entiated aggregation. Consequently, the detailed composition of clinical work is regarded as something that lies solely within the purview of the clinicians immediately involved. General acceptance of this opaque and ultimately privileged conception of clinical work reinforces the pernicious separation between clinicians and managers that continues to plague too many healthcare organisations.¹⁴⁻¹⁷

In contrast, a pathway based model of clinical governance goes beyond the issues that are the focus of risk managers and quality coordinators. Based in a condition-specific conception of clinical work, it invites the people who do the work to define, describe, assess, and manage what they do as teams. It explicitly recognises the centrality of clinicians to the performance and organisation of clinical work and provides clinicians with a medium for integrating the clinical, resource, and organisational aspects of care. In doing so it provides a way for ensuring the responsible autonomy of clinicians. As all professions jointly and routinely enact the methods, structures, and processes outlined above, they will enfold the authority of a system of clinical self governance "into the soul"¹⁸ and realise its developmental potential.

Contributors and sources: PJD has a disciplinary background of political science, policy studies and health services management. SM has a disciplinary background in health services management and economics. RI has experience in semiotics, linguistics, and organisational studies. DJH's background is political science, policy studies and medical sociology. The paper is based on ideas and concepts developed during research projects on the organisational preconditions for clinical work systematisation conducted over the past 15 years. This paper arose out of meta-level discussions about the findings of several of these projects conducted in Australia, England, and Wales. The chief investigator on all these projects was PJD. SM and RI were co-investigators on several projects. DJH has supported more recent, similar work in the UK by PJD and SM; he acted as a sounding board for the ideas presented.

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Summary points

Clinicians are at the core of clinical work and should also be at the heart of clinical governance

Many trusts' clinical governance arrangements treat clinical work as an undifferentiated aggregate

Failure to take account of the detailed composition of clinicians' work results in their disengagement from management

Integrated care pathways are needed for common (high volume) conditions

A mechanism is required to support all those involved in patient care in systematic evaluation of their overall performance

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Commentary: Model could work

Nigel Edwards

Degeling and colleagues provide an excellent case study of how an activity designed to help improve the quality and safety of health care runs the risk of being seen as an unhelpful managerial imposition.¹ The reasons why this has happened and the possible responses to it provide some important insights into the more general project of improving the NHS.

One of the biggest problems in many healthcare systems is the gulf between the front line clinical staff and policymakers and managers. In most organisations a strong link exists between the top of the organi-

sation and the front line, and commands issued at the centre will generally be understood and implemented. In health care, however, the hierarchy is often disconnected, resulting in two separate discussions—one for policy makers, managers, and politicians about their aspirations and interests and a second for clinicians about their work. Both are legitimate, but problems arise because these two fail to connect or interact dysfunctionally. Matters are often made worse by the use of jargon and language that alienates front line staff because it is often rather abstract and does not relate to the realities of their work.

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The understanding of this disconnection has led, over the past few years, to a great deal of discussion about how to “engage” clinicians in reform. Unfortunately, this carries the strong suggestion that reform, clinical governance, and other proposed improvements are an externally imposed intervention consisting of time limited projects separate from the everyday life of clinicians. Degeling and colleagues propose an approach to this problem that redefines clinical governance as an integral part of everyday work and is expressed in terms that relate to the improvement of patient care. This seems much more likely to motivate doctors.

Their proposal to make clinical governance more clinically relevant is almost certainly applicable to the wider goal of improving the NHS. Reform tends to be seen in terms of an attack on professional autonomy and as forcing reluctant clinicians to adopt a new agenda. In contrast, the approach suggested here is that reform can be achieved by working with the grain of professional practice.

There are several preconditions for the success of this model. Firstly, it needs a recognition that the defi-

nition of professionalism includes using techniques to improve the safety and effectiveness of care, to standardise it where appropriate, to take responsibility for the financial resources required, and be accountable for quality and performance. These may seem inimical to the notion of professional autonomy, but paradoxically these measures are probably required to preserve it because they permit a transparent and defensible account of practice, including decisions not to adhere to guidelines. The second is that policy makers and leaders develop objectives and ways of working that are meaningful to clinicians, are supported by performance management and appraisal systems, and help them do their work more effectively. The alternative is imposed targets and ways of managing health services that create opposition, alienation, and ultimately a failure to change that could prove terminal.

Competing interests: None declared.

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One hundred years ago

The necessity for improving the teaching of massage in England

Sir,—As massage and exercises are now recognized in England as valuable therapeutic agents, it is time that something was done to improve the training of the English masseur or masseuse. This is the only way of stopping the “invasion of England” by the Scandinavian “medical gymnast.”

The mechanical manipulations that are now taught to nurses under the name of “massage” are useless for the treatment of local affections. I have seen massage carried out in large London hospitals in a way that has been nothing but an often elegant and intricate but useless playing about on the skin. Beyond a slight stimulation of the superficial nerve endings, the effect of such a massage must be absolutely *nil*.

The French and the Germans have attempted to make an “art” of massage, and have invented an enormous number of complicated movements that can only appear ridiculous to an intelligent practitioner. As a handicraft, massage is very simple and can be learnt in a few days, but it is absolutely necessary that the masseur should have a knowledge of the muscles and their actions and the position of the principal blood vessels and nerves to be able to carry out instructions intelligently.

The treatment must necessarily differ according to the structure one wishes to reach. For instance, the emptying of the superficial blood vessels is effected by means of a superficial “effleurage;” a wasted muscle is kneaded or “pétrissaged” in its whole extent, and the breaking down of adhesions or muscle infiltrations is effected by means of a localized friction over the affected area. Suppose I have a patient suffering from the common affection of supraorbital neuralgia with

palpable thickening of the nerve sheath, and wish to cure this by massage, how is the masseur to carry out my instructions if he does not even know the position of the nerve? For the proper giving of exercises—and without additional exercises massage is not often indicated—the knowledge of the action of the muscles is essential, as every one knows that the number of muscles implicated in any muscular action varies with the primary position of the patient. The correct giving of the exercises is of special importance in the treatment of lateral curvature.

The superiority of the Swedish masseur does not depend on the knowledge of any specially effective manipulations, but simply on the fact that he is taught the necessary anatomy and can therefore intelligently carry out one’s instructions.

At the two chief gymnastic institutes in Stockholm the training extends over two years, but this includes the teaching of drill and some theoretical teaching that would be considered unnecessary in England. I believe that a year’s, or even a nine-months’ training would be sufficient for an intelligent person to become a useful masseur or masseuse, especially as massage has at present only a limited use in England.

If the medical profession object to this training from the fear of turning out yet another set of unqualified practitioners it will be necessary for them to self-undertake cases of local massage if they wish to obtain such good results from this treatment as is obtained on the Continent.—I am, etc.,

G. B. Jacobi.

London, W.

(*BMJ* 1904;i:1347)