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Paper: Broadening the Patient Safety Discourse: Theorising Patient and Public Involvement as Empowerment

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Abstract

Over the last decade a considerable patient safety movement has emerged in health frequently driven by the high profile campaigns of patients and their families affected by patient safety incidents (PSIs). Despite this situation, there has been little discussion about what can be learned from the perspectives of these patients and the wider public in developing a patient safety culture. This situation is being increasingly challenged and raises questions in patient safety about what the voices of patients and the public tell us, how these might be captured and what is lost by excluding these perspectives and experiences from existing learning systems. This is analysed in the paper by looking at the emergence of user involvement across health and the public sector and the drivers for involvement in patient safety. These developments raise a number of problems about power inequities, accountability and harmful and oppressive service provision. These issues are seen to require new types of medical relationships that go beyond paternalism and the clinical indicators and individual agency of a narrow medical model to embrace more shared and empowering models of treatment and decision-making. Given this context, it is argued that in order to develop the involvement agenda further in patient safety, there is a need to contest the atheoretical nature of much of the current literature on PPI, in order to develop a much more critical discourse, around patient and public participation in patient safety, as empowerment.

Background: Drivers for Involvement in Health

The late 1990s marked a distinct shift in the language of user involvement in healthcare, with the emergence of a strong policy and later in 2001, a legal imperative, which emphasized the importance of patient and public involvement (PPI), as part of New Labour’s NHS modernisation agenda in the United Kingdom (UK). In healthcare practice, this commitment to user involvement came much later than in other parts of the public sector. A key emphasis driving policy developments, has been to stress the importance of participation as an important way of improving the performance of healthcare services (Baggott 2005). Rutter et al. (2004) have also suggested that the participation of service users can improve the quality of services, clarify what patients want and enhance democratic principles. The development of this agenda was given greater
momentum by the evidence from serious clinical and service failings in healthcare, highlighted in the UK by high profile inquiries (for example, Children’s heart surgery in Bristol 2001, Alder Hey, Royal Liverpool Children’s Inquiry 2001, which examined the retention of patients’ organs without consent, Shipman 2001-2005, which looked into the murders of large numbers of patients by the GP Harold Shipman.

These inquiries, frequently fought for by patients and their families, harmed by patient safety incidents, highlighted the importance of developing safety cultures that dealt both with the prevention of harm to patients, as well as reinforced demands from the public for greater accountability from healthcare services and regulatory bodies (Davies and Shields 1999; Irvine 2004). The Bristol Inquiry Report was particularly important in stressing the need for PPI to be treated as a central feature in building a safety culture, both as a way to prevent the occurrence of errors and ameliorate the effects of harm to patients (Bristol Royal Infirmary Inquiry 2001).

This thinking has since led to a bewildering range of policy initiatives on involvement in healthcare (Department of Health 1999: Department of Health 2000; Department of Health 2003; Department of Health 2006). These have emphasized the benefits of PPI in improving the quality of individual care and in making changes to improve the performance of wider systems and services (Department of Health 1999). More recent attempts to develop and embed PPI across NHS services have seen World Class Commissioning (Department of Health 2007), Lord Darzi’s High Quality Care For All: NHS Next Stage Review (Department of Health 2008) and the NHS Constitution (Department of Health 2010), all reflect the shift of involvement to the forefront of the policy agenda and to recognize this as one of the key challenges to be addressed by NHS organizations. Current requirements to involve patients in their care and treatment are reflected in registration requirements for all NHS Trusts (Care Quality Commission 2009). The NHS Act (s242 (1B) 2006) also places a legal duty on NHS organizations to make arrangements to involve and consult with patients and the public on the planning and provision of services and in the development of proposals for change. Yet despite this considerable momentum to involve patients and the public in healthcare over the last ten years, there is still little evidence that involvement is a mainstream activity that sits alongside other policy and performance requirements in the NHS (Department of Health 2008; Healthcare Commission 2009; Parsons, Winterbottom et al. 2010). In the context of patient safety, evidence suggests that trying to achieve PPI has been even more difficult than in mainstream health care.

The Development of Patient and Public Involvement in Patient Safety

In the area of patient safety, a number of documents have set out clear expectations for NHS Trusts to develop PPI in patient safety and more recently at Board level (National Leadership Council 2010). The document Clinical Governance: In The New NHS sets out clear expectations for NHS Trusts to develop PPI as an integral part of this work (NHS Executive 1999). Safety First (Department of Health 2006) outlined a national approach to developing patient safety in the NHS, and recommended that patients and
carers were enabled to play an integral part in all initiatives to introduce a patient safety culture change within the NHS. Part of this approach included the establishment of a national network of patient champions to work in partnership with NHS organizations, as well as requiring these organizations to implement local initiatives to promote greater openness with patients and their families when things went wrong with their healthcare. In developing the considerable reforms to professional regulation post the Shipman Reports (2001-2005), Tackling Concerns Locally - Report of the Clinical Governance subgroup, strongly highlighted the importance of patient, public and carer involvement as central to the delivery of high quality healthcare. The report highlighted involvement as providing an important “early warning” alongside other indicators, “that the conduct or performance of a healthcare professional is slipping below acceptable standards” (Department of Health 2009:3).

Yet, despite these recommendations, Vincent and Coulter have noted that what is most remarkable about the multi-faceted nature of the patient safety movement is “the lack of attention paid to the patient” (Vincent and Coulter 2002:76). Their research highlights that there are actually a number of areas in practice where patients can contribute to the safety of their care. For example, in helping to reach an accurate diagnosis, choosing an appropriate treatment, management strategy or safe provider, ensuring treatment is properly adhered to and monitored, and identifying adverse events and side-effects and acting upon them.

Coulter and Ellins (2006) have reinforced this evidence in their systematic review of the patient safety literature. They note that whilst research in this area is still in its infancy, key findings show that patients want greater openness and honesty from health professionals when affected by patient safety incidents (PSI). Patients were also thought to have the most potential in ensuring the safety of their care and to prevent the occurrence of errors in key areas such as making informed choices about providers, helping to reach an accurate diagnosis, sharing decisions about treatment and procedures, contributing to safe medication use, participating in infection control initiatives, checking the accuracy of medical records, observing and checking care processes, identifying and reporting treatment complications and adverse events, practising effective self-management, including treatment monitoring and shaping the design and improvement of services (Coulter and Ellins 2006). To develop this agenda further, they recommended the development of innovative strategies to support patients and health professionals to work in partnership, while arguing that these would “need to be subjected to formal evaluation so that best practice could be identified and applied across settings” (Coulter and Ellins 2006:172).

However, despite these opportunities for involvement, in areas such as clinical governance in NHS Trusts, there appears to be little evidence of successful strategies to promote patient and public involvement (Pickard, Marshall et al. 2002). The National Audit Office reports (NAO 2003; NAO 2007), covering both acute and primary care found that PPI remained one of the least well-developed components of clinical governance arrangements. Some evidence of good practice however is provided by Fleming-Carroll et al.’s (2006) study, which looked at families as partners in a patient
safety committee in a hospital environment focused on caring for acute and chronically ill children. This work was guided by principles of patient and family centred care, which respected and was responsive to individual patient preferences, needs and values in guiding clinical decisions, in conjunction with the entire family. The authors concluded that “a task-oriented partnership between families and healthcare workers has proven to be a productive model for advancing paediatric patient safety” (Fleming-Carroll, Matlow et al. 2006:96).

More generally however, what is clear from recent evidence emerging from inquiry reports into clinical failings in the NHS (Colin-Thome 2009; Mid Staffordshire NHS Foundation Trust Inquiry 2010), is that there has been a distinct lack of progress in involving patients and the public in patient safety. Given this context, the publication of the White Paper Equity and Excellence: Liberating the NHS (Secretary of State for Health 2010), with its strong rhetorical stance on PPI, provides an important opportunity to consider how involvement in the patient safety agenda can be further developed. Peat et al. (2010) argue that a key priority now in developing the PPI agenda in patient safety, is to explore “how and how well existing and future interventions might support patients’ contributions to patient safety in different contexts (Peat, Entwistle et al. 2010:24).

**The Need for a More Critical Discourse on PPI in Patient Safety**

In exploring the debate about how to develop PPI in patient safety further, this paper poses a more fundamental question about the way in which the whole debate on involvement in patient safety has been conceptualized. What is raised is the issue of the absence of a more critical discourse around involvement, which leads to questions about values, the contested nature of involvement and the way in which issues of power, conflict and the empowerment of patients and the public have been largely ignored in the construction of a patient safety movement over the last decade. These issues are seen as fundamental to address if more progress is to be made regarding PPI in patient safety.

More broadly in patient safety, mainstream orthodoxy on developing a patient safety culture concentrates on highlighting the role of systems and their design in causing error, rather than error occurring in organizations through the unsafe and individual acts of employees (Perrow 1984; Reason 1997). Central to this thinking has been the notion of creating a non-punitive reporting environment that is just and fair to health professionals and which allows them to feel safe enough to report PSIs free from the threat of punishment and litigation (Reason 1997; Secretary of State for Health 2001). These ideas have assumed a dominant position in the approach to addressing patient safety internationally (kohn, Corrigan et al. 1999; WHO 2005).

These dominant perspectives are now increasingly being challenged by patients and the public and particularly by those directly affected by PSIs, who have sought to open up a wider debate about medical harm and the construction of patient safety reforms,
nationally (Ocloo 2008) and internationally (WHO 2007; Newell, Jones et al. 2010), and their role in this process. What is noticeable about these patient perspectives is the way in which they have highlighted issues to do with the power of the medical profession and the failure of wider systems to deliver accountability when harm occurs to patients (Alsop, Jones et al. 2004; Fallowfield 2010; Ocloo 2010). This thinking on accountability, tied to the need to develop a ‘just’ organizational culture, has been far less recognized in initiatives to promote a safety culture in healthcare (Ocloo 2010). This is despite the recognition that governance and accountability are central to the performance of healthcare systems (WHO 2008). These perspectives from harmed patients and their families, raise difficult questions about developing a systems approach in patient safety that addresses both the need for a non-punitive culture, whilst also delivering appropriate systems of justice and accountability that are fair to patients and their families.

In 2009, the Health Select Committee Report into patient safety highlighted various systemic processes that failed to ensure that when a patient was harmed they (and their families/carers) received a full and open explanation; apology and an undertaking that all necessary steps would be taken to avoid the same harm coming to another patient in the future (House of Commons 2009). They concluded that whilst the NHS had made some progress in this respect, too often there was still a lack of frankness on all these accounts (House of Commons 2009). Key systems identified as failing patients in addressing their concerns were complaints procedures, coroners inquiries and lack of independent support from NHS Patient Advice and Liaison Services. Their strongest criticism was aimed at the failure of the then Labour government to implement the NHS Redress Scheme 2006 (as an alternative to litigation on claims up to £15,000 through the courts), despite passing the necessary legislation. This situation was viewed as hindering the development of a safety culture, which could not be developed in the context of powerful competing interests between openness and medico-legal concerns (House of Commons 2009).

With respect to NHS complaints systems, this has been a particular area, where patient dissatisfaction has been well documented, over many years (Department of Health 2003b; National Audit Office 2008; Parliamentary and Health Service Ombudsman 2011). These reports have frequently highlighted complaint procedures failing complainants and widely viewed by those making complaints as lacking in independence. The complaints system was reformed in 2009 as a way to improve the way it operated. It currently consists of a two stage procedure consisting of a first ‘local resolution’ stage which entails the individual complainant raising their complaint directly with the individual practitioner, with the NHS organisation concerned, the commissioner of the service or with the organisation’s complaints manager. Complaints that are not resolved at this stage can then be referred by the complainant to the Health Service Ombudsman to have their complaint dealt with independently of the organisation being complained about.

The first stage of the complaints procedure has come in for considerable criticism over the years because it does not provide an avenue to get an independent investigation.
The organisation being complained about is responsible for investigating the complaint. More recently concerns have also been raised about the role of the Ombudsman as too narrow. A complaint is accepted for formal investigation or intervention by the Ombudsman only if the person has suffered injustice or hardship as a result of poor service or maladministration and only if there is the prospect of a worthwhile outcome. In 2009-10 this meant only 3% of complaints were investigated out of about 15,579 complaints received (House of Commons Health Select Committee 2011). On this issue the committee noted in their Report that significant concerns have been raised by patients and patient representatives about the numbers of cases accepted for investigation (as set out below):

‘Our biggest concern about the Ombudsman is that [...] they take very, very small numbers of complainants, either as official investigations or what they describe as intervention where they don’t investigate a complaint but they will contact the trust. Combined it is something like 2% to 3% of those people that take their complaint to the Ombudsman. So we are talking about thousands of people who have, for whatever reason, felt that the response they received locally was not adequate, who do not receive any kind of independent scrutiny of that response’.

The Select Committee also highlighted concerns by the voluntary group Action against Medical Accidents, they made the point that:

‘Bearing in mind that the Healthcare Commission had dealt with 7,827 independent reviews in 2007-2008 these figures would suggest that many people are being ‘bounced’ back to attempt further local resolution with the NHS body they are complaining about. Whilst we accept that in some circumstances this might be appropriate, we are worried that in others it is not’ (House of Commons Health Select Committee Report 2011:13).

What is especially significant is that these concerns about the operation of the NHS complaints procedures have been raised in a context in which there has been a significant increase in NHS complaints. 2009-10 was the first full year of the new NHS complaints system. That year complaints rose by 13.4% to 101,077, the biggest annual rise since 1997-98 when records began a decade ago (House of Commons Health Select Committee Report 2011). For 2010-11 total written complaints (148,200) show either a decrease of 2.4% from 2009-10 or small increase of 0.3% depending on how you look at the data (NHS Information Centre 2011).

**Patient Safety and the Medical Model**

Given the issues raised above, it is argued that broadening the patient safety discourse to include the perspectives of patients and the public is important in a context where evidence-based medicine and the randomized clinical trial are viewed as ‘the new gold standards in the healthcare field’ (Timmermans and Berg 2003:27). However, in patient safety Leape et al (2002) have highlighted the need to identify wider forms of knowledge and practice as part of developing a systems approach to patient safety than those
produced through traditional biomedical research (Leape, Berwick et al. 2002). From a patients’ perspective, Sharpe and Faden (2001) have also have argued that the process of defining medical harm is not value free, but tends “to reflect a narrowly clinical interpretation of harm that excludes non-clinical or non-disease-specific outcomes that the patient may consider harmful” (2001: 116). Consequently, there is a need for a broader knowledge framework for the evaluation of medical harm and the imposition of risk that is based upon a more patient centred ethos (Sharpe and Faden 2001).

From a broader social science perspective, the limitations of a biomedical approach have long been criticized by medical sociologists for focusing primarily on the individual body as the primary unit of analysis when explaining disease, rather than the socially constructed nature of health and illness (Nettleton 1995; Bury 1986). Writing about medicalization in the USA, Conrad (2005) has strongly suggested that there is a need for sociologists to adopt a much wider political and economic perspective when looking at processes that cause considerable harm to patients. Whilst doctors are still seen as the gatekeepers in terms of access to many drugs, he argues that it is the pharmaceutical companies that have now become the major drivers in medicalization, in aggressively promoting their products to doctors and directly to the public (Conrad and Leiter 2004; Conrad 2005). Summerton and Berner also raise issues when looking at risk, about the need to understanding ‘everyday interactive practices’ (Summerton and Berner 2003:19) through which different actors construct safety. From this viewpoint they argue, ‘risks are collective - but often contested – outcomes that emerge in situated experiences and socially embedded interactions. An important task is thus to analyze the interpretations and meanings that actors ascribe to both risk phenomena and the interactions through which these evolve’ (Summerton and Berner 2003:19).

These critiques of a medical model are therefore seen as having considerable relevance to developing an involvement agenda in patient safety, given the importance of a critical discourse in developing user involvement more broadly in other parts of the public sector.

**The emergence of User Involvement as Social Movements in Health and Social Care**

With respect to this involvement agenda, Cowden and Singh (2007) point to the late 1970’s and throughout the 1980’s as a particularly significant period in Britain, which saw a series of campaigns by disenfranchised groups and communities (Black, anti-racist, feminist, lesbian and gay and disability rights movements) take place around welfare services. In healthcare, this saw a number of health social movements (for example, women’s groups challenging the medicalization of childbirth, disability and mental health groups rejecting a medical model as a source of oppression), act as an important political force in achieving broader social change (Brown, Zavestoski et al. 2004). Health Social Movements (HSMs) can be seen as providing “collective challenges to medical policy and politics, belief systems, research and practice that
include an array of formal and informal organizations, supporters, networks of cooperation and media” (Brown, Zavestoski et al. 2004:52).

In healthcare, these types of groups were vocal in challenging a wide range of oppressive behavior and discrimination that has echoed campaigns in many other parts of the public services. Connected to these challenges from user groups and social movements, related sociological arguments emerged. These criticized the limitations of a biomedical model of health and illness (Friedson 1970; Oakley 1976; Rogers and Pilgrim 1991) and challenged the nature of the more traditional and paternalistic doctor-patient relationships defined by sociologists such as Parsons (1951). This led to calls for new types of medical relationships in which the individual patient was more active (Gabe, Bury et al. 2005) and empowered (Friedson 1970) and which embraced more informed and shared models of treatment and decision-making (Charles, Gafni et al. 1999; Rutter, Manley et al. 2004).

Other arguments focused on the way in which some groups experienced poorer and unequal access to healthcare (Townsend, Davidson et al. 1988; Acheson 1998). Sociologists also highlighted concerns about the very nature and disabling effects of the professions and their role in the provision of healthcare iatrogenesis (Illich 1974; Illich, Zola et al. 1977; Schon 1983). These issues emerged alongside wider concerns in health to do with rising costs, litigation, the influence of the pharmaceutical industry and growing protest from patient groups (Blane 1991). These problems provided the basis for measures aimed at curbing the autonomy of the medical professions and addressing the traditional imbalance of power between doctors and patients (Friedson 1970; Blane 1991).

The emergence of an involvement agenda in patient safety and particularly challenges from harmed patients can therefore be seen as part of a new social movement in healthcare that forms part of a much bigger discourse on patient and public involvement in health since the 1970s. This discourse has sought to challenge the dominance of a medical model and highlighted the importance of recognizing lay perspectives in defining health and illness. Campaigns by harmed patients (for example, Bristol 2001, Alder Hey 2001, Shipman 2001-2005, Mid-Staffordshire 2010) have been at the forefront of demands for change in patient safety, and their struggles have acted as a catalyst for a major shift in thinking in this area. This has stressed the importance of PPI both as a way of delivering safer care and improving the performance of health services, through a shift away from paternalism (Secretary of State for Health 2001; Donaldson 2008) to patient empowerment (Colin-Thome 2009) and partnership (Vincent and Coulter 2002; Coulter and Ellins 2006). Developing a partnership approach in patient safety therefore reflects a broader shift in healthcare that recognizes the importance of placing patients and the public at the very centre of their care and decision-making (Secretary of State for Health 2010). What is lacking with this agenda is an understanding of different ways in which patients and the public can be empowered in the involvement agenda.
Patient and Public Involvement as Empowerment

The development of an empowerment agenda to drive patient and public involvement in patient safety was seen as a central component of the Bristol Report. This report viewed greater PPI as the only way to move beyond a culture of continuing secrecy, anonymity and paternalism, to create a better quality health service, giving patients and the public a much greater degree of ownership over their own healthcare and in decision-making processes, based upon patient empowerment (Secretary of State for Health 2001). A key challenge was seen as not only how to embed key principles of PPI in the NHS, but how to devise mechanisms to ensure these principles became a reality and went beyond tokenism in empowering patients. Post-Bristol, Kennedy (2003) – who chaired the inquiry, expanded upon his views on empowerment to argue that in the provision of healthcare, patients and doctors were both experts in their own fields and so should work in partnership together.

Almost ten years after Bristol, the Colin-Thome Report (2009) on the failings at Mid Staffordshire NHS Trust, have highlighted continuing issues about the need to empower patients and the public in their care and health service delivery. With respect to individual care, information, choice and the need for patients to be “seen as equal partners in their own care”, described as “the meeting of two experts when a patient meets their clinician”, is seen as vitally important (Colin-Thome 2009:18). More broadly, the report called for patients and the public to be provided with and made more aware of methods to support their engagement, particularly when and where they have concerns. This greater level of involvement included being able to hold organizations with a role in monitoring and commissioning services to account for ensuring patients and the public were involved in the “design, delivery and quality assurance of health and care services” (Colin-Thome 2009:18).

To date what appears to be lacking in these discussions about empowerment and involvement in patient safety, is recognition of the contested nature of involvement. This contested agenda raises issues about tackling power inequities, abuse and exclusion in the provision of services that have been well documented more broadly in health and social care. More broadly in the public services, the term ‘service user’ has come to describe a range of people on the receiving end of health, welfare and social care policies and services (Beresford 2005). These individuals and groups have used the term ‘to challenge and change their shared experience of oppressive policies and provision’ (Beresford 2005). The term can therefore be understood as part of a much wider discourse that has emerged across the public services to explain the drivers for greater involvement in service delivery. This understanding is lacking with the shift in terminology to patient and public involvement.

Across the public services a range of theories have also emerged aimed at empowering service users who have challenged the nature of oppressive and discriminatory service provision (Beresford 2003). This situation sits in contrast to the largely atheoretical nature of much of the literature on PPI in patient safety (Peat, Entwistle et al. 2010).
Theorizing involvement practice in patient safety is therefore considered a necessary stage in developing new approaches to involvement based upon patient empowerment and partnership.

Given this context it is argued that empowerment strategies taken more broadly from health and social care could be used to inform and develop thinking on how to develop the involvement agenda further in patient safety. These theories have been important in highlighting issues of power and conflict in organisational contexts that might be useful in contributing to a more structured approach to guide and evaluate PPI in patient safety.

Despite this lack of critical debate in patient safety, evidence shows that power inequities are important and that a ‘knowledge and status imbalance between patients and practitioners affects the ability of a patient to adopt safety-related behaviours (Davis, Jacklin et al. 2007; Davis, Kountanji et al. 2008; Peat, Entwistle et al. 2010). Research by Peat, Entwistle at al (2010) has also shown that many patients are uncomfortable and unwilling to challenge health professionals’ opinions and practice. Whilst at the collective strategic level, they found a power imbalance was reflected in the way that patient representatives were largely expected to work within existing systems in improving quality and safety. This was seen as problematic as it denied these individuals the space to redefine the issues and thus bring their own lay perspective. Theorizing involvement practice in patient safety is therefore considered a necessary stage in developing new approaches to involvement based upon patient empowerment and partnership.

**Developing Empowering Practice in Health and Social Care**

In exploring concepts of empowerment and user participation, Starkey (2003) argues that the term empowerment is contested and has its roots in many different traditions and movements (e.g. the civil rights, anti-racist, women’s and disability movements, mutual aid etc). She concludes that “the liberalational model of empowerment, focused upon people’s lives and roles within society, is likely to be more relevant to people than consumerist definitions narrowly focused on having a voice within services” (Starkey 2003:273). In looking at a consumerist approach to empowerment in health, she locates this approach in the conservative policy of the 1980’s and 1990’s, reflected in legislation such as the NHS and Community Care Act 1990, and the NHS Plan (Department of Health 2000). In the latter document, she argues, the empowerment of patients is seen to be transmitted through “information provision and redress” (Starkey 2003:276). A consumerist model of empowerment is therefore seen as “defined by service providers and policy makers, and has a narrow, individualised focus on people’s ability to make choices within predetermined service systems” (McLean 1995) cited in Starkey 2003: 277).

In contrast, a liberational model has been defined as:

‘A process of personal growth and development which enables people not only to assert their personal needs and to influence the way in which they are met, but
also to participate as citizens within a community... empowerment implies that processes of social and civic life should be designed to support and enable the participation of those who have previously been excluded from them. This means that change has to take place within social systems as well as within individuals and within services’ (Barnes 1997:71) cited in Starkey 2003: 277).

As part of this debate a number of participation models have emerged, which show a range of lay participation in decision-making is theoretically possible (Arnstein 1969; Feingold 1977; Charles and DeMaio 1993; Hickey and Kipping 1998), stretching across a participation continuum that focuses on giving information and consultation on the consumerist end to partnership and user control at the democratization/liberational end. In practice however, Braye (2000) also points out that whilst these models of participation can appear conceptually opposed, in practice they also frequently operate alongside each other.

When thinking about empowerment in a social work and social care context, the development of an Anti-Oppressive Practice (AOP) approach, has brought together different strands of thinking, which have been used to empower service users. AOP is based upon the premise “that society is unequal and that the problems faced by service users have a personal, cultural and structural dimension” (Dalrymple and Burke 2006:49). Challenging oppressive practice is seen as the driving force of anti-oppressive practice (Adams, Dominelli et al. 1998), alongside the empowerment of individuals and communities.

The emergence of these ideas in social work can be traced to challenges in the 1970's to the way that social work and social welfare individualised social problems affecting a range of social groups, that were ultimately to do with wider issues of political and structural inequalities in society (McLaughlin 2005). Whilst early critiques concentrated on class and challenges to the pathologising of the poor as responsible for their own poverty, by the 1980's and 1990's, the focus had shifted to how a number of groups were oppressed in society on the grounds of their race, gender, disability and sexual orientation. This saw the emergence first of Black, anti-racist critiques and feminist critiques (Ahmad 1990; Braye and Preston-Shoot 1995; Dominelli 1996; Macey and Moxon 1996; Dominelli 1997; Dominelli 2002), followed later by anti-discriminatory practice critiques covering disability (Oliver 1984; Oliver 1990), sexuality (Lees 1983; Brown 1998) and age discrimination (Quinn and Tomita 1986).

Opening up a values discourse has been central to this thinking, which recognizes the role that values play in shaping organizational cultures which are never value free. Braye and Preston-Shoot (1995) have argued that in the context of social care provision, real change will require a number of key actions. At the heart of this is the need to reassess the traditional balance of power between users and professionals, to take account of what users want rather than imposing oppressive and non-negotiated solutions upon them. A key requirement for practitioners from this approach will be the need to engage with users and their networks in ways that do not stereotype through
age, disability or mental health, nor oppress people through their race, sex, sexuality or class status. This will require practitioners to challenge experienced oppression and inequities, through individually focused goals, as well as at a structural level (Braye and Preston-Shoot 1995).

In the context of health and social care, it is difficult to evaluate how successful empowerment strategies to involve users have been, given the lack of evidence of impact and effectiveness (SCIE 2004). Pecket al. (2002) however, highlight trends in the 1990s coinciding with the empowerment of mental health service users in society. These have challenged professional narratives on the nature of mental distress, particularly in professions such as social work (Peck, Gulliver et al. 2002). Beresford (2000) has also argued that the professions of social work and social care are more advanced in the area of promoting user involvement than other related disciplines, even though these professions still have a long way to go in addressing oppressive and discriminatory practice (Beresford 2000).

**Conclusion**

This paper has argued that despite the much publicised discourse in patient safety about achieving patient and public involvement over the last ten years, there has still been little progress in realising this agenda. In looking at this lack of progress, little attempt has been made to locate the issues on involvement in patient safety in much wider debates about how user involvement has emerged and been addressed in other parts of the public services. More broadly within health and social care, a range of theories and practices have emerged to drive involvement, that draw upon arguments relating to tackling oppressive and discriminatory social structures and health inequalities and power inequities between professionals and service users. These theories provide considerable opportunities for enabling a greater understanding about the barriers that inhibit involvement in patient safety and ways for developing patient and public involvement as empowerment in the future.
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