by suggesting that the medical model is based around treatment of the illness whilst nursing takes a more caring 'holistic' perspective. Simon felt that there was little in common with his role as a psychologist and that of other professional groups.

Bill differs slightly from Simon when he suggested that some aspects of care remain common to professional groups. An example was the process of assessment where each clinician approached the patients' condition in a unique professional way:

The context of assessment is different, for nurses it's looking at caring and the effect of the illness, for a medic, its signs, symptoms, the commonality is that we all assess but we all do it differently to reach the same goal.

Although respondents identified skills both unique and common to individual disciplines, there was also a willingness to identify commonality and reduce

duplication in tasks. Zeb preferred the view that much of health care could be termed '*generic*' with potential for a shared skill base within community mental health team working:

We've actually made a big effort to get rid of this idea of people referring cases to individual disciplines because all professionals are capable of doing social care and health care...there are differences in professions but I expect a shared knowledge to form a generic worker and move away from I'm a social worker I've got a different training and that's a health job.

In a further exchange, Zeb celebrated the idea of transferring skills from one discipline to another to form a more encompassing role:

We'll provide the training if clinicians can't perform the skill...social workers know more about the nursing and medication side of things since working in CMHTs...a care pathway would enhance peoples skills, it doesn't mean you stop being a social worker.

Other respondents felt that care pathways were promoting generic working and identified certain areas along a patients length of stay where this occurred such as the procedure for a patient's admission and the process of mental health assessment. For George, a shared assessment tool minimised professional points of view from dominating the problems, and provided a comprehensive assessment of need:

Different disciplines cover the same ground at the beginning of admission, to group those disciplines together and set a single goal means it should be quicker and less repetitive.

Peter promoted the need for generic working across the professions although suggested that it may dismantle the structure of professional groups.

However, this view was tempered by the fact that some tasks were defined by current legislation such as a specific role for psychiatrists in the form of the Responsible Medical Officer and the Approved Social Worker role for social services staff. This observation begins to break down the tasks into areas specific to a discipline group but more clearly identifies the differences in clinician roles. In this way Peter has defined working roles according to lawful practice as opposed to rhetorical or philosophical positions.

Derrin identified the commonality of role across the discipline groups and questioned the level of specific work attributable to OT within mainstream psychiatry compared with OT in medical and surgical conditions:

The OT is not the only person that does ADL work with the psychiatric patient, nurses are prompting him and giving feedback. With the stroke patient, it's very clear what the OT does in that rehab. and we have specific expertise.

Following a similar vein, Zac also expressed difficulty in differentiating between the role of the nurse and an OT on psychiatric wards, but suggested the difference could be reduced through better role clarity. The underlying message being that much of mental health work was common to most professions:

The nurse's role is more securely defined with assessment, care management and encouraging people to interact with others on the

ward, so that leaves OT's working on domestic and social skills and groups, both have similar outcomes.

George identified that although people work in isolation much of the core tasks overlap leaving scope for reduced duplication. The effect of working in isolation serves to give the impression of a unique identity and separation from the team:

Nursing, OT and psychologists are doing lots of jobs, which are identical and therefore wasteful of resources, by working in isolation both interpersonally and geographically. The psychologist works in Carden Road, off-site and we only see him at ward rounds.

Zac spoke about the different ideologies professed by the team members such as the social model and the medical model but questioned the degree to which clinicians deferred to these within practice. For Zac, much similarity in role and perspective existed across the professional groups, regardless of professional defensiveness and mythical constructions of professional ideology. Later in the interview, Zac noted that discipline groups worked towards very similar outcomes in care. Zac referred to a working group meeting to evidence the observation that '*professions were willing to recognise and respect both commonality and difference rather than take up entrenched positions*'. However the researcher observed professions to disagree both on the remit of what they do and the outcomes that they should work towards. For example, data from interviews with nurse respondents suggested that OT work should be focused towards providing specific groups for people with schizophrenia.

During a second interview, Peter observed commonality between the nursing and OT role but recognised that both occupational groups used a different language and interventions to achieve similar outcomes:

The end product of what OT's and nursing wanted wasn't that different. You can get caught up in language rather than saying that the outcome is independent living as free from symptoms which is a rose by another name.

A possible consequence of examining the core function of professional groups is to determine those tasks that could be undertaken by lesser-qualified personnel at reduced costs. However, the position assumes that a less skilled occupational group can perform mental health work to the same standard. George identified that the agenda of introducing health care support workers served to challenge the need for qualified staff. George argued that the role of the nurse was balanced between that of administration and caring where *'admin gets done at the expense of therapy'*. It is argued that nurses would engage in therapeutic activities if time and resources were available. George ventured the opinion that a care pathway may justify the case for qualified staff because the care pathway could re-engineer the care process to make it more *'highly skilled'*. However, George acknowledged that many tasks undertaken by both qualified and unqualified staff were identical.

Not all respondents felt that nurses should extend their role into another profession's remit. Mike for example argued that nurses should limit their role

and responsibility. Mike also questioned whether commonality in role was a good outcome for the wider spectrum of psychiatric practice:

Nurses have wanted to take on further roles in psychiatry, such as what an OT does and the school of nursing has pushed this. Nurses have tried to use OT skills in groups, when strictly it should be left to OT's because nurses are not trained like an OT.

Care pathways have the potential to expose commonality in role, which ultimately questions duplication of work in psychiatric practice. Some respondents have considered duplication of work tasks as both a both positive and negative outcome for the organisation of care. However, the question of duplication also leads onto skill mix, particularly in finding the most appropriately skilled personnel to carry out psychiatric work. Many respondents identified that a care pathway would delineate the role and function of a mental health worker more clearly and lead to a more appropriate role function within the team. However, this observation conflicts with other findings of the study where there was great difficulty in defining the work of psychiatric professions (see chapter six).

Conclusion

In this chapter, the process of developing the care pathway and its impact on the MDT has been explored. Respondents have commented that the process made them question roles and responsibilities of both themselves and others. Professions defended their roles by asserting a professional signature over the remit of their work. A frequent example was the need to carry out a unique

professional assessment. Respondents have provided a critique on the value of certain professional interventions for people with schizophrenia. Reference has been made to the use of evidence based practice.

Clinicians from all discipline groups paid superficial attention to the aims of the project. This may have been done to ensure that the proposed template of a care pathway did not adversely affect practice. Many respondents observed that practice was not greatly altered by the care pathway. In many ways, respondents were trying to adapt the process of a care pathway to match their own requirements (Lipsky 1980) and this may be one way of overcoming the threat of a care pathway.

An intriguing finding is the readiness for some clinicians to establish for themselves a mandate to critique their colleagues. This was mainly achieved by exploiting a perceived position of power to expose these supposed faults in practice. The two areas typically selected were the evidence base upon which clinicians practice and the perceived effectiveness and efficiency of their clinical work. A dispute over the ownership of some areas of practice appears to have been the vehicle for much of the antagonism.

In this chapter, the process of uncovering duplication in role and function amongst the team has been explored. Defining one's role appears to have raised questions over how the team functioned. Some respondents acknowledged that the process led to a greater understanding of role and

function, albeit with a poor use of the care pathway within practice and minimal departure from usual care patterns. For example many respondents noted that the care pathway changed very little the daily routines of work. Professions that had an allegiance to individualised care were less comfortable with generic roles. The support for generic roles appears to stem from the assumption that much of mental health care remains common to all of the major discipline groups. It is also assumed that psychiatric work can be adequately described to enable comparisons of work roles across professional groups to take place. Respondents in this study had great difficulty in being able to describe what they do and this could be why the impact of a care pathway on MDT functioning was less than favourable. It remains inconclusive whether a care pathway for psychiatric practice would be effective in aiding clarity over professional interventions.