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‘Pastoral practices’ for quality improvement in a Kenyan clinical network

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A B S T R A C T

We explain social and organisational processes influencing health professionals in a Kenyan clinical network to implement a form of quality improvement (QI) into clinical practice, using the concept of ‘pastoral practices’. Our qualitative empirical case study, conducted in 2015–16, shows the way practices constructing and linking local evidence-based guidelines and data collection processes provided a foundation for QI. Participation in these constructive practices gave network leaders pastoral status to then inscribe use of evidence and data into routine care, through championing, demonstrating, supporting and mentoring, with the support of a constellation of local champions. By arranging network meetings, in which the professional community discussed evidence, data, QI and professionalism, network leaders also facilitated the reconstruction of network members' collective professional identity. This consequently strengthened top-down and lateral accountability and inspection practices, disciplining evidence and audit-based QI in local hospitals. By explaining pastoral practices in this way and setting, we contribute to theory about governmentality in health care and extend Foucauldian analysis of QI, clinical networks and governance into low and middle income health care contexts.

1. Introduction

There has been excitement about the potential of quality improvement (QI) for enhancing global health and calls for a ‘quality revolution’ in health care (Kruk et al., 2016). Yet, despite the existence of QI methodologies and some understanding of QI barriers and facilitators (Batalden and Davidoff, 2007; Buckley and Pittluck, 2015), we know little about how to develop social and organizational processes to convince professionals to implement QI into practice (Berwick, 2012; Hanefeld et al., 2017).

Evidence-based medicine, based on a dominant positivist epistemology, has become ‘the gold standard’ in health care. Yet implementing evidence into clinical practice is often slow and contested, complicated by professional power, politics, social norms and contextual conditions (Greenhalgh et al., 2004; S. Timmermans and Berg, 2003). By explicitly considering the role of power in the social construction of knowledge, Foucauldian theory may explain how evidence and QI are produced and why they may, or may not, be implemented.

One QI strategy is the development of clinical networks (Flynn, 2002), providing lateral and relational forms of governance. Clinical networks connect professions and organisations, aiming to diffuse evidence, best practice, expertise and learning across health systems, and thus facilitate standardised high quality care. However, clinical networks rely on good leadership and network leaders often have no hierarchical authority, so their leadership must *influence* improvement by changing how network participants understand themselves and what they do (Addicott et al., 2006; Provan and Milward, 1995).

Recent research (Ferlie et al., 2013; Waring and Martin, 2017) suggests that clinical network leaders may influence change by exercising what Foucault (2007) describes as ‘pastoral power’ and constructing a shared ‘governmentality’. This provides a novel way of conceptualising the organisational and social processes facilitating QI. However, this nascent explanation requires theoretical development and testing in different empirical contexts. Moreover, little research has examined clinical networks using Foucauldian analytical frames in low and middle income countries (LMICs) (Ferguson and Gupta, 2002; Lemke, 2011), where networks may provide an effective mode of clinical governance in the absence of governments able to change or regulate behaviour (De Herdt and Oliver de Sardan, 2015).

We use the Foucauldian concept of ‘pastoral practices’ (Waring and Martin, 2017) to explain the construction of governmentality and related QI processes within a Kenyan paediatric clinical network. Below, we discuss Foucauldian theory about governmentality, pastoral power, pastoral practices and how these have been used to explain clinical networks and QI. We then describe the network we studied, our qualitative research methods, and empirical findings. Finally, we highlight

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our contribution and its implications for theory, policy and practice.

2. Governmentality, pastoral power and their application in health care

Foucault's early work examined the interrelationship between power and knowledge, using medicine as a prime example. Foucault explained how taken-for-granted truths, which both enable and constrain thought and action, were constructed by institutionalised modes of categorising, ordering and ranking, which emerged from historical struggles between actors promoting competing truths (Elden, 2017; Foucault, 2008). Thus, Foucault argued that scientific method for 'discovery of truth is in reality a certain modality of the production of truth' (Elden, 2017: 185). Foucault (1977) then described how by making individuals knowable and visible within organisations (using 'panopticon' prisons and hospitals as examples), 'disciplinary power' led individuals to internalise and regulate their own behaviour according to institutionalised categories, modes of ordering and social norms.

While Foucault's (1977; 2008) ideas inspired research exposing 'technologies of domination', he was clear about the need to 'cease' describing the effects of power in negative terms (e.g. excluding, repressing, censoring and concealing), noting that 'power produces' knowledge, individuals, reality and truth in ways that may also benefit individuals and society (Foucault, 1977: 194). Indeed, Foucault's (1993) final ideas explored 'techniques of self' permitting individuals to cultivate their own identities.

Foucault (2007) developed the concept of 'governmentality', which linked technologies of self and technologies of domination, to explain transition from sovereign states, ruled by force, to neo-liberal states, governed at a distance through 'practices of freedom' (Rose, 1999). Foucault (2007: 108) defined governmentality as 'the ensemble formed by institutions, procedures, analyses and reflections, calculations and tactics … that has the population as its target, political economy as its major form of knowledge and apparatuses of security as its essential technical element'.

In simpler terms, governmentality explains mechanisms through which governments impose their will on citizens, who internalise the 'mentality' of 'government', come to think of themselves as part of a population, and regulate their behaviour in the collective interest. Governmentality explains how, by inciting, inducing, seducing, and making various actions easier or harder, governments are able to allow citizens to make the 'right decision', negating the need for direct external control (Dean, 1999; Lemke, 2011; Rose, 1999).

Dean (1999) distinguishes four 'dimensions of governmentality' relating to ways of: (1) seeing, perceiving and making things visible; (2) thinking, questioning and producing truth forming 'the episteme of government'; (3) acting, intervening and directing, practical rationalities, modes of expertise, mechanisms, techniques and technologies; and (4) ways of forming subjects, affecting individual and collective identities. He notes: 'regimes of government … elicit, promote, facilitate, foster, and attribute various capacities, qualities and statuses to particular agents. They are successful to the extent that these agents come to experience themselves through such capacities'. (Dean, 1999: 32).

Foucault's (2007) related concept of 'pastoral power' explains the processes through which governmentality is internalised. Pastoral power draws on the metaphor of the relationship between pastors and their congregation, with pastors ('shepherds') acting as intermediaries between Christian discourse and the Christian community (their 'flock'). Pastors are accountable for inculcating moral behaviour, so the behaviour of their community determines the reputation of the pastor, who achieves their own salvation through the salvation of the flock.

Pastoral power also explains the relationship between discourse, individual subjectivities and behaviours in other settings. For Dean (1999), pastoral power can be thought of as about cultivating ethical behaviours benefitting collective social welfare. Thus, contemporary pastors may include experts or therapists promoting socially or clinically desirable behaviour (Rose, 1999). Indeed, Foucault (2007: 199) notes: 'In its modern forms, the pastorate is deployed to great extent through medical knowledge, institutions and practices'.

In health care, quality regimes (Flynn, 2002; van Rensburg et al., 2016), patient safety initiatives (Martin et al., 2013; Waring, 2007), evidence-based medicine (Ferlie and McGivern, 2014; Ferlie et al., 2012) and transnational diffusion of evidence, research and practices (Ferguson and Gupta, 2002; Geissler, 2015) have been explain as forms of governmentality. Clinical networks have also specifically been explained in terms of governmentality (Ferlie et al., 2012, 2013; Flynn, 2002; Waring and Martin, 2017).

Drawing on Dean's (1999) four dimensions, Ferlie et al. (2013) argue that effective clinical networks operate through evidence-based governmentality, involving the assemblage of four elements: an *episteme* framed in relation to evidence-based guidelines; practices and mechanisms linked to clinical audit making health care provision and outcomes *visible*; local *technical* processes through which guidelines and clinical audit are enacted; and their use to shape individual and collective professional *identities* in a way facilitating reconfiguration and improvement of health care services. Relatedly, Ferlie and McGivern (2014) explain network leaders exercising pastoral power, using clinical audit to make performance visible, thus disciplining doctors to use evidence-based standards to maintain their professional identity.

Developing the application of governmentality and pastoral power in health care further, Waring and Martin (2017) describe four 'pastoral practices' shaping identities and behaviours in clinical networks: (1) '*Constructive practices*', identifying and re-coding rationalities, translating the 'scripture' of evidence in a way relevant and comprehensible to local communities; (2) '*Inscription practices*', involving 'sermon' like communication and framing, encouraging network members to internalise re-coded discourses; (3) '*Collective practices*, whereby 'pastors' shape and frame subjectivities for the wider 'flock', defining and reinforcing collective boundaries. This encourages communities to collectively control behaviours, extending Foucault's concept of 'technologies of the self' to 'technologies of the collective'. Accordingly, professionals develop their collective social identity through socialising as a professional community; and (4) '*inspection practices*' in which 'pastors' provide ongoing guidance to the community, identifying practices and subjectivities conforming with or deviating from acceptable behaviours, and in doing so creating, maintaining or disrupting social order.

Governmentality scholars have been criticised for 'Eurocentrism' (Ferguson and Gupta, 2002; Lemke, 2011). Similarly, while there is some research on governmentality in health care in LMICs (Brown, 2016; Geissler, 2015; van Rensburg et al., 2016), we know little about its role in clinical networks and QI in LMIC health care contexts. Thus, we analyse governmentality in a Kenyan clinical network using theory about pastoral practices.

3. The Clinical Information Network

The 'Clinical Information Network' (CIN) is a paediatric health care network spanning 14 Kenyan public district hospitals, aiming to improve health care for Kenyan children. CIN operates within the Kenyan Medical Research Institute (KEMRI) – Wellcome Trust Research Programme (KWTRP). The network developed from collaboration between researchers, the Kenyan Ministry of Health and the Kenyan Paediatric Association, focused on adoption of recommended evidence-based practice and overcoming barriers to their adoption locally and collectively. CIN held its first formal network meeting in 2013 (English, 2013; English et al., 2011, 2017).

As in many LMICs (Chandler et al., 2009; Willis-Shattuck et al., 2008), the quality of health care, morale and motivation of clinical staff in Kenya are often low (English, 2013; English et al., 2011). Common illnesses (e.g. diarrhea, pneumonia, malnutrition and malaria), account

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