“A Fine Race of Girls”

Occupational Therapy and Clinical Governance in the District Health Boards of Aotearoa New Zealand

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Abstract

Clinical governance frameworks were constructed in New Zealand District Health Boards (DHBs) to address increasingly visible problems in the delivery of a high quality, value for money, safe and client-focussed publicly-funded healthcare system, staffed by clinically competent professionals. Prominent discourses favour an environment where health workers are considered responsible and accountable for their conduct and practices, reflecting DHB preferred knowledge and beliefs. The construction of clinical governance frameworks incorporates technologies of discipline, both foregrounding the emergence of subject positions aligned with quality and safety, and acting as instruments of surveillance so that conduct at all levels of the organisation can be monitored and corrected. This research explores how clinical governance discourses circulating within DHBs have produced a change in the subjectivities of occupational therapists and how their resulting subject positions have affected their everyday practices with clients.

A post-structural Foucauldian discourse analysis methodology was used to identify the prominent discourses within a range of documents from two moments in time: just after the emergence of DHBs in New Zealand (2003-05) and twelve years later (2015-17), to make transparent changes in occupational therapist subject positions and practices. Research goals were twofold: firstly, to identify both dominant and receding discourses impacting the formation of occupational therapy subject positions; secondly, to reveal how occupational therapist subject positions influenced what practitioners did in the name of occupational therapy in New Zealand DHBs.

Findings suggest that clinical governance frameworks have produced changes in the behaviour and practices of occupational therapists working in the DHBs. Subject positions whereby they engage in and demonstrate responsible, accountable and competent practice, risk minimisation, quality improvement, value for money, and client-centred behaviours and practices are foregrounded. Their practice extended beyond face-to-face client interventions, to include participation in activities which ensured the system as a whole conformed with discourses that prioritised efficiency and value for money across a population through standardisation of processes and focus on core practices. Coveted professional occupational therapy subject positions embracing a holistic, problem-solving, compassionate and individual approach somewhat receded, but appeared under certain conditions when the therapists exhibited resistive behaviour.

Occupational therapists now hold two complex jobs: their front-line face to face patient intervention, and their behind-the-scenes quality, efficiency and risk management on behalf of the organisation. This means that they have to ‘walk the line’ between valued professional subject positions and those preferred by the DHB. It is an ethically and professionally tricky path to navigate. Serious engagement in reflective practices through external, confidential supervision as well as application of political reasoning through occupational justice activities are possibilities for future discussion.

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Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signature:

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(now Mrs. Mitchell)

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...in 1968. Students came pouring into the bus at Karangahape Road, smiling and saying their good-mornings. I was tapped on the shoulder from behind by a man, enquiring who they were (a not infrequent enquiry) – and when he heard that they were O.T. students he proceeded to tell me of his encounter with the profession, gradually reaching a crescendo : “a fine race of girls”.

- Frances Rutherford
Principal 1955-1972
NZ School of Occupational Therapy

Chapter 1 Introduction

> Everyone in this health organisation has two jobs: improving the system of care as well as providing care.
>
> – *Robin Gauld, Governance of the New Zealand Health System*

Chapter overview

This introductory chapter provides background to set the scene for the following chapters, but more importantly, describes the purpose of the study and how I locate myself within it. This thesis poses the question "How has clinical governance influenced occupational therapy practice within District Health Boards in Aotearoa/New Zealand?" I have used a post-structural Foucauldian discourse analysis as the methodology to underpin the research.

For an initial understanding of prominent constructs, I first briefly define 'governance', then describe the idea of 'clinical governance', and its relationship to the main delivery points of socialised medical care in New Zealand, the District Health Boards (DHBs). I also give a concise definition of occupational therapy which, as a profession engaged by DHBs, is the subject of my study. Importantly, I give an initial sketch of the meaning of 'Foucauldian discourse analysis' since I will use this approach to examine the clinical governance frameworks influencing the practice of occupational therapy in New Zealand DHBs. I also address the purpose of the study, and what I hope will be its outcome, which naturally poses the question of why I became interested in clinical governance, and leads to me positing my rationale as to why this study is important to occupational therapy practice, in particular. I continue with an overview of the research design. Finally, I provide a synopsis of each chapter, making visible the structure of the thesis.

What is governance?

Even before considering a definition of 'clinical governance', we need to have an understanding of the broader concept of 'governance' itself: what it is, and how it is applied. Farazmand (2004) traces the concept of governance back as far as the first empire of Persia, and its administrative system, under the king-emperors Cyrus and his son Darius, both historically acknowledged as "the Great". Darius' own words about the need for governance come down to us through two and a half millenia: "no empire can survive, much less prosper without a 'sound economy and sound administrative system'." (p. 11).

In the modern world, Farazmand now defines governance as:

> A participatory process of governing the social, economic, and political affairs of a country, state, or local community through structures and values that mirror the society. It includes the state as an enabling institution, the constitutional framework, the civil society, the private sector, and the international/global institutional structure. (p. 11)

Expanding on these ideas, applied governance is a way to ensure that the establishment's processes of administration, organisation and management visibly and actively operate in a manner that fulfils at least six basic criteria (Farazmand, 2004):

- Up-to-date
- Competent
- Pre-emptive
- Reactive
- Responsible
- Answerable

Defining clinical governance in the New Zealand context

Although central to this study, it has become clear that clinical governance is a fluid concept, and one of the things this study demonstrates is how, at different moments, various discourses are foregrounded and become dominant. One early document that describes clinical governance, but does not name it as such, regards it as "a systems approach for the New Zealand health and disability sector" (Ministry of Health, 2003a). While, historically, there have been multiple discourses at play concerning how New Zealand's healthcare provision should be managed, prominent discourses concerning patient safety arising from the United Kingdom in the 1990s encouraged the take-up of a structure of clinical governance already embedded into the UK National Health System (NHS). Here, concerns had been raised regarding the competence of medical professions and the resulting safety of the patients using the NHS (Gottwald & Lansdown, 2014; Haxby et al., 2010; McSherry & Pearce, 2011; Wright & Hill, 2003). The conditions of existence that produced these discourses questioning practitioner competence and patient safety facilitated the appearance of "surfaces of emergence" (Foucault, 1972, p. 45) within NHS institutions, enabling the construction of a NHS clinical governance framework.

After similar medical failures in New Zealand resulted in investigations of malpractice, such as the 1988 Cartwright Inquiry (Women's Health Action, 2014a) and the 2000 Gisborne Cervical Smear Inquiry (Women's Health Action, 2014b), the New Zealand government also acknowledged the presence of a patient safety and quality of care problem associated with the delivery of healthcare. The government took note of the patient safety and quality of care discourses coming from the UK and reasoned that practice behaviours associated with this framework would provide a high quality, safe and efficient healthcare system through regulation, monitoring and surveillance of clinical practice.

District Health Boards

Early in its tenure, the Fifth Labour Government introduced the New Zealand Public Health and Disability Act 2000, defining twenty DHBs, each responsible for the funding, provision and delivery of healthcare services in a designated geographical area. As of 2021, the remit of the

same twenty DHBs continues to include the provision of effective and efficient healthcare services, aiming to reduce health disparities and to encourage community involvement in healthcare (Ministry of Health, 2020)[1]. Through this legislation and supporting documents, the newly formed DHBs were obligated to develop what might be termed 'quality of care frameworks'. The DHBs, then, were effectively designed at the outset to incorporate an early form of clinical governance into their organisations (French et al., 2001; King, 2000, 2001, 2004; Ministry of Health, 2003b; National Health Committee, 2001; New Zealand Public Health and Disability Act 2000). I will examine some more recent descriptions of clinical governance in later chapters.

Occupational therapy

The World Federation of Occupational Therapy provides a definition of occupational therapy as:

> A client-centred health profession concerned with promoting health and well-being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by working with people and communities to enhance their ability to engage in the occupations they want to, need to, or are expected to do, or by modifying the occupation or the environment to better support their occupational engagement. (World Federation of Occupational Therapists, 2012)

Occupational therapists (OTs)[2] in New Zealand reference and take up this ideal definition; it appears on the profession's official association website (Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa [OTNZ-WNA], 2021). Additionally, OTNZ-WNA recognises that in Te Reo Māori, *whakaora ngangahau* (occupational therapy) is understood as the "reawakening, or restoring to health one's activeness, spiritedness and zeal". The work of Molineux (2010) is also cited, arguing that occupation should be considered to be "active, ...purposeful, ...meaningful, ...contextualised and ...human" (p. 17), impacting on health. When considering the impact of clinical governance on the practices of occupational therapy, these understandings should be kept in mind as they are the deep beliefs, the truths, and the knowledge of the profession. They inevitably influence the response of occupational therapy practitioners to clinical governance discourse, when they seek to identify opportunities and benefits within these discourses that might also be understood as attempts to direct and also restrict practice.

The troubled nature of clinical governance

There are some concerns associated with poor understanding of clinical governance, and I believe it is necessary to examine them. Firstly, despite shifts in allied health structure and leadership,

[1] In April 2021, the New Zealand Labour government announced two new national health bodies, Health NZ, and the Māori Health Authority, which will supercede the twenty Districts, as perhaps a 'national super-DHB'.
[2] Occupational therapist(s) usually abbreviated as OT(s) in the text. Occupational therapy as a discipline has been written longhand to distinguish it from practitioners, except in lists and tables where the difference is clear.

problems and conflicts can occur between managers and clinical leaders due to conflicting discourses that prioritise different objectives and/or outcomes. Research suggests that recognition of the tension between "clinicians, health managers and policy makers... could be used to help understand the differences in their world views [and] bridge the divide" (Maani & Cavana, 2007, p. 195). Secondly, there is a claim that clinical governance causes "confusion, debate and disagreement on quality care" (Som, 2009, p. 98) due to insufficient clinician knowledge. This finding was supported by Staniland (2009) who also found that while organisational documents reported clinical governance practices were being enacted, not all staff understood or agreed with the take up of clinical governance. She argued that "the quality of care for patients will remain a paper exercise until organisational and practice issues were addressed" (p. 271). Finally, a later systematic review of 19 studies (Phillips et al., 2010) concerning how clinical governance played a part in healthcare delivery quality and safety suggested that frameworks were also "poorly understood ...equated with bureaucratic control or medical dominance" (p. 606). They were "fragmented, ...focus[ing] mainly on process rather than outcomes" (p. 602). Additionally, excessive use of practice guidelines were seen to restrict opportunities for quality development, yet create work around performance measurement rather than what was actually clinically needed. The research team concluded that it was "professional leadership, ...well-resourced peer support networks ...improvements driven by professionals at the practice level [and] funding of time for clinical governance" (p. 606) that should be primary drivers in the construction of clinical governance frameworks.

On the other hand, Walsh (2014) reaffirmed that the concept of clinical governance does have potential, due to the focus on clinical effectiveness, risk management, patient involvement, audit, use of information services, and education and training. Importantly, though, Walsh stressed that full roll out of a clinical governance initiative is costly and that, in his opinion, the only justification for implementation is the achievement of real outcomes showing improved quality of care for patients. At the same time, Davies et al. (2014) cautioned that inclusion of allied health professionals, (such as OTs, speech-language- and physio-therapists), is often an afterthought in quality initiatives.

Regardless of the health service knowledge of, and support for, clinical governance, it adds another framework that clinicians and managers alike must understand and work within. It calls for clinicians to participate in governance and quality improvement initiatives because "everyone in this health organisation has two jobs: improving the system for providing care as well as providing care" (Davies et al., 2014). However, sustaining the role of quality development alongside a clinician role is often challenging when clinical priorities take precedence; for some clinicians, conflict can arise when attempting to participate effectively in both roles. Ensuring adequate staffing and proper staff ratios are recommendations in the UK *Berwick Report* (National Advisory Group on the Safety of Patients in England, 2013), as a result of the finding that

inadequate staffing can create low morale, make it difficult to retain experienced staff, and more critically for patient care, build the potential for increased risk and safety issues through not having the time to develop or review treatment interventions.

How clinical governance is defined and enacted can therefore be problematic. My study shows that multiple discourses are involved when considering the meaning and construction of clinical governance, and that intricate manifestations of relations of power run throughout its framework. As such, I would suggest that it can be difficult for OTs to understand how their personal and collective subject positions are produced by discourses circulating within the DHBs. In affirming that health professionals' roles have two components, clinical and quality care service provision, clinical governance arguably creates subject positions for OTs in New Zealand to lead change and challenge ineffective systems and processes. However, shortcomings in its implementation, notably the apparent under-resourcing to free clinicians' time, and the lack of mechanisms to bridge the different worldviews of managers and frontline staff, put any initiatives at risk. It is also challenging for OTs to uncover ways that would enable them to actively exploit, work within, or resist the impact of clinical governance on their practices. As the web of discourses is complex, it is not surprising that Wilkinson et al. (2011) concluded that "the active engagement of all clinicians with quality improvement is essential but as yet largely unrealised" (p. 45). For this reason, I believe it to be essential that discourses in relation to clinical governance and occupational therapy are uncovered and laid out for clinicians and the occupational therapy profession to consider through research, education and discussion.

Foucauldian discourse analysis

To delve deeper into the intentions behind, and the outcomes of, clinical governance, I have used a Foucauldian discourse analysis methodology, originating from the work of the influential French commentator Michel Foucault. His uncovering of the relationships between institutional power and the individual gave rise to what he termed 'governmentality': multiple power networks operating throughout society that are produced from types of knowledge concerned with external political security, internal security, and economics (Schirato et al., 2012). Foucault's governmentality has allowed me to, (using Foucauldian terms), 'make visible' the operation of dominant discourses and power relations associated with DHB clinical governance frameworks. I used a governmentality lens to show how the regulation of the behaviour of a particular population occurs, in this case, OTs working in DHBs and is introduced later in the chapter.

I investigated how particular knowledge, conveyed by political, economic and institutional discourses, produces (Foucauldian) 'subjects' such as OTs who adopt and engage in specific

practice behaviours (Auckland DHB, 2014, 2018; Waitematā DHB, 2014a)[3]. Furthermore, Foucauldian discourse analysis enabled me to understand and reveal the analytics of power (Dreyfus & Rabinow, 1982), the micro-practices, and the disciplinary techniques acting on DHB subjects. These mechanisms act to produce particular subjectivities and subject positions, through which preferred behaviours and practices are normalised to be taken up by practitioners and workers at all levels of the organisation (Auckland DHB, 2014, 2018; National 20 DHB Talent Management and Leadership Development Group, 2018; Waitematā DHB, 2014a).

I also looked to Foucault's later work and his growing understanding of "the relation of the individual to himself" (Foucault, 1980 in Paras, 2006, p. 109). Here, subjects hold agency to shape their own behaviour through self-surveillance and discipline (Paras, 2006), as well as truth telling, confession, reflection and problematization[4], producing possibilities of free choice and resistance in their 'doing', or conduct (Foucault, 1978).

Foucauldian discourse analysis requires both an understanding and actual use of the writing and ideas of Michel Foucault. To structure and guide my research, I have therefore used the notions from Foucault's books, or as he has called them, "toolboxes" (Patton, 1979, p. 115). While 'archaeology', 'genealogy' and 'problematization' (Foucault, 1970, 1972, 1977a, 1978) provide the necessary scaffolding for the thesis, I have particularly focussed on how the technologies of 'governmentality' and 'biopower' (Foucault, 1978) are exercised. This is because the discourses associated with the formation of subjects and subjectivities are made visible by application of these technologies and their associated disciplinary mechanisms. Within the remit of clinical governance, these technologies shed light on how both OTs, the subjects, know themselves, and how occupational therapy practice is known (Weedon, 1997). In essence, I am interested in how these mechanisms act to produce the expected behaviour made visible by what OTs do in their daily practice.

These important Foucauldian ideas are introduced in the next chapter, and detailed terminology is more fully addressed in Chapter 3: Foucauldian methodology.

Purpose and outcome of the study

My thesis will show that dominant discourses associated with the quality and safety of care can produce expected occupational therapy practitioner subjectivities and subject positions. I will also show that clinical governance discourses may have produced behavioural change through the introduction of alternative truths, changing knowledge and practices. Foucault's methods have provided one way of understanding how discourses construct what we know and believe to be

[3] The DHB written name, as with many other Māori names, has evolved over the years, and 'Waitematā" is now the preferred usage. To avoid confusion, I have rendered names of departments, documents and references exactly as they were written at the time, although they may now be considered anachronistic.
[4] See Chapter 2: Study design and tools

true: in this case, clinical governance discourses produce practitioners who are expected to carry out their work with patients from the particular standards of practice endorsed by DHBs, such as quality assurance and safety.

Further, I posit that practitioners are expected to take up responsibility to participate in, and be accountable for, both professional self-governance and governing the system in which they work. My post-structural, Foucauldian discourse analysis study exposes the discourses that underlie the clinical governance frameworks which influence occupational therapy practice. This is important since occupational therapy professionals now seem to be expected to combine two roles; first, as traditional practitioners, and second, engaging in DHB governance. It is in this second role where they must be held (and be seen to be held) accountable and responsible for the delivery of high-quality, safe and economical healthcare.

Although the concept of clinical governance has been widely discussed during the last 20 years (Travaglia et al., 2011), I aim to provide an understanding of the history and concept of clinical governance, from a New Zealand perspective, that is accessible and relevant to OTs. Further, I explore the notion how clinical governance has influenced the way occupational therapy practice may be undertaken in New Zealand DHBs. By using Foucauldian discourse analysis, I reveal how OTs working within the public health system are governed not only by their professional board, the Occupational Therapy Board of New Zealand (OTBNZ), but also by the DHB in which they work.

My hope is that this study will open up a clear understanding of the underlying mechanisms that have played a part in normalising practice behaviours associated with the implementation of clinical governance systems. I believe this discourse analysis will generate insights that may enable OTs to make conscious decisions about how they practice within the context of the DHB workplace. More broadly, I believe that, although focussed on occupational therapy practice, my investigation and findings will be of interest to, and perhaps applicable to, the wider health professions, particularly those in allied health which are client-facing, such as physiotherapists and speech-language therapists, as well as practitioners in social work. Finally, I wanted to investigate, and leave open for discussion, the implications for practice that are a result of clinical governance discourse: what are the constraints and the opportunities; where is there likely to be resistance or "counter-conduct" (Foucault, 2007a, p. 201); how may 'what occupational therapists are expected to do' affect their clients?

Locating myself in the study

In my career as an occupational therapist, I have often wondered what caused occupational therapy practices to change from those I was trained as a student to carry out, to the practices required by the DHBs in the present. As a new graduate in England in the early 1980s, I fully

expected to provide interventions using therapeutic craft modalities and adaptive equipment that we, the therapists, constructed as solutions to unique, individual self-care and quality of life problems experienced by our patients. A humanistic, enabling approach was what we had been taught at Dorset House School of Occupational Therapy, Oxford. I believed that what we learned there, the knowledge and skills imparted to us, must be the true way of 'doing' occupational therapy. Dorset House was a renowned educational institution for occupational therapy training – the first occupational therapy school in England.

However, almost immediately, in my first job, I was told "we don't do that anymore" (Senior OT, Ealing Hospital, London, England). I wondered why, but did what I was told, moving away from crafts to focus on physical and cognitive assessment, together with learning and applying various neurological rehabilitative approaches based on ideas coming from physiotherapy. Seven years later, I moved to California and worked in a not-for-profit hospital, carrying out similar interventions, but this time, there was an emphasis on time management, progress reporting and limits to treatment based on underlying cost and what insurance would pay. Finally, I arrived in New Zealand, expecting to work with neurological patients requiring rehabilitation and was again told "we don't do that anymore" (Senior OT, Waitematā DHB, Auckland). Rehabilitation, as I knew it, had been replaced by two main occupational therapy practices, toileting and breakfast group followed by discharge as soon as possible. What had happened?

I was increasingly troubled because I had a deep faith that occupational therapy practice provided a unique approach to improving the quality of life of those people who were excluded from the everyday activities available to others in society, just because they were labelled 'disabled' or had 'special needs' of some kind. Why were there limits being placed on what we did, with, or on behalf of our patients? Over time, I noticed that both myself and some of my colleagues looked to find ways round the rules, through extensive reasoning, argument and negotiation, in order to provide the interventions and equipment we believed our patients needed to participate effectively in their natural environment, referred to as "gaming" [the system] (Ministry of Health, 2012, p. 4). Why did we feel we had to do this?

I became interested in the concept of clinical governance while working in New Zealand DHBs. Over time, I held a number of different roles, initially as a front-line clinician, and then progressing through other roles as clinical supervisor, professional leader, clinical leader and ultimately to a combined position as a professional and clinical leader. As I became part of the DHB leadership structure, it became clear to me that front-line OTs had little awareness and more importantly, understanding, of the concept of clinical governance and how it potentially impacted their practices.

It seemed that, prior to my study, when I discussed clinical governance with OTs, the concept did not appear to have made its way into the mainstream awareness of clinicians. That conclusion is

supported by the findings of Gauld and Horsburgh (2015), who discovered that "only limited implementation has occurred" (p. 1). Additionally, I noticed that OTs seemed unaware that the system in which they worked was quietly being restructured, to suit a clinical governance framework that placed constraints on what they traditionally could do for, or on behalf of, their patients. While they realised that certain features of their daily practice were narrowing down, or in some cases, ending, the practitioners did not seem to understand why. Conversely, there was little realisation that new practice spaces and subject positions might produce opportunities for the construction of new, more effective practices, providing practitioners understood the system and positioned themselves to take up and develop potential quality improvement initiatives offered through participation in projects and research.

Significantly, clinical governance systems signalled that OTs not only had a responsibility and duty to ensure they practiced competently in accordance with their professional registration requirements (Occupational Therapy Board of New Zealand [OTBNZ], 2018d), but also an obligation to practice in a particular way laid down by DHB policy such as job descriptions (Counties Manukau Health, 2014d), standard operating procedures (Waitematā DHB, 2014b) and codes of conduct (Auckland DHB, 2014, 2018).

I began to believe that this lack of awareness of the mechanisms of clinical governance was a risk to a range of stakeholders, which in my research include individual clinicians, their clients, DHB multidisciplinary teams, and the occupational therapy profession as a whole. So I was prompted to look further into how clinical governance had influenced occupational therapy practice through engaging in this study. I wanted to make visible my learning, so that OTs could be better informed about the mechanisms in play that produce changes in their practice behaviours, which, I believe, are important to identify and make transparent.

My thinking led me to consider the impact of the introduction within New Zealand DHBs of proto- clinical governance frameworks in the early 2000s. While my research started from that point, I gradually realised there were more events over time that have shaped our current occupational therapy practices. Foucauldian discourse analysis has enabled me to reveal those mechanisms of power that I believe have been instrumental in influencing practice, and to lay them out for consideration and future discussion.

This thesis provides my analysis and interpretation of the changing practices of OTs working in DHBs in New Zealand. As is the custom in Foucauldian discourse analysis, I do not make recommendations for future practice and I acknowledge that my interpretation is but one 'truth' within a plurality of 'truths'.

Rationale

A key driver for undertaking this study is that I could find no research conducted in New Zealand looking at how occupational therapy practice has been influenced by the introduction of clinical governance into DHB healthcare provision. A search of literature linking OTs and clinical governance revealed very few articles from the early 2000s, and all were from the United Kingdom (Cusack & Sealey-Lapeš, 2000; Dingle & Hooper, 2000; Sealey, 1999; Welch, 2002; Wilks & Boniface, 2004). So, with an identified gap in the literature, I believed it was time to consider how clinical governance might be shaping occupational therapy practice from a New Zealand perspective.

I believe my study is important because I have identified a power shift from DHB OTs being self-governing within their profession to being subject to multiple organisational governance demands, through the DHB they work for. There is now an expectation that clinicians not only demonstrate their professional competence to practice within DHB policy, but also actively contribute to the governance of the health system through taking on an additional range of 'responsibilities' and 'accountabilities' aimed at producing an 'effective health system' with 'proven outcomes'. As a result, an addition to the subjectivities and subject positions of OTs has been necessary, resulting in the 'two jobs' (Gauld, 2013) – the clinician working directly with patients on the front-line, as well as working behind the scenes, developing quality assurance initiatives that indirectly impact the front-line care received by patients.

From a Foucauldian perspective, power relations circulating through internal networks of policing and discipline will produce subjects (Schirato et al., 2012) that adhere to particular, desired, workplace practices. The take-up of clinical governance discourses suggests that everyday DHB normalised technologies of discipline, such as close surveillance, timetables, and rules and regulations, are in play on the bodies[5] of DHB subjects, including occupational therapy clinicians. These technologies of discipline reflect DHB 'preferred' clinical governance discourses that involve the delivery of safe, cost effective healthcare. The new subject positions that are produced and taken up by individual clinicians ultimately create practice behaviours impacting what is done for, and with, their patients. I believe it is important to identify these mechanisms and make them transparent, so that practitioners better understand why they do what they do.

Research design overview

My research design is strongly underpinned by the literature of Michel Foucault, particularly the books published in his lifetime that captured his thinking from archaeology, to genealogy and then to problematization (Foucault, 1970, 1972, 1973, 1977a, 1978, 1988a). Transcriptions of his lectures and anthologies of his work provide a necessary further explanation of certain concepts,

[5] Foucauldian. See Chapter 3: Foucauldian methodology

in his own words, such as governmentality and biopower (Foucault, 1991a, 2007a). As I have found Foucault to have a challenging writing style, the majority originally in his native French, I have also sourced and read material from a wide range of secondary writers and researchers who have both studied, critiqued and/or applied Foucauldian discursive analysis in their own work. I felt I needed to explore these secondary sources to clarify my understanding of Foucauldian notions in order to understand and apply them appropriately to my own work. Secondary sources include but are not limited to: Barry et al. (1996); Cheek (2000); Dreyfus and Rabinow (1982); Elden (2016); Gutting (1990, 2001, 2003, 2005, 2011); Gutting and Oksala (2018); Hook (2001a); Kendall and Wickham (1999); Koopman (2013, 2019); Lemke (2019); MacDonnell (1986); McHoul and Grace (1998); McNay (1994); Miller and Rose (2008); Mills (2003, 2004); O'Farrell (1989, 2005b); O'Leary and Falzon (2010); Paras (2006); Patton (1979); Rose (1999); Schirato et al. (2012); and Zamora and Behrent (2016).

Documents

My analysis has drawn on a select, but representative number of original source documents at all levels of the New Zealand healthcare service. They include legislation, produced or held by the New Zealand Parliament, Hansard, the Beehive, government departments, appointed committees and contracted services, and the Wellington and Auckland National Archives. More specifically occupational therapy-related documents have also been sourced from DHBs, OTBNZ and OTNZ-WNA, as well as some documents from the private collections of clinicians and academics.

One problem I have encountered is that frequently, New Zealand 'quality documents' tend to refer to practices that were or are connected to the clinical governance framework, but not named as such. I found only glimmers of these discourses, using other terminology. Therefore, I have had to identify alternative descriptors used to refer to the same ideas contained within the concept of clinical governance. As suggested earlier, instead of naming clinical governance as an object in and of itself, a similar collection of practices is called "a systems approach for the New Zealand health and disability sector" (Ministry of Health, 2003b). Study of the discourses present within this document reveal the same beliefs and behaviours as clinical governance, reinforced by statements that promoted ideas such as: 'leadership should occur at all levels'; 'practitioners should engage in teamwork with a shared vision and shared outcome plan'; and 'practitioners must use resources wisely and they should participate in the continuous improvement of work processes'. Furthermore, workers were expected to demonstrate accountability and take responsibility for the quality of work they engaged in, as well as conform with the organisation's standardised care procedures, processes and practices. As a result of the use of many alternative descriptors for clinical governance, I needed to read and re-read the documents carefully to ensure that I was identifying those pieces which, together, signal the presence of clinical governance discourse.

A history of the present

Current practice, when using Foucauldian discourse analysis, is to not engage in a standard literature review, but rather to conduct a 'history of the present', otherwise known as a 'genealogical analysis', utilising Foucauldian tools selected to suit the particular scenario. As my thesis aims to reveal how occupational therapy practice has been influenced by clinical governance, Chapter 5: 'A history of the present' has investigated the emergence of occupational therapy practice in New Zealand in the years after the Second World War. This chapter establishes the formation of the OT as a subject within New Zealand society. Furthermore, it reveals how New Zealand politics, economy and social discourse has shaped the subjectivities and subject positions of OTs, producing from them particular behaviours and therapeutic perspectives discourse promoted as 'true' at that time in history. Finally, Chapter 5 acts as a moment that can be compared with the emergent- and post- clinical governance moments analysed within this study.

Moments

I selected two periods, or historical 'moments' to analyse in depth. The first, Moment 1, 2003–05, I chose because clinical governance was a relatively new concept, and associated systems were in the process of being constructed in the DHBs, especially in the light of (then) recent legislation. The second, Moment 2, 2015-17, revisits the DHBs to reveal what discourses were at play in shaping clinical governance practices at that later moment in time for comparison. In Foucauldian terms, history is generally not linear, but contingent and discontinuous, challenging the notion of evolving and progressive history. What we do depends upon which prominent discourses are promoted as truth. Moment 2 is an opportunity to make visible how clinical governance has been constructed in response to the changes in legislation and health policy since Moment 1, and their effect on occupational therapy practice.

I analyse both Moments separately with the findings presented in separate chapters. In Chapter 9: Discussion, I then bring together the findings from each moment in a history of the present, essentially a commentary on how *current* occupational therapy practice is influenced by clinical governance.

Chapter overview

Chapter 1. Introduction

Here, I have summarised the content of the thesis as a whole. I outline my intent to use Foucauldian discourse analysis to reveal the discourses and power structures that underlie the clinical governance frameworks present in New Zealand DHBs, which also influence expected occupational therapy practices in this country. I have explained my purpose and the outcome I hope to achieve, while locating myself in the study. The chapter also provides a rationale for

selecting two moments that reflect a contingent, rather than linear, nature of history and how subjectivities and subject positions of the DHBs' subjects are related to the dominant discourses that act to circulate power in a particular moment.

Chapter 2. Study design and tools

Some of the reasoning behind the selection of methodology and method is examined here, leading to how I arrived at Foucauldian discourse analysis as a preferred methodology. I move on to a fuller introduction to the significance of Michel Foucault and his contributions to history and philosophy, and begin to look at discourses and their formation. I then 'open the toolbox' and look inside at the kind of 'tools' that I select as being applicable to this study, including the overarching concepts of archaeology, genealogy, problematization, governmentality and biopower. Finally, I look at what it means to 'immerse' in this methodology, and the process of beginning to collect data.

Chapter 3. Foucauldian methodology

This chapter offers a detailed account of the post-structural Foucauldian discourse analysis methodology used in this study. The contents of my own Foucauldian 'toolbox' are reviewed, and I follow the flow of the research process using an appropriately Foucauldian epistemological school of thought and theoretical perspective, followed by the methodology and the method. I explore discourses from the point of view of governmentality, and especially subjectivities and subject positions which become the tools of choice when conducting the analysis of documents. Foucault's archaeology and genealogy are discussed as they apply to discourses, and this is followed by a separate examination of his ideas regarding discipline. I conclude by looking at neoliberalism as a form of governmentality.

Chapter 4. Method

This gives a chronological account of how I conducted the study. Ethical approval was not required for this study because I was analysing mostly publicly available organisational documents only and not engaging in any methods involving people's own words, such as those gathered through interviews. Where appropriate, I did approach people as document sources, or as consultants for advice on where to obtain documents if the texts were not easily available in the public domain. This consultation was acceptable to the ethics committee and did not require any further ethics consideration or input.

Chapter 5. A history of the present

Rather than a traditional literature review, I briefly present a history of how a space was created for the profession of occupational therapy to surface in New Zealand. I offer insights into the social, political and economic context associated with the emergence of occupational therapy after the Second World War, thus providing a foundation on which to present this study. I show how a

profession specialising in reablement through occupation emerged in this country, separate from nurses and physicians, due to the problem of management of certain groups of patients residing in hospitals: mental health patients languishing in asylums, tuberculosis patients convalescing in sanitoriums, and recovering soldiers. During and immediately following the Second World War, it was this latter cohort in particular which provided the impetus for the creation of a profession other than nurses and physicians specialising in reablement, with non-medical support coming from, for example, the New Zealand Returned and Services Association.

I consider how OTs were constructed to provide practices that fulfilled a particular role in the rehabilitation of patients requiring specific physical and mental health interventions that would prepare them to return to and participate in society, with a focus on quality of life and, where possible, to return to work. I also discuss how occupational therapy practices involved the use of arts and crafts with individuals and groups, and finding solutions to overcome various disabilities, often using modified equipment and graded activities to achieve rehabilitation goals.

This chapter additionally outlines how the Occupational Therapy Act, 1949 legislated the formation of a regulatory body, the Occupational Therapy Board, which oversaw the development of the occupational therapy training programme (Rosser, 1956; Rutherford, 1976), and registered appropriately trained OTs (Buchanan, 1972/1990; Rosser, 1956/1990). It also shows how a separate non-governmental body, the New Zealand Registered Occupational Therapists Association (NZROTA), provided a means of professional communication, support and educational opportunities to members. Although it had no regulatory function, it and its successor, the New Zealand Association of Occupational Therapists (NZAOT) provided OTs with a means of knowledge acquisition, training and 'practice truths' through journals, newsletters, workshops and conferences. In summary, I show that OTs, in effect, 'professionally' governed themselves for a considerable period of time.

Chapter 6. Contingent events (Moment 1 2003-2005)

In this chapter I consider the economic, political and social conditions that emerged from the world economic crisis in the mid 1970s which produced change within healthcare delivery. I discuss how neoliberalism has been taken up as a solution to economic recovery, and how discursive constructs and concepts such as individualism, the free market (privatisation) and decentralisation (McGregor, 2001) from neoliberal thinking have filtered through and produced a different way of understanding and providing healthcare.

I show that these discourses produced the conditions for clinical governance frameworks to be constructed initially in the UK NHS and then in New Zealand healthcare organisations. As for the associated beliefs, that individuals are empowered and considered responsible for their own healthcare, I show that they appear at first sight to align with occupational therapy's fundamental values of occupational and social justice (Townsend & Polatajko, 2007); are a seeming fit with

New Zealand legislation, importantly the Treaty of Waitangi, and He Korowai Oranga, the Māori Health Policy (Ministry of Health, 2014b); and satisfy the healthcare requirements of the three principles: partnership, participation, protection (Ministry of Health, 2014c).

This chapter provides an opportunity to consider the full impact of neoliberal economic ideas on the emergence of clinical governance, including the counter-arguments against the shift from collective to individual responsibility (McGregor, 2001) suggesting the possibility of increased inequality and decreased access for all to quality healthcare. I question whether a conflict has arisen for OTs, particularly when the occupational therapy profession is calling practitioners to work with, and attempt to provide healthcare services for, the section of the population most in need of occupational therapy intervention: the socially challenged, the poor and disabled (Hammell, 2015).

Chapter 7. 2003-2005: Professional governance

Here, I present a Foucauldian discourse analysis of the findings from the first of the two Moments, 2003-05, where a study of documents from this period reveals a change that occurred in the discourses about how healthcare provision should be administered.

I argue that the introduction of clinical governance in the guise of 'professional governance' disrupted the circulation of power mechanisms within the DHBs, giving rise to a shift from practitioners being self-governed through their professional body to being increasingly governed by the DHBs in which they work. This shift required them to take up additional responsibilities and accountabilities and demonstrate their competence to practice according to the policies of the DHBs as well as to their professional regulatory body.

I also posit that surveillance started to become embedded in daily normalised practices, resulting from standardisation, as a theme of this moment. Here, OTs were required to shift from humanistic, individualised, holistic[6], problem-solving subject positions to subject positions that focussed on economic effectiveness, population health and uniform practices embedded in policy and procedural guidelines. However, it was also a moment where counter-discourses from the profession remained in play and provided a means of resistance. Discourses from professional beliefs remained strong, holding power to undermine the dominant discourses circulated by the organisation, an example being the tension between clinical decision making and economic prudency.

Chapter 8. 2015-2017: Two roles

I present a Foucauldian discourse analysis of the findings of the second Moment, 2015-17. My analysis sees that changes in practice are not linear and predictable, but contingent on new

[6] Holism: "A belief that the whole organism is greater than simply the sum of its parts". Johnston, R. J., Gregory, D., & Smith, D. M. (Eds.). (1994). *The dictionary of human geography* (3rd ed.). Blackwell. (p. 250).

problems arising in the delivery of healthcare to the population. DHB quality systems were modified to provide solutions to the healthcare delivery problems that surfaced. Hence, analysis has indicated that DHBs have required practitioners, in this case, OTs, to reconstruct their subject positions, subjectivities and practices according to the truths and knowledges circulated by the DHBs within the second moment.

Here, I show that neoliberal ideas have retained their prominence, continuing to influence the discourses pertaining to healthcare delivery. Clinical governance frameworks within New Zealand DHBs normalised favoured organisational behaviours which produced clinicians holding subject positions aligned with DHB values, practicing within standardised guidelines.

In this moment, study of the documents reveals the emergence of allied health[7] clinical leadership directorates featuring a clear take up and structuring of clinical governance within named allied health services (Chadwick, 2017; Chester, 2014; Chester & Kennedy, 2009; Counties Manukau Health, 2014d, 2015a, 2016). While there is a continued establishment of standardised practice policy and service initiatives (Counties Manukau Health, 2019a; Waitematā DHB, 2014b), there is also a shift of focus to understanding of and engaging in patient experience through programmes, sometimes termed 'walking in my shoes' initiatives, and patient stories (Piper, 2017; Waitematā DHB, 2017a). Formalisation of professional development opportunities and career coaching for and inclusive of allied health respectively, also surfaced (Heap, 2019; Waitematā DHB, 2019). These have variously included funding for professional development (Waitematā DHB, 2016d), assisting with the cost of course attendance, and construction of new roles, such as the "Allied Health Quality Improvement Lead" (Waitematā DHB, 2018), signalling a multidisciplinary approach within directorates and opportunities for OTs to engage in wider DHB quality improvement initiatives.

Chapter 9. Discussion

In this final chapter, I provide a critical analysis of the findings in relation to existing knowledge and the implications for the profession. I refer to my original question: "How has clinical governance influenced occupational therapy practice?" and confirm the dominant discourses at play within the moments I chose to study. I show that specific moments of time have produced particular occupational therapy practitioner subject positions and subjectivities. I discuss how these subject positions vie with other subject positions taken up from alternative sources of knowledge and truth, counter discourses. I consider how the resulting dominant subject positions have acted to influence expected occupational therapy practitioner behaviour and what may be 'done' by OTs in daily practice. I also consider possible directions for further research, education,

[7] Allied health: According to Chadwick (2017) 'allied health' can have many meanings. It is used in this study to refer to a diverse collection of professions: Therapies, including OT, Scientific, e.g. laboratory scientists and Technical, e.g. medical radiation technologists. For this reason, it can also be referred to "Allied Health, Scientific and Technical workforce" Waitematā DHB Corporate Clinical Governance Team. (2010). *Clinical governance*.

policy and practice that will add to the field of knowledge of occupational therapy practice within a system of clinical governance and clinical leadership.

Summary

In Chapter 1, I have provided an overview of some of the key constituents of the study, outlined the area of interest and some background, and identified the main question of interest. I have also offered some brief definitions of the four elements of the thesis: clinical governance, District Health Boards, occupational therapy and Foucauldian discourse analysis, while briefly describing the historical-philosophical methodology of Michel Foucault. After examining the study's purpose and intended outcome, I have presented an overview of the research design, which included a discussion about source documents and a short introduction to Foucault's 'history of the present' and 'moments'. Finally, I have outlined the content of each chapter, and hinted at the main findings and their implications.

Chapter 2 Study design and tools

> Discourse must not be referred to the distant presence of the origin, but treated as is and where it occurs.
>
> *– Michel Foucault, The Archaeology of Knowledge*

Introduction

I selected Foucauldian discourse analysis as the underpinning methodology and method for this study, and in this chapter, I present the reasons for this decision. I introduce both Michel Foucault as philosopher-historian and the concepts of historical analysis he constructed. I also introduce Foucauldian discourse analysis and consider some criticisms of the approach. I then turn to Foucault's toolbox for a glimpse inside, focussing on the main methodological concepts that I have selected for use within the study. Finally, I introduce the notion of documents as written texts, the data source for this thesis.

Selecting methodology and method

When I first started thinking about Doctoral research, I originally planned to undertake a mixed methods approach, using questionnaires and interviews. So the original questions guiding my first (PGR2) research proposal reflected the type of information that could be gleaned from the use of these methods. Questions I had in mind to ask included:

- What did occupational therapy clinicians know about clinical governance?
- Did they use another name to describe clinical governance practice?
- What aspects of clinical governance had affected their practice?
- How did OTs cope with the expectation that they carried out two roles – practitioner and quality developer?
- How were they supported to achieve both roles?
- How do clinicians and managers work co-operatively together to achieve a framework of clinical governance that is acceptable to both sides?
- How do government, DHB and professional documents guide clinicians to practice within a clinical governance framework?
- Is there resistance to implementing this concept and what are the consequences?

Although I found these guiding questions to be a useful starting point, I began to realise that if I used mixed methods, I would not collect the kind of information that was needed to answer my overall question. Rather, the questions above were more suited to asking clinicians directly what they thought and knew about clinical governance. This starting point assumed that what influenced practice was already known, but, as a seasoned therapist, this assumption did not feel correct. I was having trouble locating what actually was the source of changing practice associated with clinical governance. I thought that maybe clinical governance was more of a tool, or perhaps in Foucauldian terms, a technique, applied to health systems to change practice, rather than the

actual cause. I slowly recognised that my interest in how clinical governance influenced occupational therapy practice was more complex than I, at first, thought.

After reading Foucault, I realised that a Foucauldian discourse analysis approach would be a better fit for my question. I saw that Foucault's 'toolbox' of analytical tools could better uncover the hidden discourses of current occupational therapy practice in the clinical governance literature. I liked the notion of knowledge being contingent, that random, chance events could be connected to form discourses and, even more, that Foucault's later work developed into focussing on dimensions of experience, (what people do), delving into the history of a problem rather than a period of history. I felt that this approach would open up new avenues of analysing data that would not have been available to me if I had selected a qualitative descriptive methodology.

What lies beneath

What I actually wanted to reveal and understand were the hidden mechanisms that acted to produce a change in occupational therapy practice, rather than collecting the opinions of OTs, who did not seem to be aware of the introduction and application of clinical governance in the first place. Once I realised that I also wanted to know the 'what and why' behind 'how' practice had changed, I then knew that a mixed methods approach using questionnaires and interviews was not going to provide the data or outcome I was interested in. Foucault, on the other hand, provided tools to inquire and reveal what was in play beneath the surface, producing change in practice. By unearthing the historical "traces left by history" (O'Farrell, 2005b, p. 133) that triggered change in occupational therapy practice, I was provided with a means to understand the occupational therapy practices of the present related to clinical governance.

A move to Foucauldian discourse analysis

I was introduced to Foucauldian discourse analysis through the AUT Doctor of Health Science programme. Further reading of Foucauldian literature prompted me to write a second proposal that could take a different approach to the way the guiding questions were written and the choice and collection of more appropriate data.

I reconstructed guiding questions that would lead me to conduct an inquiry that focussed on revealing the underlying discursive power relationships in the delivery of healthcare that has shaped present day occupational therapy practice. I focussed particularly on the effect of clinical governance, together with welfare and neoliberal ideas situated in the social, economic, political and historical contexts of particular moments in time. My revised questions were:

- What were the historical practices and subjectivities of OTs?
- What was known about clinical governance?
- How did clinical governance become a part of practice?
- How have current occupational therapy practices changed?

I also changed my method of data collection to analysis of selected documents, in line with the traditional Foucauldian discourse analysis method (Arribas-Ayllon & Walkerdine, 2008). Preliminary preparation through reading a wide variety of texts pointed to particular moments in time, where occupational therapy practice first emerged as a profession, and later, where many of the original practices were put aside in favour of new ways 'to do' occupational therapy.

Methodological choices and application

Michel Foucault: Power, knowledge and control

By the time of his premature death in 1984, the philosopher-historian Paul-Michel ('Michel') Foucault was probably the most recognisable public intellectual of the day. He had already spent nearly 15 years as Professor of History of Systems of Thought – his own chosen title – at the prestigious Collège de France, latterly drawing huge crowds to his lectures as far afield as California (Eribon, 1991, pp. 313-314).

Among Foucault's early contributions to 20th Century thought was the application of structuralism – the idea that elements of human culture must be understood by way of their relationship to a broader system (Calhoun, 2002) – to the relationship between knowledge and power (Raskin, 1984). Immanuel Kant's earlier perspectives[8] on knowledge, rationality, and reason formed the basis for Foucault's understanding of historical forms of knowledge (Foucault, 2007b). His essential thesis is that "power and knowledge directly imply one another" (Foucault, 1977a, p. 27), and that "for knowledge to function as knowledge it must exercise a power" (Foucault, 2007b, p. 71). Thus his view of the relationship between power and knowledge is not only that they are inseparable; for Foucault, 'knowledge is power' also means that power produces knowledge. I return to this idea in Chapter 3: Methodology.

Foucault's examination of power takes a further step, maintaining that power and resistance, too, are inseparable (Foucault, 1978), and that institutional preferred knowledge and conduct can be challenged by a "swarm of points of resistance" (p. 96) spread throughout their power networks. This resistance would provide opportunities to create behaviours that are different from, or even oppose, the intended result. In *The history of sexuality, Volume 1: An introduction* (1978), Foucault responds to criticism that he does not address how resistance is produced, and elaborates on how he believes subjects themselves control their own behaviour through ethical techniques

[8] See Appendix B: Foucault the philosopher-historian

of care of the self[9], which he later defines as "those intentional and voluntary actions by which men not only set themselves rules of conduct, but also seek to transform themselves" (Foucault, 1985, p. 10).

Foucault's approach to power in the modern world highlights that, as a disciplinary control, it is actually concerned about what has not been done by bodies due to resistance to, or failing to meet a given behavioural standard. In order to correct such 'deviant' or non-compliant behaviour, disciplinary measures are employed to align conduct with often precise and detailed norms ('normalization') which are deeply embedded in modern-day society, an example of which might be standards for medical practice (Gutting & Oksala, 2018).

Foucauldian interpretation of history

For Foucault, history is not a narrative, but a platform (Gutting, 2005) from which humans construct, comprehend and experience the world (O'Farrell, 2005b). His view is that history does not entail continuity, but is rather a series of discontinuities, and, as such, is constructed from the effects of contingent events. He is therefore interested in the breaks, changes and differences that occur during moments of time (Poster, 1982). His history does not evolve, but is disruptive, discontinuous, different and contingent. Foucault's history is one of understanding the simultaneous play of power and production of knowledge in order to understand the construction of truth at moments in time (Poster, 1982), which impacts the behaviour of all those who are connected to it. He describes and compares particular experiences and practices from specific moments in time, revealing how political, social and economic relationships act to change discourses impacting upon the behaviour of subjects within these chosen moments. He argues that the contingencies and effects of these moments have impact on the present, shaping the behaviour of populations and individuals alike.

Foucault's histories of ideas; of thought; of the present

Foucault applied particular terms to describe historical categories within his methodology, including the 'history of ideas', the 'history of thought' and the 'history of the present'. The term 'history of ideas' Foucault uses to mean "the analysis of a notion [an idea] from its birth, through its development, and in the setting of other ideas which constitute its context" (Foucault, 2019, p. 115). The 'history of thought', is used by Foucault to encompass his concept of 'problematization'; "the way an unproblematic field of experience or set of practices... becomes a problem... and induces a crisis... [it] is the history of the way people begin to take care of something" (p. 115).

[9] 'Care of the self' is primarily associated with 'techniques of the self', a form of self-discipline. This is examined in the next chapter in the description of Foucault's understanding of discipline

A ‘history of the present’ utilises Foucault’s concepts of ‘archaeology’, ‘genealogy’ and ‘problematization’ as tools to critically examine power relations and political struggles. Foucault said his method was “a critique of our own time, based upon retrospective analyses” (Simon, 1971, p. 192). While all three ‘histories’ of ideas, thought and the present have been used in this study to varying degrees, the use of the ‘history of the present’ predominates.

Foucault’s methodology also produces a method of analysis through the application of his tools: archaeology describes and orders the historical traces laid out within the texts forming discourse, genealogy offers up an explanation of cause and change to behaviour produced by the effects of power acting within discourses. Together, as ‘a history of the present’, they have the capacity to reveal, track, map, display and explain the course of multiple discourses and their effect. By plotting a genealogical map, and studying power relations, discourses, non-discourses, disruptions, interruptions, discontinuities and dispersions of events to understand phenomena, Foucauldian researchers are able to explain the construction and production of objects and subjects within periods in history, revealing the presence of discontinuous, contingent events rather than a linear history (Garland, 2014; Revel, 2014).

History of truth

Although his writing is often considered as comprising distinct periods of thought, Foucault considered his corpus to be a single piece of work[10] (Kelly, 2016), the ideas in his books eventually constructing (O’Farrell, 2005b) a “history of truth” (Foucault, 2006, p. 235). From an overarching viewpoint, Foucault has clearly constructed and expanded his methodology in order to examine the practices and outcomes associated with the take-up of dominant narratives in the production of truth. Foucault’s approach to truth is that it is not absolute, but constructed, and that we should understand how it is produced, rather than attempt to define it. Chapter 3 investigates this approach in more detail, and examines what Foucault calls “games of truth” (Foucault, 1997, p. 296): the interaction of discourses and practices which are both true and false, and how they are associated with power relationships.

Discourses and discursive formations

Discourses are “constituted by a group of sequences of signs, in so far as they are statements, ...they can be assigned particular modalities of existence” (Foucault, 1972, p. 121). Foucault also maintains that discourses are “practices that systematically form the objects of which they speak” (Foucault, 1972, p. 54). He writes of discourses as being active, where something is done, producing a visibility to objects. In other words, discourses can be defined as “a system of statements which constructs an object” (Parker, 1992, p. 5) under certain conditions.

[10] See Appendix A: A corpus of work. Foucault publications as tools

This understanding acts as a guide to locating discourse in text. The physical manifestation of a discourse situated within a text is a corpus of associated statements that together produce a named object, a "discursive formation" (Foucault, 1972, p. 121). Discourses constitute knowledge and through networks of power relationships produce subjectivities and social practices (Weedon, 1997). Foucauldian discourse analysis provides a method of studying discourses, their power relations and the resulting constructed reality situated within a particular historical setting. Through the study of discourse, it is possible to reveal how dominant societal 'truth and knowledge' is constructed, by the interweaving of power and knowledge, and, at the same time, make transparent what truths and knowledge have been disregarded or relegated to the margins of society by rendering them silent, absent or indistinct (Foucault, 1972; Kooji, 2014; Thompson, 2011).

I have used a Foucauldian discourse analysis methodology because I wanted to understand and reveal the power mechanisms in play within the DHB system of clinical governance that have influenced occupational therapy practice. My concerns in this study are focussed on how discourses related to clinical governance have been instrumental in shaping the expected behavioural practices of OTs. In Foucauldian terms, I am interested in the production of subjectivities and subject positions of OTs, resulting from the effects of both discourses and power relations circulating in organisations which require the take up of clinical governance practices.

Discourse is not an exact copy of reality, but a reality that is formed from knowledge that is written down and is constructed from cultural norms. Thus, what is included, or more importantly excluded, can be selected; what we can be or do, or not be or do, is identified. This results in an inseparable power/knowledge relationship that permeates throughout a society, an important concept that will be examined in Chapter 3: Foucauldian methodology.

Critique of Foucauldian discourse analysis

Graham (2005) suggests that Foucault has been criticised for failing to define a clear, consistent research method, preferring a more flexible approach, which has led to variations in interpretation as to how to engage in and use his work. Ballinger and Cheek (2006) challenge this viewpoint suggesting that it is more likely that a poor understanding of and misinterpretation by researchers using his philosophy to underpin their work that positions Foucauldian methodology to be critiqued in this way, not Foucault's work itself.

The very flexibility in how Foucault's work can be interpreted has produced concerns that his philosophy and approach could be misused (Hook, 2001a; Mills, 2003). As an example, Mills suggests that Foucault's invitation to use his methodology as desired could be employed to justify some of the more serious unethical arguments and events in the world, such as the Holocaust. Clearly then, when using Foucault's methodology and methods, great care must be paid to the selection and application of his work. For me, 'taking care' included making sure that my research

question was appropriate for this methodology; that ethical considerations were discussed with my supervisors and university ethics advisors, with steps taken to manage anything that might cause concern; and carefully planning how the research would be carried out, including placing boundaries around research areas of interest and precisely defining terms, so there would be no confusion what was meant by the research implications (Mills, 2003).

Opening the toolbox

Analysis of discourses using Foucauldian methodology involves using components of Foucault's 'toolbox', which will be examined in greater detail in Chapter 3: Foucauldian methodology. Many of the 'tools' are scattered across Foucault's books, articles and lectures, posing a challenge to a new researcher, who must get to grips with a prolific and sometimes mercurial figure. Here, I briefly describe the tools that are important to my analysis, some of which will invite further description as they appear in the following chapters.

Selection of tools

My own experience of conducting Foucauldian discourse analysis has found me referring closely to his writing to understand how he has used his methods in his own research, as well as examining his tools and trying them out to identify which ones were most suitable for my research needs. To ensure that I was selecting and using Foucault's methodology safely, I planned and conducted the research using university guidelines and regular discussion with my supervisors. The Foucauldian tools I used have been laid out both here and in Chapter 3.

Foucault's ideas of 'archaeology' (Foucault, 1970, 1972), 'genealogy' (Foucault, 1977a, 1978) as well as 'problematization' from which ethical 'care of the self' and 'truth-telling' emerge (Foucault, 1978), provide the framework for the study. Archaeology provides the structure, a means of delving into history layer by layer, to uncover, organise and describe discursive traces. Genealogy enables me to build upon the structure of archaeology through the study and mapping of phenomena, such as the power relations, discourses, disruptions of events, etc. Problematization allows me to pose a question in the present and look into history to answer it, while ethical care of the self and truth-telling are technologies that are involved in discipling the self and controlling one's own conduct. All of these phenomena act as both constraints and opportunities in relation to the behaviour of the subjects of the study.

Archaeological inquiry: A descriptive method

Archaeology refers to Foucault's method of describing and writing history. It is a descriptive method, with a clear framework: "one that digs down into the past, uncovering the discursive traces of distinct historical periods and re-assembling them, like so many distinct layers or strata, each one exhibiting its own structured pattern of statements, its own order of discourse" (Garland, 2014, p. 369). Archaeology "can only be what is said" (Hacking, 2006, p. xii), producing events

formed by discourse and revealed by analysis of traces of statements from within texts and other historical artefacts (Gutting, 1989). It decentres man as the subject and maker of history where continuity is paramount, to a "non-subject centred history of thought" (Gutting, 1989, p. 229) comprised of discontinuities and breaks.

The concept of archaeology stems from Foucault's early thinking, which was influenced by structuralist thought of the time, including Gaston Bachelard (1884-1962), Foucault's doctoral sponsor Georges Canguilhem (1904-1995), Louis Althusser (1918-1990) and Thomas Kuhn (1922-1996) (Garland, 2014). They focused on the analysis of conceptual frameworks and how change occurred through the take up of changing ideas, historical events or extinction of a practice within science. By using his method of archaeology, Foucault was able to work across several human sciences to identify and study discourses of interest in an historical setting. Archaeology enabled him to comprehend the progression and development of phenomena to their current state of being and has been described as an "examin(ation of) the discursive traces and orders left by the past in order to write a 'history of the present'" (O'Farrell, 2021, para. 5).

Genealogy

In time, Foucault became more interested in constructing a concept of power and its relationship with knowledge as an underlying mechanism for change. The archaeology model was indeed not flexible enough to enable him to analyse the data to see how the influences of power and knowledge could change the course of a phenomenon. He needed a new model that allowed him to both describe and make a study of the outcomes that would reveal the mechanisms responsible for causing change in behaviour. Hence, in effect, he expanded archaeology into a new model, which he called 'genealogy'[11], also known as 'a history of the present'. Foucault explained what he meant by 'history of the present' (Roth, 1981) in a 1984 interview: "I set out from a problem expressed in the terms current today and I try to work out its genealogy. Genealogy means that I begin my analysis from a question posed in the present" (Foucault, 1988b, p. 262).

Gutting (2005) believes Foucault's archaeological model is, in fact, well described in *Discipline and punish* (Foucault, 1977a), but that his concept of genealogy is more open to interpretation because his methodological tools point the way, rather than set down a defined process. If it is accepted that Foucault's understanding is that truth is actively produced by the dynamic experiences of people, then the experience of the use and effects of his tools by researchers would seem to me to be an acceptable approach when using his methodology. His writing leads the way.

[11] As Foucault was interested in the present, what was happening and how it was happening, and his thinking had already taken up influences from a number of philosophical perspectives, it is unsurprising that 'genealogy' was influenced by the work of another philosopher: Nietzsche (Gutting, G. (2005). Foucault: A very short introduction. Oxford University Press.). Foucault called him "the philosopher of power" (Foucault, M. (1980b). Prison talk. In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings 1972-1977*. Vintage Books.), and in fact Nietzsche had already used the term 'genealogy' to describe a concept linked with his own philosophical ideas in addressing power.

He experiments, builds and changes methods as his thinking and ideas are constructed over time. As he says, “I like to open up a space of research, try it out, and then if it doesn’t work, try again somewhere else” (Foucault, 1991a, p. 74). Therefore, I believe that there is both guidance from Foucault’s own experiences of conducting actual research, as well as an assumed flexibility on the part of researchers, to not only select appropriate tools from his toolbox but to develop their own research pathway that they consider most appropriate for their specific area of interest.

Problematization

Foucault’s perspective on control and power was consolidated in *L’Histoire de la sexualité* (*History of sexuality)*, beginning with the first volume: *La volonté de savoir (An introduction)* (1976a, 1978), and while he continued to argue that power is always present in social systems, he also suggested that power is connected with *what people do* and *how they act* in a social system. Foucault terms this ‘problematization’, which he defines as “how and why certain things, (behaviour, phenomena, processes), became a problem” (Foucault, 2019, p. 224). It is concerned with ‘regimes of knowledge’ (the truth gained from science); regimes of practice (strategies and power relations) and the relation of the self (truth, power and the self) (Frederiksen et al., 2015).

Problematization focuses on complex networks of power, employing a number of techniques (Lynch, 2014). Similar tools are utilised to those of genealogy, but discourses within problematization became “dimensions of experience” (Flynn, 2003, p. 38) because Foucault wanted to highlight the importance of practices, what people do, emerging from their understanding of what is considered real and true at the time. These discourses were considered to be an active interaction of knowledge, power and subjectivity (Penalver, 1994) except where power and knowledge traversed each other, becoming the points of resistance (Foucault, 1978, p. 95). “Points of resistance are present everywhere in the power network...forming a plurality of resistances” (pp. 95-96). They act by challenging and regrouping power relationships and can effect change to the order of prominence of dimensions of experience, providing an alternative to what is considered ‘the truth’. Foucault describes problematization as:

> The analysis of the way a field of experience and a set of practices – which were accepted without any problem, which were familiar and silent, or at least beyond discussion – become an issue and raise discussions, debates, and incite new reactions, and so induce a crisis in habits, in practices, and in institutions. (Foucault, 2019, p. 115)

Problematizations emerge through *both* words and actions and are enacted through inquiry on subject matter that is deemed problematic (Koopman, 2014). In problematization, the analysis of ‘dimensions of experience’ enables the researcher to uncover the interplay of structures and mechanisms appearing, colliding and disappearing over time, enabling a mobility across groups quite separate from each other, providing a method of making connections, through traces left by their interactions, that would not have been identified through his previous methods (O’Farrell,

2005b). What is also important about problematization is that Foucault clarifies his position on the issue of freedom and what people do. People have the capacity to resist power through "specific actions and words, which can be traced historically" (2005b, p. 70). Through the application of technologies associated with 'care of the self', like reflecting on what action to take in a particular situation, people are free to produce ethical solutions that may result in behaviour contrary to the desired conduct of the institution.

Problematization and discourse

The concept of problematization also extended the meaning of discourse, whereby Foucault argued that discourse was not only that which was produced by the actions of speaking and thought, but consisted of many other activities as well as forms, patterns and rules (Frederiksen et al., 2015). Foucault (1978) considered discourse to be just one of many discursive and non-discursive practices that aided the construction of reality made visible by a "dense web that passes through apparatuses and institutions" (p. 96). This widening of the notion of discourse opens up a broader range of resources from which to gather data, some examples being memoirs, broadcast interviews, assessments, lecture notes, legal texts, journals, textbooks, and other artefacts describing practices and activities. In my study, I have looked for intersections where occupational therapy practices cross with clinical governance mechanisms, pinpointing crucial events within the discourses. In some cases, practices have been subject to power/resistance struggles, resulting in a change in practice.

Problematization and governance

At both population and individual level, problematization is an essential tool. In the context of my study, it enables me to question why the nationalised healthcare service, previously supported by the New Zealand government, is no longer acceptable in modern day healthcare at the population level. At the level of individual bodies, application of problematization, associated with the ethical practices of truth telling and care of the self, is essential when considering the implications of free choice of individuals to reflect upon their daily activities, and where ethically or morally found wanting, be able to resist the effects of power, enacted by others, on themselves. I recognised that delivery of healthcare by the state in New Zealand has become problematic at various moments in time and so problematization is valued as a tool to investigate what is happening. The State has enabled various practices to emerge, contingent to the conditions of the moment, in attempts to remedy the problems they had identified, such as how to rehabilitate soldiers after the Second World War by the introduction of OTs, or deliver safe and effective healthcare within a tight economic remit by the formation of clinical governance frameworks within DHBs. Problematization enables me to draw on the breadth of Foucault's thinking while also focussing on the every-day practices situated within the discourses and, importantly, through his ethical notion of 'care of the self' consider the implications of individuals' ethical responses and free choice of individuals to take up or resist the power enacted by others, in recognition that

they also hold and could wield power to affect the outcomes of local and sometimes national positions of truth.

Problematizing healthcare provision works with both archaeology and genealogy to generate the conditions that have enabled me to reveal how multiple discourses were at play, questioning the quality, safety and efficiency of early healthcare frameworks. Importantly, these tools also have revealed the prominent discourses, bringing them to the fore, that endorsed clinical governance frameworks as the current truth: 'better' than what had gone before.

Governmentality

I also look to the closely related Foucauldian notions of governmentality (Foucault, 2007a, 2008a), biopower, and biopolitics (Foucault, 1978). Here, he argues that bodies and populations are regulated through 'technologies of power' as a form of discipline[12]. Disciplinary mechanisms, such as surveillance, punishment, as well as reward, typically act in institutions such as hospitals, to produce desired behaviours that the dominant institutional discourses favour. In effect, disciplinary mechanisms create the 'doing'; they work in conjunction with these notions, explaining why and how particular behaviours can be produced by the effects of power. Alongside technologies of power are technologies of the self (Foucault, 1978), whereby individuals hold agency to self-regulate their behaviour, for example, through reflection and confession within the context of professional or clinical supervision.

First appearing in his lectures in 1978, Foucault uses the term 'government' to refer to all the ways that were devised and intended to control the behaviour (or conduct) of individuals and populations at every level of society. He defined government as "the set of institutions and practices by which people are 'led'.... It is a set of procedures, techniques and methods that guarantee the 'government' of people" (Foucault, 1991b, p. 176; Lemke, 2019, p. 244) through "the conduct of conduct" (Lemke, 2001a, p. 2). He argues that it is a relationship of power that "does not act directly or immediately on others; ...it acts upon their actions: an action upon an action, on possible or actual future or present actions" (Foucault, 1982d, p. 340). An example might be regulatory codes of conduct such as those published by DHBs (Auckland DHB, 2014, 2018; Waitematā DHB, 2014a).

Governmentality is the way we think collectively about governing and is "the emergence of a set of practices...occurring largely through the institution of the state...which mobilises populations through political economy...realised by the apparatus of security" (May, 2014a, pp. 175-176). It is set by authorities of delimitation who hold the power and knowledge to promote preferred discourses about what practices should be engaged in to achieve a certain goal. The practices extend from the government of the self through to the government of others (Lemke, 2001b).

[12] Technologies of power are described more fully in Chapter 3: Foucauldian methodology

Technologies of power are fundamental to Foucault's notion of "governmentality" (Foucault, 1988d, p. 19) and he describes two ways to exercise power: "biopolitics" (Foucault, 1978, p. 139) and "biopower" (1978, p. 140). They operate at different levels and can co-exist. However, it should be noted that both terms were only fleetingly referred to before Foucault moved onto considering the exercise of power by liberal and neoliberal governance, and so were never fully explained (Patton, 2016). The following is my understanding of these terms based upon my reading.

Biopolitics

Biopolitics looks to explain how political power is exercised through the state governance of *populations* rather than individuals and is concerned with security (Patton, 2016), accountability and the political economy (Dean, 2010). The government is focused on governing all people in the population, and so is concerned with the population's overall wealth, health, welfare and contentment from an economic lens, that is, "the government must be economical, both fiscally and in the use of power" (2010, p. 29). This type of governmentality is managed in two ways. Firstly, via the collection and collation of individual statistics that, together, produce information on populations as a whole, which a government can use to plan the governance of a society (Mendieta, 2014) through jurisdiction and law (Dean, 2010). Secondly, through the construction of spaces where groups are collectively managed by technologies of discipline, such as barracks, hospitals and prisons (Dean, 2010). Biopolitics features in my study because delivery of quality, value for money healthcare in New Zealand has been made visible as a government problem. The problem has produced a response by the government that involves devolved regulation of healthcare delivery through legislation, health strategies and reconstruction of hospital systems via the introduction of clinical governance frameworks. Practices of OTs are influenced by the effects of the disruption of health delivery in the DHBs, which are sometimes constraining, while also sometimes providing opportunities.

Biopower

Foucault uses the term "biopower" (1978, p. 140) to describe a technology of power where power is focused on the body. Two forms are described by Foucault: "anatamo-politics" (Foucault, 1978, p. 139), which is concerned with how individuals are governed by external mechanisms, "the action on the actions of others" (Patton, 2016, p. 113), the "body as a machine" (Foucault, 1978, p. 139) that is subjected to discipline. Secondly, 'techniques of the self', which are products of pastoral power and a means by which individuals govern *themselves* (Foucault, 1985). The regulation of populations was further explored in Foucault's genealogies, presented as a series of lectures between 1977-79 at the Collège de France and posthumously published as *Sécurité, territoire, population (Security, Territory, Population)* (Foucault, 2004c, 2007a) and *Naissance de la biopolitique (The birth of biopolitics)* (Foucault, 2004b, 2008a). Both are crucial to this study, since OTs are disciplined on a daily basis so that DHB approved behaviour is normalised,

and they engage in supervision, which is meant to be an opportunity for self-reflection of practice (or as Foucault might say: 'confession'). However, this supervision could easily be construed as surveillance if not conducted safely and confidentially.

Foucault's work is a good fit for the questions I wanted to ask, as he both addresses the relationship between knowledge and power (Morris & Patton, 1979), and his later lectures also tackle political power and the influence of neoliberalism in society (Zamora, 2014; Zamora & Behrent, 2016). Neoliberal ideas have made their way into the multiple discourses that have come together to produce DHB clinical governance frameworks, that promote economic prudency, efficiency, quality assurance and client-centred approaches. Since practices aligned with clinical governance are intended to be taken up by OTs, I will discuss neoliberalism as an art of government in the next section.

I have also become aware of practices that have been minimised or eliminated, including a reduction in 'thinking outside the box' due to economic and risk mitigation practices enforced by being required to follow approved guidelines. For me, two particular examples that I experienced as a clinician stand out. At one time, OTs were skilled in making custom splints and equipment for their clients. Post-2000, these practices have been minimised and ready-made splits and equipment are the standard solution. The second, albeit small, example of where an occupational therapy intervention has been eliminated due to cost containment (or more euphemistically: 'prudent use of resources'), is that after a total hip replacement, long-handled 'reachers' are no longer provided by the New Zealand health service. Instead, the client is provided with an information sheet showing where to purchase one privately. Both the 'off-the-shelf' intervention, and the shift in responsibility to self-supply equipment is a profound change in experience for occupational therapy clients.

Neoliberalism: An art of government

Neoliberalism is a way of thinking that relates to economics and free trade, but has been applied to health care in an effort to control the cost of provision of healthcare to defined populations, including New Zealand. Neoliberalism is attractive to many and various political stances because of the emphasis it puts on individuals being responsible for their own healthcare and making their own (informed) decisions (McGregor, 2001). Foucault (2008a) interprets neoliberalism as a particular art of governing human beings, a "general art of government" (p. 131), "a practice, a ...way of doing things, directed towards objectives and regulating itself by continuous reflection" (p. 318), aimed "towards the multiplicity and differentiation of enterprises" (p. 149). He argues that as an art of government, neoliberalism constructs humans in economic terms where a person "is an entrepreneur of himself, ...his own capital, ...his own producer, ...the source of [his] earnings" (p. 226). Furthermore, he suggests that the people in society who produce high incomes will enjoy the benefits of high human capital in the form of being able to pay for certain

advantages in society for themselves and their families, such as education, child care and health (pp. 244-245).

Neoliberal governance does not favour social practices that are intended solely to benefit the disadvantaged in society through social programmes providing health, education and cultural equity[13]. Instead, where programmes exist, they are scrutinised for their cost and effectiveness, "a permanent criticism of governmental policy" (Foucault, 2008a, p. 247). Lorenzini (2018) expands Foucault's definition, claiming neoliberalism to be a "particular art of governing human beings" (p. 154). She argues that neoliberalism can be understood in three ways. Firstly, it is a cluster of technologies of power that act within a social environment and produce certain kinds of behaviour and practices associated with neoliberal beliefs at both the population[14] and individual level. Secondly, it uses the practices of freedom and free choice to govern the behaviour of individuals and groups so that not only they personally engage in preferred neoliberal practices but are also involved in the governance of others, perpetuating the take up of neoliberal practices. Thirdly, it produces a specific type of governable neoliberal subject living in a social environment where "everything must be regulated and thus predictable" (May & McWhorter, 2016, p. 249).

As a consequence, neoliberal economic subjects are produced who favour behaviours that are based on the beliefs of individualism, a free market through deregulation and privatization, and decentralization (McGregor, 2001). How these beliefs have been actioned has varied throughout the world, at different times and depending upon the political stance of the groups attracted to what neoliberalism is thought to offer economically. Practices tend to focus on economic factors such as cost and risk as well as self-governance and reflection (Gutting & Oksala, 2018; Lemke, 2019). In this research, I have chosen to understand neoliberalism as Foucault describes it, an art of government that produces, amongst others, OTs who hold subject positions strongly influenced by neoliberal beliefs through discourse circulating within healthcare institutions and made visible by their practices in the DHBs.

Neoliberal thinking take-up into healthcare provision

From my reading of Foucault's *Birth of Biopolitics* (2008a) and Lorenzini's (2018) paper regarding his stance, I understand neoliberalism in this context as a kind of governmentality that has been incorporated into discourses associated with the construction of clinical governance. Clinical governance has been heavily influenced by discourses from neoliberal thinking (Fisher,

[13] The word 'equity' denotes 'fairness' or 'justice', for example in the way individuals or a section of the population are treated or have access to needed economic, social or health resources. This contrasts with 'equality: being provided with 'the same amount' of something, like medicine, health care or opportunity, without considering existing needs. More recent discourses foreground equity, since it takes into account this aspect of social justice.
[14] Foucault named the discipline of populations 'biopolitics', an example being population health, and the disciplining of individuals through what he called, 'biopower.' Biopower takes two forms, anatamo-politics, those external techniques of discipline administered by (e.g.) DHBs, such as policies and procedures, to produce DHB preferred subject positions and secondly, 'techniques of the self' again promoted by both DHBs and professional boards as a method of internal self- regulation through reflection and confession, that occurs during supervision.

2007), as neoliberalism became increasingly popular as a mechanism to cope with financial and economic failures in the business world[15] (Carroll, 2012), by introducing prominent discourses favouring practices associated with deregulation of government control through privatisation and free trade.

In social care, the onus of Western governments shifted from the provision and funding of a wide variety of social and health initiatives to a position that limited government involvement in social and health care. By investing in neoliberal thinking, governments could validate the construction of healthcare provision discourses that favour the need for individuals to take up responsibility for their own social and health management, rather than depend upon the government to care for them. DHBs' fixed budgets and annual plans which cap expenditure on healthcare provision and resources is therefore a justified practice within neoliberal governmentality. It is supported by discourses favouring individual responsibility and business-like healthcare delivery practices that demonstrate efficiency and fiscal prudency through careful management of public money and resources.

Immersion in Foucauldian discourse analysis literature

I conducted multiple readings of Foucault's published work alongside secondary literature by other authors as a way of consolidating my understanding, knowledge and application of Foucault's method and methodology. Deep reading of Foucauldian literature "provides equipment for certain practices of critical inquiry" (Koopman, 2013, p. 9). I therefore felt confident that my decision to use problematization and other Foucauldian tools such governmentality, biopower, technologies of power and of the self, as well as management of populations, would provide a pathway for my research.

Foucault (1994) himself says that his tools can be used by researchers *"...avec lequel ils pourtaient faire ce que bon leur semble, dans leur domaine"*: "however they wish in their [own] area" (p. 523), and when he talks of his own analysis of power, he says, "the analysis simply involves investigating where and how, between whom, between what points, according to what processes, and with what effects, power is applied" (Foucault, 2007a, p. 2). So I understood Foucault to be suggesting that, as he had the freedom to develop his research methods, he gave his blessing to researchers (such as myself) to freely utilise and modify his tools as required to investigate, evolve and develop a bespoke form of analysis suitable for the question at hand while working through the stages of research.

[15] This came about as a flow-on effect of the massive increase in the price of oil in 1973, as well as a long period of weak economic growth, resulting in major manufacturing structural changes and economic reforms impacting government policy and spending.

Foucault argues that it is the practices that tell us about the knowledge surrounding a subject; what is done; how it is done; what makes it real. Using 'madness' as an example, Bacchi (2012), comments:

> We are talking about how madness is 'thought', 'conceptualized', 'problematized', as demonstrated how the 'mad' are dealt with as a specific phenomenon. In this way attention is directed to the mechanisms involved in collecting together things, actions, gestures, behaviours, words that are to make up 'madness' as 'the real'. (p. 3)

Taking up these assertions, I focussed on gathering texts that addressed the remediation of unsafe, expensive and inefficient clinical practices. Clinical governance frameworks constructed from multiple safety and quality healthcare discourses were preferred as a solution to improved, safe, healthcare delivery via changes in clinician healthcare practices, including OTs.

Additionally, Foucault used what he called "prescriptive or programmatic texts", that laid down the rules and provided expert opinions and advice on how things should happen and how people should behave in certain circumstances. The texts he used included archives, decrees, regulations, registers, judicial precedents, autobiographies, diaries, institutional processes and similar documents that could build up knowledge of "regular daily practice" (Eribon, 1991, p. 215). Therefore, I searched for documents that would provide glimpses of daily practices in the moments chosen for my study.

A corpus of statements

One way to approach data gathering is to select a 'corpus of statements' (Arribas-Ayllon & Walkerdine, 2008) that cohere around a particular meaning and are relevant to the research being carried out. Foucault (1972) defines statements as "enunciative function[s] ...sometimes made up of fragments of sentences, series or tables of signs, a set of propositions or equivalent formulations" (p. 119). Statements constitute discourse and can be analysed with Foucault's archaeological tools (Lynch, 2014) by describing the discursive conditions, or position, from which they appear and are uttered. Statements must be both material and repeatable.

All kinds of text may be used in the construction of a 'corpus of statements', but they must be in context and have a connection to the question being asked. I ensured that the texts I collected had the capacity to provide knowledge about how objects and subjects were spoken about in the past as well as having some context in the present. I was careful to include documents that represented diverse practices so that discontinuities were made visible both over time and space. My approach was guided by Arribas-Ayllon and Walkerdine (2008) who suggested several kinds of text they think suitable for Foucauldian discourse analysis including ethnographic texts (field notes); political discourse (policy, debates, reports); expert discourse (specialist consults for advice on sourcing documents); journal articles; research findings; social interactions involving

conversation, interviews, speech and talking; and finally, autobiography and narratives, which can capture practices over time.

Summary

In this chapter I have presented the reasons why I selected Foucauldian discourse analysis as the underpinning methodology and method for this study. I also introduced Michel Foucault as philosopher-historian, and Foucauldian discourse analysis, before turning to Foucault's toolbox to describe the main methodological choices that I have selected for use within the study.

Since Foucault was clear that he continuously experimented, changing thinking and ideas, then as a Foucauldian researcher, I have been allowed the flexibility and freedom to experiment with Foucault's tools in a quest to identify those most appropriate to my own research needs. After extensive reading, I selected tools from all three moments in Foucault's opus to study the effects of power/knowledge on the construction of OTs' subject positions. Archaeology provided me with methodological tools to describe the underlying structures and the process by which constructs such as truth, objects and subjects are produced and made real. Genealogy enabled a study of cause and change through consideration of what is done to bodies to change behaviour. However, it was problematization that became a predominant feature in this research. Through problematization, I was able to examine how certain human experiences become a problem at particular times in history and how these problems are managed by society.

I next introduced governmentality (and its close cousins, biopolitics and biopower) and neoliberal thinking as an art of government, both of which permeate this thesis. Finally, I returned to Foucault and immersion in his published work and various commentaries to consolidate my understanding and verify my decision to use document analysis as my method. In the next chapter, I focus on the discourse analysis methodology attributed to Michel Foucault.

Chapter 3 Foucauldian methodology

> All my books… are, if you will, little toolboxes. If people are willing to open them and use a sentence, an idea [or] a study, as a screwdriver or spanner to short-circuit, discredit or break systems of power, including perhaps the very ones that my books come from... well, that's good!
>
> *– Michel Foucault, Le Monde Interview*

Introduction

In this chapter, I position Foucault as a *post*-structuralist, and in fact an epistemologist (Alcoff, 1993, 2013). As a Foucauldian researcher, I am especially interested in understanding the formation of knowledge, which is not only discursively produced, but specific to a time and place within society. More particularly I examine how 'preferred knowledge' has been produced, and the influence of knowledge formation on individual subject positions such as those held by OTs, resulting in changes to their routine daily practices and delivery of care to their patients. Here, I look at 'my' Foucauldian toolbox as a methodology, and I begin to assemble my tools from the toolbox. I also position Foucault within a classification structure for this thesis using Crotty's (1998) research process categories, where I look at the epistemology, theoretical perspective and methodology within which this study is situated, and some of the tools associated with them. Foucault's work on technologies of discipline, although most closely related to genealogy, is extensive enough for me to examine it separately, after which I address ethical care of the self.

My Foucauldian toolbox

Foucault's concepts of archaeology, genealogy and problematization, previously described in Chapter 2, loosely correspond to three consecutive periods of his thinking. He builds his theory systematically: one upon the other, but his terminology throughout is fluid, expanding, changing and sometimes dropped, as he moves forward with his emerging philosophy. Foucault's methodology produced concepts unique to his thinking, that, in effect, constitute his method of analysis. By developing his own methodology and method, he was able to place subjects within a period in history and, by plotting a 'genealogical' map, study the power relations that created particular behaviours in a defined time and place. Through comparison of moments he was able to reveal how the present was different from the past and yet, how the past contingently constituted the present, i.e. "a history of the present" (Foucault, 1988b, p. xxiv (Introduction)). Thus genealogy is a history of the present, looking at different historical moments, stems from the method of archaeology; and problematization then becomes a history of a problem, rather than periods in history. His methodology provides tools to identify and trace the historical role of certain dominant ideas produced and enacted at specific moments in history.

Featuring prominently throughout Foucault's work is the concept of 'discourse', which, in addition to the definitions in Chapter 2, in an historical context he uses to mean "the material

verbal traces left by history" (O'Farrell, 2005a, p. 133), a certain "way of speaking" (Foucault, 1972, p. 213). My question is concerned with how discourse has constructed the practices[16] associated with the concept of clinical governance and how these practices have been enacted and have actively shaped the behaviour of OTs working in DHBs. Through comparison of discourses and practices produced within different moments, I seek to reveal the mechanisms at play that have produced the practices and conduct of OTs aligned with, and required by, present societal, economic and political demands in New Zealand.

Foucault's 'toolbox' referred to his philosophical thoughts, ideas, and research processes, which he freely offered to readers, suggesting that they find their own way to use and adapt to their own research. The Foucauldian tools that proved useful in this study include archaeology, genealogy, power/knowledge, biopower, governmentality, discourse and subject positions. Other related concepts have also been considered where relevant, such as anatamo-politics, biopolitics, technologies of discipline and technologies of the self. Two notions that focus predominantly throughout Foucault's corpus of work are the production of truth and the formation of the subject/self, both of which feature prominently in my research.

I make use of Foucault's message that societal behaviour is contingent on both the discursive construction of the 'preferred truth' and the individual's or population's response to this version of truth, relative to particular moments of history. Societal behaviour can change as a response to the autonomy of an individual[17] to resist societal rules and regulations (Schwann & Shapiro, 2011). Foucault asserts that individuals are turned into 'subjects' through the action of power relations, and, more specifically, what they do to themselves, through use of technologies of the self, which may involve confession, supervision, reflection and how they will behave under certain defined conditions (Foucault, 1982b).

The research process: Positioning Foucault

I have classified Foucault's work and the resulting methodological process using the summary presented in Table 1. For this study, I take the stance that reality is socially constructed, transmitted by language that produces named objects in the world. I also accept that there is no one truth, but multiple interpretations of what is the truth, and that power is inextricably associated with what is considered the dominant truth within a moment. I acknowledge Foucault's argument that power is productive, a prominent idea which underpins Foucauldian discourse analysis.

[16]Practices: The application and/or use of an idea
[17] A single human being, a person

Table 1. Research process as applied to this study (Crotty, 1998)

Epistemology	Theoretical perspective	Methodology	Method
Constructionism	Post-structuralism	Foucauldian discourse analysis	Document analysis

Each of the sub-branches of the research headings are expanded in the following sections: Constructionism as an epistemology, Post-structuralism as the theoretical perspective and Foucauldian discourse analysis by way of methodology. The Foucauldian ideas of discipline and surveillance are arguably extensions of Foucault's genealogy, but they are a sufficiently important topic to merit their own separate discussion.

Epistemology: Constructionism

Although Foucault is considered a philosopher-historian, philosophy as study of the fundamental nature of knowledge, reality, and existence, and the basis and limits of human understanding (Butler-Bowdon, 2013, p. 1; Oxford English Dictionary, 1989) is too broad a measure. Foucault's 'philosophy' is often used to produce frameworks to see and understand knowledge, and in this sense, he could be considered an epistemologist, using such thinking to explore and expose the ideas or "truths" underlying the processes and workings of organizations within contemporary culture. In doing so, he initiated an ongoing discussion about the character and relationship of knowledge and power (Gutting, 2003).

Here, we are concerned with the social construction of reality: people within a group or society construct their own reality through take-up of certain knowledge that becomes their accepted truth, and produces their understanding of the reality of the world around them (Berger & Luckmann, 1966). Of particular note is that humans produce society itself through discourse and related practices.

Rejecting structuralism

Structuralists focus on the relationships between the parts and with the whole. Thus, they see everything as inter-related, where the structures and order within systems do not change, and words and ideas have no independent meaning; it is only the relationship between them that gives them meaning (Gutting, 2001). Like the Swiss linguist Ferdinand de Saussure (1857-1913), who preceded them by almost fifty years (Mambrol, 2016), structuralists argue that language represents things and concepts through the recognition of similarity and difference, by comparison of one thing to another. The anthropologist Claude Lévi-Strauss (1908-2009), who coined the term "structuralism", maintained that human thought and behaviour was the result of unconscious structures producing truth within culture and society (Gutting, 2001).

Foucauldian commentators often assert that his writing contains structuralist underpinnings (Mills, 2003; O'Farrell, 1989; Oksala, 2012; Olssen, 2003; Palmer, 1997; Smart, 1983), yet Foucault himself both resisted and rejected attempts to place his work within specific philosophical categories (Gutting, 2001; Kelly, 2014)[18]. He also indicated that he had trouble with post-modernism, saying that he did not understand what is meant by "modernity" in France (Foucault, 1998b, p. 448). Perhaps his most famous response is the defining, but enigmatic:

> Do not ask me who I am and do not ask me to remain the same. Leave it to our bureaucrats and our police to see that our papers are in order. At least spare us their morality when we write. (Foucault, 1972, p. 19)

Theoretical perspective: Poststructuralism

Although Foucault did not align himself to any particular philosophical approach, academic consensus prominently associates him with *post*-structuralism. (Mills, 2003; Oksala, 2011; Olssen, 2003; Palmer, 1997). Poststructuralism shares some concepts with structuralism, but it is also sufficiently different to set it apart.

Poststructuralism is a slippery construct; it changes and means different things when applied to different bodies of work. Loosely, it can be described as a movement that has different meanings associated with certain moments over time and also takes on different connotations depending upon whose work is being considered (Peters, 1999). Generally, it may be considered 'a theory of knowledge and language' (Agger, 1991, p. 112), where language is considered central to the construction of human society and subjectivities through the production of competing economic, social and political discursive practices (Weedon, 1997). Societal knowledge, therefore, is generated from discursive practices, constituting a plurality of versions of what is real and true. Knowledge formation is fluid, subject to challenge and change and is understood from multiple subject positions in the context of its history and cultural circumstances.

Post-structural analysis is concerned with the use of language to construct objects such as texts, which, when studied, become a means of understanding the way reality is constructed within society (Cheek, 2000). The original meaning situated within texts becomes inconsequential (Butler-Bowdon, 2013) because post-structuralists claim that the text ceases to belong to the original writer, i.e. it becomes 'destabilized' (Palmer, 1997). The reader is therefore freed to deconstruct the text and make multiple interpretations that may result in conflicts, shifts and discontinuities of meaning. Language is used to represent ideas, producing systems of knowledge

[18] Clearly exasperated, he wrote in the foreword to the English edition of *The order of things*, "'commentators' persist in labelling me a structuralist. I have been unable to get it into their tiny minds that I have used none of the methods, concepts, or key terms that characterize structural analysis" Foucault, M. (1970). *The order of things: An archaelogy of the human sciences*. Vintage Books. , and further emphasised his disdain for labels in a later interview: "I have never been a Freudian, I have never been a Marxist and I have never been a structuralist"

that can be set up to claim that some knowledge is the 'absolute truth' (Butler-Bowdon, 2013; Mann, 1994; Stevenson, 2014).

Pluralism

Poststructuralists argue that there are no absolute truths in the world, but multiple, or "plural" interpretations of what is true and what is understood as real; therefore, what is 'normal' can be questioned, and 'truths' can be challenged (Cheek, 2000). Cheek maintains that there is a need to have access to 'plural' explanations for what is understood as real in order to recognize, include and analyse what otherwise may be 'silences' in the data. By identifying what is missing, as well as that which is present, voices that are traditionally left out of a discourse have an opportunity to be heard. The result is that the dominant discourses constructing the 'normal' can be questioned, providing an opening for current 'truths' to be challenged (Cheek, 2000).

Truth: Regimes, games, power

Foucault believed that truth was a constructed concept and relative to the beliefs of specific time periods. Rather than define truth (O'Farrell, 2005b; Weir, 2008) Foucault has an extensive oeuvre that focusses on how it is produced in the world, describing "truth" as:

> A system of ordered procedures for the production, regulation, distribution, circulation and functioning of statements…linked…by a circular relation to systems of power which produce it and sustain it, and to effects of power which it induces and which redirect it. A regime of truth. (Foucault, 1976b, p. 14)

A statement is "an action through speech" (Mills, 2003, p. 65), and statements are controlled by power relations: not everyone or every institution is able to make statements. As such, some statements will be more powerful than others. For Foucault, a regime of truth is relative to the society in which it is produced, because circulating discourses define what is true and what is not, specific to place and time. He also argued that the rules associated with the construction and use of preferred truths in each society's "regime of truth" (Foucault, 1976b, p. 13) can change in response to the relationships these truths have with science, politics, economics and social issues (O'Farrell, 2005b) calling them the "general politics of truth":

> Truth is a thing of this world: it is produced only by virtue of multiple forms of constraint. And it induces regular effects of power. Each society has its regime of truth, its "general politics" of truth: that is, the types of discourse which it accepts and makes function as true; the mechanisms and instances which enable one to distinguish true and false statements, the means by which each is sanctioned; the techniques and procedures accorded value in the acquisition of truth; the status of those who are charged with saying what counts as true. (Foucault, 1980a, p. 131)

In *The history of sexuality, Volume 2*, he reflects that the overall goal of his work has been to produce "a history of truth" (Deere, 2014; Foucault, 1985, p. 11), and considers truth to be an

"event", an "experience"[19] , that is actively produced, rather than a pre-existing notion that is found (O'Farrell, 2005b). Foucault further states that he is not interested in telling the truth, but that truth should be understood as dynamic experiences that people engage in themselves (2005b), therefore, his tools were designed to examine truth from the perspective of "practices and outcomes" (Weir, 2008, p. 370).

Importantly, Foucault (1997) argues that truth[20] is produced through the interaction of specific rules, procedures and constraints, that consist of both true and false discourses and practices (Deere, 2014), a process he calls "games of truth" (Foucault, 1997, p. 296). Such games of truth exist within regimes of truth (Lorenzini, 2015) and are linked with power relationships through "practices of control" (Foucault, 1997, p. 281) that act to place particular limits on behaviour with the aim to generate particular desired behaviour as an end result[21]. The outcomes produced by games of truth may be considered successful or unsuccessful and may or may not be taken up (1997, p. 297), implying a freedom of choice in the selection of truth and the formation of subjectivity. Foucault suggests that games of truth are linked with ethical behaviour, the care of the self, the care of others, and that we do not have to accept institutional regimes of truth and we do not have to take up preferred institutional truths into our subjectivities (Lorenzini, 2015); we have freedom of choice (Foucault, 1997). There may, of course, be implications attached to behaving in an alternative way through not accepting and acting on preferred truths, i.e. resisting, whereby the individual is punished.

Before the products of games of truth are enacted, the credibility of the subject to speak the truth should be examined. Therefore, 'who' is speaking, how they are speaking and why they speaking (Foucault, 1997, pp. 296-297) is crucial. As an example in the context of this thesis, the speaker may be a group or an individual (such as managers) representing a consensus of opinion (e.g. occupational therapy practices must done a certain way because they are more efficient and cost effective) emanating from a network of power (managers, leaders, clinicians) within a constraining institution (such as hospital). If credibility is recognised through the circulation of power relationships, then the "truth" being put forward may be taken up. It is important to recognise that there are many "truths" circulating at the same time and not all will be considered credible.

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[19] An 'experience' can be understood as the result of "fields of knowledge, types of normativity and forms of subjectivity" forming a connection with each other within a specific culture at a particular moment. Foucault, M. (1985). *The use of pleasure: Volume 2 of the history of sexuality* (R. Hurley, Trans.). Vintage Books. (p. 4).

[20] Foucault also discusses "truth" alongside the production of scientific discourse and knowledge at particular historical moments in the context of epistemes in "The order of things"

[21] Although Foucault more commonly refers to games of truth as constructions, he acknowledges that in certain situations, games of truth can also be descriptions, such as "an anthropological description of a society" Foucault, M. (1997). The ethics of the concern of the self as a practice of freedom (P. Aranov & D. McGrawth, Trans.). In P. Rabinow (Ed.), *Michel Foucault. Ethics, subjectivity and truth. Essential works of Foucault 1954-1984. Volume one* (pp. 281-301). Penguin Books. (p.297). However, in this instance, I am interested in games of truth as a construction and the relationship between rules and power relations.

A historical analysis of truth, through study of practices and their outcomes, is instrumental to understanding the construction of truth (Weir, 2008). Change occurring over time is unexpected, unintended, haphazard, discontinuous, or with breaks and can be contradictory (Gutting, 1989; McNay, 1994). Foucauldian history does not assume there has been a linear progression, but as Nietzsche postulates, history emerges "from chance" or "by chance" (Foucault, 1984c, p. 78; McNay, 1994, p. 89). For Foucault, it is contingent upon events surfacing from social, economic and political problems at particular moments. He demonstrates how the prominent knowledge of a moment is constructed as 'the truth' through relationships of power, discourse and the 'games of truth' that are played out within societal institutions, producing subjects who behave in particular ways under certain conditions.

Foucault's understanding of the production of truth has been essential to my research, since his inquiry into the history of truth has produced 'Foucauldian' tools associated with the construction of distinct moments of his thinking. I have attempted to reveal how OTs construct their subjective truths from the games of truth played within both the professional and institutional arenas that provide the spaces in which they, as subjects, exist. The truths OTs have taken up have created particular subject positions, contingently shaping their behaviour and practices at certain moments in time. This is essential Foucault: the constant throughout his work is finding ways to understand and demonstrate how the selective construction of preferred knowledge (truths) in a society, along with the action and effects of particular disciplinary experiences, act collectively and individually to produce subjects who engage in acceptable societal behaviours appropriate for particular moments in time.

Productive power and power relations

When Foucault discusses power, he emphasises that power should not be understood purely in a negative sense, "Power is not evil. Power is games of strategy" (Foucault, 1997, p. 298). He argues that, "power…exerts a positive influence on life, that endeavours to administer, optimize, and multiply it, subjecting it to precise controls and comprehensive regulations" (Foucault, 1978, p. 137). Although he acknowledges that power does constrain behaviour, on the other hand, it is crucial to recognise the positive outcomes associated with the use of power, "power produces, …reality …domains of objects and rituals of truth. The individual and the knowledge that may be gained from him belong to this production" (Foucault, 1977a, p. 194).

The body is both productive through all kinds of activity yet 'docile'[22], subjected to often invisible, fragmented, micro-forces that work on a body both internally and externally that make the body behave in a certain way. The body has a subjectivity that is endowed (empowered) by power relations. Foucault (1978) insists that "power is everywhere" through the play of multiple

[22] "A body is docile that may be subjected, used, transformed and improved". Foucault, M. (1977a). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). Penguin Books. (p. 136)

productive relationships. It arises from the "very depths of the social body" (p. 94). Importantly, power relations "are both intentional and non-subjective...they are imbued through and through with calculation: there is no power that is exercised without a series of aims and objectives" (pp. 94-95). When conducting an analysis of texts, this point of Foucault's is essential to keep in mind. He indicates that the power conveyed within the relationships producing practices is often local, yet anonymous. For instance, the DHB service plan documents I analysed were produced by unnamed authors who are in relationships of power with 'others' producing DHB strategic plans. Service plans carry the discourses within the strategic plans which are interpreted and further produced as plans and practices for frontline clinical service providers, the practitioners, to carry out. Of course, Foucault also maintains that "where there is power, there is resistance" (p. 95), so it does not automatically mean that the practitioners will agree to and carry out the plans and practices.

Methodology: Foucauldian discourse analysis

In this section, I describe the dominant terminology associated with Foucauldian discourse analysis, especially the ideas which produce discourses, and the relationship of archaeology and genealogy to discourses, and discourse formation. I also examine what happened when Foucault reached the limit of what he could do with archaeology, which gave rise to the allied 'tool' of genealogy.

Discourses

Discourse is central to both Foucauldian methodology and Foucauldian discourse analysis. Multiple discourses circulate preferred truths and knowledge within organisations and society. They are integral to both archaeology and genealogy, the formation of objects, subjects, the soul, subjectivities and subject positions. They therefore play a prominent role in my analysis. By being contingent on specific events and circumstances that play out within a prescribed place and time, discourses emerge from social, economic and political discursive fields[23] (Weedon, 1997) relative to that particular moment in space and time. While multiple discourses are at play in any one moment, circulating through networks of power, it is the dominant discourses that are highly influential in the construction and emergence of social, economic and political policy and legislation.

The will to truth

Dominant discourses act as a conduit for transporting the knowledge and truth of a moment that produce certain beliefs and practices. As such, discourses create the conditions for the production

[23] Foucault examined "how" discourses are constructed through the application of his method of genealogy. This deals with a random "field of objects" to be discovered and encountered, focusing on uncovering discursive and non-discursive practices as a series of events, "the discursive field" Penalver, P. (1994). Archaeology, history, deconstruction: Foucault's thought and the philosophical experience. In R. Miguel-Alfonso & S. Caporale-Bizzini (Eds.), *Postmodern studies. Reconstructing Foucault: Essays in the wake of the 80's* (Vol. 10). Rodopi. .

of behaviour change in society within a particular moment. Discourses provide the means to the "will to truth" (Foucault, 1981, p. 54), which necessarily encompasses the intention to exclude or constrain. Foucault goes on to say:

> This will to truth is, in its very general form, the type of division which governs our will to know (notre volonté de savoir), then what we see taking shape is perhaps something like a *system of exclusion* [emphasis added], a historical modifiable, and institutionally constraining system...[It] rests on an institutional support: it is both reinforced and renewed by whole strata of practices... books, publishing, libraries, learned societies in the past and laboratories now. (pp. 54-55)

Discourses are also used to justify what an organisation does, and so are an integral part of governance. Institutions, where discourses circulate, set up the conditions for behaviour change through the use of disciplinary mechanisms, such as procedures, rules, uniforms and drills (Foucault, 1977a). While the knowledge and reasoning behind what people do is produced by discourse, it is their practices that make visible what they understand as true. What people do, their practices, therefore, in these institutions, is contingent on the preferred 'truth' discourses becoming dominant. In institutions such as hospitals, discourses create hierarchies, rules and procedures that result in particular games of truth, behaviours, and outcomes. They define the selection of specific research methods that will uphold the organisation's perspective, *and act to exclude other research that does not*. It is an insidious, reiterative process that normalises particular behaviours on the bodies and subjectivities of targeted beings (such as OTs). In the case of OTs, the outcomes of their conduct have implications for their patients/clients in what healthcare interventions can be delivered and received.

As indicated in the data gathered for this research, Foucault's toolbox has created possibilities to delve deeply into the discourses and subject positions held by OTs exposed to the rigors of clinical governance. The data sheds light on how the profession has responded to the application of this form of governance.

Power is transported and deployed through the fluidity of discourses, therefore the tracking of a discourse should be free of restrictions and limitations. Foucault understood discourses as affecting multiple strands of a phenomenon, enabling visualization, understanding and transparency of how power is spread through "dispersed events" (Foucault, 1972, p. 24) in an organisation and how power manifests at local levels. Placing great importance on power linkage, he called it a "capillary form of power" (Foucault, 1980a, p. 39), "a micro-physics of power" (Foucault, 1977a, p. 26).

Foucault suggested that the often deeply hidden reasons why a phenomenon that has developed can be revealed, aiding the understanding of how local, tiny disruptive forces influence change at a national level. He argued that by mapping these links, the intentional, yet non-subjective, power

relations at play are made visible. Foucault looked for "patterns of order", not interpretation, arguing that texts must be figuratively laid out flat for review – the patterns made clear as a map. He also stressed the importance of making "connections" (Foucault, 1980a, p. 38), which could be very small, but which created "shifts and displacements" (p. 39) that would ultimately result in changes in the structure and power mechanisms of the phenomenon. Sometimes there would be elimination, other times only modification of a situation. Foucault argued that what was important was the mundane detail that this system of linking provided. It also had an important function in understanding how tiny disruptive forces influenced change, because the transition was not generally smooth. Rather, changes were a reaction to what had gone before, and were sometimes challenging, sometimes filling in gaps, sometimes being more inclusive. Mapping these links also helped to see what was known at the beginning, what worked and was seen as useful, what failed and whether the phenomenon took on a new form or faded away.

By examination of multiple documents from different moments in time, I was able to track tiny disruptions that when considered together within a Moment, and then compared with other Moments, provided evidence of change. For example, my analysis revealed how patients were selected to receive occupational therapy: Post-war, where biomedical discourses favoured reablement of hospitalised patients, those people referred to occupational therapy were automatically assessed and treated by a therapist using an array of treatment modalities. The question of whether or not they should be treated never arose, and duty of care could range over several months. In Moment 1, economic discourses favouring economic prudency and limiting interventions on the basis of need were influencing the practices of OTs and constraining the treatments they could provide to patients, reducing duty of care. By Moment 2, economic discourses favoured further restriction and, in some practice areas, decision-making was removed from individual OTs through the introduction of algorithms and vetting systems that excluded certain patients from receiving OT services if they did not meet certain criteria, ending duty of care. Long periods of treatment in hospital had faded way, now replaced by short interventions or nothing at all, thus ending duty of care and minimising cost to the DHB.

Objects and subjects

Objects are a product of discourse[24] (Foucault, 1972); they are entities that appear to be unconscious and passive, and do not act on other things. Although Foucault did not differentiate between material and discursive objects (Foucault, 1972), it can be useful to discriminate between the two when discussing objects applied to particular situations.

[24] Rules of formation of objects (Foucault, M. (1972). *The archaeology of knowledge* (A. Sheridan Smith, Trans.). Routledge. pp.44-54): Arising from a surface of emergence (where an object first arises, such as family, work, society); enabled to come into being by authorities of delimitation (those who have the power to produce the object); through grids of specification (the systems through which the object was described, separated and analysed). Exists within a complex set of relations at varying levels and is placed at the 'limit of discourse', neither within or outside the discourse itself.

Both discursive and material objects are formed within discursive formations, which can be recognised groups, professions or scientific disciplines. Material objects are things that are concrete and can be understood through the senses (Kooji, 2014). They can be seen, touched, smelt, heard or tasted. Examples from occupational therapy related material objects would be tape measures, wheelchairs, craft materials and assessment kits. Discursive objects are abstract and intangible and are better understood as concepts, ideas and models (Kooji, 2014). Examples of discursive objects used by OTs are instructions on how to do or make something, assessment protocols and theoretical practice models.

Objects are categorised to align with particular practices and emerge in specific time periods as conditions change (Foucault, 1972). For instance, objects emerging from the practice of occupational therapy in and after the Second World War include craft equipment and a programme of graded activities, while contemporary occupational therapy practices would be entering data into an online occupational therapy report with standardised headings to report occupational dysfunction or apply for the provision of adaptive equipment through the completion of an on-line form (virtual objects). So, objects can signal changes in practice because they are related to particular time periods. They are contingent on the rules that govern what practitioners are able to do with, and provide for, their clients within an occupational therapy scope of practice and DHB remit, and within a moment.

Foucault describes two types of subject: there is the subject who is controlled by and dependent on an exterior entity and then there is the subject who knows itself and is controlled by its own ethical beliefs and conscience (Foucault, 1982b, p. 212; May, 2014b, pp. 496-501). Therefore, subjects can be produced from two technologies. The first are the technologies of power, where subjects are constructed by the impact of disciplinary power and bio-power through practices imposed by authorities such as a sovereign or an institution, or in the case of bio-power, the state, producing bodies and populations who behave in a particular way (Arribas-Ayllon & Walkerdine, 2008; Taylor, 2010). The second are technologies of the self: subjects are constructed by what individuals do to themselves in the context of ethical ‘care of the self’ practices in order to transform themselves (Foucault, 1988d). Subjects are self-aware and able to decide for themselves how they will behave (O’Farrell, 2005b).

In my study, subjects include OTs. Subjects are conscious and have agency and are capable of producing subjectivities that affect their own behaviour. They are able to actively experience and encounter the world through engaging in activities such as reasoning, reflecting, thinking and feeling. Because of these dynamic qualities, subjects are able to produce subjectivities as the result of selecting and taking up discourses circulating in their environment. The discourses act to produce behaviour change. Subjects and subjectivities can only be produced by the effects of

power emanating from agencies such as those found in society, government, economics, religion and culture.

Objectivising of the subject

In his later work, Foucault considered how subjects may be objectivised. He calls this phenomena "dividing practices" (Foucault, 1982b, p. 208). He explained that subjects are divided into categories that represent the constructed, named, societal behaviour they exhibit, "the mad and the sane, the sick and the healthy, the criminals and the 'good boys'" (p. 208). In this way, they become objectivised. Through the application of power relationships, humans are grouped and labelled as types of objects. For instance, 'girls', 'carers', 'occupational therapists', 'patients'. Hence there would be an awareness of behaviours that could be named as 'normal' and 'not normal' as well as the promotion of behaviours that 'are wanted' and the discouragement of those 'not wanted'. This gathering and analysis of knowledge then, is productive, leading to the development, practice and normalisation of desired behaviours and ways of doing in society.

Then, the individual 'docile bodies' within these groups of objects are directly subjected to power mechanisms through techniques of discipline and Panopticon surveillance. Through engagement in normalised, everyday practices, these docile bodies become self-aware, productive human individuals, who are now not only objects, but also subjects, created as a result of being both the conduits and effects of power (Armstrong, 2019). As subjects are created in this way, it sets the conditions so that individual subjects categorised into groups within a society share common subjectivities. They share common knowledge and common rules of behaviour. They take up particular subjectivities and subject positions.

Subjectivities and subject positions

Discourses bring to prominence multiple truths and knowledge from which subjectivities and subject positions are produced. Discourses and subjects are interconnected; they make each other thinkable. Because of this close relationship, discourses can be replicated until such a time when they intersect with more powerful discourses. When discourses cross, they may be changed, relegated to the background or eliminated altogether. Foucault (1982b) maintains that subjects must be free to consciously choose what knowledge and truth they take up from discourse. Subject positions enable "people [to] make sense of who they are by locating themselves within culturally circulating discourses and narratives" (Guilfoyle, 2016, p. 123). The construction of subject positions produces particular behavioural responses. Subjects freely take up subject positions from multiple discourses, which shape the individual characteristics of their own 'self' as well as the way they carry out their roles in society. In this study, OTs are the primary subjects of interest; they are constructed as a product of the biomedical discourse. They have been named and categorised as professionals who are involved in reablement. They hold professional subject positions that are based on beliefs that participation in occupations, or 'doing', promotes healing.

As individuals, there are multiple discourses that OTs may also take up into their subjectivities, including the discourses circulating in DHBs favouring clinical governance behaviours that may enhance, replace or conflict with their professional beliefs and behaviours.

As subjectivities are also the ways we know ourselves and what we do, my own subjectification informs me of some of the subject positions I take: I am Yasmin, a middle-aged European female, an occupational therapist and researcher who provides supervision to other OTs and does work as an auditor for a regulatory board. Knowing myself and my subject positions is an important part of the reflexive research process, because I need to be aware of any bias or belief that may impact my interpretation of the findings, particularly as my study is focussed on identifying and naming the subject positions and subjectivities that make up every day practice for OTs.

The self and the soul

The internal self, or 'soul' of a person is itself a discursive construction. The self is shaped by external, historical and societal circumstances and is "born rather out of methods of punishment, supervision and constraint" (Foucault, 1977a, p. 29). This infers that a person's 'self' or 'soul', is therefore not an innate, unknown phenomenon. The soul becomes knowable and thus the behaviours and conduct of a person - a 'body', arising from the action of a body's 'soul', can be categorized, described and named, the result of subjection (1977a). This then enables the society to ask the question, 'Why did the person do that?'. This simple action of being able to question behaviour opens it up to interrogation, as if it were a scientific analysis. The behaviour can then be dissected and compared with the behavioural norms of the particular period of time in which the action happened, thus creating a body of knowledge specifically suitable for controlling behaviour during that moment in time.

Discourses within archaeology

Archaeology acts as a framework with which to conduct Foucauldian discourse analysis, and is described in Chapter 4, which looks at the method I used in detail. In this section, I outline the formation of discourses and the underlying conditions, the application to archaeology, and the extent to which archaeology can be useful.

The rules of formation

As discursive formations are "a group of statements that belong to a single system of formation" (Foucault, 1972, p. 121), Foucault argues that there are certain rules associated with the construction of "*discursive formations*". These rules occur when attributes such as order, functioning or correlation can be discerned between such elements as "objects, mode of statement, concepts, thematic choices" and are called "elements of division" (Foucault, 1972, p. 41). Such elements must obey the "*rules of formation*", which are "conditions of existence...in a given discursive division" (p. 42). Foucault goes on to say that conditions of existence are embedded

within discourse (p. 42), where the 'rules of formation' comprise the "surfaces of emergence" (p. 45), the "authorities of delimitation" (p. 46) and the grids of specification" (p. 46). The rules of formation are a way of thinking about knowledge that is accepted as real and/or true and which forms the basis of a particular domain of knowledge.

Surfaces of emergence

Surfaces of emergence are the locations where certain discursive objects first appear (Foucault, 1972; Kendall & Wickham, 1999; Wang, 2017). They are defined locations where words and statements are linked to particular temporal, spatial, social and cultural conditions, thus enabling discourses to produce specific named objects in a particular moment. Examples would be the emergence of occupational therapy in locations such as hospitals; community, sanatoriums and asylums being the product of political, economic and health discourses.

Authorities of delimitation

The authorities of delimitation are those who hold the authority to place limits on the actions of the discursive object (Foucault, 1972; Kendall & Wickham, 1999; Wang, 2017). Examples in this study would be governments, politicians and representatives within institutions such as hospitals, who hold the power to designate space for occupational therapy departments and allow occupational therapy to be practiced on the wards. Within the institutions, authorities of delimitation may also constitute particular doctors, nurses and occupational therapy experts who have played a role in constructing and producing OTs and occupational therapy practices in a New Zealand context.

Grids of specification

Grids or forms of specification are products of discourse. They function as systems that describe how discursive objects are categorized and relate to other important discursive constructions and ideas (Foucault, 1972; Kendall & Wickham, 1999; Wang, 2017).

For example, grids of specification produced from occupational therapy professional discourses would include discourses supporting occupational therapy's fundamental belief that occupation is essential for health, so that practice is orientated to enabling people to participate in occupation for well-being. Other discourses focus on the 'whole person', supporting holistic assessment and intervention practices; while further discourses construct the belief that each person is unique, supporting the notion that OTs apply novel problem-solving skills to their practice, providing customised solutions to specific needs of particular patients. Clinical governance discourses, on the other hand, have produced grids of specification emerging from quality, safety and prudency discourses. Practices from these discourses involve employing ways of minimising cost of healthcare delivery, providing quality healthcare for all through responsibility and accountability, eliminating inequality through identification of need rather than desirability or improving quality

and participation in life and ensuring practitioners are competent to practice through surveillance, policy and oversight.

Enunciative modalities and the formation of concepts

In *The archaeology of knowledge* (1972), Foucault considers what links statements together, their "enunciative modalities" (p. 55). To uncover these relationships, he asks questions of the texts, such as: Who wrote the document and what is their subject position?; What is in it for them? What gives them the right to speak?; What is the institution associated with the discourse? This field of statements gives rise to concepts applicable only to their historical context. The next step, the 'formation of concepts' (p. 62), also has certain rules in order for statements to be disbursed within a discursive formation. There must be an order of "succession" (p. 63), as well as fields of "presence" (p. 64) and "concomitance" (p. 64) and "procedures of intervention" (p. 65). In practice, these rules mean that researchers must look for regularities and characteristics of particular discursive practices and compare them from one time period to another.

Limits to archaeology

The 1969 lecture/essay, *Qu'est-ce qu'un auteur? (What is an author?)*, essentially acted as a conclusion to Foucault's period of archaeology and made way for the next stage of his thinking: genealogy. Where Foucault's thinking eventually differed from his major influences, the structuralists, was his interest in how unconscious thought and hidden structures influenced changes in phenomena and practice, rather than merely description. This became a crucial underpinning of his ideas (Garland, 2014). He argued that by taking a birds-eye view of these structures through an historical lens, the truth would become visible. However, he acknowledged that because archaeology was a descriptive tool, it only permitted him to reveal and lay out the ideas underpinning a practice. It also did not enable him to address what had caused a change to a phenomenon. While writing his archaeologies, he indicated that he had not yet developed a tool that would enable him to explain change, so, "I left the problem of causes to one side; I chose instead to confine myself to describing the transformations themselves, thinking that one day, a theory of scientific change and epistemological causality was to be constructed" (Foucault, 1970, p. xiii).

The shift to genealogy

Dreyfus and Rabinow (1982) emphasise that "genealogy is complimented and supported by archaeology" (p. 106) explaining Foucault's comments in *L'ordre du discours* (1971). However, in the later *Surveiller et punir: Naissance de la prison* (1975b): (*Discipline and punish: The birth of the prison* (1977a)), the methodology Foucault used for his concept of genealogy remained heavily influenced by archaeology (Gutting, 2001). While he continued to construct the four categories of archaeological analysis: objects, concepts, modes of authority and lines of strategic action, he progressed the method so that he could describe not only the discourses themselves,

but map and connect multiple discourses to reveal the power-play producing changes to knowledge truths and the effects on conduct (Foucault, 1977a). Foucault's genealogy[25] shifted the focus of research onto the analysis of the effects of power within institutions on practices (Foucault, 1977a; Gutting, 2005; Hook, 2005), particularly the relationships between discursive and non-discursive practices (Hook, 2005). Hook (2005) argues that the purpose of genealogy is 'the generation of critique' (p. 7) and that researchers should not look to unearthing truths, but, more importantly, to consider 'truth-effects' (p. 8), guided by extra-discursive practices.

Linking theory to practice

Analysis through an historical lens was unique at the time, but in keeping with Foucault's academic background as an historian. His was not a linear account, as is usual with history, but contingently in sequence, to clearly reveal how events influenced each other over a defined period of time. With genealogy he therefore sought to question established 'truths' and look deeper at the invisible events of the past that shaped people's lives in the present. In this way, new realities could be formed. Foucault also saw genealogy as a method of "linking theory and practice" (Tamboukou, 1999, p. 205). He took up a diverse array of practices in society, from prisons to sexuality, and opened them up to scrutiny, looking for the deeper mechanisms that were interplaying and controlling the development of the phenomena in question (Mills, 2003).

The principles of genealogy

In *L'ordre du discours* (1971): (*The order of discourse* (1981)), Foucault's 1970 inaugural lecture at the Collège de France, he warns that, when conducting genealogical research, there are ways that 'truth', and hence 'knowledge', can be limited. Knowledge can also sometimes even appear to be false (Gutting, 1990). Foucault argues that authors of texts, the disciplines formed around particular knowledge, and the rules around who has access to the knowledge and has the authority to speak, all contribute to limiting the truth. They act as systems of exclusion. Discourses, therefore, provide only a "gleaming of a truth" (Foucault, 1981, p. 66).

In order to remediate this problem of limitation, Foucault lays out four principles that guide genealogical analysis that enable the opening up of discourses for analysis: the event, the series, the regularity and the condition of possibility. These notions, he says, oppose the more traditional concepts of signification, unity, originality and creation, respectively. Firstly, the "principle of reversal" (p. 67) emphasises the need to consider "discourse as an event" (Hook, 2001a, p. 531), negating limitations imposed upon discourses by authors, disciplines and other authorities. When

[25] There is some argument that Foucault did not produce a clear methodological analysis for genealogy, such as that laid down for his concept of archaeology, to be found in *The archaeology of knowledge.* (Gutting, G. (2005). *Foucault: A very short introduction*. Oxford University Press.) suggests there is only one persistent use of the concept as an historical genealogical study, and this forms the framework of *Discipline and punish* - although he does acknowledge that *The history of sexuality* has been cited as a second example of Foucault's use of genealogy. However, Gutting also argues that since the remaining volumes of *The history of sexuality* were not completed, there are no full genealogical studies associated with it, maintaining that the first volume only introduced a plan for a series of genealogical histories that were, in the end, never written.

discourses are considered as "sets of discursive events" (Foucault, 1981, p. 69), they are constructed as material objects. The relationships of power surrounding the object under study can be mapped to their fullest extent through the analysis of discourses sourced from numerous texts within a particular field of concomitance. Secondly, the "principle of discontinuity' guides researchers not to look for one continuous, progressive discourse from origin, but for a series of "discontinuous practices" (Foucault, 1981, p. 67) that present in many forms, such as running alongside, crossing, eliminating or being oblivious to each other. Thirdly, the "principle of specificity" provides a further understanding of discourse as a "practice" (p. 67) that is enacted on objects, providing a regularity to discursive "events" rather than the world being understood as predictable and in unity. Finally, the "principle of exteriority" advises researchers to stay with the 'external conditions of possibility' (p. 67) and not look for deeper meanings 'hidden' within the discourse (Fadyl et al., 2013) as a 'creation' or origin viewpoint would suggest.

The principles of genealogy applied

Foucault's advice sets the approach I have taken to discourse analysis in the two analysis chapters. Following a comparable strategy outlined by Fadyl et al. (2013), and Nicholls (2008), I have utilised a variety of texts that represent a wide breath of discursive events and practices related to occupational therapy and clinical governance, within and external to DHBs, that establish the effect of clinical governance on occupational therapy practice. I have mapped multiple discourses from many sources, acting in different ways with each other, from and in particular spaces, locations and moments. Sources include texts from the NZ government, to OTBNZ through to local DHBs and the services within them, connecting the 'local' with the 'global' (Nicholls, 2008). The mapping established the circulation of power and its relationships between discourses. As discourse is never static (2008), ruptures, fissures and tensions on the surface of discourses could be located, making visible the shifts that enabled new manifestations of discourse to emerge. I have studied texts that have revealed discourses concerning the practices of OTs at different moments in time. In Moments 1 and 2, I have specifically conducted an inquiry into how discursive events associated with clinical governance have influenced and changed occupational therapy practices in the extra-discursive environment of the DHBs, producing a shift to organisational preferred practices. In other words, I have looked in the texts to pinpoint changes in local material occupational therapy practices that clinical governance discourses circulating within DHBs have made possible.

Genealogy: Descriptor and critic

A number of writers have attempted to explain genealogy (Powers, 2007)[26]. Tamboukou (1999) suggests that genealogy is concerned with the "processes, procedures and the apparatuses by

[26] While Foucault's genealogy was placed solidly in history to understand the "history of the present", by examining epistemic shifts in the history of the past, it is not clear just how much Foucault aligned his own interpretation with that of Nietzsche. Academics have debated this question and tend to conclude that both philosophers held similar

which truth and knowledge are produced" (p. 202). O'Farrell argues that genealogy addresses the "constraints that limit the orders of knowledge" (O'Farrell, 2005b, p. 69) while Garland suggests that genealogy is "the idea of using history as a means of critical engagement with the present" (Garland, 2014, p. 367). Foucault indicated that genealogy was concerned with studying ourselves and understanding who we are through the domains of knowledge, power and ethics (Mendieta, 2014). As such, Foucault wants to know the origins of the current rules, practices and organisations that hold power over a society 'in the present' in order to evaluate and understand the entitlement to such an assertion by looking to the past (Gutting, 2005). In this way, genealogy assists researchers to study where a phenomenon has come from and how the impact of seemingly unconnected historical events may have influenced its present state of being.

Discursive and non-discursive practices

With genealogy, described as a "history of the present", Foucault introduced discursive and non-discursive practices which are specific to time, place and culture, contingent and bound by rules. Foucault understands "practices" as "what is said and what is done, rules imposed and reasons given, the planned and the taken for granted meet and interconnect" (Foucault, 1991a, p. 75). He suggests that practices are patterns of behaviour at play within the person's society, culture and social group that the person is obliged to take up (Foucault, 1997, p. 291). Discursive practice, in Foucauldian terms, is the formation of knowledge produced from discourse. Understanding what "practices" are, is essential, as "problematizations emerge in practice" (Bacchi, 2012, p. 2). In this study, the practices associated with healthcare delivery became problematic and a solution was sought. What emerged was a discursive formation, clinical governance, that in turn, produced change in the practices of OTs when providing interventions for their clients. As such, I understand that practices make power/knowledge visible because they are frequently present where discourses cross each other and so they can highlight knowledge/power connections.

Foucault argues that discourse does not underlie all cultural forms. He names non-discursive domains as including "institutions, political events, economic practices and processes" (Foucault, 1972, pp. 179-180). In his opinion, forms of art and music, political and social relations are not discursive (Foucault, 1998a):

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beliefs, although it is said that the phenomenological approach Nietzsche used, together with some of his cultural beliefs, would not have sat well with Foucault.
Foucault's 1971 paper, Nietzsche, la genealogie, l'histoire (Nietzsche, genealogy, history), published in the compendium Hommage à Jean Hyppolite (Homage to Jean Hyppolite) Bachelard, S., Dagognet, F., Canguilhem, G., Foucault, M., Guéroult, M., Henry, M., Laplanche, J., Pariente, J., & Serres, M. (1971). Hommage à Jean Hyppolite. Presses Universitaires de France. , does not compare his own interpretation with that of Nietzsche, (Foucault, M. (1984c). Nietzsche, genealogy, history (D. Bouchard & S. Simon, Trans.). In P. Rabinow (Ed.), *The Foucault reader* (pp. 76-100). Pantheon Books. https://noehernandezcortez.files.wordpress.com/2011/04/nietzsche-genealogy-history.pdf , yet is regarded as an important insight into Foucault's thinking (Rabinow, P. (Ed.). (1984). The Foucault reader. Penguin Books.). In later years, during an interview, Foucault commented, "The only valid tribute to a thought such as Nietzsche's is precisely to use it, to deform it, to make it groan and protest. And if commentators then say that I am being faithful or unfaithful to Nietzsche, that is of absolutely no importance." (Foucault, M. (1980b). Prison talk. In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings 1972-1977*. Vintage Books.).

> There is nothing to be gained from describing this autonomous layer of discourses unless one can relate it to other layers, practices, institutions, social relations, political relations, and so on. It is that relationship which has always intrigued me... I tried to find the relations between these different domains. (p. 285)

The non-discursive practices in this study include the DHBs and externalities such as political and governmental mandates, inquiries and demographics. Through the application of genealogy, I have examined the relationship between discursive and non-discursive practices that, together, have produced systems of knowledge pertinent to the practices of OTs (Olssen, 2014).

Production of change

Genealogy allows observation of how power operates at a discrete level through discourse, a perspective which is missing in archaeology alone. It is not the big events that create change, but the little, mundane, seemingly unimportant, unconnected practices produced by discourse at the micro-level. When these are linked up, together they become the force to create change (Gutting, 2005). Discourses can therefore be understood as the powerhouses that produce change in knowledge and truth and practices. 'Truth' emerges only when certain discourses are taken up within a society and said to be true by bodies who are seen as presenting the truth, such as scientists, educational institutions and health systems, and are then upheld and reinforced amongst society members by the use of rules, constraints and the power mechanisms that maintain the belief about what is true. What is not true follows from what is true, as it would, in essence, be the counter-argument.

Power, knowledge and truth

Foucault's idea of the inextricable relationship between power and knowledge: "I have been trying to make visible the constant articulation I think there is of power on knowledge and of knowledge on power" (Foucault, 1980b, p. 50), means that when a body uses its existing power to influence some state of affairs, that very action results in a change in the conditions that previously existed. The change would now be a catalyst whereby *new knowledge had to be produced* to manage or explain the new conditions. Over time, the new conditions will have generated further new knowledge in an almost cyclical manner.

Close relationships between power and knowledge have effects on what becomes 'the truth' in society, as "knowledge linked to power not only assumes the authority of 'the truth', but has the power to *make itself true*" (Hall, 2013, p. 33). Foucault (1977a) himself asserts: "There is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time, power relations" (p. 27). He further suggests that a relationship of power is defined by its ongoing effects:

> It is a mode of action that does not act directly and immediately on others. Instead, it acts upon their actions: an action upon an action, on possible or actual future or present actions. (Foucault, 1982b, p. 220)

Discipline

The Foucauldian idea of 'discipline' was mentioned earlier as (arguably) an extension of his genealogy, but since the concept has important application to this study, it is here explored in more detail.

For Foucault, discipline is a series of practices that when applied, can control what a body does. It is exercised by compelling an individual to act in a certain way by setting out rules as to how something is done, where it is done, and what the required time frame is for completion. The power of discipline is constituted by the application of "hierarchical observation, normalising judgement and examination" (Havis, 2014, p. 113). Individuals holding positions of power and authority in organisations are positioned to introduce and apply disciplinary technologies of power into the system, acting on targeted individuals, often in the belief that changes to practice will result in quality improvement. The associated disciplinary and surveillance techniques effectively control the conduct of individuals by changing conditions within a particular environment causing individuals to behave in a particular way that is more desirable to the organisation.

An understanding of disciplinary power and the techniques associated with disciplining individuals is relevant to OTs working within DHBs, who are subjected to techniques of discipline aimed to ensure competence, safety and quality of service delivery and professional practice. This discipline is applied both from within their place of work and from their professional regulatory organisation, the OTBNZ. Techniques of discipline have the effect of shaping behaviour so that OTs conduct themselves in particular ways, required by these organisations. In the following sections, I discuss the Foucauldian understanding of discipline as a 'technology of power' in the context of techniques of discipline and techniques of surveillance, including the analogy of the Panopticon.

Double-entendre

Foucault seems to have been fascinated by the concept of 'discipline', which can be understood as both:

1. "The meticulous control of the operations of the body" (Foucault, 1977a, p. 137)
2. "A field of study" ("Discipline," n.d.) e.g. occupational therapy

In *Discipline and punish* (Foucault, 1977a), he plays with the meanings of the word - both the word and its meanings are the same in his native French. Firstly, disciplinary power in the form of 'technologies of discipline', acting on individuals to produce docile bodies that are "subjected,

used, transformed and improved" (Foucault, 1977a, p. 136) through the minute oversight and control of daily activities. They become compliant and behave in particular ways preferred by those holding power within society. Secondly, the constant subjection of disciplinary power on groups of docile bodies producing named 'disciplines' (p. 137), such as accountancy or engineering. Disciplines are present in societal institutions, schools, armies and importantly for this thesis, within medical establishments. Medical disciplines are primarily considered to be physicians and nurses, but other disciplines allied to health, including occupational therapy, are subject to particular kinds of disciplinary power related to medicine and are influenced by biomedical discourses that act to define what healthcare approach is 'best' for society in a particular moment in time. Individual members of disciplines are expected to conduct themselves in a normalized manner that reflects the truths of the collective discipline.

Training docile bodies

Foucault is concerned with what he calls "docile bodies", "a target of power… [capable of being] …manipulated, shaped, trained, which obeys, responds, becomes skilful" (Foucault, 1977a, p. 136) and where "the analysable body is joined to the manipulable body" (p. 136). To Foucault, docile bodies explain how individuals are controlled politically, economically and culturally within society at a level below consciousness. Docile bodies are malleable objects from which the ideal subject for a specific purpose can be constructed and produced through the application of technologies of discipline, such as training mechanisms. They "may be subjected, used, transformed and improved" (p. 136) through institutional regulatory practices aiming to produce "order and discipline" within society. Power is exercised on individuals through the practices of surveillance and regulation at the "level of the mechanism itself – movements, gestures, attitudes, rapidity" (p. 137). These practices are generally so subtle that they frequently go unnoticed; "meticulous, often minute techniques … a micro-physics of power" (p. 139). The effects, however, produce individuals who accept and demonstrate the normalized behaviours expected in the institution. OTs are identified as docile bodies in this research. They are subjected to surveillance and regulation of practice within the organization in which they work. Their professional practices are limited and adapted by techniques of power implemented within the DHBs to conform with the clinical governance frameworks embedded within the organisational system. Examples of technologies of discipline aimed at producing the correct conduct expected of the ideal OT include undergoing a period of student training; participating in practice observation and feedback; following timetables, wearing uniforms; and abiding by departmental rules.

Technologies of power

Foucault's (1977a) construct of the 'disciplinary' society emphasized the part discipline plays as one way of maintaining the behaviour of individuals in society. Discipline is not power itself, but is made of an assortment of mechanisms, by which power can be exercised via and on people,

making them "object(s) of knowledge" (O'Malley, 1996, p. 189). Such 'technologies of power'[27] are forms of discipline. They include not only surveillance, but many other mundane practices that involve people organising their space, time and their everyday activities (Patton, 2014). Mechanisms of power can be productive as well as restraining and are exercised in many institutions and organisations such as hospitals, prisons, schools and the military. Foucault provides examples of technologies of power in *Discipline and punish* (1977a), that produce behaviour change in "docile bodies", such as the use of timetables, drills, close observation, supervision and the use of space (Foucault, 1977a, pp. 135-139). Other examples related to a medical setting might, for instance, be the institutional rules and use of hospital bed space, rehabilitation timetables and prescribed activities to control what a person 'did' in hospital.

Observation, normalisation, examination

Foucault describes the importance of 'observation', whereby constant surveillance can alter behaviour; 'normalization', or reform, as in prison programmes aimed at improving the offender' behaviour prior to release from prison; and the 'examination', such as an exam at school or an assessment of a patient in a hospital, important because they are documented and become part of an individual's record of behaviour. The 'clinical gaze' is one specific form of observation described by Foucault in *The birth of the clinic* (1973), and is explained in Appendix A.

He also gave a specific example of achieving discipline through observation by describing the model 'Panopticon' (Foucault, 1977c), and argued that it was one way that a society could produce "docile bodies" (pp. 135-169). Surveillance is important in my research since there is now a normalized practice of auditing at both the DHB level through performance and peer reviews, as well as at the OTBNZ through the ePortfolio. OTs in the 21st Century essentially self-surveille through reflection, goal setting and participation in clinical supervision, and also receive 'panoptic' surveillance through a process where a registered OT may have their ePortfolio selected for audit at any time.

Panopticon

A Panopticon is a structure that allows one person to observe all residents in an institution without them actually knowing whether or not they are being watched. The original concept for the Panopticon, shown in Figure 1, was invented in the 18th Century by the English philosopher and social reformer Jeremy Bentham (1748-1832), as a way to apply passive power to maintain control of the behaviour of a person.

[27] There is some confusion in translations of Foucault from the French, where he uses the word "techniques", which is normally translated as the English plural noun "techniques", but seems often to have been rendered as "technologies" to more accurately portray the intent at the time.

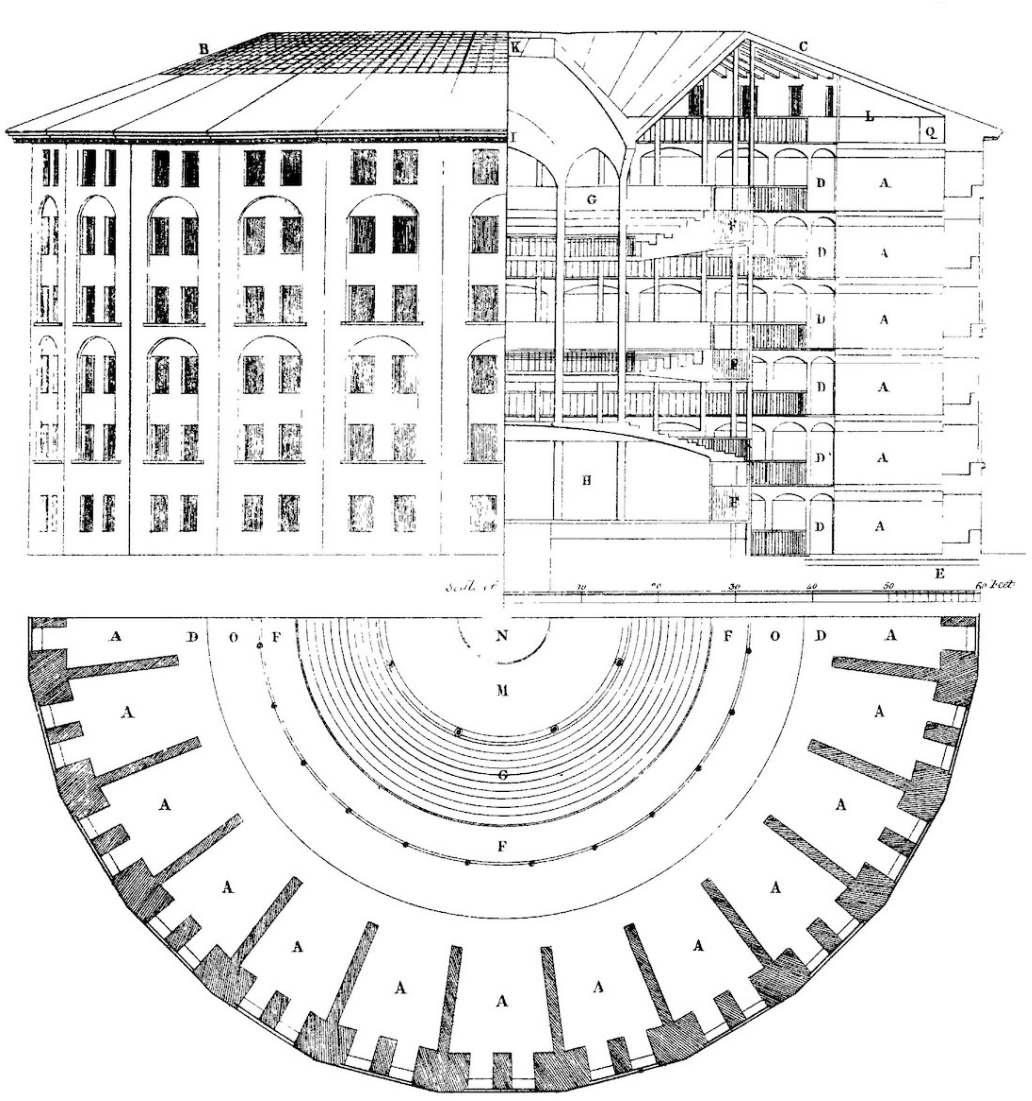

Figure 1. Plan of Jeremy Bentham's Panopticon prison 1791. Public domain.

Likewise, Foucault used the term ‘docile bodies’ to describe an object that can be moulded by disciplinary force or action, such as being placed in a cell in the Panopticon. In this model, control by physical punishment such as flogging, mutilation or even execution was unnecessary, since behaviour would be changed by isolation, the feeling of being constantly surveyed, and the threat of consequences. This surveillance mechanism proved so powerful that the Presidio Modelo, a prison in Cuba consisting of four Panopticon buildings, was designed according to Bentham’s concept with no cell doors (Ryle, 1996). Figure 2 shows prisoners at Presidio Modelo assembling outside their cells.

Figure 2. Prisoners assemble outside their open cells in a Presidio Modelo Panopticon, Isla de Pinos, Nueva Gerona, Cuba. Photograph circa 1940s. Orphaned work.

The Panopticon is an important concept, and one that continues to be used in society today, albeit in a much less brutal form, to maintain social order (Foucault, 1977c). In my study, behaviour is changed and normalized due to the very fact that OTs know they could be undergoing surveillance at any time, both in their workplace and through the OTBNZ. Examples of 'panopticonism' are still everywhere to be found; for instance, the behind-the-scenes monitoring of equipment supply by the Ministry of Health appointed agencies, Enable and Accessable[28], who check equipment assessors' online activity for any sign of excessive distribution of equipment, warning clinicians not to 'game' the system because they will be identified and disciplined.

Normalisation

Foucault discusses normalisation in *Discipline and Punish: The Birth of the Prison* (Foucault, 1977a). Individuals are subjected to normalising disciplinary techniques designed to induce "subordination, docility, ...and... the correct practice of duties...so that they might all be like one another" (p. 182). These disciplines are applied to the bodies of individuals to ensure they learn and engage in the correct behaviours expected of the institution they inhabit, such as a school or a hospital. Foucault (1977a) provides an example of disciplining, including observation of time management, acceptable behaviours and following regulations. Through repeated use, the practices become normalised into every-day behaviour. Individuals who have taken up alternative behaviours and ways of doing things, may be considered deviants, their behaviour and actions in

[28] A private company contracted on behalf of the Ministry of Health "..to administer the funding for the provision of environmental support services for those meeting the eligibility criteria and residing in the Auckland locality of the Ministry of Health." Accessable. (2003). *Specialised assessor equipment manual. A modified version of the original equipment manual for the Auckland and Northland Regions*. (p. 1). The company aims to provide "efficient management of resources and to deliver effective services to eligible clients" (p. 1).

need of ‘correction’ through “multiple forms of training” (p. 179), observation and surveillance designed to make the individual conform with the expected modes of conduct.

Examination

Completing this triad of disciplinary actions on the body is the ‘examination’. For OTs working in DHBs, one example of an ‘examination’ is the annual Performance Development Review (PDR). This process may include live observation of practice, audit of clinical note-writing, discussion of past professional development goals and setting of professional development goals for the coming year. The OT usually meets with a manager and/or senior therapist, and the documents associated with the process reviewed. If the documents show that the OTs performance is at the required standard, the PDR is signed off. If there are practice concerns, then disciplinary actions might be offered to remediate any identified gaps in the OTs professional development and conduct, such as goal-setting along with additional training, supervision and preceptorship.

Resisting discipline

If people do not comply with the disciplining procedures put in place for them to follow, they may be subject to various forms of punishment by those wielding power. Foucault states “the truth-power relation remains at the heart of all mechanisms of punishment” (Foucault, 1977a, p. 55) which, he argues, is the crux of getting people to behave in a certain, desired way, based on what is considered the truth of the moment. Punishment is a way to make power operate more efficiently. Its application to a body is the consequence of that body behaving in a way that is contrary to the expected norm. By making studies of French history, Foucault has demonstrated that over time, punishments for similar, unwanted behaviours in society have changed according to the requirements of the governing body at specific periods in time. The threat of punishment appears to be a great modifier of behaviour, usually producing conformity rather than resistance.

In the case of OTs, graded procedural disciplinary steps are clearly stipulated and carried out by the OTBNZ, the regulation authority, should a therapist deviate from the normalised conduct expected from a registered professional. The consequence of not responding to disciplinary requirements may result in the (rare) ultimate punishment of removal of registration to practice as an OT.

Ethical care of the self

As technologies of the self, care of the self and truth-telling are mechanisms by which discipline is enacted by an individual upon themselves, as opposed to external influences. Truth-telling, or ‘parrhesia’, in a Foucauldian sense, is to tell and know the truth about oneself (Foucault, 2014), for example, practices of self-examination such as reflection and confession, may be a part of truth-telling. These practices are currently exercised within supervision by OTs as a condition on scope of practice (OTBNZ, 2019b). Technologies of the self are important in the self-

determination or agency of subjects enabling self-transformation of behaviour, ethically caring for themselves, caring for others and endowing them with the ability to participate in the ethical government of others (Foucault, 1997). The self-determination that is produced by these technologies of the self enables individuals to make decisions about what they will do in certain situations, giving them freedom to resist if they disagree with preferred behaviours advanced by discourse.

Summary

In this chapter I have presented the classification structure for the research process in terms of epistemology, theoretical perspective and methodology, and each of the sub-branches associated with them which are relevant to this study. In particular, I have described the major concepts associated with discourses, and how they relate to the Foucauldian 'triad' of archaeology, genealogy and problematization. I have also paid close attention to 'discipline' from Foucault's perspective, as a technology of power that shapes behaviour and practices within organisations such as DHBs, and shown some real examples of the disciplinary process which are in use today.

Chapter 4 Method

> Do not ask me who I am and do not ask me to remain the same.
>
> – *Michel Foucault, Introduction to The Archaeology of Knowledge*

Introduction

In this chapter, I examine the method used to keep true to the application of Foucauldian discourse analysis. I describe how I built a discursive archive of documents associated with the historical moments I selected to study, including searching for, selecting and sourcing appropriate material. I then explore the way I conducted document analysis through the use of a number of different table layouts enabling application of both Foucault's archaeological method and genealogical analysis. Finally, I address how I considered and ensured ethics, validity, rigour, trustworthiness and reflexivity within this study.

The discursive archive

When conducting post structural analysis in the style of Foucault, data gathering should include a variety of representative materials sourced from selected periods of time, space and in a variety of formats forming a discursive archive (Foucault, 1972; Hook, 2001a; Lynch, 2014).Therefore, I searched widely, tracing the history of occupational therapy back to its origins in several countries and searching for documents that described the occupational therapy practices that were to the forefront at certain periods of time. The purpose of my approach was to ensure I had an historical baseline from which to compare current occupational therapy practice in New Zealand.

The concept of clinical governance is a relatively recent idea, but has origins in world health policy stemming back as far as the Second World War (Roosevelt, 1941). Discussions, arguments, agreements, legislation attempts and approaches to Western healthcare delivery have taken place at various moments in time. Aware that components of clinical governance were practiced as separate entities before being connected within a governance framework, I searched widely for material that concerned both historical manifestations of individual quality and safety practices as well as the more recent concept of clinical governance. I searched both world-wide and then to a more local New Zealand setting, looking for documents revealing the introduction and application of clinical governance into New Zealand healthcare, as well as allied topics like neoliberalism.

Data gathering has proven to be an emergent process. It was by no means linear and I collected material from different time periods, places and content as it surfaced. I organized and stored the material as it emerged, for further and closer analysis, using NVivo and Endnote. The material arrived in various forms, documents, book chapters, photographs, for instance. Collecting the documents was largely intuitive (Farge, 2013). Sometimes I selected a document because I could

see there was an immediate connection with occupational therapy and clinical governance. At other times, the link was less clear or even absent, but where I felt there should be or expected to find something, I kept the document for further scrutiny, as absence (or silence) of discourse is also an important signal of subjugated voices, and must be considered too (Foucault, 1978).

Collection of material also occurred alongside a preliminary analysis of the documents that have surfaced from my searches. The analysis, although more of a superficial scan of the material, did, in many instances, prompt me to ask new questions and respond by searching for additional documents to shed light on the specific problem that had come to light. It has often taken a great deal of time to locate documents containing supporting and/or specific information.

Nonlinear change

Foucauldian history does not assume there has been a linear, evolutionary progression to history, but, rather, as Nietzsche postulates, that history emerges "by chance" (Foucault, 1984c, p. 78; McNay, 1994, p. 89). Foucauldian history places emphasis upon the analysis of contingent events arising from societal behaviour considered socially problematic at particular moments in time. Change occurring over time is unexpected, unintended, haphazard, discontinuous, or with breaks and can be contradictory (Gutting, 1989; McNay, 1994). Following Foucault's lead, I realised that I would need to both expect to see and recognize evidence of irregular, overlapping changes in practice with no official stopping and starting points, as well as, in some cases, a continuation of traces of old practices that still remained in some form. I kept vigilant for signs of practices dying away or disappearing and then reappearing at a later time. I found that the selection of particular temporal moments provided a way of examining 'slices' of time with a view to understanding how occupational therapy practices of the present time were produced from historical events and problems.

Time periods: Moments of interest

I identify three time periods of interest, detailed in Chapters 5, 6, and 7. The first moment, post-World War II, became the baseline for 'a history of the present'; I describe the early governance and practices of OTs prior to the advent of clinical governance. The two later time periods, 2003-05 and 2015-17 respectively, have been selected for analysis due to them being crucial moments after the introduction and influence of clinical governance.

A history of the present

In Chapter 5, I conduct the first steps in my plan to complete 'a history of the present', replacing the traditional literature review. My original plan had been to write a literature review focussing on the literature pertaining to clinical governance, which I did, but eventually realised that a Foucauldian 'history of the present' where I could closely study the practices and subject positions of OTs, was more in line with the reason for the study. My alternative to a literature review

provides insight into why the occupational therapy profession emerged in New Zealand after the Second World War. I was able to probe into how the profession was governed and positioned within the healthcare system prior to the emergence of clinical governance. This sense of how early OTs were governed forms a baseline for comparison with more recent subject position and practices. The research also fills what I perceived to be a gap in my knowledge. I am not a native New Zealander, only settling in New Zealand in 2004, and so I have not experienced OT practice in NZ prior to the advent of clinical governance. I therefore wanted to access historical occupational therapy documents as a way of connecting myself to past practices and gain an understanding of how more recent occupational therapy practice has held onto, dropped, or added to those past practices, in line with Foucault's non-linear approach to research. Through conducting a 'history of the present', I was able to investigate how occupational therapy practices of the past could reveal a history of occupational therapy practices of the present.

Two moments for analysis

In Chapter 6, the first moment of analysis, I considered documents related to the changing organisational healthcare service practices influenced by clinical governance affecting occupational therapy after the formation of the DHBs in the early 2000s. In Chapter 7, the second moment, 2015-17, after study of additional documents, I contemplate how allied health services emerging from clinical governance frameworks within DHBs have provided OTs (and similar professions) with a clear mandate on how to practice in a DHB setting.

For both moments of analysis, I place occupational therapy practice in the social, political and economic context of the time, drawing from the documents an understanding of how occupational therapy practice has been influenced by multiple discourses coming together to produce behaviours associated with clinical governance that have been taken up and normalised into everyday practice.

Documents as written texts

One example of language actively producing knowledge is written texts. Texts act as a conduit for the transmission of statements and fragments of language within discourse, producing and representing multiple truths and realities. As a post-structuralist researcher, I believe healthcare practices to be 'textually mediated' (Cheek, 2000, p. 39), whereby texts represent reality while concurrently shaping healthcare practice. Therefore, my analysis is primarily through the study of multiple texts that have actively shaped healthcare service delivery in New Zealand.

Sourcing and selecting documents

Once I had identified the guiding questions and moments to study, I began to think about the sources and type of documents I would need to inform, conduct and complete my research. The thesis would require literature and documents addressing:

- Foucauldian studies
- Clinical governance
- Early occupational therapy practice
- Post-governance occupational therapy practice in the DHBs
- Relevant historical social, political, economic events in the world and New Zealand
- Healthcare provision in New Zealand and the UK

The literature and documents would cluster in particular chapters according to their subject matter and purpose, but some texts would also be referenced throughout the thesis to provide consistency, reasoning and support to the ideas and thought processes and arguments running through the study.

Throughout this thesis, I identify and analyse discourses articulated in a wide selection of documents produced over particular periods of time that have built up an understanding of how clinical governance frameworks function. Some of the documents have been used to show how utterances and statements within discourse played a part in constructing the emerging, as yet unnamed, idea of clinical governance (WHO Working Group, 1989). Other documents provide evidence concerning the emergence and naming of "clinical governance" (Department of Health, 1997) and reveal how the construct became normalised in the UK. More recent documents have revealed the take up of key ideas by the New Zealand government who, through policy, transferred the responsibility to construct and embed governance frameworks into the emerging structures of the DHBs. This work has been essential in my quest to discover and reveal the relationship between clinical governance and changing occupational therapy practice.

The search for documents

The very premise of using discourse and history to uncover a history of the present voids the traditional approach of a narrow literature review that focuses only on research papers. What is instead required is a much wider search outside the confines of scientifically derived articles to look further afield to non-traditional sources. Therefore, for Chapters 5, 6, 7 and 8, I searched widely for a breadth of occupational therapy and governance-related documents so that I could construct both past and present occupational therapy subject positions and practices for comparison during analysis. My collection included a variety of 'grey'[29] material, such as government documents, international policy and historical accounts of practices.

Clusters of statements

To be able to uncover and reveal the origins and meaning of particular discourses, I searched for documents containing relevant discursive formations. For example, when looking for statements concerning the framework of clinical governance applied within the DHB, I found that statements originated from a variety of sources, such as individuals, organisations, governments, boards,

[29] Materials and research produced by organisations outside traditional academic sources

archives, etc. Frequently, I noted, these statements were written in the form of euphemisms, such as, 'for your own safety' or, 'to protect the public' but I intuitively considered them as glimmers of discourses concerning safety, accountability and responsibility. Identifying clusters of discursive formations in a variety of documents suggested the presence of a prominent discourse, signalling the need to engage in further analysis to gain an understanding of what was happening and why, in the moment they appeared.

Document gathering and analysis

I conducted data gathering and analysis alongside each other, generally working on one period at a time. The analysis guided what further texts I would look for and whom, where needed, I should consult to access them. As Foucault himself firmly believed in direct personal experience (Foucault, 2000a, 2000b), I considered I was at liberty to consult with other people knowledgeable in the field who could direct me to additional material. I selected Foucauldian tools that would enable me to identify, classify and also analyse the effects of power on discourse, such as shifts, disruptions, gaps and lurches associated with the relationships between occupational therapy subject positions and clinical governance practices.

Planning document sources

I planned to gather documents from a variety of sources. I was already aware of certain documents that would be of use, including a Clinical Leaders Association of New Zealand report (Wright et al., 2001); *In good hands* (Brown et al., 2009); the *New Zealand Health Strategy and Road Map* (Minister of Health, 2016a, 2016b); *New Zealand Disability Strategy 2016-2026* (Office for Disability Issues, 2016) and the *Clinical Governance: Guidance for Health and Disability Providers* (Health Quality & Safety Commission [HQSC], 2017). I also knew there were documents from local DHBs that would be valuable for my research. These documents included:

- Standard operating procedures
- Policy documents (practice guides)
- Annual plans
- Values statements
- Quality documents
- Project plans that OTs might be involved in
- Supervision policy
- Service structure diagrams - particularly in allied health
- Leadership and clinician job descriptions
- Details of continuing professional development opportunities
- Documents pertaining to roll out of clinical governance in different DHBs and services
- Research, quality and consumer feedback documents.

I also knew that the archives of both the OTBNZ and OTNZ-WNA were valuable repositories of texts, as they held documents such as historical board meeting minutes, position statements, journals and continuing competency requirements for the profession. I was already aware that a

large number of documents were available in the public domain, but I suspected that some historical and intellectual data held by different authorities would require permission to access and then searching by hand for relevant documents.

Consultants

I identified and wrote to potential 'consultants' who might be able to identify documents I could use in my research. 'Consultants' were selected people who worked within, or who were leading the development of clinical governance frameworks in New Zealand. I purely asked them to identify documents for analysis; I did not interview them or think of them as participants. I approached consultants to request access to DHB, allied health and occupational therapy documents relating to clinical governance and occupational therapy practice and quality policy. These included Chief Executive Officers (CEOs) of local DHBs, and the CEOs of both the Occupational Therapy Board of New Zealand (OTBNZ) and Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNA). I also contacted Dr. Robin Gauld who is longitudinally studying clinical governance in New Zealand, and Dr. Robin Youngson, a past member of the Clinical Leaders Association of New Zealand (CLANZ), for their recommendations on suitable documents. I also made a request though the OTBNZ website for documents from the personal collections of OTs who have participated in clinical governance quality initiatives and have documented their experience. Finally, I contacted local Professional Leaders of occupational therapy and a Director of Allied Health to request access to relevant documents that would provide insights to service and practice policy.

Each consultant required a different process in order for me to acquire the documents they held. These processes ranged from activating the Official Information Act (OIA); working through the DHB educational department and identifying a preceptor to gather the documents on my behalf; the permission and discretion of a professional leader; signing a confidentiality agreement to access OTBNZ archives; freely being able to check the archives of OTNZ-WNA, with the permission of the CEO. Some documents were unreservedly provided from private collections without any process required. Requests for information, and approvals, are summarised in Appendix C.

Searches for documents

I conducted numerous searches over the period of my enrolment in the DHSc. programme when aspects of clinical governance came to light that needed further clarification, and as I began to identify discourses at play. Multiple searches were essential because the nature of health systems is that they constantly identify new problems and try to fix them, generating new understandings of how healthcare, clinical governance should be delivered (HQSC, 2013; HQSC, 2017). The material arrived in various forms, including documents, book chapters, tables and photographs.

On-line resources

Much of the searching for documents I could do by accessing on-line resources, with Google and Google Scholar being the predominant search engines. I used this search strategy since I found that Google offered the widest possible reference source of both academic and grey literature, as a starting point to gathering and identifying relevant literature that indicated clinical governance discourses were occurring. I have used the many words, terms and author names that I identified from a broad reading of books and articles, (including the reference lists they contain), initially recommended to me by my advisors, workshop presenters and other students in the DHSc. programme. The searching essentially snowballed as I identified useful documents and continued to follow up their references. The references that surfaced led to a wide variety of documents including books, government papers, academic papers and newspaper articles that provided a repository of information and knowledge connected with healthcare delivery discourse.

Scholarly papers

I also accessed scholarly papers via the AUT library system, usually on either Proquest or Ovid. Additionally, weekly summaries of new articles from requested categories were provided by subscriptions to Google scholar alert (New Zealand health law; New Zealand health government policy; clinical governance), The King's Fund, GOV.UK (publications: research and analysis, Department of Health), NHS England and HIIRC Digest (New Zealand Ministry of Health). I reviewed each notification for literature relevant to my thesis, and located promising abstracts and full PDFs for new articles via the AUT library 'articlelinker' 'ebscohost' search engine. Some, particularly Foucault-based, required careful reading and rereading before adding to my growing body of knowledge and reference list.

Search terms

Some examples of key words for searches that I have used include: "clinical governance"; "world health organization clinical governance"; "health and social care"; "third healthcare revolution"; "systems thinking, systems dynamics healthcare"; "systems thinking, systems dynamics healthcare New Zealand"; "healthcare management theory"; "health theory"; "social theory"; "high quality care for all"; "the third revolution in health"; "clinical governance and occupational therapists"; "quality"; "health systems" and "models of health". Where individual writers produced informative papers about or on topics about clinical governance, I searched specifically for other writing they might have published. For instance, searches for clinical governance authors include "Som"; "Darzi", "Travaglia" and "Gauld". I also searched Auckland City Council Library with the following key words: "New Zealand Health System"; "Manuel Castells"; "Robin Gauld"; and "Nicholas Garnham", with primary source publications accessed where available.

Search sites

- The King's fund: A UK website that holds a variety of health publications available to the public. I found it a valuable source for articles about clinical governance.
- The World Health Organization (WHO): This website contains both historical and current WHO publications influencing healthcare delivery around the world. Examples of search words I keyed into this website were more about healthcare in general: "patient safety"; "physical activity"; "primary health care"; "health education"; "health policy"; "health promotion"; "health risks"; "health services"; "health surveys"; "health systems"; "health workforce"; "hospitals"; "rehabilitation"; "risk assessment"; "risk factors"; "ethics"; "mental health";
- The British Medical Journal (BMJ): This website was a source of historical documents about the introduction of nationalised healthcare and the introduction of clinical governance to the UK National Health Service. I looked for: "NHS 50th birthday 1998"; "Clinical governance"
- Government websites were a productive source of documents for legislation, parliamentary debates and papers advising governments; strategies: In particular, I searched the government websites of New Zealand (Beehive, Auditor General, Ministry of Health), UK (NHS England) for documents providing information on healthcare delivery and clinical governance.
- I searched the Oxford Brookes University on-line archives for texts associated with the history of Dorset House School of Occupational Therapy and the British College of Occupational Therapists website for signs of clinical governance practices in their postings.
- In New Zealand, I searched multiple public DHB websites, including Waitematā DHB, Auckland DHB, Counties Manukau Health and Wairarapa DHB for annual plans, allied health service plans, occupational therapy job descriptions and associated texts. I was able to collect multiple documents signalling the presence of clinical governance through these searches.
- Sometimes, where documents have not been available on-line, I have needed to conduct a further search or request a specific item. There have been a few times where the document is unavailable and so I searched for alternative material.
- Blogs and university sites for leads to suitable documents and books, including:
- Progressive geographies – the blog of Professor Stuart Elden writing about Foucault
- Foucault news – maintained by Dr. Clare O'Farrell, who is an authority on Foucault
- Mary Silcock – a blog by an OT who was studying occupational therapy practices.
- Patter – a blog about academic writing from Professor Pat Thomson.

YouTube video

I discovered that there is an increasing body of presentation and discussion available online in video form: I searched YouTube for relevant clinical governance and health video clips such as Manuel Castells and Ted Talks presentations, an example being "What if our healthcare system kept us healthy?" (Onie, 2012). I also viewed Graham Gibbs's talk about Foucauldian discourse analysis (Gibbs, 2015), Robin Youngson's presentation on compassionate care (Youngson, 2012) and Robin Gauld's discussion about clinical governance in New Zealand compared with the UK (Davies et al., 2014).

Books and journals

Books that had been recommended from various sources I have either obtained from the Auckland Public Library, such as *Democratic Governance and Health* (Laugesen & Gauld, 2012) or purchased for my own library, e.g. *Revolving Doors* (Gauld, 2009b). I also searched the Book Depository and Amazon for books more widely related to my study, example search terms being "Foucault", "discourse analysis", "clinical governance" and "occupational therapy practice". Early accounts of occupational therapy practice I searched for in out of print textbooks written and used by early OTs and students. Where original early texts were not available, I either attempted to acquire a later edition, or as a last resort, referred to data from secondary sources citing the original author. Finally, I have used my own collection of both the New Zealand Journal of Occupational Therapy (NZJOT) and OT Insight, as well as selected editions of the British Journal of Occupational Therapy, to search for evidence of particular occupational therapy practices within the moments I was studying.

On-site visits and hand searches

The Auckland Archives, The Wellington Archives, Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa (OTNZ-WNA) and the OTBNZ held documents in these collections that could not be accessed on-line, which necessitated a visit in person and, with permission, the photographing of the documents of interest. Most of the documents from OTNZ-WNA have been collated in the National Archives by four OTs who formed the Legacy of Occupation Research Group. This material is the source for *Legacy of Occupation* (Gordon et al., 2009), about the first OTs trained and registered to practice in New Zealand, including individuals' first-hand historical accounts of practicing as OTs, and accounts of writing the original legislation for the Occupational Therapy Act 1950. The accounts provide an understanding of how occupational therapy emerged in New Zealand after the Second World War, how the profession was governed, and the practices OTs engaged in at the time. The material additionally contains historical minutes of OTBNZ meetings, position statements, journals, continuing competency requirements for the profession, reviews of the profession and education reports and annual plans for local DHBs from the early 2000s.

Selecting DHBs and contacting consultants

As I needed to place limits upon my research, I selected three DHBs from which to identify consultants who could recommend or provide documents for my research. Being large metropolitan DHBs, I considered them to be leaders in innovation and so believed them to be good indicators of how far clinical governance discourse had infiltrated DHBs. The first DHB responded very cautiously. I was not allowed to visit the DHB nor could I personally [remotely] search limited areas of the DHB database for relevant documents or even sit beside an employee while they searched for documents. It was only through indirectly activating the Freedom of Information Act, that I was able to access a very limited selection of archived and current

documents related to the DHB's allied health and occupational therapy service. These documents included standard operating procedures (occupational therapy), policy documents (essentially practice guides), supervision policy, two examples of the Allied Health Clinical Governance Group minutes, and professional development/course application procedure documents. I was unable to access any documents pertaining to 'quality', or project plans that OTs might be involved in, nor any service structure diagrams (particularly in allied health, leadership and clinician job descriptions), research, quality or consumer feedback documents. I specifically asked for an Allied Health Quality Plan and was informed that one was in development (refused access) and that there had not been a previous document of this kind for allied health in this DHB.

By contrast, the second DHB I approached was more accommodating. The CEO referred me to the Research Office where I was advised of the process that would enable me to access documents related to occupational therapy practices. The office was very helpful, as was the Occupational Therapy Professional Leader at the time. She became the contact person and supplied me with a wide breath of documents, and also arranged for me to attend a meeting of senior OTs from across the DHB to ask them in person for access to or recommendations about documents. The documents supplied included the Allied Health Directorate Strategic Plan, 2017; credentialing in occupational therapy; the Audit Tool for documenting occupational therapy; minutes of the clinical governance group; the desk file for professional leaders, and induction and orientation processes for new or redeployed OTs. I was also able to publicly access various quality improvement documents, including a strategic plan.

The third DHB provided documents that were not labelled 'clinical governance', but spoke of 'professional governance' of OTs. However, the descriptions were clearly inspired by clinical governance, focussing on ideas such as quality and leadership.

Other consultants I contacted, namely, the CEOs of the OTBNZ and OTNZ-WNA and Professor Robin Gauld and Dr. Robin Youngson respectively provided me with access to meeting minutes, archives, gave encouragement and sent documents detailing clinical governance and compassionate care. After a call for documents via OTBNZ, I also received material from six individuals. Some were job descriptions, another was a clinical governance document published by the New Zealand Health and Safety Commission. Others referenced private practice and so, although they were interesting, I could not use them.

Table 2 below provides a summary of my document sources for the chapters which deal with History of occupational therapy, Moment 1 and Moment 2. While sources for Moments 1 and 2 were the same, the 'History of the present' chapter also required documents only available from historical collections.

Table 2. Sources of documents

Chapter 5 **History of the present**	**Chapter 6/7** **First analysis moment**	**Chapter 8** **Second analysis moment**
National Archives	DHBs	DHBs
Association newsletters	OTBNZ minutes	OTBNZ minutes
NZBOT Minutes	OTNZ-WNA minutes	OTNZ-WNA minutes
Parliamentary debates	OT Insight	OT Insight
NZ Legislation	NZJOT	NZJOT
Text books	MoH	MoH
Legacy group book	Legislation	Legislation
	Advisory groups	Advisory groups
	Text books	Text books
	Consultants	Consultants
	Private collections	Private collections

Archaeological method

There are a number of methods in Foucauldian discourse analysis that can be used to examine the discourses running through the texts (Willig, 2015). As an overarching model, I applied Kendall and Wickham's (1999) 'seven steps' to using Foucauldian discourse analysis, that they say are essential for "in action archaeological research" (p. 26). For my research, the steps have provided a way to apply selected tools associated with Foucault's *Archaeology of knowledge* (1972). By following Kendall and Wickham, I was able to conduct an analysis of documents that were either from or referenced the "institutional sites from which particular discourse is applied" (Foucault, 1972, p. 56).

The 'seven steps' provided a way of revealing the discursive relationships circulating within the institution, enabling me to identify, name and describe specific objects and subjects (occupational therapy and OTs respectively) located in the non-discursive domains of New Zealand healthcare institutions[30]. The subjects perform the everyday practices associated with the effective functioning of the institutions using particular objects connected to their profession. I followed Kendall and Wickham, interpreting the steps to improve my understanding, in a way that I could easily apply to my specific analyses across my two Moments, and help with comparing/contrasting the pre-2000s time period: the genealogical 'history of the present' (Chapter 5). My interpretation of each of the steps, using some examples from this history of the present is:

[30] Non-discursive domains include: "institutions, political events, economic practices and processes" Foucault, M. (1972). *The archaeology of knowledge* (A. Sheridan Smith, Trans.). Routledge. (p. 179-180)

1. A way to understand the relationship between what is said and/or written (located in documents, for instance) and what is visible (for example, hospital buildings, equipment). The analysis of written documents and texts revealed statements that described what OTs are expected to know and what they should do. Examples of the documents I used were professional text books and training manuals, hospital and departmental rules and regulations, processes and guidelines. When I placed the content of the texts in context alongside descriptions of the physical environment of the institution and the material objects used by the practitioners, such as the occupational therapy department, wards and equipment, my understanding of how OTs are constructed and what they do in these settings became clearer.
2. Understanding how the institution is ordered. Again, taking the hospital and occupational therapy as an example, I was able to identify the hierarchies and relations that govern the positioning of OTs within the organization. For instance, I noticed that external hierarchies were at play, (see Chapter 5) in early New Zealand health organisations. Occupational therapists at that time reported to the Director of Nursing for New Zealand (Rodgers, 1998), who assigned them to hospitals, rather than the clinician choosing where they worked. In hospitals, professional and support worker hierarchies intermingled and formed a complex web of relationships both vertically and horizontally (e.g. doctors, nurses, assorted support staff), both throughout the hospital and within services (e.g. OTs, craft instructors, technicians, volunteers).
3. Study of the documents constructing the procedures, guidelines, protocols, etc. for the institution gave insight into prominent discourse that, in turn, acted to construct what was considered 'the true knowledge' for that moment. These documents revealed the visible, repeatable, every day behaviours and actions of people, including OTs, occupying the hospital space, showing the extent and limitation of their practices.
4. Analysis of the emergence and production of named subjects and their associated subjectivities and subject positions enabled me to identify the subject positions of OTs (subjects) at different moments in time. For instance, I now understand OTs to have held subject positions at different moments that produced in them behaviours that labelled them as "problem-solvers" (Gordon et al., 2009), "individual-centred" (Gordon et al., 2009, p. 49; Walden, 1941) "patient-centred" (Willard & Spackman, 1963, p. 8) and "persuasive" to obtain co-operation from both staff and patients (Maling, 1944; Skilton, 1981).
5. I was able to identify the domain of occupational therapy in a healthcare institution at a particular moment through following Foucault's description of "Surfaces of emergence" (Foucault, 1972, p. 45).
6. Similarly, "Authorities of delimitation" (p. 46) enabled me to identify the bodies holding power to set the extent and limits (the scope) of the profession.
7. I used Foucault's "Grids (or forms) of specification" (p. 46) to ascertain how occupational therapy was constructed as a profession that provided re-enablement through occupation.

Data analysis: Interpretive grids

Like many researchers, I found application of Foucault's tools challenging, so I sought some examples of ways to conduct data analysis. I found Carabine (2001) to be particularly useful, who, in a worked Foucauldian example, provided a general guide for genealogical analysis, and a list of helpful suggestions, which I was able to distill:

- Select your topic
- Know your data
- Identify themes
- Look for inter-relationships between discourses
- Identify discursive strategies and techniques
- Look for absences, silences, resistances and counter-discourses
- Identify the effects of discourse
- Provide context; both background and power/knowledge networks within the period
- Be aware of limitations of research, data and sources.

Individual document analysis

I modelled my 'individual document analysis table' on Carabine's analysis advice, her worked example, and further reading of Foucauldian literature describing, defining and applying both archaeological and genealogical tools (Arribas-Ayllon & Walkerdine, 2008; Foucault, 1972; Kendall & Wickham, 1999; Powers, 2001; Stevenson, 2014). From these sources, I created the following table (Table 3) to guide me through the analysis of each document, making this the most fundamental step, the 'base' document, in the archaeological method.

By this time, I had collated the documents into the Moments I had selected to study, plus the pre-2000s contribution to the history of the present, so I tended to work on several documents at once from the same time period. I read each document several times and notated important statements and words in the text, then went through each document again, transferring my thoughts into the form, using the headings to guide my thinking. Being a visual thinker, I needed visual representations and tabulations of the relationships between documents at different times, and I developed and modified several templates and tables along the way to record the data.

The following page shows the base document: my individual document analysis table.

Table 3. Developed base to aid with individual analysis of documents, after Carabine (2001)

Individual Document Analysis Table
Document name:
Context: Background to issue:
Conditions of existence: (historical contexts – political, social, economic, world, NZ) Contextualise the material in the power/knowledge networks of the period
Corpus of Statements: (constructs the discursive object – essentially relevant quotes)
Governance: (structures & processes employed to manage OTs conduct at professional & DHB employee level)
Authorities of limitation: (who by? e.g. OT Board; other bureaucratic positions)
Discourses at play and surfaces of emergence: (sites where certain discourses operate) Medical: Professional: Neoliberal: Managerial: Economic: Political: Social: Welfarism: Clinical governance
Discourse: themes, categories, objects and inter-relations:
Foucault's notion of Power:
Technologies of self / techniques of power and discursive strategies that are employed:
Absences and silences:
Resistances and counter discourses:
Effects of discourse (behaviour – what is being governed? e.g. financial; professionalism)
Subject positions and subjectivities: (Discursive subject positions of OTs)
Limitations:
Additional notes:

Analysis of similar documents across moments

Next, I created a sheet that would help me organise my analysis, structured so that I could compare similar documents from different sources. The process generated a large number of completed tables, so I have shown a single example in Table 4 on the next two pages. These particular charts I used to analyse DHB values and mission statements texts, looking for repeating statements that produced dominant discourses favouring preferred knowledge that informed individuals how to behave. I then considered what subjectivities the preferred behaviours circulated by the discourses might produce.

The next step was to think about the ramifications for OTs as subjects and what subject positions they would be expected to hold. Finally, by comparison of one Moment with another, I identified a shift in practice from dominantly professional governance in Moment 1 to marked DHB governance in Moment 2, whereby core practices are emphasised rather than a broad traditional occupational therapy scope of practice that was still evident in Moment 1.

Table 4. One example analysis of similar DHB documents across the two Moments.

Documents: DHB Values and mission statements (from District annual plans)

DHB	2003 - 05	2015 - 17
Auckland	'Healthy communities, quality healthcare' (Auckland DHB, 2003a, p. 1) **Integrity:** Open, honest, direct **Collegiality:** Value people and staff – diversity; teamwork **Humanity:** Compassion; take risks, courage in roles – to achieve vision **Innovation:** Better ways of achieving outcomes **Research and development:** Information for decisions / actions **Excellence:** Quality service delivery **Access:** Engagement of others **Fun:** Positive stimulating environment	'Healthy communities. World-class healthcare. Achieved together' (Auckland DHB, 2015, p. 10) **Welcome:** We welcome you as a person **Respect:** We respect nurture and care for each other **Together:** We are a high performing team – colleagues, patients, families **Aim High:** We aspire to excellence and the safest care
Counties Manukau	'To work in partnership with our communities to improve the health status of all, with particular emphasis on Māori and Pacific peoples and other communities with health disparities' (Counties Manukau DHB, 2005, p. 1) **Care and respect:** dignity, value cultural differences **Teamwork:** working together; valuing others skills/contributions **Professionalism:** Integrity; ethics **Innovation:** Seeking new ideas / solutions **Responsibility:** Developing capabilities / results, accountability for collective and individual actions **Partnership:** Collaboration across health sectors for population health and independence	'Healthy together' (Counties Manukau Health, 2015a, p. 7) **Valuing everyone:** Make everyone feel welcome and valued **Kind:** Care for other peoples' wellbeing **Together:** Include everyone as part of the team **Excellent:** Safe, professional, always improving
Waitematā	'To make a healthy difference' (Waitematā DHB, 2003b, p. 4) **Openness:** transparency **Respect:** dignity **Integrity:** truthful **Customer focus:** serve customers well **Compassion:** thoughtful – protect mana / self-esteem / dignity	'Best care for everyone' (Waitematā DHB, 2016a, p. 8) **Everyone matters:** patient, family, staff **With compassion:** work is vocation rather than job; caring approach – aware of and desire to relieve suffering; promote wellness **Better, best, brilliant:** continuous improvement, national leader in healthcare delivery **Connected:** with community, in organisation across teams and disciplines, seamless and integrated care, best possible outcomes **'Our values shape our behaviour and how we measure and continue to improve.'** (p. 8) (Separate document and web page that addresses behaviour associated with values (Waitematā DHB, 2021))

Example analysis of similar DHB documents across the two Moments (Table 4 contd.).

DHB	2003 - 05	2015 - 17
Subjectivity: Summary of the 3 DHBs – similar themes	**Culturally safe practice:** Inclusive, embrace diversity, culture **Teamwork:** Valuing others, collaboration across organisation / sectors / community **Compassion and care:** Protect dignity and mana, respect, self-esteem **Courageous:** Take risks and 'do' to achieve vision **Quality and Innovation:** Problem solve, generate new ideas aim for better outcomes; provide quality service **Accountable:** Be accountable for collective and individual actions **Fun:** Enjoy work **Professional:** Be open and honest, demonstrate integrity, be ethical, knowledgeable – and well informed Addresses some general behavioural traits wanted by the organisation, particularly around being an 'individual practitioner' - still able to take risks and problem solve, rather than conforming to standardised interventions. However, must be accountable for actions. Silent on financial prudency, but might be included under accountability. Would need to dig down for more detail. Not emphasising client-centred practice, but clear on addressing diversity. Practitioners can still enjoy work and their professional conduct is acknowledged as being part of what they should do.	**Person-centred care, indirectly embracing diversity:** Every individual is a 'person', welcome and valued **Compassionate care:** Caring, kind, relieve suffering, respect **Teamwork:** Seamless, integrated care **Quality and innovation:** Continuous improvement, best possible outcomes, **Safe practice:** Excellence, professionalism **Gone quiet on accountability** except that ADHB refers to 'we' **Also silent on financial prudence** Need to probe deeper to micro level as this is the macro level and addresses the main points that the DHBs want to advertise to the world – caring, trusted, high quality integrated, safe service. It does not go into what the staff have to do and experience to achieve these subjectivities. **Professionalism** becomes part of excellence and safe practice, which could be construed as pushing it to the background while the idea of 'safety' becomes paramount Feels more process driven, humanistic words and actions are still present but over-shadowed by more of an emphasis on quality and safety practices. **No mention of having fun at work**, but, rather, in Waitemata DHB's case, more about relieving suffering and the job being a 'vocation' – almost a religious approach and perhaps harking back to past centuries when healthcare was provided by religious charities.
What does this mean for OTs?	**During this moment, an OT is a subject who has the freedom to behave compassionately from the heart and also has the capacity to customise interventions so that they are most suitable for individual patients / families.** This practitioner is governed primarily by the OT scope of practice, which is broad, and enables multiple solutions / outcomes for individual situations. The DHB does govern the practitioner, seeking accountability, but there is scope to make professional decisions and engage in novel problem-solving that provides effective outcomes for the patient. Practitioners are also able to enjoy their work. • **Professional** • **Caring and compassionate (from the heart)** • **Problem solver** • **Innovative** • **Team player** • **Culturally aware** • **Accountable** • **Enjoy work**	**During this moment, an OT is a subject who is expected to follow certain rules and procedures laid down by the DHB.** Professional governance is still present, but DHB governance has become more prominent, with professional governance essentially placed in a supporting role. Compassionate care is delivered in a particular way, as are the interventions provided by the practitioner. Practitioners are limited by service guidelines, funding, and identification of core practices. They must participate in the provision of quality interventions, safe practice and effective outcomes at all times. No time to have fun! **Person-centred;** including recognition of diversity **Compassionate care** (being compassionate in a certain way) **Team player** focussing on integrated care **Focus on and participation in continuous quality** and innovation initiatives **Safe practice** through professionalism and excellence

Analysis of governance across time periods

After taking up advice from my supervisors, I developed another table template that I used on many occasions for comparison of documents across the time periods in order to make visible change in governance. Table 5 shows this template which enables the application of Foucauldian methodology to my analysis of how OTs were governed across the two Moments and pre-2000. The completed table is too large to reproduce, as it contains many document references.

Table 5. Foucauldian template for governance comparison across Moments and pre-2000s

Governance of occupational therapists Analysis table looking across time periods and multiple documents			
		Time frames	
Foucauldian toolbox	History (pre-2000)	First moment (2003-05)	Second moment (2015-17)
Conditions of existence			
Historical contexts: Political; social; economic; world; NZ			
Authorities of delimitation			
Examples of governance documents employed to manage OTs' conduct at a professional and DHB employee level.			
Discourse and discursive formations			
Surfaces of emergence; The sites and bodies where certain discourses operate			
Discourses at play (medical; managerial; professional, etc.)			
Evidence of formation of subjectivities and subject positions of OTs (glimpses of discourse)			
Grids of specification: The products of dominant discourses – (preferred knowledge/truths)			
Power			
How is power dispersed across the organisation impacting OT? Who holds it?			
Techniques of power			
Application of discipline and all its relevant techniques, punishment, technologies of self			
What is being governed? (Behaviour; practices) Reflections on findings			

Discursive formation of occupational therapy subject positions

Stevenson's (2014, p. 55) table examines the formation of subject positions in her thesis. I adapted this as Table 6 to help with exploring the production of objects, subjects, subjectivities, practices and technologies of power relevant to occupational therapy and OTs in these time periods.

Table 6. 'Helper' table of discursive construction of OTs. After Stevenson.

Discursive construction of occupational therapists at selected moments (some examples)			
	OT pre 2000	OT 2003-05	OT 2015-17
What is the object being constructed through discourse? How? Why?	OT professional Legislation Social welfare thinking Post-war reablement; improved quality of life; return to community	OT professional within DHB service employed by localised AH team Legislation Recession 1973-1975 Neoliberal thinking Quality and safety concerns due to malpractice Cost and efficiency of healthcare delivery, competence, responsibility and accountability	OT professional in AH service placed within organisational service & also required to have second job of DHB quality, safety assurance. Legislation and directive from government Economic crash 2008 Continued neoliberal thinking Cost and efficiency of healthcare delivery; competence, responsibility and accountability
What are the names of the subjects being produced through discourse?	Occupational therapy clinician, senior, Head OT	OT clinician OT supervisor OT professional advisor AH team leader Attached to a particular service, e.g. older adults. Managers set the service policy/ plans.	Director of Allied Health AH Operations managers Professional leaders AH team leader Clinical service leaders Senior clinicians Clinicians: sent out to MDTs
Subjectivities	Professional Reports to Head OT; carries out practice as taught in training, which is regulated by OT board; new grad oversight by OT from the board; needs to be registered by the board after a period of successful training. Referrals via physician – report back to physician on patient progress in OT. Belief that occupation is essential to health Misunderstood by colleagues 'Right type' Empathy OT decided on treatment for patients and persuaded them to participate.	Professional Concept of allied health teams introduced into DHBs. Reports to generic team leader. Early take up of AH Service in some DHBs with DAH and PLs, yet in other DHBs AH clinicians including OTs, were part of a specific service such as older adults, with professional advisors attached to the separate services. Informal recognition of specialty areas, such as stroke rehab; enabling clinicians to apply for courses relative to their specialty (no protected budget for professional development). Patient centred and need to document patient goals introduced – OT works with patient to achieve goals. Focus on Duty of care; Need vs desirability	Professional Still named as OTs but blurring of roles and drive towards IDT approach where patient is centre of care and essentially part of team. Further development of AH service and meshing of roles. Some positions generic, Senior Allied Health Professional (SAHP) with protected time to engage in project work, supervision, etc. Additional identity and allegiance with DHB: values and mission – specific training Core skills Patient centred – patient goals – OT walks alongside and provides education and information

Examples of discursive construction of OTs (Table 6 contd.).

	OT pre 2000	OT 2003-05	OT 2015-17
Practices that the subject engages in	Clinical duties are priority Patient focused Associated with teams Works in OT department / on wards Problem-solving and holistic practices Persuasive Agent of state Conducts self in a 'ladylike' (white, female, middle class world view) manner	Clinical duties priority. However, more focus on competence, particularly with introduction of the Health Practitioners Competence Assurance Act 2003 and restructured OTBNZ, focusing on competence and regulation. PDR process in place but intermittent in practice. Flat structure: clinicians, supervisor, TL, indirect relationship with PL Working within requirements of Treaty required – training in cultural awareness Opportunities to develop practice guidelines for use by OTs. Reflective practice. Participation in supervision	Clinical duties *and* Quality role = 2 jobs Patient experience Seamless journey Discharge planning starts at admission Value Prudent decision making – re supply of equipment and safe to discharge Participation in quality and safety initiatives; demonstration of accountability, responsibility, competence, financial prudency and professional development activities
Technologies of power applied to produce / change behaviour	Sees patients only through referrals from physician (sometimes enacted as a 'blanket' referral) Dress and conduct code Matron's rules re seeing patients on the ward Responsible for keeping inventory of equipment and materials current Clear limitation of role to use of craftwork in the rehabilitation of patients Apprenticeship-type training Extension of physicians' gaze and in effect, power. Scope of practice first developed in 1990, but no bodies or mechanisms enforcing adherence. OT clinicians essentially managed themselves – high trust that they were carrying out their role competently	Patients referred by physician, also blanket referrals and self-referrals from the community. TL is immediate manager – part of a particular service. Some practice policies published, such as wheelchairs, splinting, OT prioritising in AT&R. Expected to conduct self per professional scope and competencies. APC needed third party signoff and confirmation by supervisor. TL checked annually the APC current. Clinicians made decisions re: annual leave requests and professional development needs in OT meetings and then referred on to TL for sign off. Few internal DHB mechanisms to ensure quality and competence. High trust that clinician was performing role competently.	Monitoring, surveying, auditing Peer review, PDRs, PIPs, courses and conferences procedure; documenting policy; standard operating procedures – OT; documents capturing DHB expectations of conduct of OTs. Surveillance of self and others. Reflective practice. Participation in supervision

Moving on from tables to mind maps and power point diagrams

The tables were a useful precursory exercise in the actual application of some of Foucault's concepts and provided the structure I needed to commence the analytical process. To make connections and understand the effects of discourse, I also constructed mind maps hand drawn on paper and in PowerPoint, and I became very familiar with the detail in the texts, in preparation for further inquiry, analysis and interpretation that would be written into draft chapters.

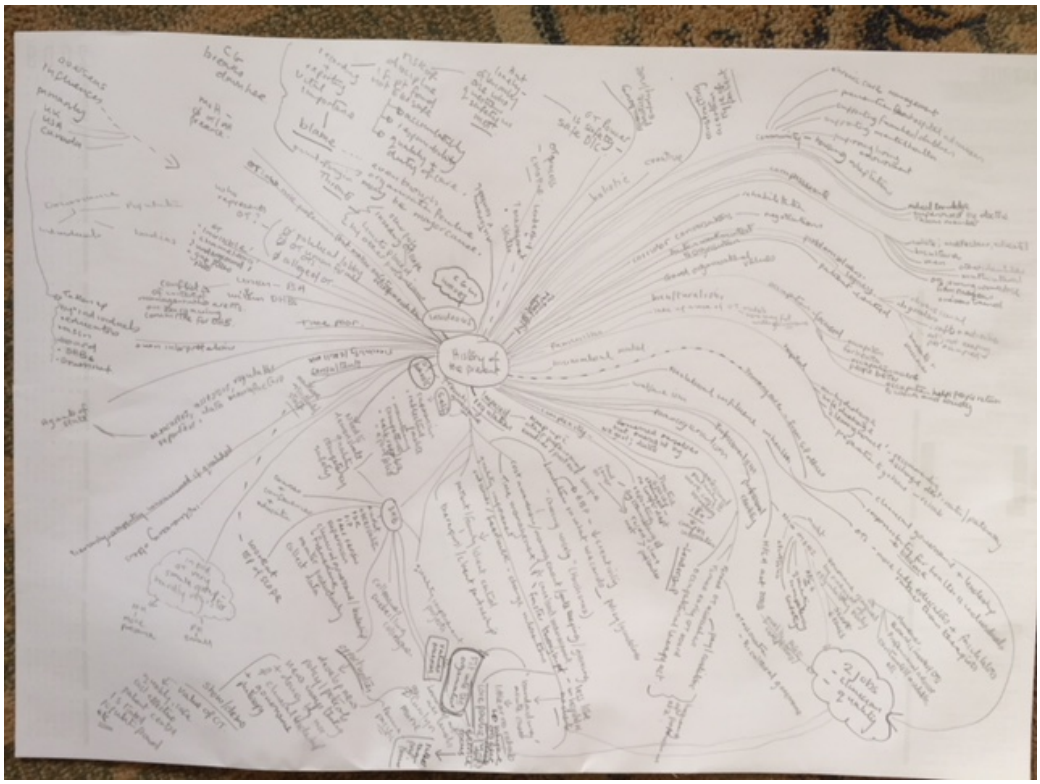

Figure 3. Early formative mind map. Author's work.

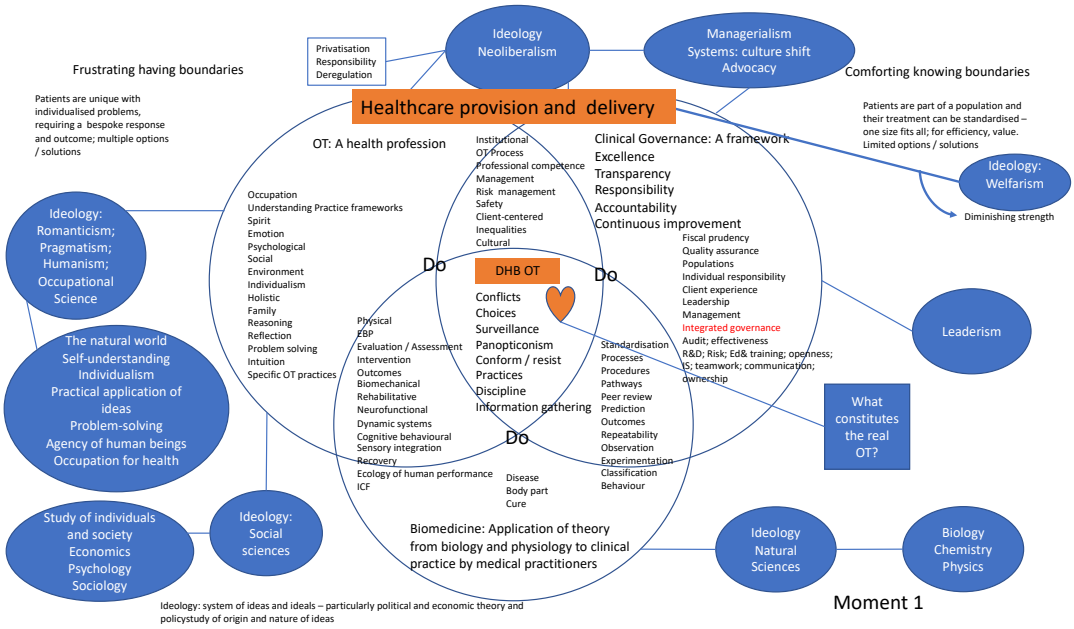

Figure 4. Thinking visually using Powerpoint. Author's work. Some additional examples of my 'Powerpoint thinking' are shown in Appendix D.

Archaeological inquiry

The use of archaeological inquiry enabled me to build structure into my research because it served as a defined process with which to study my collection of documents from different moments. The inquiry process provided a means to identify and describe the discourses within the texts and keep them ordered according to time and space. The process revealed relationships between discourses by uncovering clashes, overlaps, extinction and replacement of discourse in my research. As such, archaeological inquiry became a crucial tool that enabled me to map out and reveal the discrete and interconnecting structures present within the web-like grids of the discourses identified amongst the texts. This is what Table 6 (earlier) aims to do: create a categorical framework for the products of various discourses in each moment.

Genealogical analysis

While I was able to organise my study through application of the rules and principles described in his notion of archaeology, so that particular discursive formations and their relationships were becoming more evident to me, I also used a number of Foucault's analytical notions of 'genealogy' to investigate how the effects of power/knowledge discourse circulating within institutions produced behaviour change (Hardy, 2010) in people's daily practices through the uptake and normalisation of perceived 'truths'.

Foucault's four principles of 'reversal', 'discontinuity', 'specificity' and 'exteriority' (Foucault, 1981, p. 67), helped me recognise discourse more clearly as construction of events that produced material practices driven by the interests and actions of related bodies. I also began to understand the importance of looking for and mapping any discontinuity of discourse that reflected its contingent nature, where 'chance' is a factor in the production of events. Finally, I realised that the boundaries of discourse, setting the 'conditions of possibility' should be sought on the surface of discourse rather than searching for deeper significance (Hook, 2005). In practice, for my study, this meant that I would not be looking for one, continuous deeply embedded discourse to explain the course of occupational therapy practice. Instead, I would be looking for multiple discourses that were in series, itinerant and discontinuous. Furthermore, these practices would be those emerging from discourse that conveyed the preferred truths at a particular moment about how to practice occupational therapy. For this reason, I considered separate moments in time where there appeared to be disruption and shift in occupational therapy practices, for further analysis. By focussing on the surface of discourse, Foucault actually means that researchers should be looking at what it does; what discourse makes possible and, conversely, what it shuts down. Close analysis of multiple texts, gathered from a wide variety of sources representative of this study's chosen time periods, assisted me in building a picture of what, for example, clinical governance discourses were 'doing' to occupational therapy practice and how OTs themselves responded to the discourses.

I recognised discourses by looking for the inclusion of certain words and phrases present in the documents. On occasion, I was able to identify sentences and paragraphs, but as most of the documents were not originally written to expose occupational therapy and clinical governance practices, these longer passages were rare. I therefore had to draw on hints at, and glimmers of discourse alluding to occupational therapy and clinical governance practices scattered throughout the texts. I then selectively applied Foucault's genealogical tools to understand how the mechanisms of power and knowledge, and the technologies of discipline and punishment were in play during each moment, producing change in societal, institutional and individual conduct. Examples of Foucault's tools I applied include 'governmentality', 'biopower' and 'care of the self', along with associated technologies of discipline, in an attempt to offer up an explanation of the effects that 'truths' of the moment had on occupational therapy practice. The tools were described in detail in Chapter 2 and Chapter 3.

Problematization

As discussed in Chapter 3, although problematization is central to Foucault's later work on ethics and the subject's 'care of the self' practices, it is also present in his earlier work (Koopman, 2014). Using this notion, I identified the issues that were problematic in healthcare delivery after the Second World War, considering the conditions for the emergence of occupational therapy as a profession. Healthcare delivery became problematized in more contemporary periods when concerns about cost, competence, safety and quality arose. The concept of an integrated clinical governance framework was constructed as one solution to resolving these problems. The effects of the problematization of health care delivery at particular moments are considered in this study with regard to the changing subjectivities, conduct and practices of OTs.

Considerations

Challenge

What has been challenging is to reveal what practices are as a result of clinical governance and what are not. When placed within the social, political and economic contexts of time periods, so many other considerations come into play, including being subjected to professional governance and regulation, overseen by the OTBNZ. In many instances, the discourses merge and the waters become muddy. However, I have tried to identify, track and prioritise discourses associated with the clinical governance expectations of quality and safe service provision within the remit of value for money, accountability and responsibility. I specifically looked for discourses carrying these notions through to the practices of OTs in the space of the DHBs.

Ethics

I confirmed through consultation with an AUT Ethics Committee Advisor that an ethics approval was not required for this proposal as the data were sourced purely from documents. Many of the

documents I gathered were publicly available, including government and DHB policy and legislation and I did not require permission to access them. Other documents from DHBs, the OTBNZ, and OTNZ were provided after I followed different processes associated with each organisation. These included requesting an Official Information Act response, engaging with a DHB's Education department and identifying a DHB representative to collect and send documents to me and signing a letter of confidentiality for a further organisation.

The Treaty of Waitangi is clearly inserted into New Zealand clinical governance documents as well as into New Zealand occupational therapy practice. Throughout the proposal, I maintained an awareness of the Treaty of Waitangi by reading literature concerning cultural practices, health and history from respected authors such as Sir Mason Durie (1998, 2001), Dianne Wepa (2005) and Michael King (2003), in order to ensure that my writing was appropriately informed, constructed and conformed with bicultural standards of competence and safety.

Validation

It can be argued that Foucault's method is not based on the scientific method, therefore it is not necessarily generalizable and the findings apply only to that group which is being studied (Foucault, 1991a; Mills, 2003). In Foucault's methodology, the researcher is considering historical events; discourses can only be examined after they have occurred. Foucault believed that all phenomena are on-going and ever changing; that issues are open to interpretation and are influenced by the environmental, social and political contexts of moments in time and history. In this respect, content of documents, such as recommendations, could be seen as out-dated as soon as they are written, but the threads of discourses remain in the documents and so can continue to be monitored and tracked through study of the documents – their survival or extinction shaping how a practice develops or fades away. I have addressed these considerations in that I do not claim that the findings within this thesis can be generalised. Nor do I suggest that predictions can be made to determine the course of further practice. I have presented the implications of the discourses for consideration; maintaining a healthy scepticism is critical to Foucauldian methodology, as with other forms of inquiry.

Rigour and trustworthiness

Although they do not at all advocate for a standardised method of discourse analysis, Greckhamer and Cilesiz (2014) argue that there are a number of challenges when addressing rigour and trustworthiness within naturalistic inquiry. Trustworthiness is concerned with the validity and credibility inherent in the research (Lincoln & Guba, 1985). Discourse analysis is problematic because of the highly interpretive nature of the approach when conducting analysis and producing findings from the texts used, so Greckhamer and Cilesiz (2014) recommend a number of ways to ensure that rigor and credibility are clearly addressed and visible. They suggest that analysis of discourse should be conducted within a clearly, yet concisely described framework while also

recommending a number of tools that, they say, can provide some clarity to the analysis methods used. These are "chronicling" (p. 430) and "tabulating" (p. 431) the process of analysis; "narrating the process of interpretation" (p. 434) and "crafting a description of the findings" (p. 435). I have followed their recommendations and have used their tools in this chapter to describe the process I used to analyse, interpret and finally present findings from the documents used for this study.

In addition, I used other methods to ensure rigour, such as collecting texts from multiple sources, including different DHBs, OTBNZ, Parliament, to the point of saturation, where enough information has been collected to gain understanding of the event being studied (DePoy & Gitlin, 2005, p. 205). I also contacted consultants for advice on suitable documents to study so that there were others apart from myself, who distantly played a role in the selection of documents. I kept an audit trail in a series of five notebooks throughout the course of my study, where I documented what I planned to do and what I did. The notebooks became a useful reference when describing my method for this chapter. I also attended regular supervision where I discussed different aspects of my study as they surfaced, which I believe, was a form of debriefing. We recorded the supervision sessions and I transcribed them so I could think more deeply about the topics covered and then plan and carry out research activities that arose from the discussions and reflections in supervision.

Reflexivity

DePoy and Gitlin (2005) explain reflexivity as "the process of self-examination" (p. 205), and Grbich (1999) further states that researchers must consider how their own socially constructed personal beliefs and values may have influenced their research findings. Through reflection, I considered how my own life experience, family background, culture, class and education have shaped my beliefs. I also examined how my understanding and knowledge developed over the course of this research in the context of my position of being a white, female, middle aged, educated immigrant in New Zealand. I tried to maintain an open mind during my research, recognising there are multiple constructions and interpretations of phenomena and events, mine being just one of many. In Chapter 1, I introduced myself and described how I was drawn to my research topic.

Furthermore, I kept a reflective account of my readings and thoughts as my knowledge grew and I began to be more critical of my understanding of the influence of clinical governance on occupational therapy practice. These reflections I typed into my phone as they occurred 24/7 and emailed to myself, collating them into 50+ pages of "Yasmin's thoughts". I believe my collation of 'thoughts' were integral to my reflexive approach to the study (some snapshots are shown in Appendix E). The reflections helped me realise that my interest in this study was more about what changing practice does to others and the implications to their lives, rather than my original goal of describing and understanding clinical governance. This insight into my values made me realise

I was very concerned with inequity and the inability of some members of society to access the healthcare services they needed, and it eventually changed the way I conducted the analysis, interpreted the texts and presented the findings.

Summary

In this chapter, I have described how I carried out the study and applied Foucault's methods. I have described how I conducted a 'history of the present' and used problematization to investigate how clinical governance has influenced the behaviour and practices of OTs. I have also revisited the archaeological method, from the point of view of a doctoral-level researcher: considering ethics, validation, rigour and reflexivity.

Next, in Chapter 5, I describe the historical period after the Second World War and the conditions that produced the emergence of the occupational therapy profession into New Zealand. I also construct the early discursive subject positions of OTs. The findings from Chapter 5 form a baseline from which to consider the findings of the two moments post-2000, after the introduction of clinical governance.

Chapter 5 A history of the present

> Occupational therapy has been defined as 'any work or recreational activity, mental or physical, definitely prescribed and guided, for the distinct purpose of contributing to and hastening recovery from disease and injury'.
>
> *– Norah Haworth and Mary Macdonald, Theory of Occupational Therapy*

Introduction

This chapter is a genealogical investigation into the network of prominent discourses present in the medical, social, political and economic literature that shaped public healthcare delivery and the practice of OTs in New Zealand, prior to 2000. The notions of particular New Zealand subjects named as 'occupational therapists' and their practice of 'occupational therapy', emerged from discursive constructions of occupational therapy which were already constituted within healthcare provision systems in the United States of America (US) and then the United Kingdom (UK) (Andersen & Reed, 2017; Gordon et al., 2009; Haworth & Macdonald, 1946; Quiroga, 1995; Wilcock, 2002). As genealogy is built on and includes archaeology, I describe the discursive "conditions of existence" comprising the "rules of formation" (Foucault, 1972, p. 42) at play. The conditions of existence acted to produce the moment when OTs first emerged in New Zealand as a new profession, working alongside medical practitioners, nurses and other healthcare workers in government and health institutions such as hospitals, sanatoriums, and asylums.

The 'ideal' OT prior to 2000

I begin my analysis by providing the context for an overview of the social, political and economic positions of New Zealand and the world that created the conditions necessary for OTs to emerge as named subjects within the New Zealand healthcare community. Through a study of archival documents, I then consider the conditions of existence that give rise to the discourses which enabled the occupational therapy profession initially to self-govern.

Healthcare in colonial New Zealand: 'Proto-OTs'

In colonial New Zealand, after the signing of The Treaty of Waitangi, 1840[31], an 'ad-hoc' system of healthcare provision was constructed. Unlike European countries, New Zealand had few

[31] The Treaty of Waitangi: Signed in 1840, a legal document considered to be the founding document of New Zealand (Archives New Zealand. (n. d.). *Te Tiriti o Waitangi/The Treaty of Waitangi*. Archives New Zealand,. Retrieved 29 November, 2020, from https://archives.govt.nz/discover-our-stories/the-treaty-of-waitangi, Mauriora. (n. d.). *Treaty of Waitangi: Maori history and health (video transcript)*. Mauriora Health Education Research,. Retrieved 29 November, 2020, from https://members.mauriora.co.nz/video-transcript-maori-history-and-health-2/). It is an agreement between the British Crown and Māori *rangatira* (hereditary leaders) and acknowledges certain rights to both Māori and Europeans (Ministry for Culture and Heritage. (2020). *Treaty of Waitangi*. Retrieved 29 November, 2020, from https://mch.govt.nz/treatyofwaitangi) in a bicultural setting. Two versions of the Treaty were produced, one written in Te Reo Māori and the second one in English. The production of practices constructed from the words and statements contained within the Crown's English version of the Treaty did not align with the construction of the Treaty written in Te Reo Māori. Each version is interpreted differently, and, historically, has produced misunderstandings between Māori and non-Māori. It was only in the 1970s that the legal power and

wealthy citizens who could act as patrons of charitable initiatives for the health and care of the 'deserving' poor, so other sources of healthcare provision arose (Department of Health, 1974). Healthcare was typically community-based and largely dependent on home-derived remedies (Belgrave, 2011a). It was in this space that unnamed "Proto-occupational therapists" (Wilcock, 2001, p. 15) would have existed, producing intuitive, humane solutions to restore health through participation in activities and occupations for people within their communities (Andersen & Reed, 2017; Wilcock, 2001).

In the mid 1800s, in common with other established colonies, New Zealand had problems with managing and containing infectious European-introduced diseases such as tuberculosis, typhoid, polio and diphtheria. Māori, in particular, were affected as they had little immunity to these diseases, to which many succumbed (Belgrave, 2011a). Discourses concerning the 'deserving' and 'undeserving' circulated (Belgrave, 2012, p. 4) whereby only certain societal groups were identified as worthy of receiving government funded care and support, including settlers in remote areas, envoys of the British government and Māori (Gauld, 2009b). Although Māori had constructed their own methods of healthcare, their susceptibility to introduced disease ultimately led to the government to recognise that Māori, along with other vulnerable sections of the population, should have access to customised healthcare services (Belgrave, 2012). Aiming to manage disease and mental illness, the otherwise *laissez-faire* government reluctantly established four district hospitals in the mid-1840s, as well as mental asylums, in New Zealand, operating alongside the already established private and voluntary ventures (Gauld, 2009b).

Biomedical[32] governance by medical practitioners

Viewed from a Foucauldian (1973) perspective, the early health system was governed by medical practitioners, where, claiming to be the experts in the classification and management of disease, doctors were the authority of delimitation for medical knowledge and interventions. The scientific discourses concerning the functioning of the body and its relation to medical practices, which claimed to cure illness and disease, gave credence to the growing status of medical practitioners, positioning them as revered members of society with power to act in a number of ways. Their gaze over the sick in the population provided a means of social and economic control, preventing the spread of disease by containing the sick in special, named institutions such as hospitals. Medical doctors not only limited the economic damage to society through the provision of treatment aimed to assist people to recover from disease, so that they were less of an economic

position of the Treaty of Waitangi was acknowledged and Māori have acted to reclaim their position in bicultural New Zealand society.

[32] Biomedical model of health: Assumption: "That each disease or ailment has a specific cause that physically affects the human body in a uniform and predictable way, meaning that universal 'cures' for people are theoretically possible. It involves a mechanical view of the body as a machine made up of interrelated parts, such as the skeleton and circulatory system". Germov, J. (2007). Imagining health problems as social issues. In B. Deed (Ed.), *Health in the context of Aotearoa New Zealand*. Oxford University Press. (p. 36). "This approach ...generally ignores the social origins of illness and its prevention". (*ibid*. Glossary, p. 343)

burden on society (Foucault, 1973), but the medically dominated health system also ensured that the wealthy had a continuous pool of labour (Wilcock, 2001). Furthermore, as doctors monitored and recorded information about their practices, this collectively became statistics about the general population's health for government surveillance and policy development (Rice, 2011; Statistics New Zealand, n. d.).

Prior to the construction of named 'Occupational Therapists', other groups, including women's auxiliary groups, volunteers, artisans, nurses (Rosser, 1956) and Red Cross workers (Occupational Therapy Board, 1956) informally carried out crafts with patients as a diversional medium (Quiroga, 1995; Wilcock, 2001). However, the construction of occupational therapy created a shift due to the claiming of crafts by OTs and naming as occupational modalities of treatment in their domain. Casual use of crafts by other groups in the biomedical space would henceforth be discouraged, as these activities were now prescriptive objects to be provided under the close supervision of a registered, trained 'expert' specialising in the use of occupation as a means of therapy[33].

International emergence of OTs: Embracing biomedical theory

The use of occupation to promote healing has a long history; 'occupational therapy' was named by George Barton as early as 1914 at a hospital workers' conference in Massachusetts, (Andersen & Reed, 2017). He was later one of five founders of the National Society for the Promotion of Occupational Therapy in 1917 in the United States (2017). This alignment with the biomedical model of health meant that both recognition of occupational therapy, and its verification as a valid profession, were achieved at an early stage (Creek, 2010). The relationship between OTs and medical practitioners was further cemented by the construction of an agreement whereby medical practitioners would issue prescriptions[34] to their patients for occupational therapy treatment (Andersen & Reed, 2017).

This process was essentially repeated in the United Kingdom, with Wilcock (2002) maintaining that early occupational therapy practice "was grounded in medical science concepts… [and] was initially used as a prescribed adjunct to medicine" (p. 4). As a result, occupational therapy was committed to having a strong relationship with science and medicine from the outset, since early practice was based on (intuitive) historical healing traditions using occupation, rather than being underpinned by its own later theoretical scientific models (Andersen & Reed, 2017). Subsequently, although this close relationship with medicine remained strong, it became clear

[33] In one instance, a Red Cross worker was the focus of discussion, for over a year, between the Occupational Therapy Registration Board and the hospital employing her, before a resolution was offered that she work as an aide in the occupational therapy department (New Zealand Occupational Therapy Registration Board, 1956, 1957a). Other workers, such as nurses who had received instruction, technicians and craft instructors, were frequently employed to carry out the work with patients in the occupational therapy departments, under the direction of OTs (Maling, 1944).
[34] Prescription: "A written instruction by a physician for the preparation and administration of a medicine...tells the occupational therapist what goals the physician has decided that occupational therapy shall attempt to achieve" (Reed, K., & Sanderson, S. (1980). *Concepts of occupational therapy*. Williams & Wilkins. (p.117).

that a narrow, linear construction of occupational therapy based only in biomedicine was unrealistic, and that the focus on occupations performed by individuals in particular temporal and environmental contexts required a broader, more holistic approach than biomedicine alone.

International models of occupational therapy

Occupational therapy professional knowledge was generated contingently as problems in healthcare provision arose, and opportunities presented themselves to solve these practically through the uptake of occupation-focused intervention. However, in response to calls to underpin the profession with practice models, OTs increasingly examined additional emerging discourses from biopsychosocial and socioecological sources (Creek, 2010; Turpin & Iwama, 2011). These later professional models were constructed to support the profession's belief in particular core constructions made visible through professional statements: "the mind and body are inextricably linked" (Kielhofner, 2004, p. 44) when justifying holistic practice; "occupation plays an essential role in human life and influences each person's state of health" (p. 44), implying that occupation is essential for health (Townsend, 2002; Townsend & Polatajko, 2007; Wilcock, 2002), and as "humans are occupational beings" (Townsend & Polatajko, 2007, p. 3) then "occupation can be used to regenerate lost function" (Kielhofner, 2004, p. 44).

The construction of practice involved challenging the early descriptors of OTs such as diversional therapists, handicraft teachers and recreational leaders producing 'busy work', and vocational trainers 'teaching' work skills. Instead, models constructed from core activities of productivity, self-care and leisure, and behavioural and communication skill management became prominent professional discourses (Reed & Sanderson, 1980). Thus, dominant discourse-producing knowledge, from multiple discursive sources, was selectively taken up by OTs in the construction of international conceptual occupational therapy models and frameworks. In turn, these models acted to selectively influence the professional subjectivities and subject positions of OTs in New Zealand at particular moments in time, depending on the power of the prominent local political, social and economic discourses circulating alongside, interweaving and crossing them.

World events and occupational therapy in New Zealand

Two significant world events created the conditions for multiple, seemingly unrelated, discourses to emerge, change prominence, and to cross and create a space for occupational therapy to be constructed in New Zealand. The discourses addressed the effects of the Great Depression of the 1930s and World War II, 1939-45.

The Great Depression

The Depression had major consequences for the health and welfare of people in Western societies, and world governments, including New Zealand, had the problems of both recovery from its effects, and restoring and growing the economy.

> The 1930s depression led to a rethink of state support. With mass unemployment, poverty was widely experienced and gained public recognition... Small outbursts of violence suggested that the unemployed would not always quietly accept their fate. In Dunedin, where the Lady Mayoress wore gloves to distribute charity, her taxi was overturned, and a drawing of gallows posted to the Mayor. As the 1935 election loomed, the Labour party allied itself with the mood of public discontent, and was swept to power with a substantial majority. (Marahey, 2000, para. 23-27).

The fusion of social, economic and political discourse

Like the British government, which looked to economic models of recovery that were somewhat aligned with a social Keynesian[35] model of economics (Turner, 2011a), the New Zealand Labour Party's 1935 election manifesto also promoted welfare and health reform and placed the Party in a strong position of power. They too planned to deliver a solution for economic recovery through the construction of government-supported social initiatives while maintaining private enterprise (Aimer, 2015) and its "individual autonomy and individual empowerment" (Fischer, 2012, p. 400). This political discourse found favour with New Zealand voters, and the first Labour government was elected in 1935, remaining in power for fourteen years (Aimer, 2015).

New Zealand's Social Security Act 1938

The 1930s Depression provided the impetus for the introduction of a health service available to all New Zealanders. Following the 1935 Labour election victory, old beliefs and knowledge supporting private and charitable systems of care were challenged by Labour politicians, particularly Prime Minister Michael Joseph Savage (Fischer, 2012). This produced a space for the production of new discursive constructs to "alleviate suffering" (Sinclair, 1959, p. 248), including the concept of free healthcare for all people in the population (Fischer, 2012). The government was well aware that the economic and social discourses of discontent surfacing and circulating within society were problematic and potentially dangerous to the status quo, signalled by "rioting and looting in Auckland and Wellington" (Sinclair, 1959, p. 251). Although this behaviour was quickly shut down by the police (Sinclair, 1959), it provided an opportunity for Labour to introduce both new policies, and ultimately, The Social Security Act 1938, aimed at providing certain welfare services to all subjects regardless of their economic situation. When the first Labour government was finally replaced in 1949 by the first National government, although the new government did not actively build on and develop the health service, neither did it repeal the Social Security Act (Belgrave, 2012).

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[35] Social Keynesianism: An economic model that, in practice, managed capitalism through state funded initiatives, such as educational, health and welfare services, as well as the construction of roads and transport systems designed to support capitalist business projects Turner, B. (2011b). Keynes, J. M. In J. Beckert & M. Zafirovski (Eds.), *International encyclopaedia of economic sociology* (pp. 382-384). Routledge. . Politicians favoured the model as they believed it would redress imbalances in the economy caused by the depression, thus supporting the continuation of private business and enterprise. Social Keynesianism was in effect "a set of policies to preserve capitalism rather than to advance welfare socialism". Turner, B. (2011a). Citizenship. In J. Beckert & M. Zafirovski (Eds.), *International encyclopaedia of economic sociology* (pp. 58-61). Routledge. (p. 60)

World War II: Aftermath and international agreements

The Second World War acted as the catalyst for the emergence of international social, economic and political discourse concerned with solving major problems such as rebuilding the world economy, preventing the reoccurrence of war and managing the spread of disease through the provision of healthcare available to all. Politicians, theorists, and medics were active in enacting and circulating the emerging social, economic and political discourses, producing an opportunity to consider and act on new ways of managing the health of populations around the world.

Prominent discourses around the world immediately after the end of World War II focused on how war could be prevented from happening again. In 1941, in his 'State of the Union' address, President Franklin Delano Roosevelt introduced the idea of the 'Four Freedoms' of democratic governance. The inclusion of statements in his speech to the American people extolled the freedoms of speech and worship and from want and fear (Office of War Information, 1942). 'Freedom from want' included the construct of "a healthy peacetime life…everywhere in the world" (p. 3). Post-war, the United Nations and its agent, the World Health Organization (WHO), actively promoted global remediation of disease and provision of healthcare as a method to prevent war. The concepts behind the 'four freedoms' statements were incorporated into the construction of the United Nations Declaration of Human Rights (United Nations Office of the High Commissioner for Human Rights, 2016).

New Zealand was an active founding member of the United Nations in 1945 (Ministry for Culture and Heritage, 2014), supporting the UN's Universal Declaration of Human Rights, (1945) and the WHO Constitution, (1946). The WHO is concerned with world public health and access to healthcare as a human right (Adhanom Ghebreyesus, 2017), stated in its Constitution:

> The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being… Governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures (World Health Organization, 1946, p. 1).

The WHO was positioned as a powerful international authority of delimitation, producing and transmitting health discourse, that has been (and continues to be) taken up politically, socially, economically and ethically in countries around the world, generating global health policy, including in New Zealand society (Department of Health, 1974). Importantly, the principles of the WHO constitution state that "Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity" (Department of Health, 1974, p. 5). This statement makes clear that health should be regarded as a holistic entity and not solely understood from a biomedical standpoint, creating an opening for the holistic approach of OTs to be given credence within the healthcare provision arena.

New Zealand OTs: Rules of formation

Foucault's writing on discourses defines authorities of delimitation, surfaces of emergence and grids of specification as "rules of formation" (Foucault, 1972, p. 42), and such features are present in the construction of OTs, from the creation of the New Zealand health system onwards.

Authorities of delimitation: Doctors in charge of hospitals

The Social Security Act 1938, as an attempt to produce a welfare state[36], would have positioned New Zealand as the first country in the world to provide free universal healthcare to its citizens, paid for via taxes (Ministry of Health, 2018). However, societal and professional discourse which constructed medical doctors as learned men who were experts in the newly emerging science of biomedicine led to them being powerfully positioned. This singled them out as authorities on healthcare practices and, importantly on how healthcare should be delivered. Collectively, medical doctors could enact sufficient power to take up or resist political health reform, and therefore shape the healthcare delivery system to one that could serve their professional interests rather than a purely societal need. As many preferred to straddle both the private and public sector, this powerful positioning enabled some medics, such as general practitioners, to resist the emergence of socialised medicine and the attempt to remove private practice in favour of government salaried positions, by threatening to strike (Fischer, 2012). Publicly funded hospitals ultimately only came into being because the government then threatened to employ overseas doctors to run the hospitals (Fischer, 2012) and the medical profession relented somewhat.

The effect of their resistance, however, was that only certain healthcare provision was free, while other services were subsidised or remained in private hands, notably general practice (Easton, 2002), creating a "dual system…state and private side by side" (Department of Health, 1974, p. 47). This resistance visibly demonstrated the power doctors could enact in society to control healthcare provision and had long lasting consequences on who could receive free healthcare, who could provide it and how it was delivered. It also provided an example of the continuing presence of powerful underlying conservative political and economic discourses supporting private enterprise, as imagined by Keynes. The outcome was a tiered health system that continued inequalities of healthcare provision in New Zealand (Gauld, 2009b), although Māori were one group that did benefit from the health and social reforms: Their life expectancy increased over time due to management of disease and improvements in hygiene (King, 2003).

Extension of the medical gaze

Doctors could not physically do everything and be everywhere. The management of patients languishing in hospitals, asylums and sanitoriums with long term physical and mental health

[36] Welfare state: A type of governance whereby the state plays a prominent part in the economic and social wellbeing of its subjects through oversight and regulation of services such as health, housing, education, safety at work and child protection Rose, N. (1996). Governing "advanced" liberal democracies. In A. Barry, T. Osbourne, & N. Rose (Eds.), *Foucault and political reason* (pp. 37-62). Routledge. .

conditions, and later, those who needed reablement to return to society and work, after the Second World War, emerged as a problem in New Zealand. Healthcare provision was constrained by the absence of professionals who could rehabilitate and transition patients out into the community. It was expensive to keep people in institutions, and in some cases considered immoral (Reed, 2008). People needed to return to and participate in society to improve their quality of life and to work, if they were able. Medical doctors did not have the time nor the skills to directly engage in the actual day to day rehabilitation interventions needed by their patients (Skilton, 1981).

Auckland Mental Hospital: A first surface of emergence

In 1938, one enterprising doctor, Henry (Harry) Buchanan, Medical Superintendent of Auckland Mental Hospital (Gordon et al., 2009; National Library of New Zealand, n. d.), supported by Theodore Grey[37] (Skilton, 1981), looked to Britain for a solution. Publications promoting the success of occupational therapy interventions led him to investigate the work of OTs, who were already positioned in designated spaces within that health system to provide rehabilitation to various groups of patients. As Superintendent, he could enact considerable power and used his authority of delimitation to convince the Public Service Commission to appoint an OT from Britain.

Buchanan arranged for a Dorset House School[38] trained OT, Margaret Inman, to travel to New Zealand to set up an occupational therapy department at Auckland Mental Hospital (Rutherford, 1976). This was the first "surface of emergence" (Foucault, 1972, p. 45) of occupational therapy in New Zealand, which was taking a similar approach to the purpose and deployment of OTs as the UK. Although the first New Zealand-trained OTs provided only asylum-based rehabilitation, their worth was soon recognised and successfully applied to the re-enablement of injured soldiers returning from the war, as well as civilian patients recovering from disease or injury acquired at home (Gordon et al., 2009). From an initial remit to work only in asylums, this success also opened up opportunities to work in general hospitals, tuberculosis sanatoriums, day hospitals and community domiciliary services.

A catalyst of authorities of delimitation

Margaret Inman would work under the direction of Mary Lambie, Director of Nursing for New Zealand, who could enact power to influence the hospital service due to her position leading the

[37] Dr. G. Grey: Director-General of New Zealand's mental hospitals from 1927-47 Brunton, W. (1998). *Gray, Theodore Grant*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 21 January 2021, from https://teara.govt.nz/en/biographies/4g19/gray-theodore-grant. Grey believed participation in occupations was healthy for people residing in mental hospitals and gained permission to employ 'teachers' to instruct patients in craftwork prior to the introduction of occupational therapists (Skilton, H. (1981). *Work for your life*. Self-published. Hudlo Printers.). Skilton reflected on whether Dr. Casson's connection with Dame Sybil Thorndike (Thorndike was married to her brother) gave Dorset House added status and influenced the decision to appoint Inman. Skilton does add that Dorset house nonetheless, had a very good training record and so there was no issue with her selection. Margaret Inman would later marry Harry Buchanan.

[38] Dorset House School of Occupational Therapy: First School of Occupational Therapy in the UK Opened in 1930 in Bristol by Dr. Elizabeth Casson, later moving to Oxford during World War II.

New Zealand nursing profession. Lambie's authority was such that, in addition to OTs, she was also instrumental in the emergence and production of New Zealand-trained dietitians, physiotherapists and social workers (Rodgers, 1998), all of whom she had the responsibility to oversee (Hazeldine, 1980, p. 6). As her roles and responsibilities grew, Inman became positioned as 'the expert' in the processes associated with the roll out of New Zealand occupational therapy. Thus, as her reputation grew, the power she could enact increased and she, along with Buchanan and Lambie, emerged as the authority of delimitation, defining both scope and limits of New Zealand occupational therapy practice. Inman actively drew on the occupational therapy knowledge she had taken up into her subject positions from her training at the Dorset House School (Rutherford, 1976) in England, but interpreted and applied it to New Zealand conditions. She effectively constructed an early scope of practice for the New Zealand OTs she would train. Rutherford Rutherford (1976) writes, "while New Zealanders were well known for their inventiveness, …Miss Inman was able not only to adopt, but use with inspiration and insight the ways of her new country" (p. 3).

Power and OTs

Following the "encouraging results" (Auckland Correspondent of the New Zealand Freelance, 1940, p. 10), from the occupational therapy department, Inman was invited to set up the first occupational therapy training school in New Zealand (Rutherford, 1976) for "this highly skilled work" ("Editorial: Health rehabilitation. [Editorial]," 1943, p. 279). Inman had become the primary authority of delimitation for occupational therapy practice in New Zealand, supported by Lambie and Buchanan. The school incorporated disciplining mechanisms likely similar to those she had experienced at Dorset House, with the intention of constructing OTs who would hold the same professional roles as herself. They would continue the same behaviours and practices that had been required of her as an OT in the UK. As at Dorset House, and in Haworth and Macdonald's (1946) textbook, women with previous training in related professions were preferred. Four women who already had training in teaching, nursing, massage and the Voluntary Aid Detachment service were selected to be the first trainees (Inman, 1940). They could be more quickly trained and placed in the hospitals to manage the re-enablement of returned servicemen.

A new practice: Treatment of returned men

> Interesting facts of the steps taken by the main hospital areas, in conjunction with the Government, to introduce the new practice of occupational therapy for the treatment of orthopaedic cases have been given by Mrs. E. M. Gilmer, who is again a candidate for the Wellington Hospital Board and is this year also standing for the City Council. Occupational therapy, she said, was of first importance in its application to returning soldiers, many of whom would be orthopaedic cases. The four base hospitals had each selected a trainee who was receiving tuition from Miss M. M. Inman, an English expert, and in turn, would act as instructresses in their own areas. Occupational therapy could be generally defined, said Mrs. Gilmer, as any form of occupation or recreation regularly employed as a curative treatment for disabilities. ("A new practice: Treatment of returned men," 1941, p. 8)

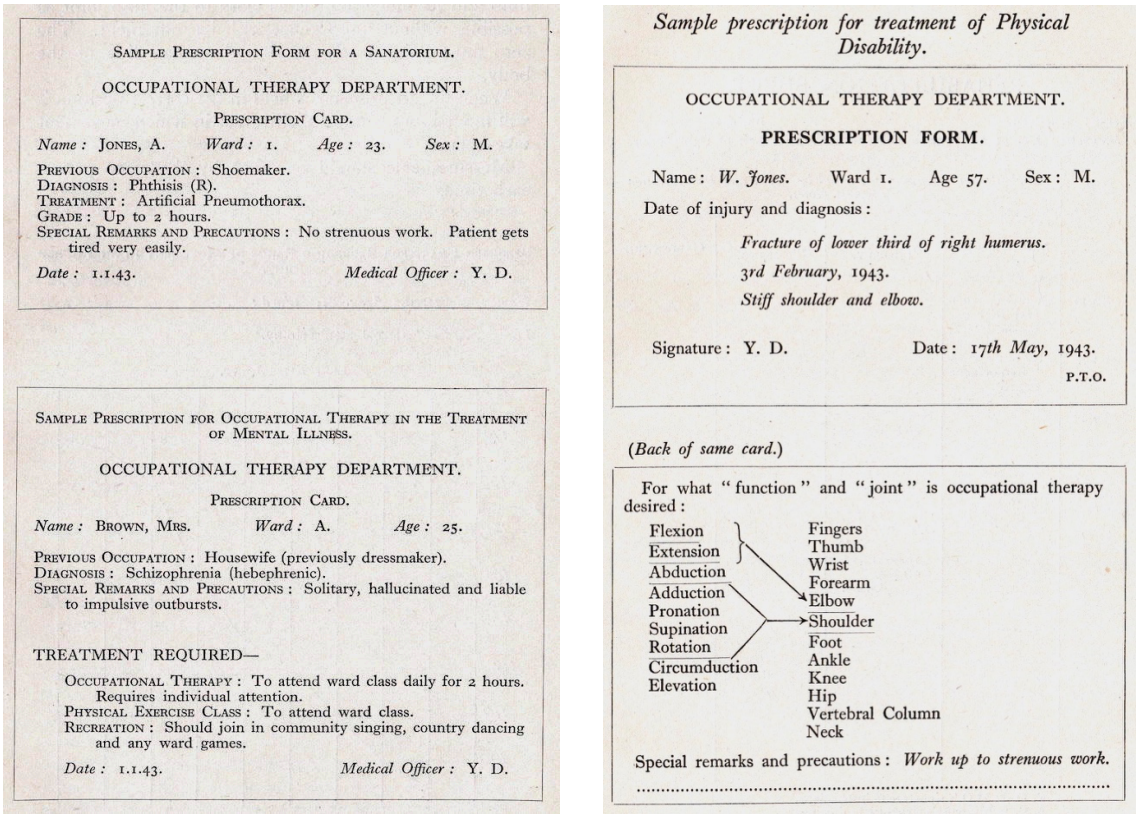
What went unsaid was that these first New Zealand OTs were also likely to know and have some experience of the expectations, behaviours and 'pecking orders' in a public organization, know that they had to adhere to them, and so were ready-made 'docile bodies' who would quickly assimilate into the healthcare workforce.

Prescriptions: Reflected power?

In the UK, OTs were not to select their patients; rather, prescriptions were clearly made and overseen by the medical team, according to these instructions:

> No treatment should be undertaken without a medical prescription and the duration of the occupation and the type of work prescribed must be strictly adhered to. (Haworth & Macdonald, 1946, p. 84)

Emphasis was placed on having a prescription form (Figure 5 below) signed by the medical officer in charge of the patient's care, complete with diagnosis and any precautions or "dangers likely to occur" (Haworth & Macdonald, 1946, p. 12) noted. Patients needed to be supervised (for safety) and monitored for signs of fatigue while in the department. Likewise, in New Zealand, OTs received prescriptions from the medical team to treat patients thought suitable for occupational therapy rehabilitation (Maling, 1944). The doctors would in turn receive progress reports, a process, which, in effect, acted as an extension of the medical gaze (Foucault, 1973) – knowing what their patients were doing through processes of surveillance and reporting by the OTs.



SAMPLE PRESCRIPTION FORM FOR A SANATORIUM.

OCCUPATIONAL THERAPY DEPARTMENT.

PRESCRIPTION CARD.

Name : JONES, A. *Ward :* 1. *Age :* 23. *Sex :* M.

PREVIOUS OCCUPATION : Shoemaker.
DIAGNOSIS : Phthisis (R).
TREATMENT : Artificial Pneumothorax.
GRADE : Up to 2 hours.
SPECIAL REMARKS AND PRECAUTIONS : No strenuous work. Patient gets tired very easily.

Date : 1.1.43. *Medical Officer :* Y. D.

SAMPLE PRESCRIPTION FOR OCCUPATIONAL THERAPY IN THE TREATMENT OF MENTAL ILLNESS.

OCCUPATIONAL THERAPY DEPARTMENT.

PRESCRIPTION CARD.

Name : BROWN, MRS. *Ward :* A. *Age :* 25.

PREVIOUS OCCUPATION : Housewife (previously dressmaker).
DIAGNOSIS : Schizophrenia (hebephrenic).
SPECIAL REMARKS AND PRECAUTIONS : Solitary, hallucinated and liable to impulsive outbursts.

TREATMENT REQUIRED—

OCCUPATIONAL THERAPY : To attend ward class daily for 2 hours. Requires individual attention.
PHYSICAL EXERCISE CLASS : To attend ward class.
RECREATION : Should join in community singing, country dancing and any ward games.

Date : 1.1.43. *Medical Officer :* Y. D.

Sample prescription for treatment of Physical Disability.

OCCUPATIONAL THERAPY DEPARTMENT.

PRESCRIPTION FORM.

Name : *W. Jones.* Ward 1. Age 57. Sex : M.

Date of injury and diagnosis :

Fracture of lower third of right humerus.
3rd February, 1943.
Stiff shoulder and elbow.

Signature : Y. D. Date : *17th May,* 1943.

P.T.O.

(*Back of same card.*)

For what "function" and "joint" is occupational therapy desired :

Flexion	Fingers
Extension	Thumb
Abduction	Wrist
Adduction	Forearm
Pronation	Elbow
Supination	Shoulder
Rotation	Foot
Circumduction	Ankle
Elevation	Knee
	Hip
	Vertebral Column
	Neck

Special remarks and precautions : *Work up to strenuous work.*

Figure 5. Sample prescription forms for sanatorium and physical disability use showing medical doctor direction of the purpose of treatment and decision on the desired outcomes. (Haworth & Macdonald, 1946, p. 133 & 127). Orphaned work.

It could be argued that the early OTs were 'subjects of power' since, superficially, they depended upon the active support of doctors to refer patients to occupational therapy, an arrangement which required them to exactly follow treatment prescribed by the doctor (Haworth & Macdonald, 1946). Thus, it would seem that they were being disciplined to behave in a particular way, to defer to the doctor. However, there is some suggestion that in practice, some New Zealand OTs resisted this arrangement. They reported being proactive in selecting patients, writing the prescriptions for the doctor to sign and professionally governing themselves through making autonomous decisions about their own treatment modalities, customised for each patient (Gordon et al., 2009). On further examination, another twist was that OTs actually positioned themselves in this relationship to add credence to their practice by reflecting the high status of the medical profession onto themselves. However, as their success with patients became known, so did their own reputation and OTs began to construct their own position of authority, enabling them to enact power.

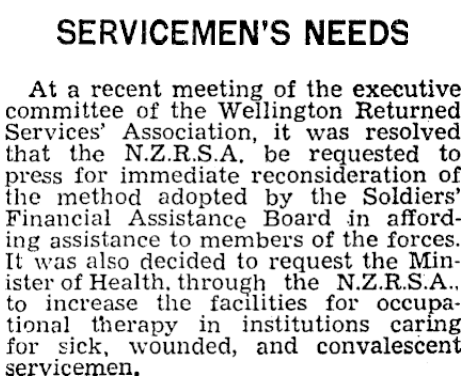
Holding direct power

I would also argue that professionally, OTs also could enact direct power due to recognition of their specific role aimed at rehabilitating injured members of society to the point where they could return to work and contribute to the flow of the economy once again.

> It was during World War 1 that it was found that the physical exercise required to carry out all sorts of activities and handcrafts, if properly graded and supervised, could be used to bring back normal function to injured limbs and could maintain the morale of patients while they were in hospital for long periods. (Skilton, 1981, p. 1)

OTs had already emerged in America and Britain, and the profession had been successful in providing reablement programmes that transitioned patients from hospital back to their communities. The UK Employment Act 1944 ensured British OTs treated "those who become capable of full-time employment in the ordinary field of industry" (Haworth & Macdonald, 1946, p. 7). They would receive occupational therapy until "complete recovery"; any who had a "residual disability", and would need retraining in "selected occupations" (p. 7); "those requiring sheltered conditions permanently or for a prolonged period" (p. 8), which meant that registered disabled people had access to a limited number of special workshops as well as "Village Settlements" (p. 8) for specific conditions such as tuberculosis.

The need to manage and rehabilitate patients residing in New Zealand institutions provided the conditions and opened up further opportunities for the construction of an occupational therapy profession in New Zealand. Recovering patients were encouraged to reengage in occupations by OTs prior to discharge, so that they might find an "alternative means of livelihood" (Inman, 1940, p. 355) on return to society. In the nursing journals, the presence of OTs was already understood to be the "link in the social aspect of medicine, …which aims at the restoration of the patient as a person with due consideration of his or her individual problems" (Spencer, 1943, p. 280).



SERVICEMEN'S NEEDS

At a recent meeting of the executive committee of the Wellington Returned Services' Association, it was resolved that the N.Z.R.S.A. be requested to press for immediate reconsideration of the method adopted by the Soldiers' Financial Assistance Board in affording assistance to members of the forces. It was also decided to request the Minister of Health, through the N.Z.R.S.A., to increase the facilities for occupational therapy in institutions caring for sick, wounded, and convalescent servicemen.

Figure 6. Economic discourse upholding the value of occupational therapy practice recognised through plans of NZRSA to acquire more funds that would provide further interventions to servicemen. ("Servicemen's needs," 1943, p. 4). Copyright Fairfax Media. Creative Commons New Zealand BY-NC-SA licence.

In the New Zealand context, OTs' subject positions and practices were influenced by the role expected of them by the New Zealand government and the institutions in which they were placed after training. This role, during and after the Second World War, was primarily to reenable injured soldiers (Gordon et al., 2009) and return them to work. Early intervention was favoured as it would be "a big economic saving" (Spencer, 1943, p. 281) for people to begin their rehabilitation while in hospital. OTs, however, were not bound by limits to length of treatment or cost of

treatment, nor selection of individual patients. Their practices were to focus on full or as much recovery as possible of all patients referred to them, and even attracted the attention of the [then] Prime Minister:

> "A sacred duty". Disabled soldiers: Government's pledge
>
> All of these men had received free, for as long as they needed it, medical attention including the services of surgeons and specialists and the provision of appliances, such as artificial limbs.
>
> Mr. Fraser said he was particularly interested in the question of occupational therapy, which had received a great deal of attention in Great Britain and the Government had established a branch for this treatment at Avondale. Occupational therapy tuition had been invaluable in hastening men's readjustments and had been continued in specially selected recuperative employment. ("'"A sacred duty". Disabled soldiers: Government's pledge," 1943, p. 3)

Their role, therefore, in the reablement of people after illness and injury was considered an important long term economic factor, which was made clear in the Foreword of *Occupational therapy in rehabilitation* edited by Macdonald (1960). The influential Lord Amulree[39] wrote of the importance of occupational therapy in the reablement process, stressing that those returning to work could be considered fully rehabilitated as they would be paying tax and thus once again participating in the economic cycle of their society (1960). This concept was also embraced by the New Zealand government, strengthening the position of OTs who were considered a vital part of the rehabilitation process.

Not always emphasised was the fact that recovering soldiers could languish in hospital for long periods of time because their injuries often took months to heal. They were generally otherwise physically healthy, so early occupational therapy was also a silent way of producing patient compliance with hospital rules by preventing boredom and disruptive behaviour. This was achieved through diverting patient attention to participating in activities and occupations. In this way, OTs held a powerful position in the control of patients' behaviour through the disciplining effects their modalities had on shaping patient conduct.

Formation of a professional association

A study of documents based on the accounts of the first New Zealand OTs shows that from the very start of the profession, a desire for self-governance is evident. However, as the documents reveal, there were many barriers to true self-governance. The women who steered the profession had to be strong, forthright and be able 'stand up' to a male dominated society, as well as to those who misunderstood the thinking behind occupational therapy, or were threatened by it. These 'proto-feminist' discourses are clearly represented in the documents that have remained from that

[39] The Right Hon. Lord Amulree, M.A., M.D., F.R.C.P. ; Physician, University College Hospital , London; President, Medical Guild for the Care of the Elderly; Past President, Association of Occupational Therapists (UK).

early period. The primary focus of the New Zealand pioneers of occupational therapy, successively led by Buchanan, Skilton and Rutherford, was to develop occupational therapy into a credible profession. This claim is substantiated by following the legal documents and the resulting professional bodies that they were involved in constructing.

Although qualified OTs were few in number, it was quickly realized that they were being sent out to remote areas of the country, to work in isolation, without the support of other OTs. Furthermore, they also had no joint voice to bargain for working conditions or their salary, which was a significant issue in a young, all-female, discipline, which was looking for self-direction and professional development in a male-dominated and controlled world. In 1947, Mary Lambie asked Hazel Barton[40] to form an association. With the help of her father, who provided legal advice, and three other OTs (Johnson, Hobcroft and Turner), a draft constitution was submitted to the Department of Health, which resulted in the registration of the New Zealand Registered Occupational Therapists Association (NZROTA) in 1948 under the 1908 Incorporated Societies Act (Rutherford, 1976). Its initial remit was "to edit and distribute a newsletter and keep therapists in touch with what was going on, elect representatives who could speak for the group in matters affecting its members" (1976, p. 6). Even so, Norah Hobcroft[41] reported that:

> As a registered association, salary negotiations were begun with resistant, all male negotiation bodies with no concept of the role of occupational therapy and went on for decades. Growing into a profession was not an easy process. I doubt if we could have stepped outside the social role of women in those years to function autonomously in defining and guiding our own profession, in a powerful, male dominated society. If we had even been 25% male in numbers... (Skilton et al., 1990, p. 10)

The Occupational Therapy Act, 1949 protected the name 'Occupational Therapy' through regulation of curriculum and examination, inspection of workplaces and registration (Lambie, 1956) and, importantly, enabled the emergence of the Occupational Therapy Board in 1950. The Board comprised a mix of doctors, nurses and OTs:

> The work of the Board was to submit Regulations which could be forwarded to the Honourable Minister of Health for his approval. These Regulations were to cover training, curriculum, examinations, registration, reciprocal agreements regarding registration and the disciplining of the profession regarding practice. (Rosser, 1956/1990, p. 20)

[40] Hazel Barton (married name Skilton) was one of the first four occupational therapists to receive their training in New Zealand from Margaret Inman. As an authority of delimitation within the profession at the time, she was involved in the construction of the documents producing the New Zealand Registered Occupational Therapists Association (NZROTA) and was appointed to the first Executive Committee of the NZROTA in 1949. In 1950, she held the positions of both Principal of the New Zealand Occupational Therapy Training School, Auckland, and the Supervisory Occupational Therapist for New Zealand (Gordon, B., Riordan, S., Scaletti, R., & Creighton, N. (Eds.). (2009). *Legacy of occupation: Stories of occupational therapy in New Zealand 1940-1972*. The Bush Press.).

[41] Norah Hobcroft held the position of Secretary on the inaugural executive committee of NZROTA, 1949. After the Occupational Therapy Act, 1949, was passed, she was also invited to serve on the first Occupational Therapy Board in 1950, by the Minister of Health.

The Board meeting minutes show that its initial concerns focused on the selection of candidates for training, the composition of the training course itself and the registration of suitably trained OTs (Occupational Therapy Board, 1950). It "made occupational therapy more acceptable. We were able to hold examinations and it proved we were here to stay" (Buchanan, 1972/1990, p. 8). Only those who were registered with the Board could name themselves and practice as OTs. Several examples in the Board minutes reveal that the board investigated and shut down, or renegotiated incidences of reported non-registered individuals doing the work of OTs; some calling themselves 'diversional therapists' (Occupational Therapy Board, 1957). Or, in one case, an overseas student nurse who was sent by her government to spend time in a New Zealand occupational therapy department, then return to her place of origin to open an occupational therapy department and practice as an OT, without undergoing approved training and registration (Occupational Therapy Board, 1958).

Oversight of OTs operated via the inspector of the Board, a qualified OT. Her role was to inspect occupational therapy departments while also overseeing the placement of students and new graduates (Gordon et al., 2009). The aim was to ensure that the quality of occupational therapy practice was up to standard (Hazeldine, 1980, p. 6). However, the Board minutes were silent on the identification, investigation and disciplining of questionable individual competence. An external source suggests that a student left the training and that in another instance, behavioural issues did occur (Gordon et al., 2009). It is possible that the silence around practitioner conduct in the Board meeting minutes may have been to respect of privacy of the clinician concerned. It may also suggest that due to the initial careful selection of suitable women, and continuing observation by the Superintendent, any competency issues were rare or were managed directly within the department or School of Occupational Therapy.

Power in the hospital

Under certain conditions, OTs were clearly depicted as marginalised by the specific role they held as it was associated with women doing craftwork activities with patients, and not related directly with the heroic hands-on work of saving lives assigned to the doctors and nurses. Positioned as an adjunct to the medical and nursing professions, some doctors and nursing staff considered the discipline superfluous (Gordon et al., 2009; Skilton, 1981). The relationships between OTs, doctors and nurses was quite complex. The close association of doctors and nurses with bio-medical science, along with their well-established professional standing, meant that they already had the credibility and could enact power to influence healthcare delivery. Members from these professional groups enabled OTs to emerge and practice in New Zealand as an alternative method of managing patients. However, what emerges from document analysis is the complexity of their relationships. In hospitals, OTs were dependent upon the oversight of the medical profession from which occupational therapy prescriptions were generated (Haworth & Macdonald, 1946; Maling,

1944). There were only certain times when the wards could be visited, and ward work activities needed to be light and pre-prepared (Timus, 1946); nothing messy or disruptive.

Nurses: Resistance followed by normalisation

The Director of Nursing supported and oversaw the emergence and production of the occupational therapy profession in New Zealand hospitals (Rodgers, 1998), however, access to patients on the ward required permission from the hospital Matron and co-operation from the local nursing staff to deliver a successful occupational therapy programme. Nurses working on the wards initially resisted the presence of OTs because of poor understanding of the purpose of occupational therapy. Some nursing staff referred to OTs as "those women" who were "downright dangerous" (Skilton, 1981, p. 11). However, as occupational therapy became normalised in New Zealand hospitals, there was written acknowledgement by the nursing profession that OTs held an important role and that their work should be "facilitated in every possible way, even - if necessary, to the readjustment of established ward routine" ("Editorial: Health rehabilitation. [Editorial]," 1943, p. 280). Documents also reveal that nurses, along with technicians, worked in occupational therapy departments supervised by OTs (Maling, 1944) and that, "for the most part, the nursing staff were cooperative, acknowledging the value of occupational therapy to each patient" (Johnson, 1945, pp. 3-4).

Physiotherapists

Winning round physiotherapists was another challenge for the early OTs, as they too rehabilitated the physically injured (Spencer, 1943). Physiotherapy discourse suggested poor understanding of the role of OTs with the physically injured, constructing OTs as practitioners who treated 'the mind' of patients while physiotherapists treated the body (Andrews, 1955). There were physiotherapy criticisms of occupational therapy practice made visible through words and written statements which suggested how OTs would have a more effective part to play in rehabilitation. The physiotherapy view was that OTs would be more successful if they had a deeper understanding of anatomy and "taught" (p. 10) patients to do more realistic crafts that would prepare the patients to earn a living on discharge, rather than "basketry or toymaking" (p. 10). Andrews also accused OTs of "far too little cooperation" (p. 9) and questionable "team spirit" (p. 9) that, she believed, could be remedied by regular team meetings, which Emery (1956), agreed, did not always occur, although he conceded that there was "often collaboration between two therapists" (p. 7), (Figure 7 below). However, reading of other texts placed OTs as active participants in team meetings, a prime example being an OT who resisted the opinion of the team in favour of her patient's goal to return home. He did return home, apparently successfully, and "Rowena [OT] was the only team member who had supported him" (Gordon et al., 2009, p. 202).

Power in the department

OTs were to collaborate with others, liaise with the staff and produce "an atmosphere of friendly co-operation" (Haworth & Macdonald, 1946, p. 14). However, in New Zealand, Skilton (1981) comments that collaboration with other professionals could be challenging for OTs, as other staff did not always understand and recognise the purpose of crafts in rehabilitation. Another problem was the remoteness of occupational therapy departments. Their placement away from the wards was not conducive to regular day to day communication with nursing and medical staff (Maling, 1944), However, for OTs, the distance may have been opportune. Isolation from other colleagues provided a site of resistance for OTs, it being a designated space to shelter and practice away from the gaze of other professionals, including doctors and nurses; medics would have to make a special visit to see their patients participating in activities based in the department (Maling, 1944). While it may have added to the mystery of what OTs actually did, I would suggest that the departmental space provided a safe retreat for those working on the wards to return to. It was a place where they could receive support from their occupational therapy colleagues, as clearly, according to Skilton (1981), they were subject to regular challenges from staff and patients regarding their daily practices (Maling, 1944). In this context, the department could be constructed as a physical space where OTs could seek refuge and refresh themselves from the rigours of being confined to working with colleagues who understood health from a biomedical framework when occupational therapy beliefs extended beyond this remit.

In occupational therapy departments there was another clear hierarchy, where the OTs were categorised as 'seniors' and 'staff OTs'. They oversaw technicians, craft educators and trained nurses who carried out the day to day craft, wood-shop and education groups (Maling, 1944).

These convalescent American servicemen in New Zealand are not aiming at R.A. standards, but they are keenly interested in sketching as one form of occupational therapy. Miss Florence Hislop, of Wellington, leads the voluntary instructors and assistants.

Figure 7. Hierarchy in the OT department: OT – Assistants – Volunteers – Patients. ("These convalescent American servicemen in New Zealand are not aiming at R.A. standards," 1943). Copyright Fairfax Media. Creative Commons New Zealand BY-NC-SA licence.

The technicians were an important presence in the occupational therapy department because they supervised the more able patients in the fabrication and repair of departmental equipment as part of the patients' recovery plan. They also developed modifications to standard equipment so that it could be used by patients with impairments as part of the rehabilitation process (Haworth & Macdonald, 1946) (see Figure 10) thus adding to the range of modalities available for treatment.

Constructing OTs by techniques of discipline

Historically, OTs have been subject to various forms of discipline and punishment. Evidence of discipline is found from the introduction of occupational therapy into NZ, including the process by which young women were selected to become OTs, and then via the training they received. A distinct 'OT type' emerged. The women who were selected to become OTs were rendered docile bodies who could "be subjected, used, transformed and improved" (Foucault, 1977a, p. 136) through training and disciplining to behave as OTs in the New Zealand context. They would need to be able to respond to direction from senior staff members, such as doctors, nursing charges and tutors. Social discourses circulating at the time probably reinforced cultural Western beliefs that middle class, educated women would already hold the knowledge and social skills required to interact appropriately with the pre-existing professionals who likely also came from similar backgrounds and understood the rules of behaviour connected with social and professional hierarchies (Phillips, 2011):

> Each Wednesday morning, Dr. Buchanan, accompanied by the Charge occupational therapist, Miss Inman and the Head nurse, went on a round of the occupational therapy groups. Everything had to be spic and span and all patients engaged in his or her craft project. (Searle, 1990, p. 16)

Disciplined women

The role of early OTs was related to the traditional construction of female roles at the time. The idea that womanhood is constructed was supported by feminists such as Judith Butler, Simone de Beauvoir and Germaine Greer; "One is not born, but becomes, a woman" (De Beauvoir, 1973, p. 301). As such, certain, defined, behaviour was expected of women, such as obedience and acceptance of the roles assigned to them by men. Traditionally, women were constructed and positioned to perform caregiver roles, and relegated to what might be termed as 'soft' occupations such as nursing, occupational therapy and clerical assistants, under the supervision and management of men, in higher paid and higher status positions.

It is not surprising then, when OTs first emerged, that particular characteristics associated with womanhood were sought during the student selection process. Male doctors were the main authority of delimitation in hospitals and occupational therapy was understood as female caregiver work. However, although OTs had constraints put upon them in their daily work practices through departmental routines and rules, as a group, they challenged certain conditions placed upon them. For instance, women tended to be paid less than men for the work they did. This position concerned OTs, who resisted by forming an association that would be involved in national salary bargaining (Skilton, 1981). Likewise, opportunities for career advancement were limited, as women were expected to permanently cease work when they married and had children. But with the emergence of the women's liberation movement, some OTs took the opportunity to return to work part time (Gordon et al., 2009).

The "others"

There were notable silences concerning the groups who were not desirable subjects to become OTs. Firstly, disabled people were discouraged, an example being Francis Rutherford, who had polio and was declined a training place at the Auckland school, but, determined to become an OT, went to the UK to train. On return to New Zealand, she eventually became the Principal of the Auckland School (Gordon et al., 2009). Secondly, men were excluded until 1965 (Gordon et al., 2009)[42]. Thirdly, recognition of the need for cultural diversity in the workforce appeared to be absent in early professional discourse. The benefits of recruiting from diverse backgrounds was only acknowledged in 1988 with the publication of "Education: A professional issue. Report on

[42] The exception being former pyschiatric nurse Andrew Rankine, one of the first cohort of 11 New Zealand students, who returned to nursing after training.

the review of occupational therapy education" (Department of Education, 1988). This report signalled a shift in thinking about the occupational therapy 'type' and future practices.

"A fine race of girls": Disciplining students through an apprenticeship-type training

The early New Zealand OTs were carefully selected. They were required to be already constructed to hold certain qualities that would produce "a fine race of girls" (Rutherford, 1972, p. 4). The documents reveal discourses favouring the selection of privileged educated females of European heritage and of a certain age. Ann Christie wrote, "women selected for training were often farmers daughters and went to boarding school; tended to be religious" (Private communication, 2018). In order to identify these "particularly fine women" (Rosser, 1956), applicants were personally interviewed by a selection panel comprising the Medical Superintendent (e.g. Doctors Buchanan, Tothill or Savage), the Director of Nursing and the Principal of Training (e.g. Inman or Skilton) (Skilton, 1981). As well as being a person of 'good standing', judged by their family background and education, they were required to present themselves well, demonstrating good deportment and dress sense (Gordon et al., 2009). Many 'memoir' statements support this view: "I went to Woodford House, a private school for girls" - Ann Spence (p. 30), "because of my age I was told to re-apply a year later" - Mary-Anne Boyd (p. 35), "I originally trained as a teacher" - Doris Aitken (p. 21), "my mother made me a new suit" - Rowena Franklin (p. 31). Furthermore, women who could think 'outside the square' and be able to come up with solutions to practical problems were also desirable; it would be a crucial component of their work as OTs. An example of this problem-solving is Sunny Bowmar's account of a situation when access was needed to conduct a class: "on arriving at the hall (for a craft class), there were no keys, …I produced a screwdriver, unscrewed the hinges off the door and that of the kitchen cupboard" (p. 27).

Students were subject to a "hierarchy of rules and regulations" (Gordon et al., 2009, p. 119). Formal titles were used (Miss) to address each other. They had to demonstrate respect and deference to their tutors and "rise to their feet when a doctor entered the room, and stand with their hands behind their backs when addressed by a senior staff member. They never walked in front of a doctor or a matron" (p. 98). The training itself included many examples of disciplining the body: "Students were expected to behave as young educated ladies. Some classes attended a modelling or charm school" (p. 99). A recommended, suitable, leisure activity was to attend proms concerts (p. 100), associated with a middle-class upbringing. Wearing the uniform was essential and there were rules as to how hair was styled and make up worn. They were not allowed to whistle, have hands in their pockets or engage in other similar 'unseemly' behaviours. In one instance, punishment was delivered by the student being "verbally criticized" (p. 107) after attending a ward round with the Charge OT.

Disciplining by bonding

Part of the training agreement was that new graduates were bonded to the Department of Health and required to work where directed for two years after training. A bond was an agreement to work for the public health system in return for the cost of training to be funded by the Ministry of Health. The documents reveal that students, in general, were not in a position to pay for their own training (Gordon et al., 2009). Their placements during this time were approved and overseen by the Advisory OT for the Board. If they broke their bond, they would need to repay a considerable sum of money; essentially a way of making sure the therapist was available in the workforce, as required by the government, with the threat of 'punishment' for non-compliance.

Disciplining professionals: Departmental routines

There were also strict rules governing what OTs did within the departments. Various women reported having to clock in and out, even for tea breaks (Gordon et al., 2009). Timetables were another way of controlling a person; control of time was exercised through schedules that needed to be adhered to. Additionally, expectations of what needed to be done or achieved ensured quality of use of time, and there were certain rules in force during specified time periods, such as the times of day when the Matron would allow the therapists on the wards to see their patients and what may be done as therapy on the wards. Therapists serving multiple sites also had their time allocated between the sites and were given time to travel and gather up the supplies needed for the particular venue they were visiting. There was an expectation that the therapist would arrive on time for therapy sessions with what was needed for the occupational therapy interventions. Another way of subtle disciplining was the wearing of a uniform. Once trained, registered OTs were identified by wearing a uniform and a badge issued personally to them (Gordon et al., 2009). It seems to have been sold to the therapists as an honour, and the badges issued became precious possessions. For example, Hazel Skilton proudly associated her badge with her occupational therapy registration number: '1' as the number is recorded in a customised inscription on the back of the badge (Gordon et al., 2009; Skilton, 1981).

Discipling through text

Foucault argued that a "corpus of knowledge" (Foucault, 1972, p. 36) is the product of discourse constructed from a system of, and relations between, utterances, statements and texts (1972). Discourse is disseminated in many ways, for example, it may be conveyed in writing and then read, both silently and aloud, verbalised through the spoken word and seen through visual images and physical actions. Discourse also circulates through the practices of teaching, training and observation, is distributed within processes, rules, regulations and legislation, and so gives rise to professional, institutional and client knowledge. Early OTs received their knowledge in many different mediums, but what survives is written text. Analysis of the text reveals the techniques of discipline used on them so that they would behave in particular ways.

One such example of written discourse in action, intended to produce appropriate practice behaviours from early OTs, is the seminal textbook *Theory of Occupational Therapy* (Haworth & Macdonald, 1946), written by Mary Macdonald, founding Principal of Dorset House School of Occupational Therapy, and Norah Haworth, UK Industrial Medical Officer. Within six years of the original 1940 printing, it had already reached the 2nd (1944) and 3rd (1946) edition. Along with later versions written solely by Macdonald, this was the primary reference for OTs and students in New Zealand prior to access to an American occupational therapy textbook by Willard and Spackman (Gordon et al., 2009), also considered an occupational therapy 'bible'. From 1947, Willard and Spackman's *Principles of Occupational Therapy* sat alongside *Hawthorn & Macdonald* as a source of additional primary knowledge (Gordon et al., 2009). This early American text and its successive editions also produced terminology and knowledge essential for effective management and administration of a department, as well as scope of practice, applied principles of practice, use of therapeutic activities, equipment for rehabilitation and therapy for specific conditions and age groups (Willard & Spackman, 1954).

These texts visibly constructed and disseminated specific knowledge that positioned the behaviour of OTs within a biomedical framework. They acted as collections of discursive guidelines and procedures which generated the professional subjectivities and subject positions of early OTs resulting in practice behaviours that enabled them to 'correctly' set up their work spaces and produce 'the right' patient assessment and treatment interventions to use with their patients. They therefore laid out the professional conduct expected of both trainee and qualified OTs, and through myriad rules and procedures disciplined OTs to produce the desired, normalised behaviours considered appropriate for practitioners at the time.

Discipling examples from Haworth and Macdonald, 1946

Examples of discipling included rules, associated scope of practice, patient prescription, working collaboratively and individual-focused care. Significantly, the text made clear the importance of holding true the specific scientific knowledge that would align occupational therapy practice with the biomedical model taken up by physicians and nurses. OTs were to draw on their study of anatomy, surgical and orthopaedic interventions and biological diseases, as well as knowledge of 'mental' conditions and psychology; all areas of knowledge relative to the conditions referred to OTs at the time. Also included were protocols associated with departmental organisation and functioning, such as staffing, safety protocols, equipment modification, correct use of treatment modalities, patient documentation and record keeping. Economic prudency was reinforced through advice on how to conduct departmental stocktaking, recycling of unwanted materials from other hospital services, sale of goods and keeping track of staff and patients through timetables. Within the pages, tiny, contained glimpses of behaviours aligned with the overarching practices later claimed by clinical governance frameworks were surfacing. Chapters were also constructed from statements concerned with how to 'do' occupational therapy with the use of

craftwork as a modality. Additionally, guidelines on the use of modified equipment and how to do associated activities were described.

Individual patient focus

Haworth and Macdonald (1946) also instructed practitioners to focus on the patient by conducting initial interviews to find out about each person, their interests and occupations. The OTs were then required to identify and engage patients in appropriate activities that, preferably, patients themselves were interested in, such as ward-work instead of crafts; and for men, "give a man manly work" (p. 83) rather than female crafts. More often than not, though, in practice, it appeared that patients initially needed persuading to engage in the activities on offer in the occupational therapy department (Skilton, 1981).

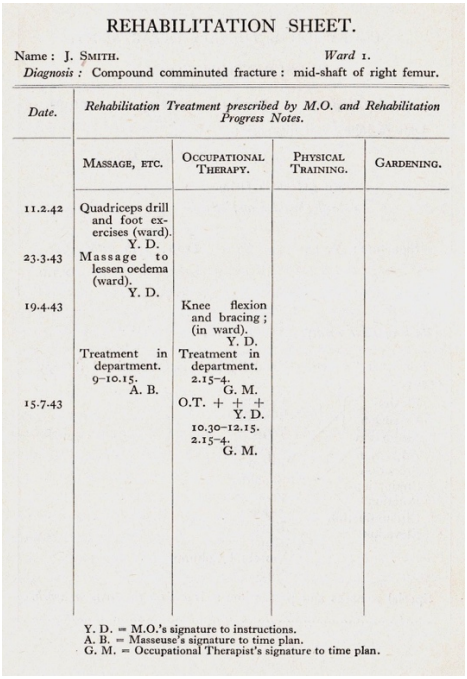
New Zealand OTs were also expected to demonstrate pastoral care (Foucault, 1982b) by ensuring that "every patient is treated as an individual" (Walden, 1941, p. 1). Although individual patient focus is not the same as the clinical governance understanding of client-centred practice, it was, nonetheless, the practitioner focussing on knowing the patient as a person and producing a treatment plan of bespoke occupations aimed to improve that person's condition. The occupational therapy domain, therefore, in New Zealand institutions where OTs were located, was to identify ways that people, such as soldiers, could be motivated, engaged and enabled to participate in occupations as part of their recovery programme. The effects of their doing extended from the hospital into society, as patients were able to return more quickly to their roles in the community and workplace, thus contributing to the status quo of New Zealand's economic cycle and the health of the population.

Management: Records, documentation; budget and accounts

Haworth and Macdonald (1946) produced many statements that laid out the rules of departmental management, and was a study in discipling the behaviour of both OTs and their patients. For instance, their textbook advised that occupational therapy patient documentation containing medical details, planning, treatment record and outcomes should be written and kept in the occupational therapy department. The OT was also advised to produce her own timetable and construct patient timetables. The textbook also included pictorial examples of early prescription forms, checklists and assessments, invoices, sales receipts that showed students and readers how these documents could be clearly laid out. See Figure 8.

Patients were initially interviewed so that they could be told about occupational therapy and asked to try it for a week. Therapists gathered personal, work and environmental information, and as appropriate, assessed body parts and behaviour, depending upon the prescription. The therapist could measure the patient's performance in the assessment and compare with the 'normal' concept of the functioning body, noting limitations of function and forming the baseline of treatment. The

treatment plan needed to align with the doctor's prescription, but could be adapted to the individual needs of each patient. Each treatment session was recorded and progress reports written for the doctors.

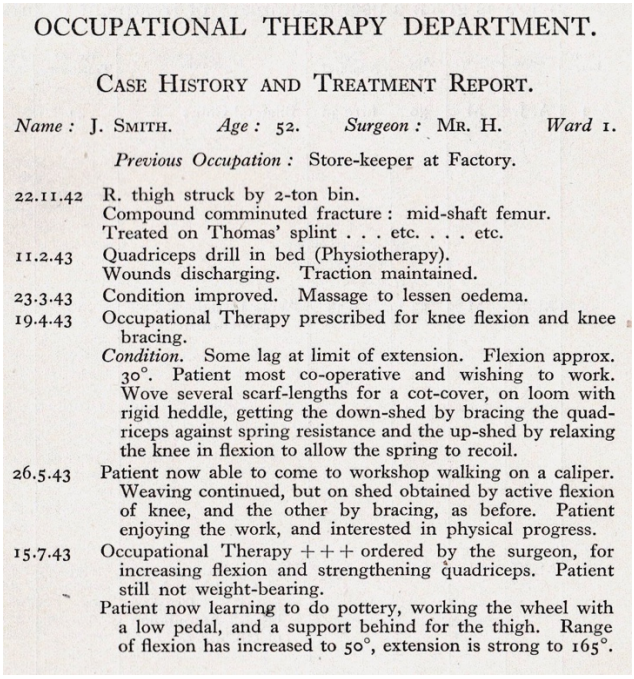


REHABILITATION SHEET.

Name : J. SMITH. *Ward* 1.
Diagnosis : Compound comminuted fracture : mid-shaft of right femur.

Date.	*Rehabilitation Treatment prescribed by M.O. and Rehabilitation Progress Notes.*			
	MASSAGE, ETC.	OCCUPATIONAL THERAPY.	PHYSICAL TRAINING.	GARDENING.
11.2.42	Quadriceps drill and foot exercises (ward). Y. D.			
23.3.43	Massage to lessen oedema (ward). Y. D.			
19.4.43		Knee flexion and bracing; (in ward). Y. D.		
	Treatment in department. 9–10.15. A. B.	Treatment in department. 2.15–4. G. M.		
15.7.43		O.T. + + + Y. D. 10.30–12.15. 2.15–4. G. M.		

Y. D. = M.O.'s signature to instructions.
A. B. = Masseuse's signature to time plan.
G. M. = Occupational Therapist's signature to time plan.



OCCUPATIONAL THERAPY DEPARTMENT.

CASE HISTORY AND TREATMENT REPORT.

Name : J. SMITH. *Age :* 52. *Surgeon :* MR. H. *Ward* 1.

Previous Occupation : Store-keeper at Factory.

22.11.42 R. thigh struck by 2-ton bin.
Compound comminuted fracture : mid-shaft femur.
Treated on 'Thomas' splint . . . etc. . . . etc.

11.2.43 Quadriceps drill in bed (Physiotherapy).
Wounds discharging. Traction maintained.

23.3.43 Condition improved. Massage to lessen oedema.

19.4.43 Occupational Therapy prescribed for knee flexion and knee bracing.
Condition. Some lag at limit of extension. Flexion approx. 30°. Patient most co-operative and wishing to work. Wove several scarf-lengths for a cot-cover, on loom with rigid heddle, getting the down-shed by bracing the quadriceps against spring resistance and the up-shed by relaxing the knee in flexion to allow the spring to recoil.

26.5.43 Patient now able to come to workshop walking on a caliper. Weaving continued, but on shed obtained by active flexion of knee, and the other by bracing, as before. Patient enjoying the work, and interested in physical progress.

15.7.43 Occupational Therapy + + + ordered by the surgeon, for increasing flexion and strengthening quadriceps. Patient still not weight-bearing.
Patient now learning to do pottery, working the wheel with a low pedal, and a support behind for the thigh. Range of flexion has increased to 50°, extension is strong to 165°.

Figure 8. Sample record sheet and report revealing treatment plans for rehabilitation of physical injuries (Haworth & Macdonald, 1946, pp. 128-129). Orphaned work.

In addition to careful record-keeping, the ability to engage in prudent budget management was considered to be an essential behaviour for all OTs, "an ingenious occupational therapist will be able to keep down the expenses of her department" (Haworth & Macdonald, 1946, p. 136) with "careful expenditure on equipment and materials" (p. 100) and realising "the importance of using waste and use of discarded materials from other departments in an occupational therapy department" (p. 123). However, there needed to be a balance between prudency and patient need, "economy is essential… but never at the patient's expense", as "the purpose of the department is to heal the patients and never to make money" (p. 135). Stock-keeping examples included cutting cane to a specific length; lining up all the fabric stock on the shelves; keeping track of all tools, counting everything to the last needle (Gordon et al., 2009) during regular stock takes and the "weekly thrift ritual" (p. 108) of making something from nothing. These examples indeed show how OTs were expected to take some fiscal responsibility for the service they provided, although at a local, departmental level, rather than from the viewpoint of the organization keeping within a government budget or gatekeeping population healthcare provision.

Finished craft products had several outcomes associated with fiscal responsibility. For instance, fabric woven by patients could then be sewn into items that they could purchase and give as presents or sold by the occupational therapy department to recoup the cost of the materials (Auckland Correspondent of the New Zealand Freelance, 1940; Maling, 1944). Strict rules were

associated with selling patient's products and it was essential to keep a record of monthly accounts, including a record of equipment and materials ordered and received to make the products, as well as any products sold. A system of accounts included keeping a work book, stock book and issue of receipts so that all goods were accounted for (Maling, 1944). Careful organisation of the department with an emphasis on display of completed patient work was also a priority because it was visible evidence of occupational therapy treatment outcomes and visitors were often shown the display (Maling, 1944). The early examples show that for OTs, direct fiscal concerns are not new; practices that demonstrate fiscal responsibility are also present in healthcare delivery post-2000, but they take a different form in the present, for example, eligibility associated with equipment allocation and rationing.

Disciplining through space allocation

OTs were allocated defined spaces in which to work., with the occupational therapy department being the main space. The discourses suggest that they were located in the grounds of an institution or, in one example, in the basement of a hospital (Gordon et al., 2009). The departments were fitted with adapted equipment designed to meet the needs of specific occupational therapy patients. For example, handles and slings could be used to adapt weaving looms while the seat on a bicycle fretsaw could be adjusted to desired knee range of motion (Figure 9).

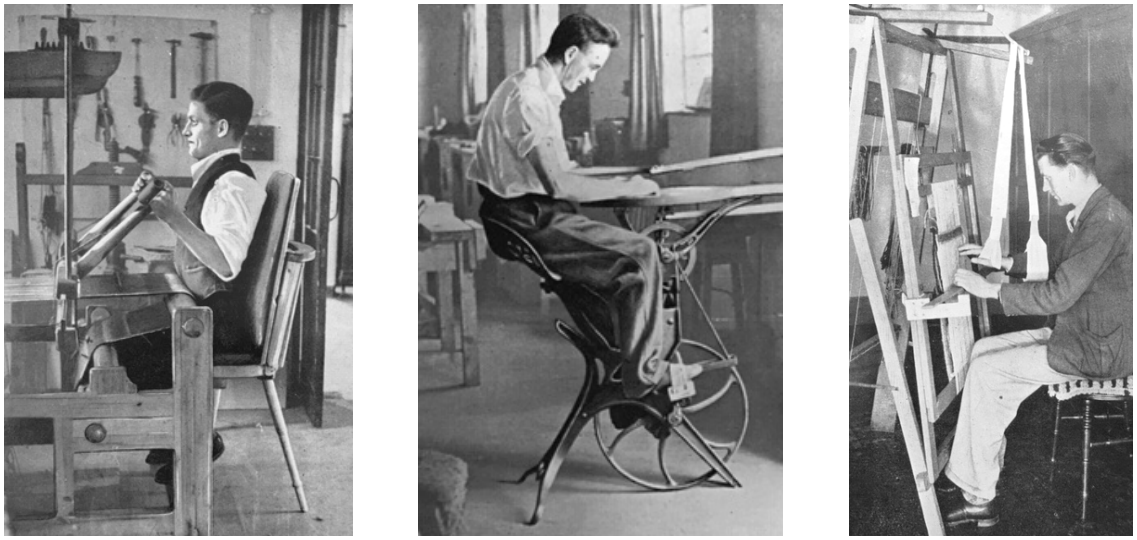


Figure 9. Adapted equipment examples (Haworth & Macdonald, 1946). Orphaned work.

Staff and supervised patients effectively built their own workrooms (Buchanan, 1972/1990) from disused looms and spinning wheels which could be modified in multiple ways for use with patients. Repurposing them provided heavier wood shop occupations as well as actually using the looms to weave lengths of fabric from the spun wool. In essence, it was quite an industry. Weaving and spinning provided both physical, social and cognitive therapy and the work could be graded according to the ability and goals of the individual patient.

Although OTs carried out most of their work in the department, they also oversaw activities on the wards, encouraging nursing staff to engage patients in craftwork such as rugmaking, small loom weaving, basketry, needlework and preparation of old materials for reuse, like winding knitting wool into balls, or making cloth strips for rag rugs. In sanatoria, these activities were aimed to "provide an adequate variety of occupation, which, besides being useful, will keep patients employed and out of mischief, and will into introduce into the ward an atmosphere of industry in place of one of quarrelling, noise and strife" (Haworth & Macdonald, 1946, p. 30). The activities needed to be such that they would not be messy, did not take up room or be considered a nuisance to nursing routines or break ward rules set by Matron. If the rules were broken, then the OT could expect recourse from the charge nurse of the ward, likely a reminder that occupations needed to be restricted to those which were clean and tidy.

Constructing, disciplining and punishing the 'naughty ones'

Discourses making visible the practices used to discipline OTs who did not comply with the rules are rare in the texts studied. Some statements bring to the fore the verbal criticism produced by senior colleagues where the physical appearance of the therapist was not acceptable, causing stress to the recipient. Another statement addressed a situation where a student who became pregnant while unmarried left the training (Gordon et al., 2009), the assumption being that it was not because she was pregnant, but unmarried, and that was unacceptable behaviour in the production of the ideal OT[43]. Unqualified people practicing without training and registration was a Board issue that resulted in the Board producing and sending letters to the agency in question requesting clarification of situation (NZOTRB, 1956). Where the rules had been breached, the agent was requested to stop practicing in the manner of an OT (NZOTRB, 1957, p. 138). However, sometimes there was collusion and protection. One OT wanted to move to another hospital prior to completion of her bond, and found a way to do this without asking the Board for permission. When the superintendent visited the hospital to talk with her, she hid in the rafters of the occupational therapy department, her Head OT not letting on to the visitor. She was called down when the superintendent had left – and transferred to her new hospital (Gordon et al., 2009).

Subject positions

The professional subjectivities of New Zealand OTs were created from international constructions of occupational therapy produced from a discourse favouring the belief that active participation in "productive work" (Stanton Woods, 1946) and occupations are essential to health. Furthermore, the training of the first New Zealand OTs was constructed and overseen by a British trained OT, while their occupational therapy reference manuals were also from overseas authors in the UK and later America (Gordon et al., 2009). However, social, political and economic

[43] Even in 1981 at Dorset House, there was some resistance to me, pregnant at the time, being allowed to remain and complete my training and exams. The Principal, Miss Edwards, fully supported me and enabled me to participate in class and take the exams, so that I became an OT. My view in retrospect is that she demonstrated *she was an OT to the core,* and I have never forgotten her kind actions and practices.

discourses produced from within New Zealand society also influenced OTs' subjectivities and subject positions. Close reading of the texts available to me from this early period have revealed the construction of a number of subject positions that, I believe, played a prominent part in the way OTs conducted their practice at the time:

- Doing it our way: A self-defining profession
- Holistic and creative problem solvers pushing boundaries
- Creators of mysterious practices: the power of silence
- Providers of humanising, individual-focused patient care
- Constructors of patient conduct
- Protectors of our patch: Organisation, safety and prudent work practices in the department

Doing it 'our own way': A self-defining profession

Discourses suggest that OTs were not necessarily close team players. They favoured autonomy and use of their own clinical judgement when carrying out daily practices with patients. In many ways, they were distanced from other professionals; they were not purely adherent to biomedicine but took a broader perspective of the body and mind within the environment. They communicated when necessary, with other professionals, particularly nursing staff, but more to ensure that staff were available to carry on activities with patients when the OT was not on the ward, rather than collaborating in combined treatment. This subject position could be constructed as 'doing it our own way'.

It is possible that OTs needed to construct themselves as autonomous because they sometimes appeared to be marginalised by other professions. To the untrained eye, early occupational therapy practices may have seemed like 'common sense' or labelled as the work of young female 'do-gooders' providing 'entertainment' for patients. It was not direct healing of the flesh. Therefore, practitioners had to resist criticism and bravely introduce methods of treatment at odds with conventional medical practices using modalities such as arts and crafts, music, dancing, singing as well as participation in self-cares, home management, use of adapted equipment and wheelchairs. Skilton (1981) indicated that the profession's reward for persisting with its unique approach to treatment was the production and distribution in 1945, of "certificate(s) of proficiency" (p. 16) for completion of training by writing a thesis. This certificate classified them as "qualified" OTs (p. 4 & 16). Skilton's statements suggest that the certification process was a visible recognition of occupational therapy's successful contribution to healthcare at that moment from "medical, nursing and physiotherapy …as well as the public" (p. 16) so it would seem that 'doing it our own way' produced the re-enablement outcomes desired of the government in spite of a sometimes, uneasy relationship with other professions.

Holistic and creative problem solvers pushing boundaries

The first graduates started occupational therapy in New Zealand a long way from their British-originated training. Hazel Skilton (née Barton) recalled, "we had no [New Zealand] models to

follow and had to rely on our own initiative and ingenuity" (Skilton et al., 1990, p. 8). The early therapists, out of necessity, had to use their initiative together with trial and error problem-solving in order to produce custom treatments that would motivate and enable a mix of people from diverse backgrounds, experiences, abilities and skills to participate in activities thought to be beneficial for their individual recovery needs. OTs also had to be mindful of the prescribing doctor's expectation of successful outcomes where, biomedically, patients needed to be 'cured'; hence the label 'curative workshop" to describe the occupational therapy department (Haworth & Macdonald, 1946, p. 65). Their holistic approach to therapy meant that there was a wider scope of options to bring into occupational therapy treatment as underscored by the statement, "Occupational therapists can justly claim to be among the first professional groups which carried over the clinical knowledge and insights of psychiatric work into the wider fields of health services" (Mirams, 1972, p. 9). This carry over of knowledge into other areas of practice produced custom solutions for individuals who needed more than purely medical intervention to recover from physical injury.

Creators of 'mysterious' practices: The power of silence

While certain colleagues clearly understood the role of OTs and celebrated their success with patient rehabilitation (Emery, 1956), there was still a mystery or lack of understanding attached occupational therapy practice for some (Skilton, 1981). OTs were not necessarily effective collaborators with other professionals (Andrews, 1955) so their role was not always understood. Poorly recognised, for example, was the concept of treating patients from an environmental, humanistic[44] and holistic viewpoint (Andrews, 1955; Skilton, 1981). Furthermore, the use of crafts as treatment modalities rather than teaching crafts as skills for employment, also appeared to be anathema for some (Andrews, 1955; Skilton, 1981). OTs seemed to keep the knowledge and reasoning behind their practices to themselves, suggesting the presence of a silence and mystery surrounding occupational therapy behaviour at the time.

For Foucault, visible silence is powerful; he argues that silence exists before discourse (Foucault, 1978, p. 27) and is a shelter from power as well as sheltering power (Foucault, 1978, pp. 100-101)[45]. Thus, there are benefits to being 'silent and mysterious', and it could be argued that OTs protected and sheltered their power by remaining silent on the knowledge and reasoning informing their practice. Additionally, by keeping silent and mysterious, where necessary, they could engage in "underground practice" (Mattingly & Hayes Fleming, 1994a, p. 296; Silcock, 2018, p. 16), which, while not documented, benefitted their patients. These were not always in

[44] Humanism: Recognition of the value of personal autonomy and human dignity (Wilcock, A., & Hocking, C. (2015). *An occupational perspective of health* (3rd ed.). Slack.)

[45] According to Foucault: "Discourses are not once and for all subservient to power or raised up against it, any more than silences are... Discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it. In like manner, silence and secrecy are a shelter for power, anchoring its prohibitions; but they also loosen its hold and provide for relatively obscure areas of tolerance."

line with organisational rules or approved by other professionals, due to being outside accepted guidelines and rules. Although there was an expectation to focus practice within a biomedical framework, these underground practices could be justified by OTs that:

> To be a good professional in attending to the meaning of disability and to elicit the strong commitment of clients, therapists were drawn to broaden the scope of clinical problems, addressing many 'real life' issues that did not yield neat, precise, or measurable outcomes. (Mattingly & Hayes Fleming, 1994a, p. 296)

An early example of this mildly resistant behaviour was an account where OTs gained medical permission to take out patients for the day under the pretext of looking for and collecting lichen to use in making dye. Not said was that it actually provided an opportunity for the group to enjoy a day outdoors, excellent for mental and physical health and mixed-company socialisation, rather than the narrow purpose of gathering lichens for crafts (Gordon et al., 2009; Skilton, 1981).

Providers of humanising, individual-focused patient care

Historical documents repeatedly suggest that there were a number of humanitarian characteristics associated with OTs and the way they practiced, including patience, kindness, compassion and a sense of humour (Gordon et al., 2009; Skilton, 1981): "What allowed us to work naturally with these patients was our daily experience of small human incidents; some were amusing or hilarious, some tender and others showed deep compassion" (Skilton, 1981, p. 13). Patients were constructed as human entities whom OTs understood as individuals with unique characteristics and needs. Engagement with patients over time enabled practitioners to observe first-hand the behaviours and capabilities of their clients, that, when reported back to the physicians, assisted the doctors to make discharge decisions associated with returning patients to their communities including referral[46] to other training initiatives that might lead to a return to paid work. OTs' daily practices were focussed on identifying and providing appropriate individualised activities for patients to 'do', as, "every patient is treated as an individual" (Walden, 1941, p. 1). After receipt of the prescription, the patient would be interviewed, and a plan of treatment drawn up from the patient's interests, aligned with what was available to do in the department, with individual-focussed care aiming to support the patient's goals.

Constructors of patient conduct

The discourses in the documents produce OTs as creators and enforcers of docile bodies. Statements reveal that they observed, measured, persuaded, kept records and reported on people in their care. Patients were subjected to interviews and then observed through the process of "supervision" during their regular sessions in occupational therapy. Their progress was continually measured and recorded in departmental notes while verbal and written reports were

[46] Referral: "to direct a source for help or information… more like a request for consultation" (Reed, K., & Sanderson, S. (1980). *Concepts of occupational therapy*. Williams & Wilkins. (p. 117))

communicated to the doctor. They persuaded patients to engage in activities that might not have been naturally selected by the patient in order to change behaviour; to construct "quieter" (Auckland Correspondent of the New Zealand Freelance, 1940, p. 10) patients on the wards, needing less management from the nursing staff, as well as to reconstruct patients' minds and bodies in order for them to be able to reengage with society as desired by the government. Their disciplinary methods included timetables for patients and progression through the stages of rehabilitation, as well as reporting on the behaviour of each patient.

Protectors of our patch: Organisation, safety and prudent work practices in the department

Patients were kept physically safe in the department by careful supervision either by the OT or by the technicians. Infection control was acknowledged by disinfecting articles made by patients in "accordance with health department regulations" (Johnson, 1945, p. 8) prior to selling them. If the patients were to be taken out by OTs, they needed to have permission from the doctor to do so (Gordon et al., 2009, p. 202). As financial resources were limited, of necessity, OTs had to be prudent recyclers of materials and equipment. They produced therapeutic tools from discarded equipment and materials (Skilton, 1981) such as looms from butter boxes, knitting needles from wire, spinning wheels from discarded sewing machine wheels and buttons from toothbrush handles (Rosser, 1956; Rutherford, 1972). In fact, "any available timber, discarded rusty reeds from a woollen mill (for looms) and discarded sewing machine wheels (for spinning wheels) …(they) built their own workroom" (Buchanan, 1972/1990, p. 7). Discarded materials from industry were also utilised (Woodwork Instructor Rotorua Hospital, Circa 1945). Early OTs' therapeutic interventions were contingent on what they had available in their environment, rather than a planned protocol of what to do.

Summary

In this chapter I have provided a genealogy of early occupational therapy. Biomedical discourses were dominant, producing medical knowledge and status that empowered physicians to both lead medical institutions and make management decisions on care provided, such the construction of the conditions for the OT profession to emerge in NZ. I have looked at how the profession emerged, how OTs were produced and disciplined, how they were governed and resisted governance from medics to professionally govern themselves. I have also considered how they influenced the conduct of their patients. Importantly, I have identified the subject positions that are important to me from this early manifestation of occupational therapy practice. The next chapter will address contingent events, where I consider how shifts in social, political and economic discourse enabled the emergence of the DHBs and the construction of a clinical governance framework within them. Importantly, I consider how discourse of the moment might have influenced occupational therapy practice by making visible prominent occupational therapy subject positions produced from statements located within discourse situated within the texts studied.

Chapter 6 Contingent events

> What makes power hold good, what makes it accepted, is simply the fact that it doesn't only weigh on us as a force that says no, but that it traverses and produces things, it induces pleasure, forms of knowledge, produces discourse.
>
> *– Michel Foucault, Truth and Power*

Introduction

Clinical governance emerged as a solution to questionable safety and quality of healthcare delivery. It sought to fix siloed behaviours, the escalating cost of healthcare provision, and prevention of 'bad apples' – clinicians engaging in unsafe practices. Through the construction of clinical governance frameworks, practice boundaries and norms would be established so that practices could be regulated and moderated and clinicians could be disciplined to follow DHB preferred behaviours.

Clinical governance is not static; it shifts and takes up ideas and practices from multiple healthcare delivery discourses circulating in society, while discarding others. Economic, quality and safety of healthcare delivery, biomedical, individual responsibility and accountability, continuous professional learning and best practice, teamwork and communication and client-centred, bicultural, equity-focussed approaches are all discourses that together, constitute clinical governance. Clinical governance is therefore a discursive object that can be reconstructed in response to contingent events, as new healthcare delivery problems emerge and new solutions are sought in an attempt to solve these surfacing problems. The preferred discourses (listed above) that construct clinical governance act to change practitioner conduct and practices so that their practices are in line with the preferred knowledge and beliefs held by the health organisations in which the practitioner works, in this case, the DHBs.

This chapter introduces selected medical, social, political and economic documents that shaped healthcare delivery in New Zealand in the pre/early 2000s. Together, the texts produced and enabled the emergence of clinical governance within healthcare organisations. The cluster of discourses they contain (as above) come together to produce a quality framework designed to ensure that healthcare workers, including OTs, behave in particular ways in order to provide safe, cost effective healthcare services. I focus on what was done in the attempt to produce this overarching, cohesive system of quality[47] improvement in the New Zealand health system through

[47] Gauld in *The new health policy* (2009a) points out that 'quality' means different things to different people. From a Foucauldian viewpoint, there will be a plurality of understandings and it will depend on how certain subjects are positioned in relation to others as to what discourses they take up. Taking Gauld's examples of a patient, health-worker and a manager (p.43-44), 'quality' understood from the subject position of a patient, would likely focus on the take up of prominent discourses featuring patient experience and what is done to the patient. Likewise, a health-worker will more likely take a subject position where quality is understood as the type and amount of care that can be provided to the patient. Managers, on the other hand, will probably hold a subject position related more to risk minimization and value for money as their understanding of quality.

the take up and application of clinical governance in DHBs in the early 2000s. In this first of two chapters, I initially provide an overview of clinical governance as constructed by the medical, political and legal authorities of delimitation in the UK. I then look at the construction of quality frameworks in New Zealand and how additional legislation shaped the construction of clinical governance in the New Zealand context. The subsequent chapter will examine the rise of professional governance as its adjunct.

I am also interested in the way the occupational therapy profession responded to the neoliberal thinking that influenced models of healthcare provision prior to Moment 1, through the analysis of a number of investigative documents commissioned by the (then) New Zealand Department of Health and Department of Education. As a result, I argue that the profession essentially acknowledged the implications of neoliberal thinking on occupational therapy practice, particularly the government's emphasis on "decentralisation", "cost-effectiveness" and "consumer-driven" delivery of healthcare (Department of Education, 1988, p. 63). Their response, in effect, prepared them for the influx of clinical governance discourses into DHBs within Moment 1, which were also flavoured by neoliberalism.

Prior conditions

Multiple discourses questioning the quality of international healthcare provision were at work prior to the actual emergence and naming of the discursive formation, 'clinical governance', and its plurality of definitions. For example, in the late 1980s, the World Health Organization (WHO Working Group, 1989) was concerned with the integration of quality assurance principles, such as, "professional performance (technical ability), resource use (efficiency); risk management (the risk of illness or injury associated with the services provided) and patient satisfaction with the services provided" (1989, p. 82). The implication was that these early practices tended to be engaged in autonomously alongside each other, by professions and hospital departments who were siloed in their approach, rather than working as a cohesive, closely inter-related system. There was no formal framework specifically designed to connect the internal parts of an organization together as an integrated, interdependent whole. Additionally, few processes had been constructed to enable close scrutiny of what was done to patients by healthcare professionals and the outcomes. Furthermore, the cost of healthcare provision available to every person in society was becoming prohibitive.

Clinical governance frameworks were constructed partly to address these perceived healthcare delivery system problems. These were an attempt to reform quality and safety of health services through accountability and continuous improvement practices within healthcare organisations (Australian Commission on Safety and Quality in Health Care, 2017; Brown et al., 2009; Gauld & Horsburgh, 2017; Scally & Donaldson, 1998). In effect, the framework produced a shift to a system of governance within publicly funded health boards and their institutions, producing a new

set of normalised behaviours alongside professional governance, thus having implications for the subjectivities, subject positions and practices of OTs in the present.

Emergence of clinical governance

The UK National Health Service (NHS) has been designed to be funded wholly from tax revenues (Portillo, 1998; Rivett, 2015), providing access to healthcare for all, regardless of ability to pay, but over time, limited revenue from taxes led to underfunding of the service (Portillo, 1998). Escalating cost and serious medical scandals created the conditions whereby discourses surfaced questioning the management of healthcare delivery. The 'New Labour' government's white paper, *The New NHS* (Department of Health, 1997) brought about major changes to the structure of the NHS (Scally & Donaldson, 1998), in line with neoliberal thinking (McGregor, 2001).

In contrast, New Zealand's public healthcare service was and continues to be structured differently from the UK, being only partially funded through taxes. Secondary healthcare - hospitals and associated services - became free under the Social Security Act 1938, currently representing over 75% of Ministry of Health spending (Ministry of Health, 2016), but primary healthcare has continued to remain in the private sector, due to resistance from general practitioners (GPs). The 'user pays' GP visits were and are only partially subsidised (Belgrave, 2011b; New Zealand Parliament, 2009), but in partial redress, the Accident Compensation Corporation (ACC) was created by the Accident Compensation Act 1972 (Accident Compensation Corporation, 2014a). Its function is to provide comprehensive, no-fault personal injury cover for healthcare as a result of accidental injury (Accident Compensation Corporation, 2014b)[48]. However, as in the UK, discourses concerning the inexorable rise in cost of healthcare services in New Zealand, as well as the country's own medical misadventures, continued to dominate discussion in political circles (Ashton, 1996).

Economics and competence

Alongside advocating individual responsibility, neoliberal discourses are concerned with efficiency and cost, and these discourses are also present in clinical governance. Here, clinicians are expected to practice careful use of resources and demonstrate financial prudency by limiting intervention, or service delivery, to only what is needed, rather than improving quality of life. A startling example of this (from the perspective of OTs) was found in the 2003 Accessable Specialised Assessor Equipment Manual: "If the equipment will only improve the quality of life for the person, this is classified as desirable and does not meet the eligibility criteria" (Accessable, 2003, p. 3). A related issue is that of professional competence: a raft of papers were produced on behalf of the UK government in response to the discourses exposing costly, yet questionable care in areas as diverse as human organ management (Redfern et al., 2000), poor management of

[48] Primary healthcare and ACC are outside the scope of this thesis, it is only concerned with secondary healthcare provision by the government Department of Health, i.e. DHBs.

cardiac services (Bristol Royal Infirmary Inquiry, 2001), and Shipman, the GP found to have murdered his patients (Smith, 2005). The discourses in these reports constructed practitioner accountability and competency as inadequate.

In addition to these investigative reports, suggestions were already being made to remediate the kind of problems that subsequently surfaced within them, evidenced by documents, such as *The new NHS* (Department of Health, 1997), and *A first class service* (Department of Health, 1998b), a trend which continued with follow up recommendations after the Shipman Inquiry: *Good doctors, safer patients* (Department of Health, 2006). Importantly, the late 1990s documents already described both a clinical governance framework and its components: the first acknowledgement in the UK that clinicians effectively held two roles; as a clinician, and as a participant in, or driver of, quality improvement. Implementation was also addressed in *A first class service*: "Effective clinical governance will make it clear that quality is everybody's business" (Department of Health, 1998b, para. 3.8), and the subsequent *Clinical governance: Quality in the new NHS* (The Chief Medical Officer, 1999).

Early clinical governance organisational frameworks were intended to create a systems approach to continuous improvement of service quality, and the safeguarding of high standards of care (Scally & Donaldson, 1998). There was emphasis placed on responsibility, accountability, quality improvement activities, risk management, identification and remediation of poor performance (Department of Health, 1998b, para. 3.11-3.12) as well as development of an organisational culture committed to lifelong learning and continuous professional development (para. 3.28). Medical staff became part of management teams, introducing clinical responsibility and leadership for service quality (Haxby et al., 2010).

In New Zealand too, problems emerged in the healthcare system concerning questionable practitioner competence. Spaces opened up providing opportunities for governmental responses with the aim of ensuring that incompetent health practices would not recur. Both the Cartwright Inquiry, 1988 (Women's Health Action, 2014a) and the Gisborne Inquiry, 2001 (Women's Health Action, 2014b), recommended health reforms intended to improve the safety of healthcare delivery in relation to the diagnosis and treatment of cervical cancer. The Cartwright inquiry, in particular, identified conflict between clinical staff and management (Wright et al., 2001). The findings also noted that there was a failure to act in the interest of patients by not recognising the dangers and risks associated with the treatment given. The Cartwright report additionally highlighted concerns regarding poor standards of care, informed consent and patient education, as well as health practitioners failing to work as a team and not having the courage to speak up (Cartwright, 1988). The Gisborne Inquiry revealed the absence of accreditation and quality control processes, such as audit, monitoring and assessment for labs; at the very least, more than a decade after Cartwright, quality and safety assurance was still a problem in healthcare provision

(Women's Health Action, 2014b). Authorities of delimitation in New Zealand now looked to the UK healthcare system for discourses that addressed quality, safety and competency assurance.

International surfaces of emergence

The initial model of clinical governance emerging from the UK aimed to construct healthcare delivery as constituted from a connected, rather than siloed, framework of multiple discourses (Scally & Donaldson, 1998), as shown in the original 'Temple' model diagram, Figure 10.

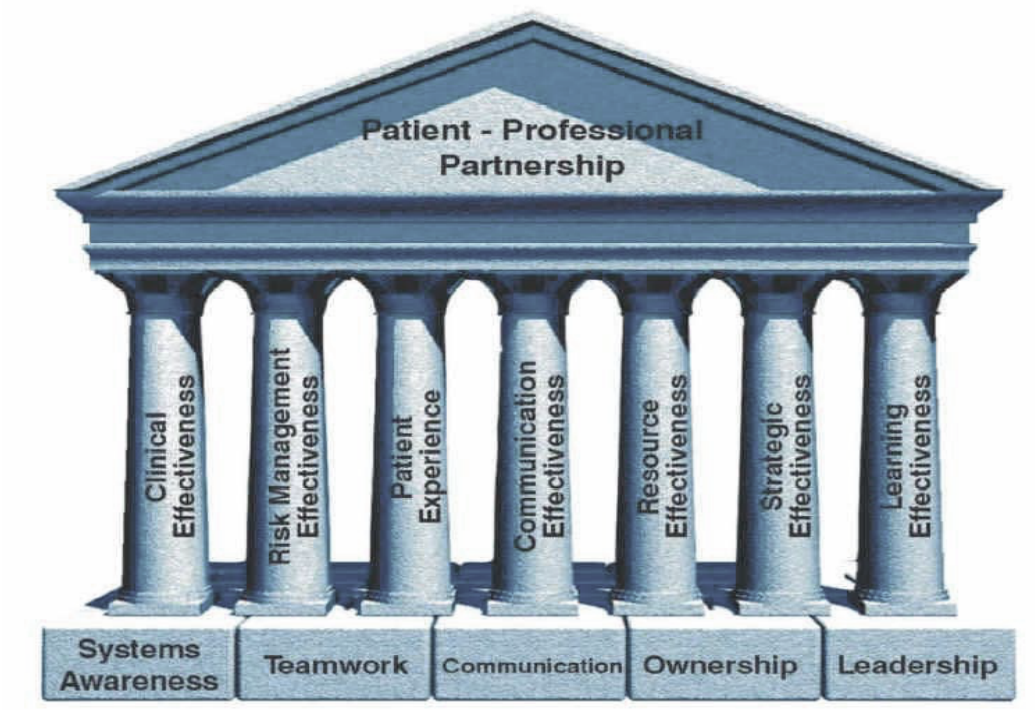


Figure 10. 'Temple' model: The building blocks of clinical governance. (Stonehouse, 2013). Copyright 2013 by the British Journal of Healthcare Assistants. Reprinted with permission.

When analysing the documents I had selected for Moment 1, I looked for statements that made visible the discourses associated with this model of clinical governance, which I considered would signify the presence of a surface of emergence – a site where discourses are at play, creating a space for phenomena to emerge. I took this original clinical governance model and thought about how they might appear in the documents (the analysis is shown in Appendix D).

The discourses in clinical governance also held the potential to construct multiple techniques of surveillance to make visible what people were doing in their daily practices to ensure "professional performance (technical ability); resource use (efficiency); risk management (the risk of illness or injury associated with the services provided); patient satisfaction with the services provided" (WHO Working Group, 1989, p. 82). The actual "surface of emergence" (Foucault, 1972, p. 45), when 'clinical governance' was named, emerging as a discursively formed object, is within the UK government's white paper, *The New NHS* (Department of Health, 1997, p. 24, para. 3.6). The government used its position as an 'authority of delimitation' to speak

and direct what would happen to healthcare provision in NHS hospitals. Prominent statements in the text carried messages that the construct, “clinical governance”, was to “ensure that clinical standards are met, and that processes are in place to ensure continuous quality improvement, backed by a new statutory duty for quality in NHS Trusts” (1997, p. 24, para. 3.6).

Multiple discourses brought together in this document produced another construction, the “third way” (2.2) of running the NHS. Biomedical discourses emphasised a behavioural focus on the ”needs of patients” (1.5), through the practices of “integrated care” (1.3), “partnership” (2.4), “efficiency” (2.4), “excellence” (2.4), fiscal management and “quality” (3.15). Technological discourses also made prominent the importance of the development and use of technology in healthcare for the benefit of both staff and patients for communication and record keeping. Further statements in the text made visible the intention to construct and activate disciplining mechanisms to be enacted on all health-workers in the NHS. The purpose of these mechanisms was to ensure all workers were aware of, and understood, that quality care was the core of their work and that all workers would need to take up the responsibility to provide quality care (6.12) within their everyday practices. Glimmers of plans to develop and utilise technologies of discipline and surveillance to produce docile bodies behaving in a certain way within a remit of clinical governance surfaced in this paper. The object, ‘clinical governance’ was constituted to ensure the following activities would be taken up and normalised into daily practices:

- Clinical audit and quality improvement processes
- Development of leadership skills
- Use of evidence-based practice
- Risk reduction initiatives
- Root cause analysis of adverse events, with changes made to prevent recurrence
- Complaint investigation
- Identification and management of poor clinical performance
- Provision of professional development opportunities
- Collection of data for quality monitoring purposes and comparison across the NHS
- Development of policy to ensure equal access to quality care for all.

Although this document provided an indication of the surfaces of emergence whereby clinical governance was named and constituted, it did not provide a succinct definition, but instead, provided opportunities for the construction of multiple definitions.

A plurality of definitions

The British document, “New NHS, modern, dependable” (Department of Health,1997) constructs an early vision of clinical governance and what it is for, but does not necessarily provide a succinct definition. Subsequently, there have been a plurality of definitions proposed to describe what clinical governance is. One is perhaps the earliest, and most quoted UK definition, that was taken up in New Zealand:

> Clinical governance is a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. (Scally & Donaldson, 1998, p. 62)

Although their definition stresses 'environment' and 'excellence', in order to clarify the definition further, Scally and Donaldson (1998) later referred back to the World Health Organization Working Group meeting in 1983, linking their definition with the WHO principles of quality assurance, i.e. professional performance, resource use, risk management and patient satisfaction with the services provided (WHO Working Group, 1989).

This quote illustrates one definition of clinical governance, but the construction and definition of clinical governance shifts from time to time. Attempts are made to fill in gaps when further problems in healthcare delivery are identified through discursive statements. The changing dominance of discourses within clinical governance frameworks produce new and refreshed associated practices to suit New Zealand healthcare delivery as envisioned by the New Zealand government.

Neoliberal economics

The construction of the New Zealand welfare state and associated healthcare delivery remained unchanged for thirty years (Belgrave, 2012). However, the 1973 international oil crisis produced a profound economic shock, and solutions were needed to stimulate economic recovery, opening up opportunities for world-wide shifts in economic, political and social discourses. The power of Welfarism governmentality weakened as emerging political discourses increasingly portrayed the health service as expensive, siloed and of questionable quality, bringing in a period of time that Gauld (2009a) terms the "reform era" (p. 1). This era, or moment, was heavily influenced by neoliberal thinking (Gauld, 2009a), where discourses touting relaxation of state control as a new way to promote economic recovery strengthened neoliberal governmentality. These more prominent discourses promoted individualism, a free market, and decentralisation (McGregor, 2001) in line with neoliberal thinking. When applied to the healthcare delivery context, health systems were constructed to focus on promotion of individual responsibility rather than dependence upon the state, privatisation of services to contain cost, deregulation from state to local bodies, aiming for an improvement in quality through local accountability and efficiency with faster response to local needs (McGregor, 2001).

The New Zealand health service had been restructured four times since 1983 (Gauld, 2009b). Prior to the introduction of clinical governance, managerial discourses[49], taken up from the

[49] Managerial discourse: Statements promoted top-down centralised, hierarchical organisational control by managers; practices involved prioritising performance, utilising performance management techniques and adherence to government and organisational systems. Discourse indicators included statements associated with expenditure, risk, cost, clinical, case, conditions, behaviour, system management.

business world, replaced clinician-led financial decision-making (O'Reilly & Reed, 2011). Healthcare provision led by managers was unpopular with the medical profession as it effectively reduced the power the profession could enact, and limited the decisions doctors could make for their patients. Medical practitioners, as biomedical authorities of delimitation desiring to reclaim power associated with clinical decision-making, favoured the discourses constructing a version of clinical governance which prioritised shared leadership in decision-making, including a "patient-professional partnership" (Stonehouse, 2013, p. 45), as well as preferring discourses that supported clinical excellence, quality, safety, patient experience, accountability and responsibility. In response, the Clinical Leaders Association of New Zealand (CLANZ) was formed, aiming to "clarify perspectives on clinical governance including appropriate, useful and practical terminology and guidelines" (Wright et al., 2001, p. 10).

Managerialism

Discourses from neoliberal thinking produced a call in the UK (followed by New Zealand) for cost containment and best use of resources in healthcare (Nicholls et al., 2000). As neoliberal practices were concerned with the functioning and management of the economy, dominant discourses pushing managerial practices came into play, enabling new mechanisms of power to be introduced into healthcare delivery from the business sector as an attempt to oversee and control spending, while also ensuring the provision of quality services within an allocated budget (Gauld, 2009a). It seems to me therefore, at this time prior to Moment 1, managerial discourses of this era constructed managers as the new "authority of delimitation" (Foucault, 1972, p. 46) in healthcare institutions. Managers enacted power in the form of engaging in practices that enabled them to autonomously make decisions about what healthcare would be paid for within the budget allocated to them. In essence, they were charged with limiting the provision of care to a finite amount of spending, shifting the idea from 'access to healthcare for all people', to a more limited concept of selected healthcare provision for those who needed it. This effectively contributed to the contingent surfacing of the "neoliberal government of health" (Miller & Rose, 2008, p. 76) discourse.

One outcome of managerialism was that professional discourses[50] were marginalised, passing into the "field of memory"[51] (Foucault, 1972, p. 64). Managerial discourse produced a preferred knowledge that acted powerfully to reduce the influence of the medical profession within healthcare systems[52]. Doctors lost the autonomy to make decisions about the healthcare provided to their patients, producing conflict within practice (Wright et al., 2001). Documents from the

[50] Statements associated with the construction of autonomous, expert, client-centred professional practice and leadership; considered by O'Reilly, D., & Reed, M. (2011). The grit in the oyster: Professionalism, managerialism and leaderism as discourses of UK public services modernization. *Organization Studies*, *32*(8), 1079-1101. https://doi.org/10.1177/0170840611416742 as "residual, but still potent" ibid. (p.1079).
[51] Old discourses no longer holding prominence.
[52] An example of a health system in operation is a DHB.

medical profession indicated that doctors were concerned about the shift in decision-making power which limited their practices (Wright et al., 2001).

Less is more

Discourses from neoliberalism as a governmentality have flavoured the clinical governance discourses, and the merging of the two produce an interesting dichotomy: while deregulation is pursued at a national government level, in order to "govern.. less ...for maximum effectiveness" (Senellart, 2008, p. 327) and provide the "freedom to choose" (Miller & Rose, 2008, p. 82), it also produces a condition whereby a network of regulations is required within the DHBs to efficiently 'govern more' through the application of techniques of discipline, because, as Foucault claims, "discipline regulates everything" (2007a, p. 45). Therefore, for a framework to operate efficiently, close regulation of behaviour is required, leading to the introduction of technologies of discipline to ensure that preferred practices are taken up and normalised into daily practices, placing much more responsibility on the individual.

This relationship between the discourses reproduced in the clinical governance documents provides one solution to the problem of publicly funded healthcare[53] delivery as a somewhat devolved system seeking to build partnerships with the private sector, such as Primary Healthcare Organisations (PHOs)[54] and Non-government organisations (NGOs). It enables the New Zealand government to oversee and control what is happening to healthcare delivery nationwide, from a distance, through a high-level stance of population health. It also enables a shift away from direct political responsibility, by empowering DHBs to construct their own local clinical governance frameworks within certain conditions laid down and approved by the government. Essentially, the government is removing itself from the logistics of individual health care provision and what happens to individuals, and, I would suggest, removing any emotion or humanity from the decision-making. It can now look at statistics and make decisions that are considered best for the population rather than the person.

While clinical governance was constructed to focus predominantly on the production of quality healthcare and specific types of practitioner subjectivities, it also constructed a particular type of client. Clients were now constructed as 'self-determining', subjects who could proactively make decisions for themselves and set their own goals. This 'accountability' discourse was foregrounded in the New Zealand Health Strategy (King, 2000). "Active involvement of

[53] Includes all health and disability services funded from taxes including public and personal health, mental health, early detection and treatment, disability support (Ministry of Health. (2002b). *Te pai me te oranga o ngā iwi. Health for all people*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/7F8B7A230A0B22E2CC256BA60072D1BA/$file/TEPAIMETEORANGA.pdf)

[54] Primary health organisations (PHOs) are funded by DHBs to support the provision of essential primary health care services through general practices to those people who are enrolled with the PHO (Ministry of Health. (2011). *Primary health organisations*. Retrieved 25 December, 2020, from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations)

consumers and communities at all levels: This principle identifies the need to have consumers and communities involved in decisions that affect them" (King, 2000, p. 9). The effect of neoliberal-flavoured clinical governance discourses, therefore, changed both the construction of subjects named as a 'client' (or 'user' or 'patient'), their relationship to the healthcare system and, by default, with practitioners, who were now required to engage in practices that were 'client-centred'. Central to clinical governance frameworks are discourses favouring economic awareness and fiscally prudent practices, also upheld by neoliberal governmentality. This economic subject position produces practices aimed to ensure that OTs are mindful of the cost of the care they provide, particularly when supplying equipment or recommending home modifications (Accessable, 2003), or deciding upon the duration of the intervention required to produce the planned outcomes or even whether to engage in services at all: "At referral, is [the client and clinical] risk and need at an appropriate level to accept this referral?" (Malcomess, 2005, p. 8).

New authority of delimitation

Overseas policies, particularly from the UK, have tended to influence and produce responses in New Zealand, that are similar, but not always identical, to those actions that were produced in the originating country. At various times, the New Zealand government has reviewed and 'imported' healthcare policies and practices, and so the concept of clinical governance was analysed in detail by those who had the authority to speak in NZ on medical issues. In this case, it was the recently formed Clinical Leaders Association of New Zealand (CLANZ), whose members were predominantly constituted from doctors and other authorities in related medical professions. By prioritising discourses favouring a shared power of clinical leadership with managers within a DHB clinical governance framework, this group deployed a discourse of shared clinical leadership that would enable them to regain some of the lost power they originally enjoyed, while also being seen to support a system redesign considered beneficial for the health of New Zealand society, economy and the political requirements of the Labour-led government.

CLANZ surfaced in 1998 (Wright et al., 2001), challenging managerialism in favour of clinical governance, arguing for a more collaborative model of healthcare delivery. After securing funding from the New Zealand government, CLANZ researched and produced three advisory papers for the government: *Clinical leadership and clinical governance: A review of developments in New Zealand and internationally* (Wright et al., 2001), *Clinical leadership and quality in district health boards in New Zealand* – i.e. the development of clinical governance in DHBs – (Malcolm et al., 2002a), and *Clinical leadership and quality in primary care organisations in New Zealand* (Malcolm et al., 2002b). The purpose of these documents was to support the construction of a framework of clinical governance discourses, by explaining the benefits of clinical governance, with particular emphasis on the importance of joint leadership held between managers and clinicians.

The Association also constructed a training manual and video, *Working together: Face to face communication* (Clinical Leaders Association of New Zealand and Nga Ngaru Hauora O Aotearoa [CLANZ], 2002). The manual was written to be delivered within DHBs "to support behaviour change for those who are serious about forming effective relationships in the delivery of healthcare services to the people who use the service" (p. 5). It was written to train health professionals to communicate more effectively with their patients, however, one of the consultants I approached, Dr. Robin Youngson, a former member of CLANZ, who provided a copy of the training manual, indicated that take up of the training by DHBs was limited (personal email communication, 2017). I found only one reference to the training being rolled out, which was in an older adult service at Waitematā DHB (Waitematā DHB, 2004a), otherwise there was an absence in the documents to which I had access.

Managing grassroots change

Although, on a macro-level, clinical governance can be understood as an overarching construct to manage population healthcare, it produces various discursive practices at a micro-level. The surfacing of clinical governance in New Zealand about the time of 2003-2005 served a number of purposes. The documents signal to me that one reason was an attempt to respond to and manage a number of individual clinician practices, considered unsafe, such as those highlighted in the Cartwright Inquiry, the Gisborne Inquiry and also the Cull Report[55] (Cull, 2001). These two latter reviews added to the clinical governance corpus in that it aimed to answer questions raised about the patient complaints process in the light of Cartwright and Gisborne, among others. It identified problems with the medical complaints process and made recommendations to ensure the accountability and responsibility of medical practitioners through changes to a number of organisations such as the Complaints Review Tribunal (CRT) and the Medical Practitioners Disciplinary Tribunal (MPDT), effectively making recommendations "for a 'one-stop-shop' to co-ordinate the investigation of all patient complaints" (Scragg, 2003, para. 1).

I understand clinical governance discourses, such as those concerning continuous improvement in practices associated with quality, safety, competence, accountability and responsibility (Gottwald & Lansdown, 2014; Haxby et al., 2010; McSherry & Pearce, 2011; Wright & Hill, 2003), as conveyors of the preferred knowledge and beliefs desired by DHBs. Clinical governance discourses act to marginalise the unwanted/unsafe medical practitioner behaviours and practices made visible in the Cartwright, Gisborne and Cull investigations, and they also bring to the fore current ideas associated with working safely and competently. Some authors name this process "change management" (Gottwald & Lansdown, 2014, p. 66; McSherry & Pearce, 2011; Wright

[55] The New Zealand government in 2000 appointed Helen Cull QC to review an overly complex system for reporting complaints about doctors and other health workers. This followed a series of complaints against gynaecologist Dr. Graham Parry, brought to a head by publicity about his mismanagement of a patient's cervical cancer, mid-way through the Gisborne cervical cancer inquiry. Parry was found guilty of failing to pick up her condition, and of mishandling her case.

& Hill, 2003), which is perceived as a positive process and "a phenomenon of daily organisational life" (Parkin, 2009, cited in Gottwald & Lansdown, 2014, p. 67). Change management enables mechanisms to be put in place in DHBs that encourage the practice of preferred behaviours, and within change management, technologies of discipline act to endorse implementation of favoured behaviours. These technologies of discipline act on the bodies of healthcare professionals, through the introduction of rules, routines, policy, guidelines, surveillance and monitoring, some technologies also acting as mechanisms to reward and acknowledge favoured behaviour. A typical example of recognition and reward is the Health Innovation Awards, initiated by the Ministry of Health and ACC in 2003 (New Zealand. Health innovation awards, 2003).

Distribution of discourses

The documents associated with Moment 1 indicated that clinical governance discourses predominantly surfaced from the top down in DHBs as a response to discourses transmitted via New Zealand government legislation, policy and strategy. At least one Annual Plan Executive Summary makes this clear from the outset:

> This District Annual Plan (the Plan) has been prepared in accordance with the requirements of the Public Finance Act 1989 and the New Zealand Public Health and Disability Act 2000 (NZPHD Act). It addresses the requirements of current policy settings and reporting requirements advised by the Ministry of Health (MOH). The activities of the Auckland District Health board (ADHB) are guided by the objectives set out in the New Zealand Public Health and Disabilities (NZPHD) Act, the New Zealand Health Strategy, the draft New Zealand Disability Strategy and the Minister of Health's expectations. The plan acknowledges the importance of relationships that support the principles of partnership, participation and protection embodied in the Treaty of Waitangi. (Auckland DHB, 2002, p. 7)

The discourses were interpreted and distributed by senior and middle managers through the construction of new organizational structures, services and written strategic policy, rather than through practices that were clinician-initiated from the bottom-up. This is evident by the absence of any mention of the frontline clinicians' role. "The ADHB has developed integrated Human Resources (HR) vision, strategic intent and goals to support the achievement of ADHB's business and healthcare service objectives" (Auckland DHB, 2002, p. 17). The documents suggested that clinicians' change in practices were produced from the effect of multiple discourses such as those favouring neoliberal principles, cultural competence, clinical governance and professional governance (Auckland DHB, 2012).

Fairness and justice

There is an argument that the neoliberal emphasis on self-determination and independence produced an opportunity for Māori voices to be heard (Bargh, 2007). Māori protests in the 1970s featured a prominent discourse suggesting that the Treaty of Waitangi had been breached and that there was little recognition of Māori rights and culture (Hayward, 2012b). Finally, in late 1986, a

Royal Commission was established with the intention to "set social policy goals and to recommend what needs to be done to make New Zealand a more fair and just society" (Richardson et al., 1988b, p. xvii), and just over eighteen months later, the Commission's findings were published as *The April Report*.

In the context of healthcare, discourses favouring "a strong commitment to the Treaty of Waitangi and true partnership [with Māori] has been expressed" (Richardson et al., 1988a, p. 46). This report affirmed the practice of biculturalism in New Zealand; a discursive construct signifying "the partnership established between Māori and the Crown by the Treaty of Waitangi" (Hayward, 2012a). The shift to biculturalism was recognised by acknowledging the government's obligation under the Treaty of Waitangi to address Māori health, by setting up a Māori health team at the government level. In the following years, this team was seen to have made a difference to accessing health services for Māori, although it was some time before the partnership became "Māori-centred" rather than "Māori-friendly", in the sense that Māori then had the control and leadership to enable them to actively participate in health policy development focussed on Māori perspectives of health (Durie, 1998; Gauld, 2009b, p. 73). Biculturalism remains a discourse unique to New Zealand and it flows into the construction of New Zealand DHB clinical governance frameworks through government and local DHB health policy in recognition of the Treaty of Waitangi.

Emergence of DHBs

In 1999, the Labour Party, led by Helen Clark, formed a coalition government in New Zealand providing an opportunity for another reorganisation of the health system, as election results had confirmed a societal dissatisfaction with the current health system (Gauld, 2009b). During the first few years of the 2000s, the New Zealand government issued no less than 35 supporting strategy documents (a typical example: *Best practice evidence-based guideline: Assessment processes for older people* (New Zealand Guidelines Group, 2003)), that contained discourses laying out the preferred knowledge and beliefs the new DHBs were to take up and implement through the construction of clinical governance frameworks and the introduction of preferred practices.

The New Zealand Public Health and Disability Act 2000 constructed District Health Boards (DHBs) as the new structure for healthcare delivery in New Zealand. There was to be a mix of appointed and elected members to sit on the DHBs whose function was to ensure that governance of the healthcare delivery services in the DHB's geographical area was appropriately carried out. Along with the senior leadership and management teams, elected members had the authority to actively make decisions concerning how healthcare services were delivered to their respective DHBs. In Foucauldian terms, these board members and senior managers were subjects constructed by the government, and as such, they were expected to hold the subject positions

produced by the various discourses influencing the government's proposed health structure. Also as government constructed subjects, they were expected to accept direction from the Ministry of Health. They were required to formulate annual plans showing how their organisation would carry out government health policy within an allocated budget, with each annual plan needing to be approved by the Minister of Health. The new DHBs were to be financed with a population-based system of funding, and were charged with developing local strategic and annual plans for the population of their local designated geographical area. These provided the conditions necessary for the DHBs to become the surfaces of emergence of clinical governance, producing a framework of new discursive objects, built to suit the requirements of a newly-reconstituted New Zealand publicly-funded healthcare system.

Quality health service provision discourse

Versions of clinical governance were first taken up in New Zealand by private Primary Care Organisations (PCOs) overseeing General Practitioner services due to a strong commitment to improve quality and clinical leadership in their services (Malcolm et al., 2002b). Additionally, glimmers of governance practices were also evident in the documents of some DHBs, such as Counties Manukau DHB and Health Waikato, which set up a clinical board and a governance framework respectively (Wright et al., 2001). However, it was at the level of the New Zealand government that a cluster of papers, associated with the delivery of healthcare in the newly formed DHBs, signalled the intent for a new kind of leadership and management.

The discussion document *Safe systems supporting safe care – a discussion document on quality improvement in healthcare* (National Health Committee, 2001) and its final report *Safe systems supporting safe care - Final report on health quality in New Zealand* (National Health Committee, 2002) addressed the problem of achieving quality improvement in New Zealand healthcare services. Instead of an overarching definition of what constituted quality, five dimensions of quality were identified. The dimensions, resting on a foundation of cultural competency were considered to be (National Health Committee, 2001, p. 13):

- Safety
- Effectiveness
- Efficiency
- Consumer responsiveness
- Access to service on the basis of need.

The first document acknowledged the quality failures in the healthcare service which had resulted in high-level public inquiries, and, to minimise the occurrence of future failure, a multi-level systems approach to quality improvement was supported. Individuals, both consumers and practitioners, teams, organisations and system agencies such as regulatory boards, were all expected to participate in quality improvement practices. An emphasis was placed upon "a co-ordinated approach to quality improvement… strong leadership at all levels… [and] …greater

consumer participation in quality improvement" (National Health Committee, 2001, p. 5). The five dimensions of quality and the four system levels were summarised in the discussion document and report by two diagrams, Figures 11 and 12.

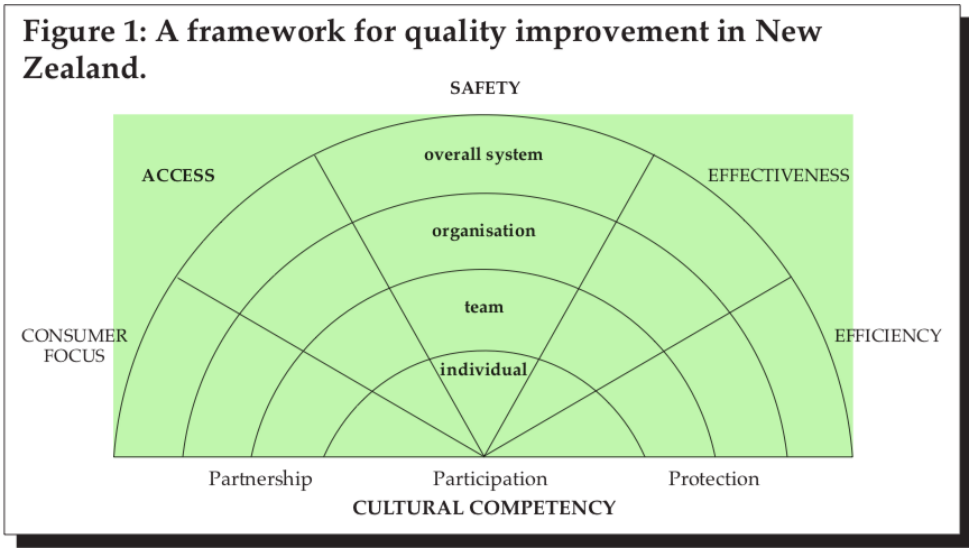


Figure 11. A framework for quality improvement in New Zealand. (National Health Committee, 2002, p. 13). Copyright NHC. Non-commercial reproduction license.

Table 1: Examples of quality improvement at the four levels

Levels of quality improvement activity	Examples
Individual	Practitioner education, benchmarking, clinical guidelines, provision of evidence-based information to consumers
Team	Clinical audits, clinical guideline development teams, peer review
Organisation	Continuous quality improvement, organisation development, facilitating consumer participation
Overall system	Regulatory requirements, encouraging collaboration throughout the sector to reduce duplication, funding of national guidelines, facilitate comparisons of quality outcomes among DHBs and between NZ and other jurisdictions

Figure 12. Examples of quality improvement at the four levels (National Health Committee, 2002, p. 13). Copyright NHC. Non-commercial reproduction license.

New legislation, in process at the time the documents were written, such as the Health and Disability Services (Safety) Act 2001 and the Health Practitioners Competence Assurance Act 2003 [HPCAA] were believed to be the external instruments that would initiate system redesign as well as regulate and monitor the behaviour of practitioners working within the health system. Furthermore, credentialing, accreditation and peer review, guideline development and sentinel event monitoring were all standardisable internal regulatory mechanisms mentioned in, and supported by, the documents. I would suggest that they were favoured because associated

discursive practices linked with safety, risk minimisation, competence and quality initiatives positioned these mechanisms as tools that could be used in the system to introduce and normalise particular behaviours into daily practice. This normalisation resulted in the disciplining of practitioners, who were expected to conform with quality principles constructed by DHBs.

The 'final report' (National Health Committee, 2002) expanded the actions needed to be taken to ensure that practices involving quality improvement became normalised within DHB culture. Practices included leadership development, the formation of quality forums for sharing 'best practice', the designation of funds for research and the construction of awards for innovative practice. The report also contained statements that emphasised the importance of further research into clinical governance and clinical leadership at all levels, acknowledging the CLANZ (2002) claim that the practice of shared leadership was a necessary component in the construction of a quality improvement framework (p. 19).

Health strategy and DHB context

Perhaps the most significant government document that guided the DHB health system pathway was the *New Zealand Health Strategy* (King, 2000), which aimed to "develop a framework for action; identify the government's key priorities; provide DHBs with the context within which they will operate, and, identify the way forward" (2000, p. 1). Discourses supporting the original ideas from Welfarism were still in evidence in the statement "a health system that is there when people need it, regardless of ability to pay" (p. iii). Here the New Zealand government is signalling to its subjects, those working in the DHBs, that they will need to construct a framework that produces particular practitioner behaviours and practices so that delivery of healthcare is aligned with the government's vision of healthcare provision.

I interpret this document as a high-level disciplining text, laying out what is to be done by those working in DHBs to deliver healthcare services in a certain way. It is concerned with the application of disciplinary mechanisms associated with regulation, minimum standards, clinical review and patient rights. "Clinical governance" (King, 2000, p. 25), although only named once, is made visible and constructed throughout the text, as statements come together suggesting what the construction will *do*, including the achievement of "better health outcomes and a reduction in health disparities" (2000, p. viii). It will *be* "high performing" "efficiently delivered", with "Budgets...capped" and "Quality [will be]...the cornerstone" (p. 25). The statements are also clear that technologies of discipline would constitute part of the framework to ensure "continuous quality improvement mechanisms and initiatives... consultation... co-ordination... information management and technology...workforce development" (p. viii) and "continually monitored" (p. 9), Limits to service are addressed, as service provision will occur "*within the money available*" (document's emphasis) which is to be "used to best effect. It will never be possible for the government to do everything for everyone" (p. 2). For that reason, performance indicators would

be applied to measure DHB progress and outcomes. The aims are clearly stated as effects of quality improvement discourses:

> Over time, this framework of goals and objectives will influence all health sector processes, including needs assessment, priority setting, resource allocation, outcomes monitoring, service evaluation and planning, workforce and provider development, information systems and inter-sectorial coordination. (p. 9)

The document also lists the practices that the DHBs have already initiated to assure "safety and quality of care" (p. 25), including reportable events; credentialing; competency assurance; teams of health professionals; monitoring of people, systems and resources; setting of performance targets; setting quality standards and delivery expectations; complaints procedures; and systems to collect comparative information. There is also recognition that further construction of the framework will be needed to provide support and supervision to professionals in the form of training and continuing education, in order for them to reconstruct their practices and take up a "different mix of workforce skills" (p. 29) needed for healthcare delivery at the time.

A plurality of frameworks

Unlike Britain, where one model appears to have been applied to the whole of the NHS, the New Zealand government provided DHBs with the freedom to construct customised integrated frameworks of governance discourses for the populations they served, that aimed to improve the quality and safety of healthcare provision (Nicholls et al., 2000).

Disruption and reconstruction

In Foucauldian terms, I understand that change would be accomplished by disruption of the relationships within the existing healthcare delivery systems by the introduction and action of new, dominant discourses generated and supported by the New Zealand government and the Ministry of Health, as well as the medical and nursing professions. The discourses would flow into healthcare institutions and, by capillary action, through a network of power, be transported to all levels of the organisation as the preferred knowledge from which new behaviours would be produced. These discourses needed to be sufficiently powerful to change healthcare workers' knowledge and beliefs about healthcare delivery. If they were, practitioners' subject positions and practices, reinforced through institutional techniques of discipline, and where necessary, punishment[56], would reflect these new institutional preferences in how they provided interventions to their clients. However, because bodies also must have freedom of choice in Foucault's (1978) understanding of power, there is also the possibility of resistance to the

[56] Practices I associate with punishment in DHBs would equate to investigating questionable conduct and initiating regulatory processes that shut down the behaviour. Punishment may result in close supervision for a period of time, limitation of scope of practice, demotion, suspension, resignation, or being dismissed

dominant discourses due to subjects holding onto other subject positions that are stronger and more meaningful for them, such as professional discourses.

The noise of medicine and nursing; The silence of allied health

I would argue that Moment 1 was a period where DHBs initiated the process of building their clinical governance frameworks. The report, *Clinical leadership and quality in District Health Boards in New Zealand* (Malcolm et al., 2002a), commissioned by CLANZ, looked at the progress of 10 DHBs across New Zealand. During this moment, the report found that clinical leadership was "medically focussed" (p. 10), and although clinical governance discourses were also being taken up by nursing, the allied health professions were relatively silent in their response to clinical governance. However, when looking at DHB structures at the time, I noticed that the allied health response could have been limited due to little representation within the management and leadership structures. For instance, the orientation pack document, *Welcome to our team: Making a healthy difference*, that I was given as a new employee in Waitematā DHB in 2005 (Waitematā DHB, 2005h), has no mention of allied health in its senior management team structure. Within the 'Corporate Group', there are positions listed for Director of Nursing and Chief Medical Officer, as well as an assortment of positions representing disciplinary agencies within the DHB, such as human resources, finance, information, risk compliance, communications and corporate services; and recognition of the Treaty of Waitangi is represented by 'Māori Health' in this group. Similarly, at Auckland DHB there was no mention of allied health on their organisational structure chart (Auckland DHB, 2002, p. 41). Although there was acknowledgement that the DHB was undergoing a change programme, primarily to ensure efficiency and cost effectiveness, a later statement seems to confirm the silence of allied health (and occupational therapy) at the corporate level.

> With respect to clinical governance matters the ADHB has established a Clinical Board with effect from 1 July 2002. The management structure has also been altered to provide for joint management of operating units between a General Manager, a Clinical Leader and a Nurse/Maternity Leader working as a triumvirate. (Auckland DHB, 2002, p. 66)

Statements suggest that the common structure for allied health services at this time was that they were embedded within medical services rather than a named entity in their own right. Indeed, although quality improvement discourses were present, it was taking time for actual behaviours and practices to be introduced and normalised, each DHB having its own timeframe.

Welcoming regulation

The New Zealand Board of Occupational Therapy (NZBOT)[57] was concerned with how to strengthen the long-term credibility of the profession. A cluster of reports, published prior to

[57] Post HPCAA 2003, the name was changed to *Occupational Therapy Board of New Zealand* (OTBNZ).

moment 1 provided the conditions of existence whereby an argument to be included in the HPCA Act 2003 could be constructed. All contained glimmers of neoliberal governmentality pertaining to healthcare delivery: *Education: A professional issue. Report on the review of occupational therapy education* (Department of Education, 1988); *Occupational therapy workforce profile 1987-88* (Department of Health, 1988), *Occupational Therapy Roles and Functions* (Department of Health Workforce Development Group, 1988) and *Competencies for registration as an occupational therapist* (New Zealand Occupational Therapy Board, 1990). The content of these reports set the groundwork that would be used as a platform for the occupational therapy profession be included in the 2003 HPCAA reflecting the subtle take up of both neoliberal and clinical governance practices under the auspices of professional practice.

Education and workforce

The first document, *Education: A professional issue. Report on the review of occupational therapy education* (Department of Education, 1988) strongly argued for major change to training to "ensure that the future health needs of New Zealanders are met in a cost-effective and efficient manner" (1988, p. vii). This statement meant that OTs now needed to be trained to make prudent, effective practice choices within defined economic parameters. Emphasis was also placed on attracting a more diverse group of people to train as OTs particularly "schools leavers, mature people, Maori and Pacific Islanders, males" (p. 1). The document also acknowledged that the profession needed to be cognizant of the neoliberal concepts of "decentralisation", "responsibility and accountability", "consumer-driven", "cost-effectiveness", "value-for-money" (p. 63). The construction of a document outlining an entry-level standard of occupational therapy competence was also recommended.

The second document, *Occupational therapy workforce profile, 1987-88* (Department of Health, 1988) reported on and followed up an initial profile, completed in 1985, where workforce development quality concerns were identified and presented to the profession for response. The 1988 *profile* stated that an "ad-hoc workforce development advisory group" (1988, p. 6) was formed after the 1985 profile, and the group responded by constructing "Occupational Therapy Roles and Functions", a document that laid out practitioner accountabilities and responsibilities. The 1988 workforce profile also recommended "development of national minimum standards of occupational therapy practice" (p. 14) which could then be used as a basis for construction of a tool that monitored and evaluated individual practitioner performance.

Setting scope of practice

This third document, *Occupational Therapy Roles and Functions* (Department of Health Workforce Development Group, 1988) signalled an intent to actively construct practices in line with discourses produced from neoliberal governmentality through the use of associated terminology. The document was constructed to regulate and limit OTs' behaviour. Statements

defined what occupational therapy was, what OTs did, where they did it, i.e. the spaces where they worked, how they were expected to practice, and who they worked with as well as particular styles of working, such as autonomously or as part of a multidisciplinary team. It described occupational therapy beliefs, models and, importantly, the "Occupational Therapy process" (p. 2).

This process was a written procedural guideline to be followed by practitioners for each patient. The occupational therapy process addressed gathering of information, assessment, measurement, formulation of a treatment plan and prediction of the expected patient outcome. Occupational therapy practitioners were instructed to gather data "from a variety of sources and in various ways" (p. 3), such as interviewing, communication with all interested persons, investigating records and case histories, screening, observing behaviour, review and analysis of data, programme planning, documenting. Treatment planning essentially needed to follow the scientific method and thus contain a theoretical approach, a method of intervention, measurable goals, a schedule, a discharge plan and a means of evaluating the outcomes. OTs were also advised to consider the goals and interests of the patient and family, other professionals, and the availability of resources. These words clearly signal a shift to neoliberal thinking prior to the advent of clinical governance because they stem from concepts of health based in neoliberal thinking, such as self-responsibility, individual and shared accountability, cost and use of resources. The change in subject positions of both patient and therapist away from welfarism to that of a neoliberal stance can be seen as the effect of application of Foucauldian technologies of discipline on both patient and therapist.

Minimum standards

The introduction of the first written minimum standards of practice, *Competencies for registration as an occupational therapist* (New Zealand Occupational Therapy Board, 1990) fulfilled the recommendations set out by these three reports. The introduction of competencies aimed to set out the skills an entry level OT would need to demonstrate in order to gain registration status with the Board. The introduction of competences functioned to set out auditable standards to ensure competent, safe practice within the occupational therapy scope of practice.

OT introspection: Towards a practice shift

The profession itself recognized the need to diversify practice into new fields, such as, "work assessment, postural training, industrial psychology, work study… community" (Boyd, 1973/1990, p. 39). Furthermore, the concept of 'teamwork' was also becoming more prominent in health vocabulary and the profession recognized that OTs should be taught to take a more collaborative approach in their practice. Alison Harding (the then [1973] Course Supervisor for occupational therapy at the Central Institute of Technology) wrote, "perhaps the greatest advantage for our students is being part of a large educational complex, within a Department of

Health Sciences which is developing slowly but surely into a multidisciplinary health team" (Harding, 1973/1990, p. 38). Another area the profession was pushing during the pre-clinical governance period was self-responsibility as well as the responsibility of the profession. "Therapists are developing an increasing awareness of their responsibility to provide a high standard of service and an educational system which will be able to respond to advances in technical expertise and to the changing health needs" (Gordon, 1976/1990, p. 47). As a (then [1976]) clinical tutor, Gordon also called for "quality therapists and services they provide" (1976/1990, p. 47), noting that a therapist's responsibility is to the public and to the employer. Additionally, mention of 'lifelong learning' and the need for professions to keep up with 'scientific advances' were also concepts taken up by occupational therapy, prior to the construction of clinical governance frameworks. Lifelong learning, in particular, is in keeping with Foucault's (2008a) idea of the entrepreneurial subject in his discussion of neoliberalism.

Signals to the NZ government

At board level, the profession signalled that it wanted to be part of the HPCAA, thus remaining within the boundaries of biomedical discourse that gave credibility to the profession's practices. Some in the profession were aware that practices needed to be reconstructed in response to the changing discourses related to healthcare delivery. It was understood that to remain viable, practitioners would have to take up new practices with visible, measurable outcomes, which would necessitate the take up of discourses that emphasised evidence-based, patient centred practice, prominent within the overall clinical governance discourse. At the front line, practitioners were expected to pick up these discourses, possibly believing them to be from their profession, and, as such, may have responded by locating and embedding models and theory from abroad into DHB professional practice.

Professional regulation and the HPCAA

The New Zealand government's political need to be seen to manage professional competence and patient safety essentially created the conditions for the emergence of the 2003 HPCAA. This legislation was passed with the purpose of protecting the public from medical malpractice and was of interest not only to the professions, but also to the DHBs, who were similarly obliged to follow the requirements of the Act. For OTs, the regulatory board was renamed and reconstructed and, from then on, known as the *Occupational Therapy Board of New Zealand*. This body holds power by acting on behalf of the New Zealand government, to regulate the occupational therapy profession (OTBNZ, 2018c).

The HPCAA had far-reaching effects for health practitioners as it flowed into the daily practices of OTs, both through professional regulation and through the regulations within DHBs. Professionally, the OTBNZ continues to set standards of professional practice and competence for registered OTs that are documented (OTBNZ, 2018b) with the expectation that they are taken

up and normalised in to daily practice. Through the use of technologies of power, OTBNZ ensures distant surveillance and monitoring of OTs' conduct via a requirement to engage in supervision[58] (Occupational Therapy Board of New Zealand, 2020b) as well as more direct surveillance by random clinical audit[59], initially of the individual Continuing Competency Framework (CCFR), but ultimately replaced by ePortfolio[60] (Occupational Therapy Board of New Zealand, 2016b). The Board also ensures discipline through a complaints process (Occupational Therapy Board of New Zealand, n.d.). Application of the HPCAA produced discourses that provided OTs with the knowledge that their clinical practices would be scrutinised through additional practices involving compulsory engagement in local professional supervision and by electronic audits of their online CCFR by OTBNZ.

Also aware of their obligations under the law, DHBs introduced processes within the clinical governance framework that sought to demonstrate that the practitioners working for them were normalising the requirements of the HPCAA legislation into their practices. Surveillance became more stringent, with peer review a popular disciplinary mechanism that encouraged co-workers to formally observe each other's practices and report back on their colleague's performance. The DHBs also provided opportunities for clinicians to engage in professional supervision, a technology of the self, comparable with confession. Confession was an event where individuals were expected to tell the truth to another person, an authority who would listen and discipline. Foucault (1978) noted that confession "became one of the West's most highly valued techniques for producing the truth" (p. 59). Clinicians were obliged to engage in DHB professional supervision, meeting regularly with a designated practitioner supervisor, to discuss and reflect upon their practice experiences and decisions. By enabling clinicians to fulfil their professional registration requirements, DHBs took an opportunity to further surveille and discipline practitioners. Both parties in supervision were subject to a DHB professional supervision policy, while the meetings were usually conducted within DHB workplace and time (Waitematā DHB, 2010b). In my experience as a clinician, supervisees were commonly assigned to a supervisor rather than being able to freely choose their supervisor, which, I believe, potentially set up a situation where supervisees might not have fully trusted the supervisory relationship, limiting what they brought to supervision. This experience led me to wonder whether relationships of power within DHB professional supervision events risked favouring the DHB rather than being a

[58] As defined in the 2003 HPCAA is "the monitoring of, and reporting on, the performance of a health practitioner by a professional peer" (Interpretation, 5.1)

[59] "The systematic peer evaluation of an aspect of patient care. It involves a cycle of continuous improvement of care based on explicit and measurable indicators of quality" (Ministry of Health. (2002c). *Toward clinical excellence: An introduction to clinical audit, peer review and other clinical practice improvements*. https://www.health.govt.nz/system/files/documents/publications/moh_tce_2002.pdf)

[60] Both CCFR and ePortfolio are online programmes whereby occupational therapists reflect upon their practice, identify areas of improvement and set themselves goals to develop their knowledge and skills. Goals are completed over a specified period of time. These on-line tools were designed to be peer audited to ensure practitioners engaged in competency and professional development practices.

safe place for the supervisee, and if this environment was what was actually envisioned for supervision originally.

DHB response to HPCAA

In trying to understand how the 2003 HPCAA legislation would directly affect DHBs, documents such as the *Health Practitioners Competency Assurance Act: Policy development guidelines for DHBs* (2004) were written describing what practices within DHBs should be foregrounded. This was a document produced by an inter-DHB team of human resource management and employment relations practitioners, aimed at DHB risk reduction when employing health practitioners, including OTs. Clinicians would be disciplined from the start through "position descriptions and person specifications; employment agreements, annual practicing certificate (APC) processes, performance management, competency frameworks, code of conduct, discipline, training, personnel files, document retention" (p. 2). The associated practices that would need to be followed by both managers and the staff who reported to them included:

- Sighting and confirming current APC
- Training and education where competence is in question
- Record keeping to ensure HPCAA requirements are adhered to
- Construction and use of position descriptions
- Demonstration of competence through keeping a practice portfolio
- Maintaining organisational compliance training records for each practitioner
- Training of clinical leaders in assessment of competence and report writing
- Construction and use of credentialing processes, competence frameworks, career progression pathways and code of conduct
- Processes to follow when there are competence concerns
- Relationship with the professional board.

The safety, accountability, responsibility and competence discourses within the Act were taken up into DHB clinical governance frameworks, producing practices that permitted surveillance and control of individual practitioner behaviour associated with clinical effectiveness and risk management. This combining of discourses from different sources, I believe, blurs the visibility and understanding about why certain practices have been engaged in, and who is speaking and from what subject positions they are coming from.

What's in a name?

In Moment 1, DHB managerial discourses suggest that construction of clinical governance frameworks in New Zealand DHBs were orchestrated primarily from the top down, following the UK model. Only two of the largest DHBs, Auckland and Counties Manukau (CMDHB), are referenced in a CLANZ report (Malcolm et al., 2002a, p. 33) as taking up the formal concept

early[61]. In some cases, specific, named allied health Services were slow to emerge; for instance, Waitematā DHB's Allied Health Service structure only surfaced in 2010 (Waitematā DHB, 2010a), but the documents produced by services reveal that the practices of OTs in the DHB were already being influenced by the enactment of various quality of care and patient safety discourses. OTs were responding to service policy and taking up clinical governance discourse silently, possibly under the belief that the DHB discourses were 'professional' discourses, flowing in from professional occupational therapy, which, to a certain extent they were, due to the HPCAA and the revised occupational therapy competencies emphasising constructs similar to clinical governance (OTBNZ, 2004b).

Summary

Medical knowledge and physician status was challenged by emerging managerial discourses that questioned whether physicians should have the ability to make management decisions about the care provided. The construction of new managerial knowledge shifted the decision-making to an emerging group of hospital managers, who now had the authority to lead medical institutions and make management decisions on care provision, which had previously been the exclusive prerogative of physicians. Clinicians were positioned by managers to focus on the economic implications of healthcare provision, where 'need' was emphasised, rather than providing desirable care for an overall improved quality of life. It was no longer acceptable for OTs to use a variety of 'traditional' rehabilitation activities with inpatients, which were aimed at regaining their ability to participate in occupations over time, prior to discharge. OT practices shifted to quick interventions such as assessment of ability to perform personal cares and supply of compensatory equipment, in order to discharge patients from healthcare services as soon as possible.

I view Moment 1 as a formative period where discourses from within the 'field of concomitance'[62] (Foucault, 1972, p. 64) crossed paths with each other: neoliberal thinking, UK clinical governance, the Treaty of Waitangi, professional and managerial constructions of practice, as well as New Zealand government legislation producing the 2003 HPCAA. While some discourses were relegated to a residual position, I would argue that dominant statements from these discourses regrouped and were instrumental in what emerged as a New Zealand construct of clinical governance, seeking to address the problematic discourses of quality, safe, competent, culturally appropriate healthcare provision to New Zealand society.

[61] CMDHB established a Director of Allied Health role in 2007, although there was previously an allied health presence on the clinical board (Chadwick, M. (2017). *Allied Health Directorate: Strategic intent 2017*. Director of Allied Health, Counties Manakau Health.)

[62] Field of concomitance: Statements that relate to a different object, but are included in the statements of the object under examination

Chapter 7 2003-2005: Professional governance

> [Power is] the exercise of something that one could call *government* in a very wide sense of the term. One can govern a society, one can govern a group, a community, a family; one can govern a person. When I say 'govern someone,' it is simply in the sense that one can determine one's behaviour in terms of a strategy by resorting to a number of tactics. Therefore, if you like, it is governmentality in the wide sense of the term, as the group of relations of power and techniques which allow these relations of power to be exercised.
>
> *– Michel Foucault, The Politics of Truth*

Introduction

Statements within the texts for this first moment, Moment 1 (2003-2005), pointed to the presence of multiple discourses foregrounding 'quality improvement' and 'professional governance' rather than clinical governance *per se*. One way of understanding quality improvement is to consider it as a discursive event where system change and performance discourses meet with professional development and learning discourses to produce optimum patient experience and outcomes (Batalden & Davidoff, 2007). 'Quality improvement' and 'professional governance' filtered in from government policy through to DHB annual plans, then to senior management strategy documents. They were then interpreted by another layer of service managers and applied to individual annual service plans, including those generated by various medical, learning and development and human resources services. There was a clear pathway of power through management, as managers prioritised practices of economic restraint. These included favouring ways to best use resources by constructing different means of improving the productivity of individuals, or reducing or eliminating interventions that were either not considered core practices for the service or not producing cost-effective outcomes. A second construct evident in some DHBs was that of professional governance of clinician groups, including occupational therapy. When DHB professional governance was examined more carefully, it closely aligned with the early NHS clinical governance model (Scally & Donaldson, 1998) that emerged from legislation passed in the UK (Department of Health, 1997). This raised the question: 'why?' Examination of a number of further New Zealand documents revealed how new government legislation, aimed at ensuring the competence of professions (HPCAA), had also filtered into and impacted the operations of the DHBs. The DHB response was to construct a system of professional governance that blended in with 'quality improvement', while also showing that DHBs were 'doing their bit' to ensure that the new legislation was being adhered to.

Professional leader roles were constructed for professional groups such as OTs. These roles were not managerial, but more of a professional advisory capacity. Professional leaders did not hold the direct authority to discipline frontline clinicians; rather, professional leaders enacted power by association, and were expected to be active in the construction and roll out of professional

disciplinary practices and surveillance procedures to ensure clinicians behaved as the DHB expected them to. Professional leaders' practices were thus designed to guarantee that clinicians were taking up the DHB discourses that told staff how to practice, aligned with their particular regulatory board (for OTs, OTBNZ). For instance, they were to behave safely and competently by following rules and protocols, manage risk by reporting any hazards or patient safety concerns, live within DHB means by prudently issuing equipment and making choices about who would receive occupational therapy, and practice in a manner that was both culturally safe and client-centred. No longer were clinician professionals acting and behaving autonomously, concerned only with their profession's particular beliefs and knowledge in carrying out patient interventions. Now they were part of the DHB 'system': reporting to managers and surveilled by professional leaders to ensure that they, the clinicians, were both held accountable and responsible for what was done in the DHBs as a collective entity, while also recognising that patients were expected to hold responsibility for making their own healthcare decisions. I view this as the beginning of clinicians being handed 'two jobs'.

This chapter presents the analysis of texts that provided me with insights to the construction of professional governance within DHBs in Moment 1, and how it acted as a precursor for a further level of construction, where clinical governance is fully named and emerges into the open in New Zealand, in Moment 2 (2015-2017). It also presents dominant emerging subject positions of OTs as a result of DHB professional governance. The subject positions are interesting because they show how productive practices were also constructed from disciplinary power by finding and acting upon opportunities that became available as DHBs built their internal systems of operation.

Governmentality

DHBs and the OTBNZ are both products of political and biomedical discourses, so that there are in-built technologies of power enforcing governmentality through systems of surveillance, discipline, and where necessary, punishment of their subjects. Both the DHB and the OTBNZ's mechanisms of power act on the subjectivities of OTs, to produce and normalise new, preferred practices. Change in the subject positions of OTs through the effects of power produces behaviour and practice change in line with government policy and the perceived needs of New Zealand society. However, in a free world, as Foucault (1978) maintains, there is the option to resist, instances of which, Silcock, Campbell and Hocking (2016) have already noted, are associated with non- or slow completion of OTBNZ competencies within their on-line ePortfolios. If detected through audit, this behaviour could result in disciplining. So OTs have choices in what subject positions they take up, how they behave and what practices they 'do' with their patients, if they are willing to accept the consequences. As Foucault (1980a) writes, "individuals are always in the position of undergoing and exercising power. They are not only its inert or consenting target; they are always also the elements of its articulation. ...individuals are the vehicles of power, not its points of application" (p. 98).

Foucauldian power/knowledge

The production and dissemination of documents and texts are methods of circulating power and enacting discipline at all levels of an organisation. High-level documents produced by senior management teams, such as annual and strategic plans constructed from New Zealand government health policy documents, inform and discipline middle management, who then produce service policy based on the discourses contained within the higher-level documents. Importantly, as well as circulating power and disciplining through policy documents, Foucault argues that power is manifested in routine, everyday practices, whereby people are directly exposed to techniques of surveillance and discipline. The effect of the chain of actions in DHBs is that individuals are governed in order to behave in a particular way, producing docile bodies. As discussed in Chapter 2, a sub-category of 'biopower', named "anatamo-politics" (Foucault, 1978, p. 139) refers to governance of people by external mechanisms. Examples of anatamo-politics in action were located within the texts that laid out the disciplinary rules and procedures to OTs mundane, routine daily practices.

In this section, I consider the technologies of power that are circulating through and operating in DHBs at four levels:

- At senior management level
- At the service level
- Via professional governance
- At the clinician level

Senior management level

In Moment 1, although I found some evidence of bottom-up quality improvement aligned with clinical governance, the flow was stronger from the top-down, being led by senior managers through the roll-out of DHB annual and strategic plans, rather than clinicians. At the senior management level, the DHB plans were directly influenced by documents such as *The New Zealand Health Strategy* (King, 2000), a document released by the Ministry of Health that foregrounded quality improvement discourses as a solution to achieving "high quality care" (p. 25). Quality improvement discourses such as those favouring risk management, clinical effectiveness, clinical leadership, economic prudency, client participation and continuous learning circulated within a growing number of high-level DHB documents. As these quality improvement discourses crossed, met and aligned, they eventually produced clinical governance frameworks, as revealed in annual plans and strategies written by the three Auckland metropolitan DHBs.

The DHBs' annual and strategic plans in Moment 1 were very similar in their construction, as two examples show: *Waitemata DHB Strategic Plan, 2005-2010* (Waitematā DHB, 2005b) and *Counties Manukau DHB Strategic Plan 2006-11* (Counties Manukau DHB, 2005). The plan

documents provided an opportunity to demonstrate to the New Zealand government that DHBs were surfaces of emergence for quality improvement, safety and economic initiatives. DHBs were at work constructing loose frameworks from which policy and practices, suited to an as yet unnamed DHB clinical governance framework, could then be put together. Each DHB was at a different stage in the construction of its respective clinical governance framework, but both foregrounded similar quality improvement discourses. Very rarely, clinical governance is mentioned, as in "Strengthening of clinical governance" (Waitematā DHB, 2005b, p. 76). Sometimes leadership is acknowledged as comprising part of a quality construction, such as "developing strong aligned leadership in all areas of the organisation" (Waitematā DHB, 2005b, p. 76). Waitematā's framework would focus on a connected infrastructure and shared leadership. Discursive themes uplifted from the strategy promoted quality and safety by the construction of processes ensuring:

- A seamless service for patients to experience
- Financial prudency through practices of economy of resources and the establishment of efficient ways of working for maximum efficiency
- Patient involvement through consumer and family/whānau[63] focus
- The formation of a learning organisation promoting innovation through projects emphasising "responsibility, quality, safety" (p. 84).

Staff behaviours were signalled in DHB values and mission statements, for instance, Waitematā DHB staff were expected to conduct themselves in a particular way when interacting with each other and with their patients. Behavioural examples included showing respect and compassion, ensuring a person's dignity, being truthful, making sure patients were well served, and being thoughtful of people's needs (Waitematā DHB, 2003b).

A slightly later DHB strategic plan, the *Counties Manukau DHB Strategic Plan 2006-11*, (Counties Manukau DHB, 2005) demonstrates continued construction of a clinical governance framework. Importantly, the plan's authors identified that the functioning of each part of the system, such as the workforce, community participation, and the infrastructure of information technology and physical space, is vital to the effective operation of the organization as a whole. Furthermore, quality improvement, efficient and safe service provision must occur "at the right time and in the right place" (p. 3):

> The DHB needs to ensure the appropriate infrastructure is in place, particularly workforce, facilities, information and quality systems, that all resources are efficiently applied, and all services provided from our hospital and by other contracted providers are safe. (Counties Manukau DHB, 2005, p. 5)

[63] Māori term meaning family, or more usually, extended family and friends.

Care was taken to emphasise the importance of communication and participation at all levels through "consultation with communities…government agencies…primary care health…support services and our staff" (p. 7) in the development of the plan. The document also clearly recognises that those who work in healthcare are "the DHB's biggest and most valued resource" (p. 20). Importantly, the actions and behaviours of the workforce were linked to a major outcome, which was to "improve the capacity of the health sector to deliver quality (and safe) services" (p. 20).

The identified 'enablers' of service redesign, the workforce itself, and the implementation of quality improvement and safety initiatives would be used to achieve the outcomes. By extension, individual healthcare workers, such as OTs, would need to behave in a certain way defined by the DHB. Their practice would need to meet the Allied Health Service requirements of the community, for instance, by communicating effectively with patients and their families, ensuring there was adequate planning of services for future needs and participating in efficient information-sharing and use of resources. These DHB strategic and annual plans were circulated to service managers who were then tasked with constructing plans that shaped healthcare delivery within their particular service and fed into other services over which they exercised power. There were also services that surveilled and disciplined other services, including Human Resources (HR) and its close counterpart, Learning and Development. A typical DHB strategic planning framework from Moment 1 is shown in Appendix E.

Service level

I located a number of documents that provided insights into the operation of service-level networks involved in the diffusion of clinical governance discourses from the senior management into clinical services. The documents I selected to represent service level discourses carry the same messages from the annual and strategic plans concerning clinical governance. Study of the texts made me realise how intertwined the discourses could be and how they gained strength by being repeated again and again from different sources, yet from a particular "system of relations" (Foucault, 1972, p. 60).

Orientation

The first service document I selected was an orientation booklet originating from HR: *Welcome to our team: Making a healthy difference* (Waitematā DHB, 2005h). The prominent discourses evident in this orientation document included: Quality of care; patient experience; accountability; responsibility; ownership; resource effectiveness; risk management and learning effectiveness. HR is involved in constructing policy that provides other services with guidelines on the DHB's preferred way of managing "recruitment, …performance development …workforce planning …disciplinary policy …change management processes and …learning and development" (p. 21). In this document, an emphasis on "Customer service and quality systems" (p. 33) also emerged from the DHB's interpretation of the *New Zealand Health Strategy* (King, 2000). In line with

quality customer service and patient experience discourses, the orientation workshop document revealed a whole range of practices and techniques of discipline the new employee was expected to accept, take up and normalize into practice. Patient experience discourses foregrounded particular behaviours that were to be revealed by the way staff communicated with patients, such as being courteous, helpful, responsive, respectful, truthful and compassionate. Clinicians were also expected to demonstrate improvement in the quality of patient experience by making evident their use of effective, efficient, responsible, client-centred, and safe practices. I would suggest that this was achieved through documenting in the care records the patient's goals, what they (the practitioner) did, and the outcome.

The orientation document also signalled that HR was authorised to "prepare for growth and manage change…enhance employee capability and develop a performance culture" (Waitematā DHB, 2005h, p. 21) producing technologies of discipline aimed at performance improvement. Technologies of discipline included surveillance mechanisms such as requesting colleagues to provide peer feedback via HR questionnaires and use of technologies of the self, where the individual reflected upon and reported back on their own perceived performance. Performance feedback focused heavily on an individual's demonstration of behaviours associated with DHB values. Additionally, staff were expected to participate in opportunities to improve their clinical knowledge and skills by completing goals set in their previous annual performance development review. Disciplinary issues were managed through processes laid out in DHB policy such as complaints management and investigation. Where competence and/or behaviour was questioned, individuals would be required to participate in performance improvement practices set out in their performance management plan overseen by their manager.

Statements concerning safe practices were particularly dominant, reinforcing the clinical governance discourses that emphasised risk management effectiveness, ownership, accountability and responsibility. A health and safety discourse where "managers and employees work together to create a safe workplace" (Waitematā DHB, 2005h, p. 67) was envisioned. Technologies of discipline included policy that addressed hazard and accident management, fire safety and emergency security procedures. Staff were expected to engage in practices such as monitoring workplace and reporting hazards, using protective equipment such as gloves (when indicated by policy), participating in vaccination programmes, attending preventative injury training (such as Liten-up[64] and fire safety) and following safety and security procedures. The procedures involved associated behavioural practices: management of clinical risk by following procedures, processes, protocols, policies, best practices guidelines and writing an occurrence report should an incident happen.

[64] Liten-up: Safe patient moving and handling techniques training

I see technologies of discipline governing access to, and use of, material objects collectively emerging within this document, which indicated who had the authority to issue such materials and who could access them, and involved prominent discourses of resource effectiveness, ownership, accountability and responsibility. All staff were subject to regulations and procedures concerning the issue and use of equipment, including clothing and vehicles, identification cards, pagers, telephones, computers and email, supplied by the DHB to employees to support their daily routine roles and practices. All staff were expected to take responsibility to follow the rules in place when using these objects, thus ensuring careful and prudent use of resources and time. The emphasis here was the construction of a safe workplace through the development of a quality improvement, safety-aware and learning culture in which everybody was expected to participate.

Continuing education

Learning and Development services were responsible for ensuring staff were provided with opportunities to access knowledge essential for them to carry out their roles in a particular way, as determined by the DHB, usually in the form of workshops. While some training was mandatory for new staff or part of an annual update requirement for all staff, other competency training was available as managers thought appropriate on an individual basis. The second document I use as an exemplar is a framework written by a team from a Learning and Development service, the *Waitemata District Health Board competency framework* (Waitematā DHB, 2004b). Again, although 'clinical governance' was not named, the meaning in the text was constructed from statements that clearly linked the content to preferred conduct associated with take up of a variety of clinical governance discourses, such as learning and clinical effectiveness, ownership, patient experience and safety/risk management discourses. The service aimed to "clearly indicate what are the important behaviours here – what we expect of everyone, no matter what their position or role" (p. 2).

I was able to compare the learning effectiveness discourses in the *competency framework* document with those present in texts produced by or concerning the practices of OTs, signalling the take up of DHB preferred knowledge transmitted by service level management that reinforced clinical governance practices. For example, some occupational therapy practitioners would identify "opportunities for innovation and improvement" (p. 4) by taking up the chance to engage in constructing protocols for occupational therapy assessments and interventions. The various published DHB occupational therapy practice guidelines[65] provided OTs with the 'right' way to behave with patients, guiding their daily occupational therapy practices so that they were clinically effective according to DHB preferred knowledge. In this way, OTs were encouraged to "follow policies, protocols and guidelines designed to prevent harm (by) act[ing] in ways that ensure[d] the safety of themselves and others" (Waitematā DHB, 2004b, p. 4). They were also,

[65] Examples of OT DHB guidelines on how to do a particular OT intervention: How to make a hand resting splint; how to carry out a home visit; how to run a falls prevention group; how to do an initial OT assessment.

however, demonstrating ownership and clinical effectiveness of their profession, thus taking hold of circulating power that would enhance their own professional status.

Additionally, accountability and ownership discourses in the *competency framework* document set up expectations that practitioners would take up practices that demonstrated taking responsibility for their own actions by "admitting mistakes and moving to correct" (Waitematā DHB, 2004b, p. 6). It would also mean seeking constructive feedback, so these would be not unlike the behaviours that would be in play within the professional supervision required by the HPCAA. Here, practitioners would reflect on their practice and discuss how they could have done better in preparation for future practice. In Foucauldian terms, I would also suggest that ownership and accountability statements produce clinical governance discourses associated with neoliberal governmentality. Foucault (2008a) describes the economic subject, "homo economicus" as an "entrepreneur of himself... of his own capital... his own producer" (p. 226). These entrepreneurs are the subjects who actively take responsibility and accountability for their own actions while also looking for opportunities to develop and produce new practices, not unlike the OTs who write their own DHB behavioural standards of practice and demonstrate accountability through engagement in supervision.

Competency framework also addressed what constituted patient experience practices by foregrounding client-centred interventions through support of the 'informed choice' of patients, and by encouraging practitioners to look for ways to collaborate towards constructive, effective outcomes. When applied to practice, OTs would need to demonstrate a client goal-setting process within their assessments and show evidence that the goals were achieved. Placing assessment report forms – constructed by OTs and reviewed by a DHB document approval process – within the patient's record were a way of ensuring that there was knowledge of what was done, and that it followed protocol and was clinically effective. In taking up practices produced by clinical governance discourses, OTs themselves needed to be current in the knowledge and skills required in their particular area of work, by being proactive in following up their own development needs and learning opportunities, again echoing clinical governance discourse.

Monitoring

The surveillance aspect of clinical governance also appears in the *competency framework* document. DHB records and certificates were produced so that the staff member could keep account of workshop and course attendance, should they need to provide evidence of attendance to their manager. Internally, DHB individual professional development electronic portfolios were also being "developed and maintained" (Waitematā DHB, 2003a, p. 2) by Learning and Development, presumably signalling a shift away from paper documents. It should be noted that this Learning and Development surveillance was occurring alongside other means of surveillance. For example, DHB-appointed occupational therapy clinical supervisors were charged with

monitoring their supervisees online via the OTBNZ continuing competency framework comprising standards that constituted occupational therapy practice competence at a particular moment in time. Supervisors could also comment upon a supervisee's professional conduct and competence, and they would sign a supervision log confirming what had been discussed in supervision (OTBNZ, 2004c, p. 8). Although I cannot generalise, my own experience of supervision in Moment 1 was that I was required to have monthly supervision from the service occupational therapy clinical supervisor, which felt more like DHB surveillance, rather than a safe space to reflect and contemplate practice. It limited what I took to supervision, reflected upon and shared with the supervisor, which, in my opinion, negated the whole reason for professional supervision in the first place.

Overall, the documents revealed to me how the patient quality and safety discourses played out in the construction of policy intended to transmit DHB approved beliefs and knowledge into the practices of frontline practitioners, including OTs.

Professional governance

As a product of quality improvement and professional leadership discourses, the Auckland DHB allied health structure was reconstructed in 2002 (Mueller & Neads, 2005) initially by the appointment of a Director of Allied Health, later followed by the introduction of Professional Leaders of Occupational Therapy, Physiotherapy, Social Work, etc. These Professional Leaders reported directly to the Director of Allied Health, as the professional structure was constructed so that it functioned alongside the operational management structure. Feedback from practitioners revealed some resistance amongst staff regarding the shift from the traditional single-profession departments to interdisciplinary therapy teams and how the proposed structure would affect professional competence and leadership. Staff also signalled that they wanted to be represented professionally at senior management level in order to have a stronger voice within the DHB (Mueller & Neads, 2005).

Rather than naming the new allied health framework as 'clinical' governance, it emerged as a 'professional' governance framework. However, an analysis of the 'professional governance' framework revealed statements that clearly aligned it with clinical governance. Professional governance laid out how clinical and professional standards, risk management, quality improvement and best practice would be maintained through technologies of discipline to ensure compliance with DHB preferred behaviour (Auckland DHB, 2012). The disciplinary technologies associated with professional governance included developing processes, guidelines, programmes, clinical indicators and policy to standardise, and to provide surveillance of, daily practices. There was also an expectation that practitioners would participate in projects, reviews, audits, committees and research, but these practices would be done *in addition* to their daily clinical

interventions with and for clients, hence Gauld's contention of practitioners now having 'two jobs' (Davies et al., 2014; Gauld, 2013).

Professional governance created opportunities for a change in how different allied health professions interacted and practiced together. Collectively, the outcome of their practices would be aimed at providing an improved quality of patient care and experience through teamwork, rather than working separately within siloed professional environments. Yet there was also space provided for individual professions to address their particular practices that defined them as a named professional group, such as occupational therapy, enabling take up of OTBNZ professional competence discourses. As similar practices emerged from professional governance, compared with DHB quality improvement initiatives, I would argue that clinical governance was inadvertently masked by both constructs; it being known by other names may be one reason why, in Moment 1, practitioners seemed unaware of the introduction of clinical governance. From my own experience, I would say that it is likely OTs might have thought they had been provided with the space to act somewhat autonomously and that the origin of circulating discourses promoting changing practice was their own profession, rather than it being through DHBs taking up discourses from the Ministry of Health producing quality improvement frameworks. Therefore, I would argue that governance of the conduct of OTs working in DHBs was being actively constructed by two separate entities, the DHB and the OTBNZ, who, it is important to note, were themselves both governed by the New Zealand government through law, policy and strategy such as the *New Zealand Health Strategy* (King, 2000).

Clinician level

At the micro level, quality improvement discourses have produced grids of specification, the systems that describe how discursive objects are related and categorised. For OTs, quality improvement is revealed within DHB occupational therapy process documents, which are written to reflect best practice at the time. The documents primarily tell OTs what they should do in their daily DHB practices in order to ensure that they are following quality improvement behaviours. In one document they may be instructed how to greet and interact with clients using a client-friendly approach. In another document they may follow a particular process, such as how to assess the client's need and eligibility for a particular wheelchair and then how to correctly measure the client for the wheelchair and any required accessories. Then they may follow another document specification that provides the section headings that will enable them to write standardised DHB reports about the wheelchair assessment. These DHB documents call upon professional occupational therapy practice discourses to, in turn, support the DHB quality and safety of patient care discourses within them.

The occupational therapy DHB documents objectify and thus name and describe particular occupational therapy practices, usually associated with the physical and cognitive measurement

and reporting of people, and what they do in their daily life. In line with Foucault's ideas on power/knowledge, the documents showcase occupational therapy professional knowledge shaped by DHB conditions. With standardised practices underpinned by evidence-based preferred knowledge, the credibility of occupational practices is heightened, enabling them to hold power within DHB teams. For instance, a common example of a published, approved DHB occupational therapy document would be a home visit guideline (Waitematā DHB, 2005c), used to assess patient safety through the observation of activities of daily living in the home environment. When documented into standardised occupational therapy assessment report forms, findings and recommendations form part of the patient care record. The recommendations are designed to influence the discharge decisions made by the clinical team and align with the goals of the patient, and so become a powerful tool in DHB risk minimisation and patient safety outcomes. Thus, the occupational therapy voice is given space and time to be heard and considered in the determination of patient care.

Guideline documents are intended to shape the behaviour of practitioners and the outcomes created by their conduct. However, as Foucault notes (1997), where governance is applied in society, individuals must be able to engage in the practice of freedom; a condition for the exercise of power. Despite the risk of disciplinary consequences, where mechanisms of punishment may be applied, individuals remain able to choose (within the context of time and space) how they will behave when confronted by particular disciplinary techniques, resulting in different outcomes both for themselves and for others. In some cases, as in the construction of the occupational therapy initial assessment documentation (discussed later in the chapter), there is an opportunity to strengthen the position and power of occupational therapy by making visible what OTs actually do in a DHB. In other cases, such as Care Aims (also discussed later), there can be partial take up by clinicians, but resistance towards using it as fully intended, if it conflicts with more dominant individual subject positions.

For further examples of technologies of discipline in play on the bodies of OTs within a DHB. see Appendix D: Power-point thinking; "Done to OTs: The political technology of the body and the soul".

Discourses producing prominent OT subject positions

During Moment 1, there was one overarching subject position that pointed to seven other prominent OT subject positions produced by discourses circulating within DHBs that are of interest to me. I have named them as:

- **The DHB professionally-governed OT** produced by professional discourses merging with DHB quality improvement discourses
- **The prudent OT** produced by economic and resource effectiveness discourses
- **The safe, quality-driven OT** produced by risk-management and quality healthcare delivery discourses
- **The client-centred OT** produced by patient experience discourses
- **The biculturally-aware OT** produced by bicultural safety discourses
- **The reflective, accountable OT** produced by accountability discourses
- **The entrepreneurial OT** produced by learning effectiveness, ownership and clinical effectiveness discourses
- **OT leader** produced by clinical leadership discourses.

I also consider the idea of the Resistant OT arising from Foucault's (1978) argument that "where there is power there is resistance" (p. 95).

The DHB professionally-governed OT

Pivotal documents in the construction of the 'DHB professionally governed OT' were the position descriptions that were provided on application for a job in the DHB. These texts show a glimmer of clinical governance terminology intertwined with supporting neoliberal, professional and cultural awareness statements. As an exemplar, I analysed a position description similar to one I had received for an Assessment, Treatment and Rehabilitation (ATR) Occupational Therapist vacancy for which I applied around this time (Waitematā DHB, 2003a). The statements within the document foregrounded multiple quality improvement discourses.

- **Clinical effectiveness discourses:** OTs were to engage in evidence-based best practice to ensure sound treatment outcomes; they were to participate in professional supervision so that they could reflect upon their practice and ensure they were making safe, effective treatment decisions within their practice; they were also required to participate in the implementation of service developments within the DHB claiming to provide quality service delivery
- **Risk management effectiveness discourses:** OTs were to meet professional occupational therapy standards by participating in DHB annual performance reviews, peer reviews and performance development; they were to adhere to health and safety procedures in their daily practices to ensure safety of patient and staff
- **Patient experience and bicultural awareness discourses:** OTs were to set measurable patient intervention goals so patients experienced quality healthcare outcomes; OTs were

to have an understanding of Treaty of Waitangi and engage in bicultural practices with Māori to ensure a positive patient experience

- **Learning effectiveness and ownership discourses:** OTs were to take responsibility for their own learning and to demonstrate their learning by keeping a professional development portfolio
- **Teamwork discourses:** OTs were to collaborate with the multi-disciplinary team and the client by attending meetings and liaising with community services
- **Resource effectiveness discourses:** OTs were to prioritise clients as a way of engaging in caseload management; they were to keep equipment and resource records that demonstrated prudent use of time and use of resources
- **Strategic effectiveness discourses:** OTs would provide regular statistics concerning patient caseload and the kinds of patients they were seeing. These statistics informed the DHB about staffing levels, workload and ultimately, use of budget and future funding requirements.

The systems, economic, individual responsibility, quality, safe delivery of patient care and teamwork discourses made visible within this document construct multiple subject positions for OTs to take up. To ensure normalisation into practice, disciplinary technologies, such as keeping records, following protocols, attending meetings and documenting use of resources, were required routine activities. Training in and normalising of preferred behaviour would occur when engaging in mundane routines and following practice guidelines, reinforced by regular monitoring and surveillance of daily performance that would be assessed, discussed and further disciplined by feedback during annual performance reviews.

The prudent OT

It is important to note that the occupational therapy profession was by no means unique in being made subjects of economic discourses and integrating them into their practices. The combination of the HPCAA legislation and the increasing emphasis on DHB 'value-for-money' statements, (i.e. prudent use of resources and time), invariably meant that foregrounded economic discourses produced behaviours that were then normalised into daily practices. An example of occupational therapy practice that was changed by economic discourse is splinting, which took time and resources if the splint was made from scratch. Custom splinting was a skill that was originally taught to occupational therapy students, and many OTs made bespoke splints by hand as part of their daily practice rather than using a preformed 'off the shelf' item. The limited extent of funding was one of the many aspects of medical practice that came under consideration during Moment 1, leading directly to constraints in therapists' time, and this in turn began to limit the degree to which custom splinting could be undertaken in daily practice. *Splinting, upper limb guidelines for patients with stroke; Therapy Services* (Waitematā DHB, 2005f) marks a change in practice from custom splinting to the use of 'off the shelf' splints. This document outlines the decision-making procedure for the provision of a hand splint, as depicted by a decision-making flow chart. By following the procedure, OTs could make the decision as to whether a splint was required and if

so, whether a custom or pre-fabricated one was the best choice. This decision-making tool melded together safe, best practice as well as ensuring prudent use of resources and time.

The safe, quality driven OT practitioner

A good example of the emergence of clinical governance discourses in the occupational therapy workplace is the *Home and Older Adults Service [HOAS] quality and risk plan 2004-06* (Waitematā DHB, 2004a) which constitutes quality as a multi-dimensional phenomenon that clearly sits within a clinical governance framework. Quality care is constructed as the provision of continuous, safe, effective, efficient, responsive, equitable, appropriate and people-centred care. This document is particularly important, as the quality and safety discourses within it were intended to produce subject positions that would directly bring about change to clinician practices, ensuring behaviours that managed risk and foregrounded quality care provision. In the case of OTs, they took up people-centred care discourses, focussing on constructing a patient goal-setting tool to be used by the multi-disciplinary team with their patients (Waitematā DHB, 2005g). See next section.

The discursive statements within the document foregrounded policies and procedures for safe practice behaviours that would ensure the construction of a safe work environment. As other texts show, OTs were actively taking up these discourses by writing documents to validate, monitor, audit and evaluate their own practices (Waitematā DHB, 2005d). The HOAS quality and risk plan document also takes up a number of disciplinary strategies constructed by other services to minimize risk and promote safe practice. They include mechanisms such as clinical supervision, peer review and audit. These practices are also listed in the occupational therapy position descriptions, as seen earlier in the *ATR occupational therapist* document, and were taken up by OTs who normalized them into their routine practices. Perhaps the most substantial inclusion is "To implement the Health Practitioners Competency Assurance Act" into the service quality plan to comply with government standards (Waitematā DHB, 2004a, p. 14). This statement signals DHB recognition of the 2003 HPCAA legislation. It also, by association, acknowledges the role of the professional regulation boards emerging from the legislation, such as OTBNZ, to ensure clinicians would provide safe, quality, competent professional practice.

The client-centred OT practitioner

Client-centred discourses were prominent within the HOAS quality plan. Practitioners were to receive training through the use of the CLANZ *Working together* manual (CLANZ, 2002). The training focussed on how to communicate in a way that would be welcoming to clients, presenting information that could be understood, enabling participation in setting goals, and empowering patients to make informed decisions.

Additionally, OTs at Waitematā DHB were taking up the client-centred discourses generated within the profession by involvement in the construction of client-centred, outcome-focused goal setting. An adapted occupational therapy tool imported from Canada, the *Canadian Occupational Performance Measure* [COPM] (Law et al., 2005) was produced by the norms and taken up into occupational therapy practice. This project, informally named *Setting steps*, was intended to be a multidisciplinary initiative (Waitematā DHB, 2005e), but OTs were active in leading and rolling out the project. The final tool, *Steps/goals in your rehabilitation* (Waitematā DHB, 2005g), accompanied by a training video and script, was a response to the service plan requirement to demonstrate client-centred goal setting in the *HOAS quality and risk plan 2004 – 06* (Waitematā DHB, 2004a). The tool was used with patients in order to reveal their personal recovery goals, which then became central to team intervention planning and outcomes, rather than practitioners setting goals without patient consultation. If a patient revealed a goal to be discharged home, for OTs, it would include further discussion with the patient about, for instance, the goals concerning daily activities the patient needed, or wanted to engage in at home, and whether they wanted to be independent in that goal or would accept help to achieve it. In my experience as a front-line practitioner, if they wanted to go home, common examples of older adult patient goals would be a desire to go to the toilet independently, having assistance to shower safely and arranging for a care-worker to come and do the cleaning in the home because it was an activity they could no longer physically engage in.

The biculturally aware OT practitioner

Bicultural' discourse is meaningful to Māori as it identifies a certain relationship with the Crown through the Treaty of Waitangi. The bicultural discourse positions Māori in quite a specific way. Firstly, Māori are recognised as *tangata whenua*[66], the people of the land, who never ceded autonomy. Reparations due to historic loss of land are addressed through the Waitangi Tribunal established in 1975. Secondly, Māori hold equal social, educational, economic, judicial and health status alongside the non-Māori population. Thirdly, Te Reo Māori is one of the official languages of New Zealand while *tikanga Māori*[67] cultural practices hold equal status alongside non-Māori customs (Hayward, 2012b). So the bicultural discourse can be understood as producing an understanding that Māori and non-Māori are placed on an equal footing when it comes to human rights and expression of culture. It would seem to me that the Treaty of Waitangi, referenced as the foundation of the *New Zealand health strategy* (King, 2000), acts as a mechanism of power signalling that Māori should receive and enjoy the same privileges and experiences accorded to

[66] "A generic term for Māori comprising those with *mana whenua* [land] responsibilities – Māori who are tied culturally to an area by *whakapapa* [genealogy] and whose ancestors lived and died there; together with *taura here* [urban kinship group] – Māori who are resident in an area but who belong to *waka* [kinship via descent from 'first fleet' canoe migrating to Aotearoa] and tribes from other parts of Aotearoa/New Zealand". (Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa. (2015). *OTNZ - WNA Te Tiriti/Treaty relationship governance model*. Retrieved 25 May 2021, from https://www.otnz.co.nz/occupational-therapy/te-tiriti-treaty-relationship-governance-model/ (para. 3)).

[67] Māori customary practices or behaviours, derivation from the Māori word 'tika' which means 'right' or 'correct'.

non-Māori, such as good health, educational opportunities, land ownership and freedom to participate in cultural practices and use of Te Reo Māori.

The *Waitemata District Health Board competency framework* (Waitematā DHB, 2004b) also provides an example of clinical governance tailored to New Zealand conditions by recognition of The Treaty of Waitangi. The framework includes statements reinforcing behaviours that focussed on carrying out "partnership obligations" by practices that would "reduce inequality" (p. 5). The document preferred demonstration of culturally sensitive practices through actively seeking information from people about their cultural needs. In practice, during this Moment, OTs were exposed to cultural awareness discourses by Māori Health services that emphasized the correct way to behave when working with Māori clients. The DHBs' internal Māori Health Services constructed policy documents (Auckland DHB, 2003b; Waitematā DHB, 2003c) laying out culturally appropriate practices for healthcare practitioners to follow. The documents clearly outline appropriate behaviour to ensure responsiveness to Māori patients and whānau, and invite further communication with Māori Health Services where appropriate. Protocols for mundane daily practices are described so that staff should know and demonstrate best practice with their Māori patients, and included *karakia* (prayers), *whānau awhi* (family support), *pānui* (provision of information), *ngā hiahia hoki* (specific needs), *ngā taonga* (management of valuables), *kai* (food), *kākahu moe/horoi hoki* (sleepwear/correct use of linen), and *pomimi* (correct use of bedpans). The policies align with a number of pillars of the governance framework (See Chapter 6), particularly patient experience and clinical excellence, and OTs were expected to take up the behaviours and demonstrate them when working with Māori.

The introduction of the policies was also supported by workshop training such as *Te Pumaomao* (Murphy, 2006), a two-day course open to all practitioners in order to gain insight and understanding of Māori history, language and customs as well as providing a space to discuss practices that could be incorporated into daily life in recognition of the Treaty of Waitangi. Another example of a workshop that aimed to change practices and incorporate cultural awareness into daily interactions with Māori clients was *Tū Ngātahi: Practically implementing the treaty in your workplace* (Waitematā DHB, 2006), held at the hospital marae by Māori Health Services. As an occupational therapy practitioner working in a DHB about this time, I attended both workshops and, as a result, was able to begin to change my practice to actively consider differences between my own culture and that of Māori. By taking up the bicultural discourse, I believe I was able to be more thoughtful, respectful and responsive to the needs of Māori clients; which, in clinical governance terms, demonstrated learning effectiveness, clinical effectiveness, patient experience and communication effectiveness.

The reflective, accountable OT practitioner

OTs are known to have historically engaged in reflection and clinical reasoning as a silent, routine professional practice (Mattingly & Hayes Fleming, 1994b). I would argue that ethical practices associated with technologies of the self, such as confession and reflection (Foucault, 1978), were strengthened by discourses from the HPCAA that require supervision to be a mandatory professional practice. The confession is a particular sort of disciplinary practice that acts on the body as a kind of internal self-surveillance and monitoring process. Foucault describes the tradition of religious confession, where priests listen to their parishioners engage in 'truth telling', recounting their behaviour over a certain period of time. The priests hold the power to forgive or discipline the parishioner (Foucault, 1978). Confession can also be considered a practice associated with neoliberal governmentality, where subjects acknowledge personal accountability and responsibility for their own actions. Confession is a space where they are able to think about their conduct, tell it to an authority and receive disciplining. Likewise, in supervision, the clinician engages in a confession of their practice activities. The supervisor listens, acknowledges positive outcomes and disciplines other practices by guiding supervisee reflection to consider more acceptable future behaviour.

In Moment 1 both the DHBs and OTBNZ took up supervision requirements because they were mandated to do so by HPCAA, and clinical supervision became part of the surveillance process that OTs were required to engage in. This was regulated both by OTBNZ (OTBNZ, 2004a; Simmons Carlsson & Herkt, 2012) as part of continuing competence, and by DHBs, through the inclusion of clinical supervision in job descriptions (Waitematā DHB, 2003a). In Moment 1, practitioners took up accountability for their practices by being visibly required to demonstrate that they reflected on their practices through meeting and discussing their practices with a supervisor, and by keeping a log containing what they discussed and what they would do to improve their practices (2003a). However, in my experience, it did not prevent me from engaging in silent self-reflection and reasoning. This would sometimes lead to thoughts that were not entirely in line with DHB economic discourses, but were associated with enduring professional discourses that foregrounded quality of life and access to participation in occupation, rather than cost. This contest of discourses meant that in some cases, I needed to decide which subject position to take up at that moment – which discourses were more meaningful to me.

The entrepreneurial OT

Foucault (1977a) argues that discourses are not just constraining, but offer opportunities as well. Dominant governance discourses opened up opportunities for practitioners to construct evidence-based documents that validated their practices with patients. OTs were actively encouraged to construct occupational therapy assessment processes and forms standardised to a service and based on discourses from professional evidence produced internationally. One notable DHB project was published in the New Zealand Journal of Occupational Therapy: *Washing away SOAP*

notes: Refreshing clinical documentation (Blijlevens & Murphy, 2003). In the DHBs, the forms were a means of keeping permanent records of occupational therapy plans and interventions, and could be scrutinised should there be a problem with healthcare delivery. These forms clearly demonstrated the (neoliberal) professional and clinical governance discourses expressed through practices expected of the DHB. For instance, the reports were constructed to make visible that the occupational therapy practitioner had engaged in patient goal-setting by writing down the things that the patient hoped to achieve during their hospital stay. The reports also had the capacity to reveal whether practitioners had made careful choices when making decisions about equipment rental, demonstrating economic responsibility and competent use of professional knowledge. The documents showcased the often-hidden practices and beneficial outcomes produced by OTs so in effect, they served both DHB clinical governance and professional practice purposes.

Washing away SOAP notes was taken up in occupational therapy DHB workplaces as an assessment and documentation format (Table 7). The initial occupational therapy assessment documentation policy and accompanying report form produced by at least two separate DHB services, was constructed from their work. Waitematā DHB *Initial assessment documentation, occupational therapy* (Waitematā DHB, 2005d) and the *AT&R occupational therapy - initial assessment* form (Waitematā DHB, 2005a).

Table 7. (Blijlevens & Murphy, 2003) *Washing away SOAP notes: Refreshing clinical documentation*. Patient goal-setting. Copyright 2003 NZJOT. Reproduction rights granted.

Table 1
Client-centred note writing framework

Documentation heading	Concepts	Practice examples
Presentation		language barriers, hearing and sight issues, mood, alertness, cognition/insight, appearance,
Home (neighbourhood environment)		layout, terrain, distance to letterbox, church, community
Social/cultural environment		family, values, support, siblings, spirituality, ethnicity
Occupational performance		
Self-care	Personal care Functional mobility Community management	sleep, eat, dressing, toileting, transfers, indoors, outdoors, transport, shopping, finances
Productivity	Paid/unpaid work Household management	cleaning, cooking, laundry, hobbies, crafts,
Leisure	Quiet recreation Active recreation Socialisation	readingsports, outings, play, travel, visiting, phoning, writing
Routines		description of typical day, routines, habits, roles long and short term
Client's goals		
Strengths/Limitations		
Impairment/performance components	Cognitive Physical Affective	
Occupational performance	Self-care Productivity	
Participation	Leisure	
Intervention strategies		
Impairment/performance components		splinting, further specific assessments, seating
Occupational performance		personal care, productivity, leisure interventions
Participation		driving assessment, housing modification, education
Potential to Benefit from Intervention		

Taking a holistic position, the DHB documents constructed a process that told OTs what they needed to do, and it structured their professional conduct and practices to fit both occupational therapy and DHB discourse. The process enabled OTs to measure and record the physical and cognitive abilities of their clients to safely engage in activities they needed or wanted to do, such as being able to go to the toilet, dressing and meal making, in readiness to return to their home environment. For the DHB, when a client is able to safely participate in these activities, it signals the possibility for discharge. Therefore, the practices of the OT are instrumental in the fulfilment of clinical governance risk management and fiscal responsibility policy.

By constructing the occupational therapy initial assessment into a standardised, DHB approved process, a specific amount of time could be allocated to complete it, so it efficiently managed time; it focussed on core practice, such as self-cares and equipment provision, making it efficient and quality driven; it identified patient safety issues, thus identifying potential risk; it incorporated patient goal setting and so was client-centred; information on the social and cultural background of the client was collected so cultural awareness was built-in; it predicted patient outcomes and

who would benefit most from treatment, so it addressed practitioner efficiency. When these were combined, it also fulfilled requirements of fiscal prudence, since OTs could work through the process almost automatically: the cost of clinician time became both manageable and reportable.

I would suggest that every time an assessment form was completed by an OT, it became an opportunity to think about the practices that were available to them and make decisions about what their plan for that particular client would be. These practitioners were effectively applying Foucault's notion of 'technologies of the self' practices (Foucault, 1988d) to better relate to their patients. I would also argue that with each assessment form they completed, they would be applying their knowledge of the *Code of ethics for occupational therapists* (OTBNZ, 2004a) by reflecting on what they believed was the right professional action to take for their client at that moment. The initial assessment form made transparent their professional subject positions by what they recorded they were planning to do on the form and by completion of further patient record notes as the interventions progressed (Table 8), documenting what they actually did, culminating with a summary of the outcomes expected for the patient.

The assessment form was a starting point for demonstrating what the 'doing' in occupational therapy 'did', as it could be read by other team members as a statement of occupational therapy clinical, risk management, resource and learning effectiveness, patient experience and ownership of a particular scope of practice. I would therefore argue that the initial assessment was, for OTs, a technology of discipline that revealed the occupational therapy patient – professional partnership of clinical governance. It could also be used as a form of surveillance to monitor occupational therapy practitioner competence, acting partly as a constraint, but ensuring that the client was receiving the appropriate care as defined by the DHB.

Table 8. (Blijlevens & Murphy, 2003) *Washing away SOAP notes: Refreshing clinical documentation*. Progress note. Copyright 2003 NZJOT. Reproduction rights granted.

Table 2
Progress note format

Presentation
Occupational performance Self-care Productivity Leisure
Goals
Strength/limitations Impairment/performance components Occupational performance Participation
Intervention strategies
Potential to benefit from intervention

The OT leader: Practices in action

An unpublished draft, *Evaluation quality action plan 2006: Occupational therapy* (Molyneux, 2006) was a review summary of an occupational therapy quality plan that had been implemented within an occupational therapy service over the previous year. The text demonstrated how an occupational therapy professional leader was using clinical governance concepts in practice, although as in most other texts from this Moment, did not name them as such. The document constructs the subject positions of an occupational therapy clinical leader from clinical governance discourses, but with the added authority to manage OT staff on a daily basis.

This leader was actively leading front-line clinicians by implementing and overseeing practices, and, importantly, ensured that the clinicians had collaborated in the construction of service delivery procedures, and ultimately, the take up of practice behaviours. Clinical governance is applied in the context of New Zealand, where occupational therapy professional competency requirements flowing in from the OTBNZ have been combined within the framework along with behaviours associated with the Treaty of Waitangi, producing a practitioner/patient partnership. Statements in the document suggest that staff were consulted and involved in the development of processes that would guide their practice behaviours, indicating collaboration between front-line clinicians and their professional leader. Examples of occupational therapy practices exercised by this leader and the occupational therapy staff include those in Table 9.

Table 9. Adapted from *Evaluation quality action plan 2006*, with permission.

Evidence of governance	Example
The economic leader Efficiency / prudency / wise use of knowledge and resources (Implementation and management of environment and resources)	Careful deployment of full-time equivalent (FTE) hours and use of part-time staff. Screening and prioritisation of referrals Review of cases/ interventions and evaluation of intervention (outcomes) Reduce expenditure on rental equipment (review of monthly bills; follow equipment supply procedures)
The culturally safe, client-focused leader Patient experience (Implementation of culturally safe, client-focused discourses into practice)	Development of a patient brochure informing patients / whanau about allied health services and how to access them. Review notes to check if contact has been made by the Māori Health Service; if not, make a referral and follow up.
The clinically effective leader Quality focus (Generation and implementation of best practice policy)	Development of standardized procedures in form of policy – Home visits; stroke guidelines Development of standardized documentation report forms and processes (take up of rehabilitation documentation guideline and assessment report form from aligned service – Washing away SOAP) Development / trial of initial assessment and progress notes format Adaptation and take up of existing standard form from another service to guide documentation of home visit reports.
The risk management leader (Implementation of safe, ethical and legal practice)	Liten-up training (manual handling) Falls prevention brochure Annual update courses (fire safety, infection control, privacy / confidentiality) Training and credentialing of therapy assistants in common equipment use and supply.
The learning effectiveness leader (Implementing opportunities for management of self and people; continuing professional development)	Attendance at relevant training days and courses (e.g. wheelchairs and seating; posture management) Regular in-service / journal club schedule Some in-services focused on learning new assessment skills and communication of results. Maintain an attendance record for each in-service (data collection / surveillance) Note: Sometimes cancelled due to high workload commitments. Clinical practice placements for OT students and collaboration with OT school.

OT resistance to discourse

Foucault (1978) argues that there is always the potential for resistance. Not all OTs are compliant with rules constructed to guide their practice. It is known that on occasion, they resist, often silently (Silcock et al., 2016), by engaging in underground practices (Hayes Fleming & Mattingly, 1994). In DHBs, some practices did not sit comfortably with OTs; their subject positions produced from preferred DHB clinical governance practices may conflict with their deeply ingrained professional ethical practices.

I have direct experience of two examples of such conflict from Moment 1. The first concerns an emphasis on careful selection of patients, choosing only those who would benefit the most with respect to outcomes and cost, prioritised through a constructed process imported from the UK. The *Care Aims* assessment (Kate Malcomess Consultancy Limited, 2016; Malcomess, 2005) is a tool presented as client-centred, emphasising multi-disciplinary team work. It is designed to enable practitioners to make decisions about complex care interventions, specifically identifying those who would benefit most from their particular core practices, and prioritising those people to be seen. For OTs, this might, for example, have been assessments for equipment and housing modification.

However, I suggest that an alternative discourse could have constructed and named *Care Aims* as a rationing tool, linked with economic restrictions. If so (and were this discourse made visible to practitioners), quite different understandings and associated behaviours would have been enabled to surface. Importantly, as mentioned in Chapter 5, within the occupational therapy professional discourse, subject positions have been created around social and occupational justice discourses promoting the beliefs (the accepted truths), that participation in occupation is essential for the health of *all* people and that actions by OTs promoting the quality of life should be available to all people. If people are denied access to occupation, and are "unable to do what is necessary and meaningful in their lives due to external restrictions ...where the opportunity to perform those occupations that have social, cultural and personal relevance is difficult if not impossible", then they are in the state of "occupational deprivation" (Whiteford, 2000, p. 200).

OTs strive to counteract this state through occupational justice, the enablement of access to occupation, defined as "economic, political, and social forces which create equitable opportunity and means to choose, organize, and perform occupations that people find useful or meaningful in their environment' (Townsend, 1999, p. 154). The *Care Aims* document does not mention 'economic prudency' by name. However, selection and prioritisation of patients who are predicted to benefit most, while declining others, can be construed as ethically problematic to OTs, because of the professional discourses foregrounding occupational justice. Although the *OTBNZ Code of ethics for occupational therapists* (OTBNZ, 2004a) does address prioritisation and "allocation of available resources" (p. 3), restricting access to occupational solutions may not sit comfortably

with all OTs. OTs who continue to foreground Welfarist discourse within their subject positions may resist engaging in DHB preferred behaviours associated with rationing services and resources. The caring and supporting discourses arising from humanistic ideology construct social and occupational justice subject positions for OTs who professionally to want to consider the individual needs and desires of every patient referred to them, not only those who fit the economic brief of a DHB governance remit. In Moment 2, there was silence regarding Care Aims, suggesting that this particular initiative may have been resisted and the discourses backgrounded. In Chapter 8, alternative discourses emerge that address the management of client referrals.

The second example concerns limits on what interventions were provided to clients during their recovery, which were reinforced by another construction, the role of a 'Specialised Assessor'[68]. OTs working in certain areas of DHBs, such as physical health, community and paediatrics also held a second role in their job description as specialised assessors, and were required to work with the private company, Accessable. As an early government/private sector partnership, OTs were required to assess clients for equipment provision eligibility and abide by priority guidelines when issuing equipment (Accessable, 2003). They were expected to demonstrate economic prudency by prescribing only essential[69] equipment, rather than that considered desirable[70] to improve a person's quality of life. These conditions likely created ethical dilemmas for some OTs, including myself, who maintained a holistic, quality of life subject position retained from professional discourses that were dominant prior to Moment 1. These conflicting discourses provided opportunities for resistance through underground practices (Hayes Fleming & Mattingly, 1994), where OTs constructed novel reasoning in order to provide equipment for their clients.

Summary

Managerial knowledge and status was challenged by emerging clinical governance discourses that questioned the power of hospital managers to act alone in making decisions about healthcare provision. Foregrounded discourses preferred shared holding of power and responsibility for clinical decision making, leadership and management. New clinical governance and leadership knowledge supported redistribution of power throughout hospitals to be shared by both healthcare professionals and managers.

This chapter has revealed a moment where discourses intersected and produced the conditions for change in the way OTs practiced in publicly-funded healthcare provision. The documents analysed for this study reveal that multiple discourses were at play arising from a number of

[68] Specialised assessor: "Holds certain areas of accreditation which relate to their qualifications and experience in that field" (Accessable. (2003). *Specialised assessor equipment manual. A modified version of the original equipment manual for the Auckland and Northland Regions.* , p. 3.). Occupational therapists may be specialised assessors in household equipment, home modifications and wheelchair and seating prescription.
[69] Essential: "There is no other viable alternative. Without the equipment the person would be subject to avoidable harm and would not be able to meet the eligibility criteria." (Accessable, 2003, p. 3)
[70] Desirable: "If the equipment will only improve the quality of life for the person, this is classified as desirable and does not meet the eligibility criteria." (Accessable, 2003, p. 3).

sources, which influenced occupational therapy practice. Discourses taken up by the New Zealand government produced preferred knowledge about the best way of delivering quality, safe, value for money population healthcare. These favoured discourses drove the construction of legislation that produced the emergence of the DHBs, as well as practices in the DHBs associated with the construction of clinical governance frameworks. Preferred discourses were also instrumental in revised constructs of professional boards, such as OTBNZ, through the passing of legislation prioritising regulation and competence.

Within the documents selected for this moment, I identified a corpus of statements that, together, constructed the emergence of clinical governance frameworks (named as quality frameworks) at a senior management level in the DHBs, evidenced in their annual or strategic plans (Auckland DHB, 2003a; Counties Manukau DHB, 2005; Waitematā DHB, 2003b, 2005b). I also revealed evidence of certain quality improvement discourses circulating to middle management and through to the practitioner at the front-line via the circulation of statements within competency and quality plans (Molyneux, 2006; Waitematā DHB, 2004a, 2004b).

Additionally, my reading of the documents led me to believe that clinical governance discourses were not necessarily visible to OT clinicians at the front line, not only due to being named 'quality' but presented as 'professional discourse'. This presentation was either intentional, or because the OTBNZ competency framework echoed similar discourses, with practitioners assuming that clinical governance related statements were actually flowing in from this professional regulatory body. I would suggest that clinical governance, or 'quality' frameworks at the frontline in Moment 1 established processes to discipline practitioners into engaging in certain practices that were not only in line with the *New Zealand Health Strategy* (King, 2000), and the requirements of the New Zealand Public Health and Disability Act 2000, but also demonstrated that DHBs were fulfilling the competency requirements of the 2003 HPCAA as a safety practice, in line with clinical governance risk management effectiveness discourses. In effect, OTs were being governed for similar purposes by both OTBNZ and by the DHBs, raising the question of whether too much governance was occurring, particularly when considering the disciplinary and surveillance techniques set up by both organisations and the time taken for practitioners to engage in the various disciplinary practices associated with them. At the front line, take up of quality improvement discourses also acted to ensure practitioners engaged in practices that demonstrated acceptance of preferred knowledge associated clinical governance beliefs in clinical effectiveness, patient experience, teamwork, as well as prudent use of resources and risk management.

Clinical governance frameworks can therefore, I believe, be construed as particular discursive constructions, that act as complex mechanisms of power within DHBs. These frameworks act to ensure practitioners take up preferred DHB knowledge and beliefs in discourses circulating within

the organisation. Through changes in behaviour they normalise governance practices into their daily routines. The DHB quality improvement discourses provide practitioners with information on how to behave and practice in the DHB. For instance, discourses inform practitioners that they are both responsible and accountable for their individual competence to practice and for the collective provision and delivery of quality, client-centred care (Gottwald & Lansdown, 2014; Haxby et al., 2010) provided by the DHB. Their practices, therefore, must demonstrate that they are engaging in these behaviours, most often by documenting and reporting on what they and their colleagues are doing through, for instance, peer review, assessment reports and supervision.

Chapter 8 2015-2017: Two roles

> A growing literature shows that clinical governance can improve patient safety, care quality and financial performances. (Gauld & Horsburgh, 2015, p. 4)

Introduction

In Chapter 7, Moment 1, I considered how early features of clinical governance emerged through the circulation and foregrounding of economic, systems, quality assurance and safety discourses that met together to produce quality improvement frameworks. The purpose of quality improvement frameworks was to ensure that patients received and experienced efficient, appropriate and safe care from health workers employed within the DHBs. Rarely was space provided enabling the emergence and construction of professional governance frameworks within a standalone allied health service. The preference was for allied health to be embedded within specialised health delivery services, such as those for older adults. Although organisational quality frameworks had been introduced into DHBs by the take up of these dominant discourses, other 'clinical governance' discourses remained less prominent in some DHBs. Leadership structures, patient experience initiatives and workforce learning and development opportunities were slow to emerge, signalling that the discourses constructing these objects were still backgrounded, limiting change to practice and approach to patient care. In 2009, the delivery of quality healthcare re-emerged as a problem for the incoming Fifth National Government of New Zealand because some of the clinical governance discourses that were needed to produce full integrated DHB frameworks had still not been prioritised following the reorganisation into DHBs early on in the tenure of the previous Labour-led government. A point of rupture marked 2009 when the government enacted biopolitical power by foregrounding clinical governance and clinical leadership discourses that directed DHBs to engage in actions that were meant to remediate the emerging deficits perceived within healthcare delivery (Brown et al., 2009).

In Chapter 8, therefore, I provide an overview of documents that reaffirm the intent of the New Zealand government to ensure that the construction of clinical governance frameworks was fully implemented in the DHBs. Firstly, I consider documents that reveal a renewed wave of emerging clinical governance, clinical leadership, clinical learning effectiveness and patient experience discourses that were foregrounded and circulated by the Ministry of Health to DHBs prior to Moment 2. These clinical governance discourses surfaced with an expectation from the government that the existing, narrow, quality frameworks would be reconstructed and emerge as explicitly named clinical governance frameworks while also featuring clinical leadership representing the professional voice within the system. The revised frameworks also needed to take up collective ownership and accountability discourses that visibly favoured a patient – professional partnership in the delivery and use of healthcare services, prompting the emergence

of events focussing on patient experience initiatives. Secondly, I present examples showing that after 2009, in some DHBs, clinical governance and clinical leadership discourses produced reconstructed allied health structures that included clinical leadership at all levels, as well as new ways of working within teams, opportunities to continue learning and participate in research and, importantly, opportunities to engage in initiatives designed to provide insight into the patient experience of the services provided.

Moment 2 was a time of transition for many OTs, particularly those working in DHBs where allied health had not been entirely recognised as an entity in itself in Moment 1. I analyse a selection of representative texts associated with the opportunities opening up for OTs and explore how clinical governance discourses produced OT subject positions during this moment. Finally, I look at how OT conduct and practices were contingently influenced by this second wave of foregrounded clinical governance discourses.

Governmentality

As a precursor to Moment 2, economic discourses were again foregrounded with the occurrence of the global financial crisis of 2007-08, sparking a global recession. The newly elected National-led New Zealand government announced that the country had entered a recession and was entering a period of "fiscal consolidation" (Bollard, 2009, p. 82) where government spending would be limited. While the recession did not immediately appear to affect healthcare delivery policy, the incoming Minister of Health, Tony Ryall, refreshed the original *New Zealand health strategy* (King, 2000) by publishing an updated interpretation, *Implementing the New Zealand health strategy 2009* (Minister of Health, 2009). Economic discourses recognised "a significantly tighter funding growth path" (p. 10) that would "require effective management of cost growth measures" (p. 10) signalling "innovative use of the workforce" (p. 10). The emphasis was on "achieving better, sooner, more convenient services" (p. iii) with "increased clinical governance" (p. 9) and "strong clinical leadership and engagement and greater workforce development" (p. iii). This refreshed strategy would suggest that the government was asserting its power to govern through relations of power circulating preferred clinical governance and leadership discourses into DHBs via the Ministry of Health. Statements within the text pushed for certain behaviours to be taken up by individuals working in the DHBs. A Foucauldian analysis of this event would suggest that the notion of 'governmentality' was in play. The Minister of Health's directive acted as a technology of power that governed both populations through the 'biopolitics' of having a healthcare delivery plan for the New Zealand population while also governing through 'biopower' acting on the individual bodies of DHB healthcare workers and those individuals named as 'patients'.

DHB senior management reflected the clinical governance and leadership discourses within their District Annual Plans, inferring that delivery of healthcare aligned to government policy would

fulfil certain conditions. The appointment of clinical leaders would promote professionalism, engagement in teamwork and integrated care. Clinicians would ensure a safe and quality driven patient experience through the use of strategies providing innovation and excellence within practice (Auckland DHB, 2015; Counties Manukau Health, 2015a; Waitematā DHB, 2016a). Governmentality associated with DHBs provides an exemplar of a structure that demonstrates Foucault's (1978) notion that "power is everywhere" (p. 93) and how individuals are subjugated within the microcosm of the DHB, making them behave in particular ways. Institutions like the DHBs also control the social behaviour of the wider population by having effects beyond the institution itself, which in the case of the DHBs is the health of the population.

Foucauldian power/knowledge

Power/knowledge circulating through Minister of Health: Commissioning a report

In 2009, Minister of Health Tony Ryall used positional political power to commission The Ministerial Task Group on Clinical Leadership to examine leadership and governance in the New Zealand health system. The Task Group produced the defining document *In good hands: Transforming clinical governance in New Zealand* (Brown et al., 2009), which heavily referenced a review of NHS England, *High Quality Care for all: NHS Next Stage Review Final Report* (Department of Health, 2008), led by Lord Darzi, the UK Parliamentary Under Secretary of State. While the *Darzi Report* still favoured localised quality improvement and teamwork discourses, economic discourses that had produced practices involving cost containment, attaining targets and standards were less prominent. Notably though, the same leadership, excellence, clinical learning and development and patient experience discourses were prominently foregrounded:

- Clinical leadership: Enabling clinicians to make clinical decisions about patient care through shared leadership between managers and clinicians;
- Clinical excellence: Recognition of clinicians for their notable clinical conduct, learning and research contributions through the construction of excellence awards;
- Professional development: Opportunities for clinicians to update and learn new skills;
- Patient experience: Empowering patients to take more control over their own healthcare as partners with healthcare providers.

I would contend that the 'clinically focussed' discourses within the *Darzi Report* could be understood as a rupture of knowledge and insights foregrounding the importance of preferred clinician behaviour, thus opening up an opportunity for the New Zealand government to question whether the DHB quality assurance and professional governance frameworks emerging within New Zealand healthcare delivery went far enough to ensure patients were receiving the best care possible within budgetary limits. It provided the space and time to pay attention to the prominent overseas clinical governance discourses featuring clinicians, in order to ensure that New Zealand healthcare delivery was at the cutting edge. Hence, the NHS England *Darzi Report* became central to the New Zealand government's position on healthcare delivery due to its prominent referencing

within *In good hands* which then went on to flavour *Implementing the New Zealand health strategy 2009,* the update to the *New Zealand health strategy*.

Clinical governance unmasked

'Clinical governance' was finally named and described in New Zealand, rather than simply being referred to as *A quality improvement strategy for public hospitals* (Ministry of Health, 2001), which did not convey the multiple, diverse, discourses that had come together to produce the object 'clinical governance'. Importantly, statements within *In good hands* explicitly deployed discourses supporting the formation of partnerships between executive managers and health professionals, with joint accountability for financial and clinical outcomes. It set the conditions of possibility for these partnerships by prioritising strong clinical leadership and decision-making throughout the organisation, from the board to the front-line of care through the construction and support of clinical leaders. This organisational structure was meant to be constructed so that lines of communication would work both horizontally and vertically, as well as from the top down and bottom up, as a means of engaging clinical staff, thus enabling a redistribution and circulation of power throughout DHB organisations.

Through a Foucauldian lens, the DHBs as subjects of governmental power were to produce a revised construction of their frameworks. Therefore Moment 2 was a time of transition for many OTs, particularly those working in DHBs where allied health had not previously been recognised as an entity in itself. The overt naming of 'clinical leadership' and 'clinical governance' confirmed governmentality in action. Biopower would be held by clinical leadership at all levels ensuring that DHB-flavoured professional practice policies and regular engagement in professional supervision were taken up by clinicians through surveillance of their practice by live observations (Waitematā DHB, n.d.) and adherence to professional supervision requirements (Waitematā DHB, 2016e). Furthermore, because of the close networking of one service to another, rather than the historically siloed services, actions in one service area would produce effects in other service areas. Technologies of discipline and surveillance mechanisms constructed in one service, such as HR performance review processes, could be applied to other services such as allied health, ensuring that appropriate conduct and practices were observed by healthcare workers as they engaged in daily routines with patients and recorded for later reference if required.

The Minister of Health endorsed the *In good hands* document, instructing DHBs to implement its recommendations. As such, the New Zealand government was enacting biopolitical power to send a clear signal that all DHBs were to design and implement their interpretation of a clinical governance framework, which included clinical leadership, recognition of clinical excellence, the construction of a learning environment and the monitoring of patient experience to improve quality. To strengthen the case for clinical governance, a number of events occurred after the

publication of *In good hands*, including the passing of the New Zealand Public Health and Disability Amendment Act 2010 establishing the Health, Quality and Safety Commission.

Power/knowledge through legislation: The Health Quality and Safety Commission

Acting as the New Zealand government's authority of delimitation for the production and transmission of preferred knowledge and practices to ensure the delivery of safe, high quality healthcare, the HQSC's stated objectives and practices were "(a) monitoring and improving the quality and safety of health and disability support services; and (b) helping providers across the health and disability sector to improve the quality and safety of health and disability support services" (New Zealand Public Health and Disability Amendment Act 2010, p. 10). The HQSC therefore functioned, and continues to function, as a mode of surveillance by monitoring, gathering and publishing data on the progress of healthcare organisations. It also became a source of the preferred knowledge constructed from clinical governance, clinical leadership, quality and safety discourses (HQSC, 2021b) circulated to healthcare workers via workshops and published documents. The HQSC enacts power due to its close relationship with the government, providing the commission with the authority to oversee and implement clinical governance and clinical leadership within New Zealand healthcare delivery. It is informed by a number of sources including:

- Discourses taken up from UK healthcare delivery reports (*Darzi*/*Francis*/*Berwick*)
- The New Zealand Triple Aim framework for quality improvement
- *New Zealand health strategy: Future direction* & *Roadmap of actions*
- The Treaty of Waitangi

Power/knowledge circulating from abroad: Conditions for change

Despite Lord Darzi's championing of clinical governance, two other powerful documents circulated to New Zealand from the UK signalling areas of potential failure within clinical governance frameworks at all levels (Francis, 2013; National Advisory Group on the Safety of Patients in England, 2013)[71]. In New Zealand, the HQSC and DHBs appear to have heeded the patient care and professional excellence discourses foregrounded within these reports.

The clinician accountability and patient care discourses within the UK documents surfaced after events within the NHS Mid-Staffordshire Trust revealed that patient safety was at risk because the Trust prioritised systems, business and standards outcomes rather than patient care, leading to the likely harm and death of patients. Additionally, statements suggested that a culture of poor communication and lack of individual responsibility amongst staff had also been tolerated and normalised within practice, again compromising patient safety within the Trust (Francis, 2013). As a response, quality and safety of patient care discourses were foregrounded while economic

[71] The Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, also known as the Francis Report, 2013 and the subsequent Berwick Report, 2013, titled A promise to learn – a commitment to act: Improving the safety of patients in England.

discourses were backgrounded via emphasis on the preferred knowledge that governance was not about finance, processes and systems, but about leadership and accountability at every level, and that patients always needed to be placed first and foremost (National Advisory Group on the Safety of Patients in England, 2013). Communication and professional development discourses favoured an environment where staff could take the responsibility to speak up and be listened to; where senior clinicians received executive training so that they could develop leadership skills; where audit was used as a means of quality improvement and where there was a culture of openness and transparency with a balance of internal governance with external regulation (Davies et al., 2014). The systems discourses in the reports also favoured a change in organisational behaviours, moving away from 'blaming' individuals to investigating potential systems failures because "in the vast majority of cases it is the systems, procedures, conditions, environment and constraints they [clinicians] face that lead to patient safety problems" (National Advisory Group on the Safety of Patients in England, 2013, p. 4).

The discursive flavour of these UK reports is present within the documents published by the HQSC who, favouring the knowledge produced by the clinical governance and leadership discourses circulating within the *In good hands* report, also appeared to have taken note of the additional learning experiences transmitted through the *Francis* and *Berwick* reports.

Power/knowledge through biopolitics: The New Zealand Triple Aim

A five-year plan foregrounding clinical governance and the "New Zealand Triple Aim framework", also favoured by the HQSC (Health Quality & Safety Commission, 2021a; Minister of Health, 2016b), was promoted in the revised *New Zealand Health Strategy: Future direction* (Minister of Health, 2016a, p. 26), Figure 13.

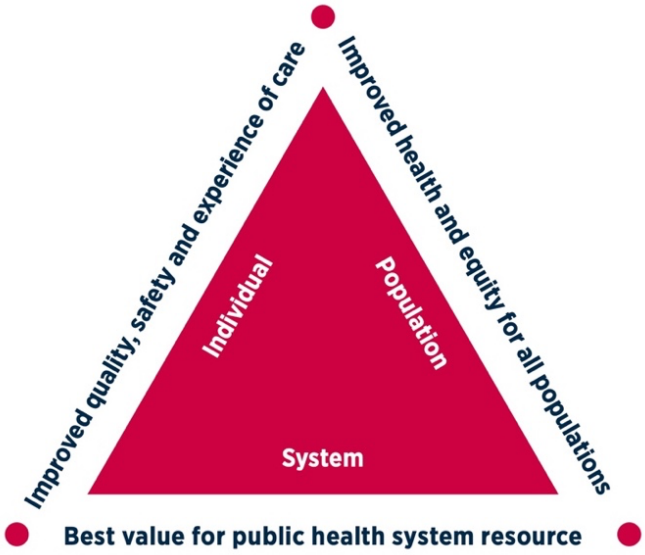


Figure 13. The New Zealand Triple Aim framework (HQSC, 2021a; Minister of Health, 2016b). Copyright 2016 Ministry of Health. Licensed under Creative Commons Attribution 4.0.

Constructed from quality of healthcare discourses, the purpose of the Triple aim was to "improve the patient experience of care; improve the health of populations; and reduce the per capita cost of healthcare" (Institute for Healthcare Improvement, 2021).

Essentially, the model promised to improve the health of a population, while reducing healthcare costs, through the use of techniques of discipline involving take up of practices aimed at balancing cost against health and care quality. Counties Manukau Health was one DHB which implemented the Triple Aim (Counties Manukau Health, 2015a). A case study (Doolan-Noble et al., 2016) evaluating Counties Manukau Health's progress in implementing the Triple Aim found that the model foregrounded, reinforced and circulated systems awareness, teamwork, quality, learning and communication discourses associated with the importance of having quality improvement structures in place, the presence of a learning culture (in CMH's case, training and innovation through their education hub, Ko Awatea) and "structured engagement with staff and community through co-design" (p. 83).

Power/knowledge through biopower: Revised health strategy and roadmap

As well as favouring the Triple Aim model, the new strategy proposed five strategic themes; "people powered", "closer to home", "value and high performance", "one team" and a "smart system" so that all New Zealanders "live well: stay well; get well" (2016a, p. 15). See Figure 14.

Figure 14. The five strategic themes (Minister of Health, 2016b). Copyright 2016 Ministry of Health. Licensed under Creative Commons Attribution 4.0.

This new direction would be aimed at influencing "clinician and patient behaviours and choices towards a more sustainable and equitable health system" (p. 1), favouring economic and equitable,

client-centred, ownership discourses. The accompanying *New Zealand Health Strategy: Roadmap of Actions 2016* (Minister of Health, 2016b) summarised multiple 'actions' that healthcare workers should engage in to achieve the goals of the strategy (pp. 26-27). In Foucauldian terms, the 'actions' can be understood as 'clinical governance' discursive practices where individuals were to be disciplined to:

- Inform and educate clients about health services
- Work in an equitable, clinical and financially sustainable way
- Address risk and continuously improve quality and safety
- Participate in collaborative partnerships
- Engage in performance management
- Improve governance and decision making processes
- Clarify roles, responsibilities and accountabilities
- Introduce workforce development initiatives
- Develop the capability to manage and regulate knowledge and technologies.

These documents clearly signalled to DHB senior management that clinical governance frameworks were to be constructed and made visible within their organisations, once again demonstrating governmentality at work through the action of biopower.

Power/knowledge acting through HQSC: 'The will to truth'

Clinical governance discourses from political documents formed a body of knowledge providing the HQSC with an opportunity to construct a corpus of statements that told people how to behave under certain conditions: when delivering healthcare to the New Zealand population. The body of knowledge provided a means to 'the will to truth' in that the conditions created by the knowledge/power relationship within the clinical governance discourse could produce behaviour change, not only within the institutions themselves and to the bodies of practitioners, but through the whole population, by changing expectations and behaviours associated with healthcare delivery. In other words, knowledge "has the power to make itself true" (Hall, 2013, p. 33) (see Chapter 3: Foucauldian methodology).

One important document published by HQSC that, I would contend, embodies the 'will to truth' for Moment 2 is *Clinical Governance: Guidance for health and disability providers* (HQSC, 2017). The document discursively constructs an understanding of clinical governance within the New Zealand context and provides examples of how practitioners are expected to behave in response to the preferred knowledge and technologies of discipline made visible within the text. It acts as a technology of power. The text positions clinical governance and clinical leadership squarely within New Zealand healthcare provision services, through the systematic foregrounding of the multiple consumer engagement clinician and workforce effectiveness, quality and safety discourses that, together construct a named clinical governance framework suitable for take up and use within New Zealand. The document summarises clinical governance as:

> an organisation-wide approach to the continuous quality improvement of clinical services. It is larger in scope than any single quality improvement initiative, committee or service. It involves the systematic joining-up of all patient safety and quality improvement initiatives within a health organisation. (2017, p. 22)

Within the text (diagram, Figure 15), delivery of patient care and patient autonomy discourses are foregrounded as "patient-centred", with an "open and transparent culture", with "all staff actively participating and partnering in clinical governance" and that there must be a focus on "continuous quality improvement" (HQSC, 2017, p. 8). Examples are provided that describe how workers are expected to behave when working within a clinical governance framework. The document, along with other HQSC publications and initiatives, such as workshops, leadership training, forums and newsletters, provides a variety of opportunities for greater understanding of and participation in clinical governance and leadership practices that can be taken back to the workplace and utilised in situ. Collectively, they operate as techniques of discipline supporting desired DHB behaviours.

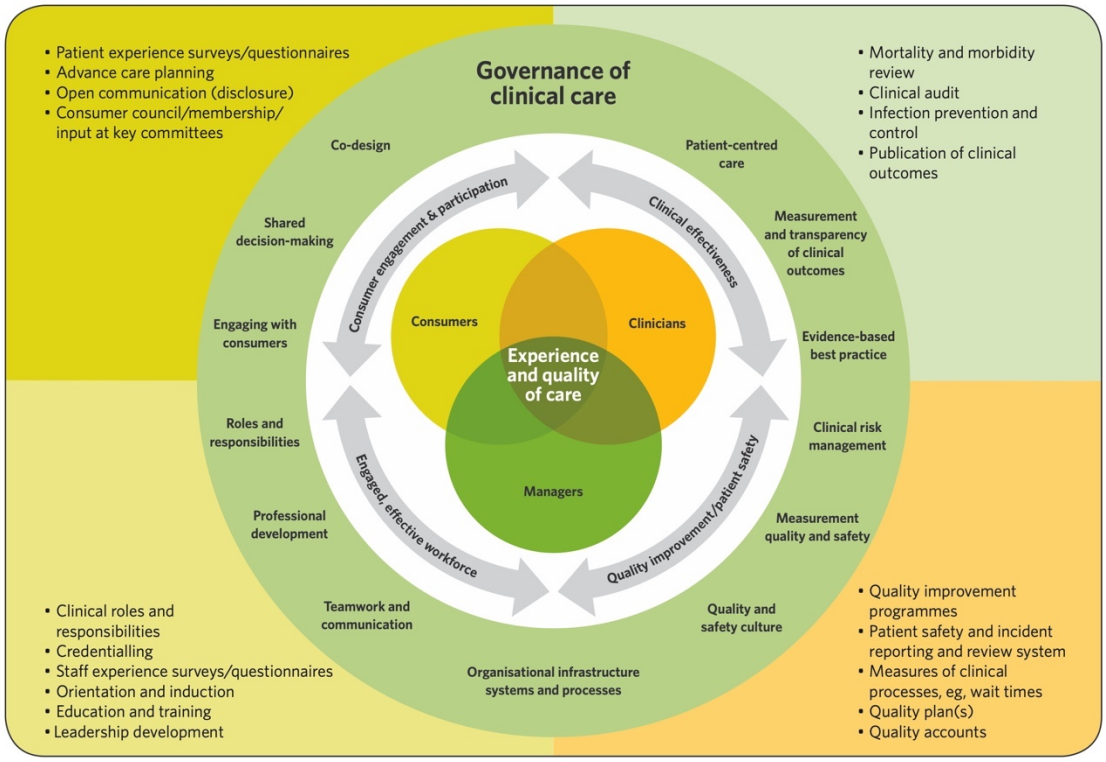


Figure 15. HQSC clinical governance framework (HQSC, 2017). Copyright Health Quality & Safety Commission New Zealand 2017. Reproduction rights granted.

Power/knowledge: The Treaty of Waitangi

The National-led government in 2014 issued a 'refresh' document, *The guide to he korowai oranga: The Māori health strategy* (Ministry of Health, 2014b) which is positioned to support other specifically named Ministry of Health and related documents and legislation; the *New Zealand health strategy: Future direction* and *Roadmap of actions* (Minister of Health, 2016a, 2016b), the *New Zealand disability strategy 2016-2026* (Office for Disability Issues, 2016), and

the New Zealand Public Health and Disability Act 2000, by providing a Māori perspective on the approach to the delivery of healthcare for Māori. However, while a bicultural discourse from the Treaty of Waitangi is present in the related health delivery documents, other concepts produced by the bicultural discourse and named in *The guide*, such as *rangatiratanga*[72] (Ministry of Health, 2014b, p. 8) and bicultural "equity"[73] (p. 9) are not named in these overarching documents. Even though the same words and similar concepts are present in the original document 15 years earlier, *He korowai oranga: The Māori health strategy* (Ministry of Health, 2002a), instead, a more general population 'equity' discourse is foregrounded in the new strategy documents.

Statements within the *New Zealand health strategy: Future direction* (Minister of Health, 2016a) reveal that its five strategic themes are constructed on the document's seven principles, including the "special relationship between Māori and the Crown under the Treaty of Waitangi" (p. 14). The principles aim to provide "improvement in health status of those currently disadvantaged; ...collaborative health promotion; ...timely and equitable access; ...a high performing system; ...partnership" (p. 14) that suggest a mix of biculturalism, clinical governance and consideration of the health needs for non-Māori. These statements do indeed appear to construct the strategy for "All New Zealanders" (see Fig. 16 above) rather than the particular bicultural conditions of Aotearoa.

Clinical governance: Guidance for health and disability providers (HQSC, 2017) reveals that the HQSC has also taken up the Treaty of Waitangi statements woven through the *New Zealand health strategy* and recognised the Crown-Treaty discursively formed principles of "partnership, participation and protection" (National Health Committee, 2002). However, it seems that the HQSC also applies 'equity' discourses to the 'whole population' rather than specifically referring to equity of Māori health in a bicultural setting. I looked for statements that indicated the presence of bicultural practice within the framework but found that while bicultural practice was not visibly named, there were indeed small glimmers of the Treaty principles embedded within the 'building blocks' of *A framework for clinical governance* (HQSC, 2017, pp. 12-20) and see Figure 15:

[72] In this context, the right for Māori to exercise control over their own health and wellbeing.
[73] The nonexistence of preventable and resolvable disparities between groups of individuals.

- "Consumer engagement and *participation"* (p. 13), which could also be understood as *partnership* with patients
- "Clinical effectiveness" (p. 15) which includes promoting equity and transparency by presenting results in different formats so all patients are included, which, to me, may imply a general attempt at engaging in a *partnership* with patients.
- "Quality improvement and patient safety" (p. 17) – that involves "consumer engagement" (p. 17) and is "patient -centred" (p. 18) which may loosely suggest patient *protection.*
- "An engaged, effective, workforce that works in *partnership* with consumers" (p. 19)

While these documents claim to reflect the bicultural discourse arising from the Treaty of Waitangi, bicultural equity seems backgrounded in favour of a more general equity discourse for *everyone* in the population. I found it troubling that, as an important discourse within the New Zealand context, biculturalism, as appearing within the texts, was not as prominent as perhaps it should be. It made me wonder who were the authorities of delimitation producing these documents and what 'games of truth' (see Chapter 3) were being played that effectively backgrounded the bicultural discourse emerging from the Treaty of Waitangi. I also wondered whether perhaps the European biomedical discourses within healthcare provision still took precedence over a bicultural discourse that favoured inclusion of a Māori perspective of health. I therefore looked to other sources of bicultural discourse that would result in OTs taking up bicultural subject positions producing bicultural practice in Moment 2, which is considered in later sections of this chapter.

Power/knowledge: Allied health and occupational therapy in Moment 2

The previous sections set up the conditions for existence of a reinforcement of discourses concerned with the delivery of safe, high quality patient care by favouring the construction of clinical governance frameworks in DHBs during Moment 2. I now examine the texts relevant to OTs and occupational therapy practices within this moment and identify the discourse and subjectivities that each produces for OTs. The texts from the larger Auckland area DHBs that I had access to (Auckland, Counties Manukau and Waitematā), demonstrated that quality frameworks were already under construction, producing various interpretations of Allied Health Services focussing on establishing a patient-professional partnership set on the foundations of clinical governance. The discourses foregrounded quality, safety and patient experience; along with clinical, communication, resource, strategic and learning effectiveness. The aim was that this patient-professional partnership would be achieved through behaviours associated with knowledge and use of systems to ensure a positive patient experience, development of teamwork skills for a positive patient outcome, active communication within and external to the DHB to ensure a smooth patient journey, taking responsibility and accountability for personal conduct and demonstrating leadership by modelling DHB approved behaviours.

Discourse in action: Emergence of allied health services

Prior to Moment 2, within the DHBs I studied, some allied health services had already emerged in their own right (Mueller & Neads, 2005) depending on the extent to which each DHB had taken up clinical governance and leadership discourses. By Moment 2, additional allied health services had emerged in DHBs empowering them to self-govern, rather than being embedded within a medical service and thus subject to medical service manager planning (Auckland DHB, 2016; Chadwick, 2017; Waitematā DHB Corporate Clinical Governance Team, 2010). For example, in 2007, a 'Director of Allied Health' role emerged along with the creation of an 'Allied Health Forum' at Counties Manukau Health (CMH) (Chadwick, 2017), providing an opportunity for an allied health "collective voice" (2017, p. 4).

In Foucauldian terms, the events occurring within CMH bring to the fore that, in some DHBs, prominent clinical governance discourses were circulating and actively producing clinical leadership grids of specification for allied health, identifying OTs, physiotherapists, speech-language therapists (SLTs) and social workers. At CMH, the discourses retained their prominence as a professional 'allied health directorate' emerged in 2010. This event shifted the reporting line of professional leaders (including occupational therapy) to the Director of Allied Health. Furthermore, the titles of the professional leaders were later renamed as 'Associate Directors of Allied Health' to reflect a wider role expectation than purely what each professional scope represented (Chadwick, 2017). The change in the reporting system also created opportunities to reorganise the allied health clinicians at the frontline into new teams that reflected the needs of populations within the geographical area served by CMH, giving more prominence to client-centred discourses and patient experience, and opening up opportunities for OTs to practice in the community setting.

Discourse in action: Power/knowledge associated with the Allied Health Directorate

In 2017, the purpose and responsibility of the CMH Allied Health Directorate was to make sure that allied health delivered competent and safe services to its geographical population through the use of technologies of discipline: workforce/professional standards, policies and documentation (Chadwick, 2017). The technologies of discipline acted as a mechanism that provided assurance of the quality and safety of allied health practices through the transformation of the clinicians into docile bodies who carried out their daily practices in a particular way as mandated by the standards and policies. The practices resulting from the application of the technologies of discipline reinforced the power/knowledge relationship between allied health and the larger DHB through recognition of a named collective of professionals (allied health) who were trusted to carry out the delivery of quality patient care because they had been disciplined to engage in preferred governance practices in line with overarching DHB strategic policy. However, shared clinical governance decision-making appeared to be selective; communication and ownership discourses associated with how and when clinical leaders informed frontline clinicians were clearly

referenced in the statement that the Directorate "holds the responsibility of ensuring the workforce is appropriately informed of strategic issues, and is consulted where it makes sense to do so" (2017, p. 8). This statement implies to me that power was still ultimately being enacted at, and circulated from, the top down – frontline clinicians only being engaged for specific purposes at the will of the Allied Health Directorate.

Associate Directors each held multiple portfolios that opened up space to further develop both clinician learning opportunities. For example, a work package led by an OT aimed to open up supervision opportunities through the development of a revised training programme (Chadwick, 2017, p. 10) to groups who may not have had supervision as part of their professional development process. While some surveillance discourses may frame supervision as a disciplining technology of the self that produces internal disciplining and regulation, other quality of practice discourses foreground supervision as a beneficial tool for safe, competent practice; a space for reflection and development of good working practices. When understood through this second lens, provision of supervision conducted in a safe, confidential environment is a construction that can be positively offered to clinicians as a learning opportunity and a benefit of working within a DHB, of value to both parties.

Occupational therapy leadership at CMH was also involved in another area: the monitoring of workforce diversity through the construction of a diversity *hui*[74] to consider how Māori and Pasifika students could be attracted into allied health careers. This initiative picks up the bicultural discourse that was backgrounded in external documents providing advice to the DHBs and foregrounds the problem of insufficient numbers of trained clinicians who identify as Māori or Pasifika. This problem had been identified in occupational therapy texts as far back as 1988, where a recommendation that specific marketing strategies be designed to target "Maori and Pacific Island People" (Department of Education, 1988, p. 18) to train as OTs.

Although the HQSC clinical governance discourse claims to embody "experience and quality of care" (HQSC, 2017, p. 12) as the core of the New Zealand clinical governance framework (see Figure 15), it leads me to wonder whether the framework really encompasses 'experience and quality of care' for Māori, when there continued to be insufficient representation of Māori and Pasifika (Counties Manukau Health, 2015b, p. 26) within the workforce and when the bicultural discourse seemed to be backgrounded in high-level healthcare documents. To me, there remains a sense of exclusion even though statements within *He korowai oranga: The Māori health strategy* (Ministry of Health, 2002a), and its later 'refresh' (Ministry of Health, 2014b) claimed to improve Māori health by considering *He korowai oranga* to be a tool that supported DHB

[74] Māori term for a general meeting for a larger audience

planning. I cannot help but ask whether the bicultural discourse should feature more prominently in clinical governance frameworks.

The Associate Director of Allied Health (occupational therapy) was also expected to participate in specific governance practices involved in disciplining occupational therapy clinicians. These practices included oversight of occupational therapy credentialing processes, practice expectations, the occupational therapy equipment loans process, student placements and student funds; a 'virtual panopticon'. Finally, there was a requirement that the Associate Director would attend particular named meetings and engage in performance management practices (Chester, 2014). I would argue that these are actually examples of chains of disciplining. The Associate Director is disciplined in that there are explicit practices laid out that must be done by them. In turn, these same practices that are carried out by the Associate Director function as technologies of discipline applied to other individuals, such as the frontline clinicians and students on placement. Then, in the case of technologies of discipline that directly impact patient care, such as the equipment loans process, the clinicians (often OTs) effectively discipline their patients by what can be offered to them in the name of an OT intervention. Patients have to adapt their behaviour accordingly, which may affect their own and their family's quality of life.

So it seems at least in CMH, the Allied Health Directorate attempted to construct a clinical governance framework aimed at taking up opportunities where offered, by identifying problematic areas and constructing "packages of work" (Chadwick, 2017, p. 4); disciplining themselves and others through policy; and reinforcing the 'top down' power circulation trend by selective communication. The formation of the allied health directorate signalled increased visibility within the DHB structure that was evident in Moment 1. Professional representation of Allied Health was now present at senior management level alongside the nursing and medical professions but the question arises whether the opinions of the frontline workers were actually taken into account if clinician consultation was restricted by the directorate.

Power/knowledge percolation from OTBNZ competencies

Professional governance within clinical governance was influenced by a change in the OTBNZ competency requirements. During Moment 2, the fourth version of *Competencies for registration and continuing practice* (OTBNZ, 2015c) was published. What may not have been noticeable to some practitioners was that the language style was noticeably different, couched in a direct active command to the passive body reading the text: "You", 'comply', 'negotiate' or 'attend', whereas previous versions were written in a softer, more indirect, third person or passive voice. This imperative style acts to interpellate[75] the reader into uncritically internalising particular beliefs and practices as a standard part of the culture they belong to, in this case the culture of New

[75] Interpellation: Individuals accept and act on beliefs and principles which, in doing so, transforms them into subjects. Louis Althusser is known to examine interpellation in his 1972 essay "Ideology and Ideological State Apparatuses" in Lenin and Philosophy and Other Essays. Monthly Review Press.

Zealand OTs. They become the OTBNZ's subject. Presented this way, "you", statements within the text clearly discipline the OT subject by foregrounding individual accountability and responsibility discourses that prefer practices such as record keeping, monitoring, equity, client-centredness, outcomes, quality improvement and safety, so that practitioners become Foucauldian 'docile bodies'. One performance indicator is particularly pertinent to Foucault's understanding of technologies of power, and how clinicians are disciplined to behave in a particular way, when it states:

> You practice within established standards, policies, guidelines, procedures, and expectations of the organisation, agency or funding body you work for. (2015c, p. 6, para 3.7)

This statement from the OTBNZ addressed to the occupational therapy practitioner positions them to act as a 'docile body' and subject of *both* the OTBNZ and the DHBs. Clinicians are expected to be compliant and follow the 'established rules', enforced by the 'technologies of discipline' active in both organisations. There is apparently little tolerance for novel thinking or problem-solving from either establishment, which constricts the belief of many OTs that the profession is one constituted of problem solvers. It does, however, open up possibilities of being excellent followers of rules and regulations.

Cultural competence

While other sources appear to have backgrounded bicultural discourse, the OTBNZ has actively foregrounded competent bicultural practice for all OTs in their texts. It is particularly conspicuous in Competency 2, "Practicing appropriately for bicultural Aotearoa New Zealand" (OTBNZ, 2015c, pp. 5-6). As subjects of the OTBNZ, OTs must demonstrate competence in certain standards when working with Māori. Their active participation is demonstrated through entries in their ePortfolio, which can be audited by the OTBNZ. OTs are required to conduct a self-assessment of their bicultural knowledge and practices, then set a goal and activities designed to further develop their knowledge and practice when working biculturally with Māori. In effect, they are engaging in both technologies of discipline and technologies of the self by following the rules of OTBNZ and reflecting on their bicultural skills, 'confessing' areas where their knowledge is limited and then planning how they can remediate their position with on-going activities, enabling their bicultural skills to grow in strength, ready for when they are called upon to use them in the future. In Moment 2, for OTs, it seems that a strong professional bicultural discourse is circulating from the OTBNZ and through into the subject positions and practices of OTs working in DHBs supporting the bicultural discourse that continues to circulate within the DHBs themselves, stemming from the updated *The guide to he korowai oranga: The Māori health strategy* (Ministry of Health, 2014b) and DHB Māori health service plans such as the CMH *Maaori health plan 2015-16* (Counties Manukau Health, 2015b).

Discourses producing OT subject positions

During Moment 2, I discovered five prominent OT subject positions of interest related to frontline clinicians produced by discourses circulating within DHBs. I argue that they demonstrate a shift from early professionally driven behaviour where OTs were able to engage in novel thinking and problem-solving. This shift compares with the eight OT subject positions which I identified as surfacing in Moment 1; OTs no longer seem to have access to, and time to attend to, those individuals within the population having the most need. Texts from Moment 1 revealed how professional behaviours were constrained by the growth of institutional technologies of discipline and surveillance favouring the quality and safety of patient care; in Moment 2, a 'refreshed' circulation of clinical governance and leadership discourses acted to increase clinician responsibilities governing their daily routines, including practices that demonstrated individual accountability in relation to the effectiveness of the whole system, rather than their particular professional responsibilities. Although in Moment 2 there seem to be constraints on what OTs do, often limiting them to core practices, I have recognised that there are also opportunities presented. Importantly, for OTs, bicultural practice was reaffirmed through the OTBNZ competency requirements and the modelling of a bicultural governance framework by OTNZ-WNA signalling the continuing professional power/knowledge that filters into DHBs. Participation in learning and research was offered to some OTs, revealing how DHBs had taken up the discourses from the UK to focus on the professional development of their clinicians through the creation of learning communities and centres of excellence for research, strengthening the discourses favouring the role of 'knowledge' in the quality delivery of healthcare. Engagement in patient experience initiatives enabled OTs to provide a caring approach in a very specific way, with insight, while also strengthening client-centred discourses by consulting patients about their healthcare experiences. Moment 2 was also when the multiple clinical governance and leadership discourses consolidated to produce a 'two roles' subject position for DHB clinicians, including OTs.

I have named the OT subject positions and how they are produced as follows:

- **The disciplined, compliant OT:** systems and professional discourses
- **The biculturally responsive OT:** re-affirmed bicultural safety and equity discourses
- **The learning, researching, communicating OT:** learning, communication effectiveness and excellence discourses
- **The person-centred, caring OT:** patient experience discourses
- **The holder of "two roles" OT:** multiple clinical governance discourses including leadership, ownership, systems, quality, safety and clinical effectiveness discourses

This is not to say that discourses evident in the early period of occupational therapy and Moment 1 have disappeared; rather that some have become less visible or backgrounded due to more prominent discourses clashing with or constricting them. Other discourses have been reinterpreted or regrouped, likely due to the changing prominence of discourses circulating into DHBs from

external sources such as the Ministry of Health rippling out to produce change to clinician subject positions and practices.

The disciplined, compliant OT

In Moment 2, OTs were subject to further policies and guidelines, ranging from DHB-wide policy to allied health and occupational therapy-specific procedures. DHB 'values' produced technologies of power, and all staff were required to demonstrate the behaviours connected with them. Examples of texts laying out expected conduct are found in such staff leaflets as *Our shared values and behaviours* (Waitematā DHB, 2014a) and *Our values* (Auckland DHB, 2014). For instance, the Waitematā DHB value 'everyone matters', is accompanied by several standards, including "'Welcoming and friendly'. The preferred behaviours are 'Makes everyone feel positively welcomed and valued', while those the DHB does not want to see, are 'Ignores or avoids colleagues' and 'Is aggressive, rude or impolite'. A section of the leaflet is shown below in Figure 16.

	Our standards	**Our behaviours.** How we are with service users and colleagues.		
		☆ Love to see	Expect to see	Don't want to see
Everyone matters	**Welcoming** and friendly	• Makes everyone feel positively welcomed and valued	• Is courteous and polite, engages people, makes eye contact, smiles • Introduces themselves using 'the 3Ms in welcome'	• Ignores or avoids patients or colleagues • Is aggressive, rude or impolite
	Respect each individual	• Brings the best out of others by recognising their different abilities	• Remembers people's names • Welcomes different views / cultures	• Makes assumptions, is judgmental or disrespectful of other people • Gossips
	Listen and understand	• Motivates others by making time to listen to their views and feelings	• Is interested in what others say	• Talks over people, doesn't let them ask questions or express views
	Speak up for others	• Encourages colleagues to speak up on behalf of others	• Speaks up every time they see poor or unsafe care or behaviour	• 'Walks by' or ignores poor or unsafe care or behaviour

Figure 16. Part of the Waitematā DHB leaflet *Our shared values and behaviours* (Waitematā DHB, 2014a). Copyright WDHB 2014. Reproduction permission granted.

These values form part of the professional PDR forms and could be commented upon during the review process. They therefore connected to a monitoring and surveillance procedure that all employees were subjected to as part of quality clinical governance. The effects of these disciplinary techniques are two-fold. Firstly they act on the clinician as a subject, a docile body, "manipulated, shaped, trained ...which obeys responds, becomes skilful ...constituted by a whole set of regulations" (Foucault, 1977a, p. 135), constructing them to be an obedient DHB employee, such as obedient 'DHB OTs', products of minute political effects, a "microphysics of power" (p. 139) on the body. Secondly, clinician conduct towards clients produces ongoing effects on the experience and actions of their patients. The preferred DHB clinician behaviours are designed to provide a positive experience for the patient, another subject and kind of docile body. In its turn, the conduct of the clinician - what is said and what is done - also acts as a disciplinary mechanism, producing a certain kind of behaviour from the patient in response. Ideally, a positive outcome

through use of DHB preferred behaviours by the clinician will be an event where the patient agrees to, cooperates and collaborates with the clinician's suggested intervention plans. This 'action upon action' (Foucault, 1982b, p. 220), does not stop here. Any monitoring, surveillance and feedback on performance will locally affect the clinicians record and on a larger scale, how successful the DHB is in carrying out government policy, by analysis of statistics concerning patient outcomes and experience. Foucault's (1977a) assertion that "disciplinary power becomes an integrated system" (p. 176) is at play here. There is a connection between the external political, economic, and social systems and the network of relations within the DHBs which together function as an apparatus producing and circulating continuous power (p. 177).

Technologies of discipline

Waitematā DHB provided me with a number of occupational therapy-specific policies and guidelines that demonstrate the technologies of power applied to practitioners in order to achieve behaviours required within a clinical governance framework. Two documents in particular were examples of technologies of discipline.

Firstly, the *Peer Review and live supervision tool* (Waitematā DHB, n.d.) was designed to "provide individual occupational therapists with the feedback they need to plan and pursue their professional development and improve the care they provide" (p. 1). Based on a selection of OTBNZ competencies, the tool provided the structure to carry out a live observation of an OT's practice, which would be performed by a peer or senior therapist. The tool, when completed, could be used to discuss the practices observed, and also formed part of the PDR, as an audit process, so that an action plan could be constructed if there were any identified practice competency gaps. For Foucault (1977a), this would be an obvious surveillance mechanism, aimed to ensure that OTs are practicing as required by both the DHBs and OTBNZ, not unlike his description of 'the examination', a "highly ritualised ...ceremony of power" (p. 184) which acts to "qualify ...classify ...punish ...differentiate ...judge ...to establish the truth" (p. 184) about a person's performance. As with the exercise of power, the use of surveillance does not necessarily carry negative connotations, especially when used in the context of teaching/learning, but as an opportunity to identify both strengths and areas where more learning and skills are required.

Secondly, the document *Standard operating procedures - Occupational therapy* (Waitematā DHB, 2014b)[76], was designed "To specify the standards of practice and administration process which will be followed by all occupational therapists (OTs) working with adult patients" (2014b, p. 2). The document acts as a medium whereby clinical governance discourses surface to produce the expected DHB standards of OT practice within physical health. The sections within the text

[76] This text was constructed mainly by myself with consultation and feedback from occupational therapy staff. I was delegated the authority and responsibility to write such a document by the Operations Manager I reported to at the time because I held the position of Clinical Leader – Occupational Therapy, and writing occupational therapy policy was part of the job description.

are technologies of discipline themselves in that that they lay out the standards for multiple behavioural and administrative procedures associated with certain routine OT practice events. Sections include: Managing referrals to occupational therapy; use of preferred occupational therapy assessments; processes associated with working with therapy assistants and students; documentation of occupational therapy interventions in patient records; collection and recording of treatment intervention statistics; occupational therapy patient transfer of care and discharge procedures; evaluation of occupational therapy services through individual practitioner audits and reviews; employer behavioural expectations; processes associated with leave and holiday cover; compulsory professional development and meeting attendance; and participation in interprofessional practice. The text also points to other related documents which additionally act as technologies of discipline where separate policy and guideline documents provide more specific detail. For instance, *Driving assessment guidelines for occupational therapists* (Waitematā DHB, 2016b) lays out the approved DHB procedures that should be followed in order to make recommendations concerning a person's ability to drive safely, while *Breast surgery post op occupational therapy guidelines* (Waitematā DHB, 2013) inform OTs how they should perform interventions after a particular type of surgery. In all, there are twenty-three specific policy documents referenced, and seven additional named assessment/report forms. The document also acts to connect relevant New Zealand legislation, OTBNZ professional standards, occupational therapy theory, and allied health occupational therapy policies, procedures, forms and manuals in use at the time, together with the conduct expected of occupational therapy practitioners working in the physical services at Waitematā DHB.

Standard operating procedures - Occupational therapy favours occupational therapy 'scope of practice' core skills, particularly assessment of personal and instrumental activities of daily living, cognitive ability, mobility and seating/positioning/pressure care. Associated occupational therapy interventions focus on education and where essential, supply of equipment or home modifications. Documentation is also a central theme, there being sixteen named events which require occupational therapy documentation, with brief guidelines on how to complete certain types being listed. Some documentation would be completed to form part of a patient's paper record while other forms are part of electronic systems. From a Foucauldian perspective, OTs as a collective group are constructed as an object by the document. At the same time, it disciplines individual subjects by rendering them docile bodies who will behave in ways expected by the DHB, so that their conduct will ensure the safety and quality of patient care and result in a positive patient experience. *Standard operating procedures* also outlines the audit process associated with the PDR, describing a range of audit tools that, when used, monitor ongoing competence, safety and quality of practice. Lastly, routine processes related to mundane activities, such as leave, holiday cover, meetings and professional development events are also documented. These documents make visible the numerous disciplinary technologies that are utilised to ensure that OTs behave in particular ways. Through the numerous clinical governance discourses within the texts, and the

inclusion of instruments that monitor their own, or others, conduct, their daily practices should be associated with competence, quality, and safety, otherwise they would be subject to further disciplining through training – or punishment, such as being placed on leave, demotion, 'suggested resignation', etc.

The biculturally responsive OT

The Treaty of Waitangi continued to be referenced (see 'The biculturally aware OT practitioner, Chapter 7) as the foundation of various iterations of the *New Zealand health strategy* (King, 2000; Minister of Health, 2009, 2016a, 2016b) and, indeed, HQSC's clinical governance framework (HQSC, 2017), I interpret these overarching texts as tending to focus on behaviours promoting the idea that "All New Zealanders live well, stay well, get well" (Minister of Health, 2016a, p. 3) rather than prioritising the health disparities of Māori and what needs to be done to remediate this situation.

Professional bodies and biculturalism

If government policy was preferring population-based healthcare delivery rather than considering health from a bicultural lens and healthcare delivery remained strongly Eurocentric, the question was whether OTs continued to take up the bicultural discourse into their subject positions. I looked to the texts collected from the professional mechanisms of power, the OTBNZ and NZAOT/OTNZ-WNA. These two authorities traditionally shaped occupational therapy professional discourse in New Zealand through the documents they produced and circulated. The bicultural discourse was clearly visible in OTBNZ documents governing scope and competence to practice and, in the case of OTNZ-WNA, in the way it constituted and practiced a new form of bicultural governance. The power/knowledge generated through discourses favouring biculturally-responsive conduct were also filtering into occupational therapy professional governance within DHB clinical governance frameworks. The OTBNZ's updated *Competencies for registration and continuing practice* (OTBNZ, 2015c) introduced a new competency: "Practicing appropriately for bicultural Aotearoa New Zealand" (p. 1), which required OTs to demonstrate knowledge associated with bicultural practices, rather than a more generic 'cultural safety' requirement. To ensure that OTs engage in the competencies, OTBNZ also randomly audits the required on-line ePortfolios of registered clinicians, a disciplining and surveillance mechanism designed to produce particular professional behaviour. Therefore, to avoid further disciplining, it was in the interest of the clinician to set and complete Competency 2. Moreover, discourses emphasising the importance of bicultural practice became visible and prominent when the New Zealand Association of Occupational Therapy changed its name to Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa, and presented the *Te Tiriti/Treaty relationship governance model* (OTNZ-WNA, 2015). This model acted to reposition and

reinforce the relationship between Māori as *tangata whenua* and non-Māori, as *tangata tiriti*[77] so that a true partnership would govern the Association. The action announced to OTs in New Zealand that their practice was no longer confined to the effects of colonisation, but in fact was actively working towards decolonisation by including Māori equally in the governance of OTNZ-WNA, the occupational therapy professional association.

Techniques of power, technologies of discipline

In Moment 2, therefore, professional discursive sources were now signalling to OTs that bicultural responsiveness was a requirement of their practice and that Māori patient experience should be part of clinical governance. One instance of the recognition of the relationship between Treaty principles and quality within clinical governance frameworks is that at Waitematā DHB, one of New Zealand's largest, occupational therapy policy drafts were now sent to Māori Services, essentially a technique of power in action that would, once the policy was published, discipline the OTs into taking up bicultural practice behaviours. Māori Services provided cultural advice and approval to ensure that policy was written appropriately from a Māori perspective and that the content was acceptable and not culturally offensive. Example policies show the exercise of Māori knowledge/power through consultation: home visits (Waitematā DHB, 2016c), which were particularly important because OTs needed to know how behave appropriately and respectfully when visiting a Māori home; Breakfast Group (Waitematā DHB, 2012) where practices needed to incorporate the management of food in relation to the body when working with Māori; wheelchair assessment and provision (Waitematā DHB, 2016f) which highlighted that permission was essential if needing to touch body parts as, for Māori, the head is *tapu* (sacred) and should not be touched.

Through consultation, this process empowered Māori to engage in *rangatiratanga* by demonstrating how the flow of Māori knowledge/power acts as a mechanism to change clinician practices and power relations within the DHBs. For clinicians, consultation provides the opportunity to practice safely in a bicultural manner, thus showing respect to, and the opportunity to give autonomy to, their Māori clients. More importantly, a better experience for Māori patients undergoing the interventions was the ultimate intended outcome. Another example is that the Career and Salary Progression Framework (CASP), (Auckland Region District Health Boards, 2018, p. 82) – an initiative that OTs were encouraged to engage in when they reached the highest level of automatic DHB annual pay increases – now required completion of a 'practice domain' concerning Māori responsiveness. In my experience, liaison with Māori Services was usually

[77] "A generic term to describe people whose rights to live in Aotearoa/New Zealand derive from Te Tiriti o Waitangi and the arrangements that the Crown has established under a common rule of law and the equity provisions of Article 3 of Te Tiriti". (Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa. (2015). *OTNZ - WNA Te Tiriti/Treaty relationship governance model*. Retrieved 25 May 2021, from https://www.otnz.co.nz/occupational-therapy/te-tiriti-treaty-relationship-governance-model/ (para. 4)).

sought to learn how to, for instance, construct and present a *pepeha*[78] correctly (University of Otago, 2019) or when seeking advice on how to appropriately communicate with Māori when conducting research (Orton, 2013, p. 43), Appendix F: CASP Objective 1. This technology of discipline rewarded and recognised the clinician who engaged in DHB approved behaviours via financial remuneration. It was another way of inducing clinicians to behave in a certain way through engagement with Māori and Māori culture, providing not only a monetary reward to the clinician, but more importantly, the opportunity to change practice through, in this case, increased knowledge of the Māori culture and how to behave appropriately in certain conditions when engaging with Māori.

The learning, researching, communicating OT

One area of clinical governance that was made visible as problematic in the UK NHS document, the *Berwick Report* (National Advisory Group on the Safety of Patients in England, 2013) was the limited opportunities for professionals to engage in continuous learning, i.e. ongoing opportunities to increase knowledge and skills. Recommendations were made to remediate this situation by the construction of a "learning organisation" (p. 5) within the NHS. In the case of OTs, participation in DHB and/or professional approved training would ensure that current approaches to patient treatment are known and can be implemented within patient interventions. Continuous learning by use of the knowledge taken up from the training implies that the most up-to-date, evidence-based, effective, safe and approved treatment can be offered to patients, which acts to improve the patient experience.

Learning and development

The learning and development discourses within the *Berwick Report* also proved influential when they were circulated into New Zealand DHBs, prompting them to act and provide opportunities for clinician learning. However, CMH had already heeded professional learning and development discourses. embracing a learning culture relatively early on (2011) by building a physical space, Ko Awatea, within its organisation in which a centre of excellence could be constructed (Counties Manukau Health, 2019b). Ko Awatea focused on quality improvement opportunities "for DHB staff, and the wider health sector, to continue their learning journey, helping develop a safe, competent and compliant workforce" (Counties Manukau Health, 2020, para. 2). The construction of this space enabled learning and development and research discourses to flow through the organisation as it was accessible to all clinicians. For example, in the case of allied health, CMH's approach to learning was further reflected in the *Allied Health Directorate: Strategic intent* (Chadwick, 2017) document, which constructed a number of initiatives, one of which was to advance education and development "to provide opportunities for staff to access high calibre training in the most convenient way, in the most cost effective way" (2017, p. 10). *Strategic intent*

[78] An introductory 'speech', based on *whakapapa*, recited during *mihimihi* – the round of formal introductions at a Māori event, or one that is respectful of biculturalism (Otago University definition)

promoted flexible workplace learning, reflective practice, increased uptake of postgraduate study options and, importantly, position stand-ins to allow time for attendance of professional development activities. Effectively, the work being done by the Directorate ensured a shift towards the construction of an allied health clinical governance discourse-influenced service framework, which foregrounded the importance of opening up opportunities for clinicians to participate in learning via the DHB-wide learning organisation as a foundation in the provision of quality health care delivery to patients.

While CMH was an early producer of physical/professional space and initiatives enabling the emergence of a learning organisation, other DHBs were following. Discourses favouring professional development and learning opportunities for allied health professionals strengthened as professional development funds were now also formally emerging in the form of ring-fenced, limited funding entities within DHB policies. For example, OTs were eligible to apply to a fund which was "for tertiary study, external courses, conferences and seminars that a staff member elects to do" (Waitematā DHB, 2016d, p. 1). The existence of the fund suggests that learning and development clinical governance discourses had been favoured, recognising that access to external professional development "enables knowledge management", and "continuous improvement" (p. 2) in the provision of quality service. On deeper, Foucauldian analysis, the fund effectively acted as a mechanism of power connected to economic remuneration through paid attendance at a workshop or course. Personal experience leads me to reflect on the effects of the form. I found that in order to be eligible to apply, pre-existing behaviours that included completing all the required annual DHB updates were a prerequisite as well as agreeing to present to colleagues on the course content afterwards. In the normal course of work, these behaviours were not necessarily prioritised by me when time was at a premium and more pressing work needed to be completed. I would now interpret the requirements as a means of disciplining applicants into correcting their behaviour by completing the training and participating in in-services. If the conditions were not met, then the application would not be approved. It was a valuable source of funding that provided clinicians at the frontline with opportunities to attend expensive courses or enrol in post-grad papers enabling access to specialised knowledge which, when acted upon and used in practice, was once again intended to improve patient experience and outcomes through the application of current knowledge. Another benefit for the clinician was that by holding the subject position of a 'learning' OT, that individual also became known for the knowledge they retained and used, positioning them as 'experts', which in turn also shaped the power they enacted and the influence they held.

Participation in research

Another area associated with learning is research. "A detailed study of a subject in order to discover (new) information or reach a (new) understanding" ("Research," n.d.), research constructs a body of knowledge that is perceived as the current truth at the time it is produced.

When findings from multiple sources of credible current research are taken up into practice, evaluated in the context of local factors including the experience of the practitioner and the circumstances of the patient to make a decision on how patient care is delivered, this action is named as evidence-based practice (Robertson et al., 2019).

Opportunities to participate in occupational therapy research resulted in two documents. In the first, an OT (Bishop) took up an emerging role of Allied Health Improvement Lead. Her project, *Occupational therapy home visits: A virtual approach*, was presented at an international conference in Australia (Waitematā DHB, 2017b, p. 92) and more locally at a DHB symposium (p. 94). She reviewed:

> how we undertake occupational therapy home visits from an inpatient setting. Occupational Therapists complete home visits for a select number of patients prior to discharge home for a range of clinical reasons. Home visits are time intensive and removes the occupational therapist from the ward reducing their availability to see other patients. (Waitematā DHB, 2017b, p. 92)

Bishop found that it was more efficient and effective to reserve home visits for patients with complex needs, and that use of other methods to evaluate home needs, including technology, was just as effective, saving money and occupational therapy time when working with patients whose needs were more basic. OTs reported back that it improved the discharge planning process, and gave them more time to interface with patients on the ward (Brott & Bishop, n.d.). This project demonstrates clinical governance in action. While the research foregrounds particular economic clinical governance discourses, including efficient use of resources and value for money, it aims to do so without compromising patient care and outcomes, and additionally, considers clinician response. From a Foucauldian point of view, the research provides an example of how lifelong learning and continuous professional development discourses enable the researcher to be positioned as an authority of delimitation for occupational therapy practice. The researcher produces new discursively constructed knowledge from which emerge practices that are introduced and normalised into occupational therapy routines. It also demonstrates how discourses circulating preferred knowledge are disseminated both externally and within DHBs through presentations of the work to a wide audience.

A second piece of work published in the NZJOT was another quality improvement initiative that looked at the "more effective utilisation of community occupational therapy resources to ensure a sustainable service, better outcomes for clients and the well-being of the occupational therapists" (Bishop & Brott, 2019, p. 19). The study indicated that since 2014, problems had surfaced in the timely provision of occupational therapy community services, due to increased complexity of cases where clients experienced multiple health conditions and associated environmental challenges at the same time, rather than just presenting with a single health issue. A centralised client spreadsheet, and an established duty occupational therapy role to manage it,

was more effective and improved occupational therapy work experience, by simplifying routine systems processes. Once again, with its emphasis on continuous learning, quality improvement and engagement of staff, clinical governance frameworks have provided opportunities for some OTs to take up subject positions that locate them as researchers. As researchers, they are empowered to study DHB occupational therapy practices that have emerged as not conducive to DHB preferred behaviours aligned with clinical governance discourses, particularly those practices that bring into question clinician efficiency, effectiveness, productivity, time management, accountability and contribution to patient experience. In the clinical setting, the aims of research may be to uncover how clinician practices can be done differently so that patients experience a more efficient and effective DHB service delivery. In this case, the authors have demonstrated a more effective way of "doing" (when compared with Moment 1 *Care aims*), appearing to take up lessons learned and advice given within the UK *Berwick Report* (National Advisory Group on the Safety of Patients in England, 2013), that has resulted in improvement of quality of patient care and practice experience for staff. What is important with this piece of research is that while the focus is on eliciting behaviour change through mechanisms of discipline, where clinicians are organised into a pattern of behaviour to manage referrals, it would appear that they are also consulted during the research about the changes and how it has affected what they do. I would argue that this action is the crux of clinical governance and leadership; the communication discourses that promote consultation, communication, listening and feedback to and from frontline staff. Power/knowledge is shared and circulated when collaboration with clinicians is foregrounded within clinical governance and leadership discourse. Collaboration as a mechanism of discipline produces a less threatening event than being told what to do and is more likely to negate or at least reduce, resistance to change in practices.

The person-centred caring OT

Discourses supporting patient/person-centred care are a feature of clinical governance frameworks. Patients are expected to take responsibility for their own healthcare decisions after being fully informed by clinicians about the healthcare options available. One way of understanding patient/person-centred care is that patients are considered partners in their own care alongside clinicians. The practice involves being responsive to individual patient needs by collaborating with the client/patient in order to produce a coordinated, enabling and culturally responsive patient care plan (Health Navigator New Zealand, 2021). DHB OTs provide person-centred care by supporting people to identify their occupational needs and goals and then providing possible solutions for that person to consider. The practices leading to self-determination and autonomy (OTBNZ, 2015b) are built in to all occupational therapy interventions through collaboration with and working alongside their patients. Self-determination is also a feature of neoliberal governance that flavours DHB preferred practices.

Through a Foucauldian lens, client-centred practice could be thought of as a disciplining mechanism associated with DHB governmentality. While both clinicians and patients are subjects of DHBs, each group is categorised and constructed from different discourses and exhibits distinct behaviours when in the DHB space and context, as a result of differing subject positions. Hence each group is identified by answering to different names. Each group has a different role to play within the DHB and yet they are closely related. As agents, clinicians govern patients on behalf of DHBs by subjecting patient bodies to DHB-preferred technologies of discipline, historically resulting in an imbalance of power. When client-centred practices are used, the power discrepancy between the clinician and patient diminishes and patients are empowered to make their own informed healthcare choices. As they have 'agreed to the plan', the patient is therefore positioned and expected to behave co-operatively rather than resist treatment interventions. From this viewpoint, client-centred practice is a mechanism of discipline that controls behaviour. Furthermore, as power/knowledge circulates between the patient and the clinician, power through sharing responsibility and consent to the intervention is passed to the patient, so accountability for the success or failure of their recovery/ rehabilitation is also shared with the clinician. Essentially, since patient conduct is controlled, client-centred care could be seen to benefit clinicians, through co-operative behaviour, although the shift in accountability and responsibility results in a more equal dispersal of power and sharing of intervention outcomes.

Some staff have participated in patient experience initiatives such as gathering patient stories (Counties Manukau Health, 2017) and participating in patient experience weeks, which have surfaced as a popular mechanism to promote person-centred care discourses within the DHBs. In a press release (Waitematā DHB, 2017a), a DHB Patient Experience Director, who was an OT, indicated that patient experience was used as a method of communicating some of the difficulties people experience when living with sensory or physical impairments. Through this increased awareness, he reported that DHB staff had constructed ways to make hospital stays easier on the patient. One example cited was a drawing competition introduced in the children's wards to make their stay in hospital more comfortable. Like client-centred care, patient experience initiatives not only empower patients by producing more empathy towards them from clinicians, but they also act to empower the clinicians. When clinicians have insight into how patients feel or may respond to treatment, they can adjust their approach to care and provide opportunities that are favourable to patients. Patient experience is closely linked to Foucauldian 'technologies of the self' where self-reflection by the clinician on what is learned through experience can produce insightful, caring, ethical behaviour towards patients. Patient experience is like knowing a person's soul and how it has been shaped by technologies of discipline (Foucault, 1977a). For a clinician, this knowledge is helpful when working with patients as they can tailor their responses to the patient's behaviours (See Chapter 3, The self and the soul).

The holder of two roles OT

A review of position descriptions for OTs shows how clinical governance is now embedded within the expectations of what an OT 'does' in a DHB. For instance, in 2014, a rotational OT position description (Counties Manukau Health, 2014d) foregrounded the DHB vision and values ("Our DHB shared Vision is to work in partnership to improve the health status of all" (p. 4)) before describing the role expectations through the key accountabilities of:

- Best practice (outcomes focussed, assessment /intervention / discharge process)
- Client focussed care (client goals /selfcare / equipment needs)
- High quality standards of care (documentation, time management, prioritisation, careful use of resources)
- Individual responsibility and accountability for professional development of self and others (PDR procedure; peer review, supervision, preceptorship of new staff, post-grad studies, research, evidence-based practice, supervision, in-services, student supervision)
- Multidisciplinary team and working relationships (safe work environment, working within budget and funding, data collection, exercise tact, judgement, respect, be discreet and sensitive)
- Legislation (NZ government legislation, DHB policy, OTBNZ policy)
- Quality (development of policy, procedures, service development)
- Health and Safety (policies adhered to, reporting of workplace hazards, identify health and safety representative)
- Cultural safety (respect, cultural awareness in lifestyle, practices and choices)
- Information technology (uses clinical information systems) (2014d, pp. 5-7)

This position description clearly demonstrates the discourses that make up the two-roles of the occupational therapy practitioner, "improving the system for providing care as well as providing care" (Davies et al., 2014). In fact, by paring the job description down to this list, it clearly reveals how the focus on participating in direct client care has shifted quite dramatically to requiring the practitioner to participate in the development and maintenance of quality clinical governance systems.

Summary

Clinical governance frameworks in Aotearoa New Zealand are constructed from multiple interacting discourses: political, biomedical, organisational, professional, economic, systems, technological, managerial and leadership, quality and safety of patient care, teamwork, communication, learning and research, client-centred care, equity and bicultural. They form a "network of dependence and communication" (Foucault, 1972, pp. 46-47) throughout DHBs, classifying the desired behaviours preferred by the DHBs. The complexity of these interacting discourses produce a DHB environment where healthcare workers, including OTs, are expected to conduct themselves and their practices in a particular way. The texts I have studied certainly reveal how OT practitioners are rendered docile bodies, conforming to DHB technologies of discipline through observance of policy and engaging in technologies of the self (e.g. the

confessional) through supervision. Comparison of one moment of time with another shows that a rupture has occurred resulting in the emergence of named clinical governance and further change to occupational therapy practice as a result. In DHBs, there is a disjunction between occupational therapy practice having become largely restricted to core practices while patient referrals are now more complex, requiring more thoughtful clinical reasoning and multifaceted intervention as a result. To remediate these conflicts, some OTs might find ways to take up opportunities to engage in leadership, professional learning and research in order to find ways to improve the quality of occupational therapy healthcare delivery within the DHB setting. On occasion, I would suggest that engagement in resistive practices, might be because personal subject positions favour provision of 'desirable' quality of life interventions, which are constricted by DHB economic discourses preferring the practice of economic prudency, limiting interventions to 'need' only. This research has also indicated that clinical governance frameworks are not static; the multiple discourses comprising them (see above) shift in prominence, while new ones are taken up as New Zealand's political, societal and economic discourses react to worldwide discourses in healthcare delivery. It may be that further iterations of clinical governance frameworks will be constructed as healthcare delivery responds to unknown contingent events to come, impacting OT practices and patient outcomes alike.

Chapter 9 Discussion

> People know what they do; frequently they know why they do what they do; but what they don't know is what what they do does.
>
> *– Michel Foucault, Personal Communication to Dreyfus and Rabinow*

Introduction

In this chapter, I bring together and discuss the findings from the previous three chapters. I consider examples of dominant themes that are illustrative of the effects of discourses from DHB clinical governance frameworks on the subject positions and practices of OTs. Where relevant, I consider my findings in relation to the work of other researchers who have explored clinical governance in New Zealand, most prominently, Gauld and Horsburgh (2012, 2015, 2017), or favoured particular OT subject positions, particularly Pollard, Kronenberg and Sakellariou (2009), who advance the concept of political activities of daily living (pADL)[79] (p. 3). I also consider the work of Mackey (2011), who advocates for the occupational therapy profession to understand themselves as holding multiple subject positions related to context that shift over time. Finally, I contemplate the implications of my findings and what opportunities my insights may open up for OTs practicing within DHB clinical governance frameworks. For me, the learning I gained from conducting this research was surprising. I had no idea at the beginning where it would take me and that I would arrive at the points of discussion presented later in this chapter

Why?

I conducted this study because I wanted to understand why my occupational therapy practices seemed to change from one moment to another. It troubled me, and became problematic, particularly in the early 2000s when I noticed that there was more to 'do' that was not directly associated with patient face-to-face interaction, and there seemed to be increasing written rules and regulations associated with practice. In this study, I have endeavoured to make visible my understanding of how I constructed this perception, by viewing the problem through a Foucauldian lens (see Chapter 3: Methodology). Something was being 'done' to occupational therapy practice in District Health Boards, which influenced what I could and could not do for my patients, and, importantly, there was a run-on effect in how they, the patients, could and could not 'do' things in their home environments. Foucault (1982c) suggests that people are unaware of the effects of their practices, but as practitioners, I believe we should be able to reflect on what

[79] pADL: Pollard, Kronenberg & Sakellariou define this concept as "the need to develop and integrate political literacy and political engagement in occupational therapy education, practice and research". They stress that "the use of the small 'p...refers to local conditions, the intricacies of accountability, interprofessional relationships, user and carer needs and individual motivations, issues that are often managerial concerns." (p.3). It does not refer to government 'Politics'.

our ‘truths’ and conduct does to ourselves as well as others, by considering the discourses that have produced our subject positions and practices.

How?

Through the application of Foucauldian methodology, I began to understand that the subjectivities of OTs were discursively constructed, and produced from a whole breadth of power relations shaped by circulating discourses from multiple sources which construct the social world around us. I also came to realise that the construction, and therefore definition, of clinical governance shifts from time to time, as attempts are made to fill in gaps when further problems in healthcare delivery emerge, and are identified through discursive statements. It is essentially a means of reining in undesirable or unsafe healthcare delivery practices (as discussed in Chapter 6: Contingent events) through the regulatory techniques of power associated with governmentality.

This understanding was confirmed when I read the Health Quality & Safety Commission’s document *Clinical governance: Guidance for health and disability providers* (HQSC, 2017), where, finally, a New Zealand-wide framework for clinical governance was presented. It acknowledged that clinical governance had been “introduced in an adhoc way or used in a fragmented manner” (p. 7). This statement supported my analysis of the texts from three DHBs selected for this study that clinical governance within occupational therapy practice appeared as glimmers in Moment 1, where, for example, prominent systems discourses produced technologies of discipline such as policies, guidelines and protocols for OTs to follow in their daily practices. In Moment 2, however, professional development and learning and patient experience discourses were also foregrounded, providing opportunities for OTs to participate in research projects and to examine how it felt, for instance, to be a patient in hospital. Although the original UK discourses remained present and were expanded more fully, the document also acknowledged the incorporation of discourses from the Treaty of Waitangi into its “dimensions of quality” (p. 7), as well as recognising “professional and regulatory bodies” (p. 3) as contributing to “the conceptual basis” (p. 3).

To conduct analysis into my initial question asking how ‘clinical governance’ had influenced occupational therapy practice, I selected moments in the recent history of New Zealand occupational therapy to analyse more closely through the study of texts obtained from a wide variety of sources (see Chapter 4: Method). I was able to see how changing discourses produced and served different constructions of governmentality within each moment. I soon realised that there had been a shift from the self-governance, self-disciplining position experienced by post-war OTs (see Chapter 5: A history of the present) to situations where post-2000 OTs were governed by DHB quality improvement frameworks and professional governance in Moment 1 (Chapter 7: 2003-2005). These would later be reconstructed as clinical governance frameworks produced from a plurality of healthcare improvement discourses regulated by multiple

governance disciplinary mechanisms in Moment 2 (Chapter 8: 2015-2017). The context for the emergence of clinical governance is considered in Chapter 6.

Shared responsibility

The clinical governance framework brought together quality improvement discourses that were already somewhat present in New Zealand healthcare institutions. What was new, effectively becoming a dominant discursive construct, was the idea that everybody, including healthcare workers and patients, at all levels and across levels, held responsibilities to ensure the success, delivery and take up of appropriate healthcare provision to the population. The importance of the formulation of a structure of relationships and networks, where everybody worked together in partnership and collaborated, became visible. In principle, then, power networks within the healthcare system were being made to change through the clinical governance discourses.

Circulation of power and behaviour change

The discourses within clinical governance frameworks ideally create behaviour change at the individual level by circulating and dispersing power to people who previously may have enacted little or no discursive power, or reducing it where there was an imbalance. Consequently, clinical governance *potentially* opens up opportunities that allow a broad range of people to legitimately speak regarding how healthcare provision happens, where it occurs, and what is done. It also acts to minimise discourses that support siloed ways of working, by favouring discourses that promote openness, communication and teamwork throughout the organisation. Leadership responsibilities are theoretically no longer the domain of managers, but shared with clinicians (Brown et al., 2009), challenging the dominance of manager decision-making regarding delivery of hospital healthcare. Furthermore, clinical leaders are authorised to speak on behalf of professions at senior management level. Everybody at all levels is required to show initiative, ownership and responsibility by demonstrating leadership through actively providing evidence for what they are doing or have done; however, in order to achieve these goals, technologies of discipline are embedded so that clinicians are rendered 'docile bodies', who can be disciplined through technologies of power as discussed in Chapters 3, 5, 7 and 8.

Aims of research

I first set out to consider the emergence of the occupational therapy profession in New Zealand. This was an event strongly constructed from biomedical and occupational therapy professional discourses. It produced the subject of the OT to provide rehabilitation through occupation to mental health patients, as a way of governing their conduct while residing in institutions, producing docile bodies. Treatment was extended to returning soldiers injured during the Second World War with the purpose of getting them back to work (see Chapter 5). The success of the first OTs prompted the New Zealand government to pass the Occupational Therapy Act, 1949 , which enabled the occupational therapy profession to hold the power to self-govern through the

Occupational Therapy Board, with strong advisory and post-qualification educational support from a professional association (see Figure 17). I felt I needed a good understanding of how occupational therapy was constructed in this early period so that I had a baseline with which to compare the two moments I had selected to study post the introduction of clinical governance in DHBs. Chapter 5 addresses the post-World War II era beginnings of occupational therapy.

Figure 17. Governance as occupational therapy emerged in New Zealand 1940-1960. Author's work.

My second, more important aim was to examine if and how the emergence of clinical governance might have had influenced occupational therapy practice in the DHBs after 2000. I selected two moments after the concept of clinical governance emerged in New Zealand healthcare delivery documents, 2003-05 and 2015-17 respectively (Chapter 6 & 7 are Moment 1 and Chapter 8 is Moment 2). When placed alongside Chapter 5: History of the present, where I looked at the emergence of the occupational therapy profession in the post-World War II era, I was able to compare subject positions and practices pre- and post- the introduction of clinical governance. When comparing the governance of the profession from post-World War II to Moments 1 and 2, it appeared to me that the governance of OTs had changed *in series* responding to ruptures triggering changes within healthcare delivery over time.

While post-2000, the emerging quality service and professional governance discourses influencing occupational therapy subjectivities and practices in Moment 1 have shifted in

prominence in comparison to Moment 2, what has become evident is that some early pre-Moment 1 and 2 professional occupational therapy discourses persist. They appear to be continuously at the heart of occupational therapy practice, constructing the belief that occupation is essential for health, and are associated with finding ways to enable people, as occupational beings, to participate in the occupations of their choosing, if they are able, particularly paid employment. This observation is supported by the work of multiple researchers of occupational therapy practice, including Pollard, Kronenberg and Sakellariou (2009), Wilcock and Hocking (2015) and Whiteford and Wright-St. Clair (2005).

A shifting healthcare provision structure

As I focussed my research on the emergence of clinical governance discourses in DHBs in the 2000s, I frequently encountered the work of Professor Robin Gauld, who has regularly authored or co-authored books, papers and research associated with a transition in the New Zealand health sector. Gauld claims this transition has been ongoing since the mid-1980s (Thomson & Gauld, 2001), and my findings corroborate this assertion where it is pertinent to occupational therapy practice. Prior to the first Moment of study in 2003-05, the occupational therapy profession conducted a review of its workforce (Department of Health Workforce Development Group, 1988) and education programmes (Department of Education, 1988), producing the first minimum standards of practice, *Competencies for registration as an occupational therapist* (New Zealand Occupational Therapy Board, 1990). These documents are discussed in Chapter 6. They signal an early awareness within the profession that there would be a future need for occupational therapy to describe its scope of practice, demonstrate safe, competent practice and construct an auditable set of standards that could be used for future practice surveillance and monitoring.

Gauld (1999) also observed that discourses associated with underfunding, austerity and "core business" (p. 576) were surfacing in healthcare provision statements prior to my period of study, Moment 1. He noted the construction of a devolved system of healthcare delivery that was "increasingly complex and disintegrated" (p. 582). He recommended therefore, that a stable system of governance supporting integrated care and performance evaluation be constructed. The documents commissioned by CLANZ (Malcolm et al., 2002a) also foregrounded discourses supporting clinical governance and clinical leadership as objects to be introduced into DHBs, noting that some DHBs had already initiated construction of frameworks in their organisations.

A further document, *Discussion Paper: Quality improvement strategy for public hospitals,* (Ministry of Health, 2001) circulates quality improvement discourses emphasising the benefits of clinical governance, by clearly constructing a basic framework of components the authors believed should be included, such as clinician involvement, teamwork, performance management, partnerships, accountability and responsibility, and evidence-based practice. The paper emphasised that "establishing a system of clinical governance in hospital would be an evolving

process" (p. 30) which my study has certainly revealed and confirmed. I found that while Moment 1 provided glimpses of early clinical governance frameworks being built within some DHBs, it was primarily through management and medical service structures. Clinical governance was rarely named as such, Instead, a variety of separate, non-integrated, quality improvement and safety discourses produced practices to be engaged in, such as prudent use of resources and client-centred care. As I have noted, in one DHB, where clinical governance was taken up early, clinical governance discourse was interpreted as "professional governance" within the allied health department (Auckland DHB, 2012, p. 7).

Even in Moment 2, although clinical governance per se was more visible within allied health structures, and certain practices taken up and normalised, there were signs that the full range of quality and safety of healthcare delivery discourses supporting the construction of clinical governance frameworks had still not been taken up, limiting the engagement of clinicians. Highly relevant to this 2015-17 timeframe, Gauld and Horsburgh conducted two studies that tracked the take up of clinical governance practices and processes in DHBs after the publication of *In good hands* (Brown et al., 2009), firstly in 2012 (Gauld & Horsburgh, 2012) and then in 2017 (Gauld & Horsburgh, 2017). The first study, open to all professionals across the (then) 19 New Zealand DHBs (Gauld & Horsburgh, 2015), revealed that clinical governance frameworks had somewhat been constructed by DHBs from variously interpreting the quality improvement discourses within the *In good hands* document. I would suggest that the results of their first study supports my argument that I found clinical governance, as defined in Chapter 1, was not so discursively prominent in Moment 1, when they write:

> Clinical governance and leadership have been central health policy planks since the delivery of the 2009 In Good Hands report of the Ministerial Task Group on Clinical Leadership. ...Since then, DHBs have invested considerable effort into developing structures for clinical governance, supporting clinical leadership and building a more engaged health professional workforce. (Gauld & Horsburgh, 2012, p. 11)

In other words, prior to *In good hands*, in all probability, it simply had not been made sufficiently clear that DHBs should construct clinical governance frameworks within their structures.

These statements suggest that, although my research has revealed evidence of clinical governance discourses appearing in government policy and circulated through services by managers in DHBs, prior to 2009, the circulating discourses were not sufficiently dominant to be named definitively as 'clinical governance'. The alternative 'quality improvement frameworks' operating in Moment 1 tended to be constructed so that power was something to be enacted *upon* practitioners, producing a different kind of subject from managers through the effects of technologies of discipline. The leadership partnership between managers and clinicians remained unbalanced. What occupational therapy practitioners did in Moment 1 was to either take up opportunities that

were presented as medical service initiatives, professional governance, and quality initiatives, or to quietly resist policy through underground practices (Hayes Fleming & Mattingly, 1994), so there were spaces where they could enact power.

Even after *In good hands* (Brown et al., 2009) was published, with the expectation that DHBs would progress with the construction of clinical governance frameworks, Gauld and Horsburgh concluded in their 2012 study that clinical governance needed a clearer definition; that DHBs should share their structural models and pool their documents with each other and that health professions needed to be encouraged to engage through, for instance, training of both qualified clinicians and students and administrative support for clinical leaders prior to 2009 (2012, pp. 85-86). Their findings also revealed a number of problematic systems and management discourses counter to the construct of clinical governance being taken up and normalised into DHB practices. Because clinicians and managers had been constructed differently, holding different subject positions, particularly concerning use of economic resources, an "us and them" (Gauld & Horsburgh, 2015, p. 3) clinical-managerial relationship was produced. While managers took up DHB economic and quality and safety of healthcare provision discourses foregrounding individual accountability as a dominant managerial subject position, practitioners continued to favour subject positions that prioritised their direct clinical responsibilities. It would appear that many clinical governance discourses failed to have sufficient effect on clinicians, with Gauld and Horsburgh's (2015) research suggesting that a lack of formal training and time to gain clinical governance practice skills and knowledge contributed to the poor take up of clinical governance practices amongst clinicians. The authors reiterated:

> The findings of this study suggest not only a failure to commit at the local DHB level in implementing a government policy within a healthcare system where powers of planning and service organisation are devolved from the centre; these also echo findings from other studies of clinical governance, which show that management commitment is critical if healthcare professionals are to feel engaged in the implementation process. (p. 5)

From my own experience of being a clinical leader at the time the second study was conducted, I would suggest that although these discourses influenced occupational therapy subject positions prior to and within Moment 2, poor understanding and partial implementation of government policy within the DHBs may have limited full active occupational therapy clinician engagement in clinical governance and leadership development initiatives. I observed resistive behaviour surfacing, particularly a reluctance to engage in non-clinical quality work that seemed to be associated with not having the time to commit to additional duties due to the need to manage full clinical caseloads. Here, it could be argued, the traditional, caring, client-focussed subject positions dominated over quality improvement discourses. I can also anecdotally attest to the inequality in the relationship between managers and clinical leaders: for example, a multidisciplinary manager at this time asserted that they had 'final decision authority' over

professional and clinical leaders. On reflection, this comment might have been generated due the dominance of the managerial discourse still being prominent and favoured; while the emerging shared leadership discourse remained backgrounded.

Gauld and Horsburgh's (2020) second study on the progress of clinical governance in DHBs was conducted in 2017, within my Moment 2, and was open to "all health professional groups in employment" (p. 781) in New Zealand DHB hospitals. Their prominent finding was that only limited progress had been made since their original 2012 study (Gauld & Horsburgh, 2017, 2020). While the study revealed there was slightly more awareness of clinical governance, and more DHB support to engage in clinical leadership events, they noted that there seemed to be a deterioration in clinical-management decision-making and change partnerships. The authors concluded that if clinical governance was to be normalised into DHB practices, then there needed to be:

> Encouragement and support from across the sector, with advice and guidance from the centre as well as commitment and support from the DHBs. ...Of course, health professionals also have a responsibility for enabling and developing clinical governance. ...Progress generally requires setting up measures for holding individuals and the system to account. (Gauld & Horsburgh, 2017, p. 57)

My research shows that, in Moment 2, OTs were exposed to discourses that produced some changes to their practices. Clinical governance and leadership discourses emerging from *In good hands* circulating within DHBs slowly produced emerging or re-designed allied health service structures. As I have observed, in some DHBs, allied health was named as a service in its own right (Chadwick, 2017; Mueller & Neads, 2005; Waitematā DHB, 2010a), rather than being contained under the auspices of medical services. Furthermore, the allied health service structures included governance leadership positions such as Director of Allied Health and Professional Leaders (Waitematā DHB, 2010a). However, the frameworks still tended to emphasise 'doing to' clinicians at the front line, through policy, guidelines and standard operating procedures, rather than engagement, feedback and take up of clinician viewpoints.

Governance, governance, and yet more governance

In Moments 1 and 2, how OTs 'do' their practices has been influenced by multiple sources of discourse (see Figure 18). I would argue that governance is enacted in Moments 1 and 2 by the action of neoliberal and bicultural discourses acting on New Zealand government policy which, in turn, has produced health legislation, distantly overseen by the Ministry of Health. The Ministry ensures that strategies and guidelines are taken up and implemented by the DHBs and professional bodies through the surveillance of their activity by reporting mechanisms and audits. Day-to-day healthcare delivery is locally regulated by the DHBs through the action of clinical governance discourse and disciplinary mechanisms, while occupational therapy professional governance is

locally regulated by the OTBNZ. The sources of discourses in Figure 18 above (Neoliberal governmentality, Treaty of Waitangi, OT professional governance and Moment 1: Quality improvement and Moment 2: Clinical governance) are closely related, whereby multiple discourses circulate and flavour 'the truths' reaching OTs. As the discourses emanating from these discourse sources wax and wane in prominence, the effect is a shift in what is considered 'the truth', and, therefore, the 'preferred' knowledge.

Figure 18. Overview: Multi-governance Moment 1 (2003-2005 and Moment 2 (2015-2017) produced by multiple discourses from multiple sources. Author's work.

OTs who take up the preferred knowledge into their subject positions are likely to shift their behaviour so that their practices are in line with DHB preferred conduct. However, my own experience also suggests that others may choose to resist and engage in counter-conduct, (see 'quiet influencers' later in this chapter, in spite of possible disciplinary consequences, a Foucauldian consequence of free choice (Foucault, 1978).

Shifts in leadership structures

Table 10 provides a summary of leadership constructions for OTs in hospitals. In 1940/50, OTs were essentially self-governed, working within, and from, a designated Occupational Therapy Department. In Moment 1, OTs were named and managed within a medical service, reporting to a generic allied health team leader, working in a multidisciplinary space, with OT professional leaders/advisors backgrounded by prominence of managers. In Moment 2, OTs were explicitly

named in the construction of an allied health service, working within a multidisciplinary space managed by AH generic team leaders. Named OT professional leaders are more prominent, but balance of power with managers was still questionable.

Table 10. Examples of shifts in leadership constructions

1940/50s	**Moment 1**	**Moment 2**
OT based in OT Department: Leadership through Charge Occupational Therapist within the OT Department. (Dalrymple, 2008)	Service-based structure: Allied health including OTs, embedded within services and not a standalone entity Limited formal input to decision-making by therapy professional leaders & advisors (including OTs). Fragmentation of allied health staff across the DHB. Allied health structure and function under consultation (Waitematā DHB, 2010a)	Allied Health Service: Named stand-alone service comprising allied health clinicians with designated leadership representation at multiple levels throughout DHB including: Chief Health Professions Officer (ADHB) Allied Health Directorship (ADHB and CMH) Professional leader OT Practice supervisors NZROTs and Therapy Assistants OT students (Auckland DHB, 2016)

"Action upon action"

Foucauldian discourse analysis made it possible for me to trace how discourses associated with clinical governance and leadership produced particular occupational therapy subject positions within DHBs (Table 11). The analysis process made visible what previously was not known to me, at least consciously. I was able to visualise how the exercise of power, carried by discourses, plays a productive role in everyday practices (Dreyfus & Rabinow, 1982). It produces "action upon action" (Foucault, 1982b, p. 220), as it circulates throughout all levels of society and associated organisations (Foucault, 2003). By conducting a Foucauldian discourse analysis, I was able to arrive at an understanding of how the effects of particular actions at all levels within a DHB held implications for delivery of occupational therapy services to patients.

Table 11. Example of how power/knowledge has produced 'action upon action' within hospitals

Surfaces of emergence	Action upon action
Prior to and within Moment where OTs first emerged in NZ Foregrounded Authorities of delimitation: Physicians	Biomedical discourses dominant, producing medical knowledge and status that empowered physicians to both lead medical institutions and make management decisions on care provided, such the construction of the conditions for the OT profession to emerge in NZ.
Prior to Moment 1 Foregrounded Authorities of delimitation: Managers	Medical knowledge and physician status challenged by emerging managerial discourses that questioned physicians' ability to make management decisions about care provided. New managerial knowledge constructed that shifted the power enacted and status held by physicians to lead medical institutions and make management decisions on care provided, to an emerging group of hospital managers. Clinicians positioned by managers to focus on the economic implications of healthcare provision rather than care for improved quality of life.
Prior to Moment 2 Foregrounded Authorities of delimitation: Clinicians and managers	Managerial knowledge and status challenged by emerging clinical governance discourses that question the power of hospital managers to act alone in making decisions about healthcare provision. Foregrounded discourses prefer shared holding of power and responsibility for clinical decision making, leadership and management. New clinical governance and leadership knowledge supports redistribution of power throughout hospitals to be shared by both healthcare professionals and managers.

Multiple subject positions, rather than 'identity'

OTs, as subjects, are able to react and respond to the discourses present in society around them, that produce a societal "regime of truth" (Foucault, 2000d). They are able to take up or reject those discourses available to them, and in the process, construct multiple subject positions. It follows, then, that in the actual 'doing' of occupational therapy, 'practices', may vary, depending upon the subject positions the individual OT either takes up or has imposed on them. The practices and expected standards become recurring patterns of conduct which can be taken up and normalised as everyday practice. A common example within DHBs is the OT assuming the subject positions associated with the practices of an 'EMS assessor' (Ministry of Health, 2014a, p. 3) where professional and clinical governance discourses, particularly economic discourses, come together. EMS assessor professional discourses produce practices that include *assessing* and *measuring* people in order to gain information to provide bespoke wheelchairs and seating, and *training* them to use the equipment. DHB EMS assessor clinical governance economic discourses favour supply of equipment for *need* only, not to improve quality of life (Accessable, 2003, p. 3, para 3.6). How OTs as EMS assessors in DHBs respond to and engage in these

practices depends upon the dominance of the discourses producing their subjectivities and their subject positions within a certain time, place and space. They may comply with or resist the economic discourses, finding novel ways to circumvent the rules. Mackey (2011) therefore contended that OTs should not be labelled with static professional identities either as a group, or individually. She claimed, as I do, that professional identities or in Foucauldian terms, 'subjectivities', do not remain the same, but are subject to change:

> Foucauldian approaches are rooted in a recognition that professional identities are contested and thus open to change rather than predetermined. In this way, occupational therapy is a dynamic concept, shaped and reshaped over time by competing and often contractionary claims. Such approaches open up fields and possibilities for critical reflection and strategic action. (Mackey, 2011, p. 133)

My study revealed a number of dominant subject positions within each moment, demonstrating how subjectivities change. Table 12 summarises, and the relevant chapters provide detail.

The table shows how subject positions have shifted, become foregrounded, backgrounded and normalised from moment to moment, in response to the particular dominant discourses acting on the subjectivities of OTs at a particular time. It makes visible the discourses I have identified as foregrounded in each moment and the expected subject positions that have been produced. What is important to note is that the discourses emerging post-war are still present in Moments 1 and 2, but in some cases have been modified or backgrounded in favour of the emerging quality and clinical governance discourses in these two time periods respectively. The enduring discourse is 'occupation is essential for health'. In many respects, then, it further demonstrates the construction of the two roles of OT clinicians – holding on to the traditional values and beliefs of the profession, yet being expected to transition and respond to a broader role involving practices that are reconstructed for the particular health service in which OTs find themselves working.

Table 12. Comparison of dominant subjectivities and subject positions produced by quality improvement discourses

Dominant subjectivities and subject positions made visible by professional, quality improvement and clinical governance discourses within the texts		
Emergence of OT profession	**Moment 1 2003-2005**	**Moment 2 2015-2017**
Prominent professional discourses: Occupation essential for health Biomedical Patient-focused Agency of human beings Problem solvers; practical application of ideas	**Prominent quality improvement discourses:** Economic Organisational Responsibility and accountability Delivery of safe, quality healthcare Client-centred Bicultural Professional development + learning	**Prominent clinical governance discourses:** Economic Organisational Responsibility and accountability Delivery of safe, quality healthcare Client-centred; Patient experience Bicultural Professional development through learning organisations
Subjectivities / subject positions		
Doing it our way: A self-defining profession Holistic and creative problem solvers pushing boundaries Creators of mysterious practices: the power of silence Practitioners embracing humanitarian characteristics Providers of humanising, individual-focused patient care Constructors of patient conduct Protectors of our patch: organisation, safety and prudent work practices in the department **Belief that participation in occupation is necessary for health**	Emerging: DHB professionally governed Prudent Safe, quality driven Client-centred Biculturally aware Reflective, accountable Entrepreneurial Emerging OT leader Resistor **Enduring belief that participation in occupation is necessary for health**	Disciplined; compliant Learning, researching, communicating Person-centred, caring Biculturally responsive Holders of "Two roles" **Enduring belief that participation in occupation is necessary for health**

Note: Subject positions at the 'emergence of profession' have not necessarily been eliminated, but rather been backgrounded by the dominant discourses constructing OT subject positions in Moments 1 and 2

Summary of findings

Occupational therapy - 1940s

Biomedical, economic and social discourses produced the emergence of the occupational therapy profession during the Second World War in New Zealand as a response to the problem of not

having sufficient trained staff to rehabilitate people languishing in medical institutions. The way patients were governed became problematic and so a different way of governing was needed to provide reablement services to patients, hence an opportunity opened up for the emergence of OTs in New Zealand.

The close relationship with certain influential medics who supported the emergence of OTs in New Zealand to rehabilitate mentally ill patients and injured soldiers proved to be beneficial. The relationship ensured a transfer of power to occupational therapy practitioners, who then held the authority to apply the specific occupational therapy practices constructed as a result of professional OT subject positions taken up during their occupational therapy training. They constructed and ran their own departments, and they predominantly professionally governed themselves within the hospitals, with some minimal oversight from the medical profession for referral purposes. Dominant subject positions at this time emphasised a belief that participation in occupation is necessary for health and practices that emphasised a caring, humanistic, occupation focussed, professionally governed approach to practice. Patients were rendered docile bodies, under the medical gaze, being cared for within a welfare system, who did what they were told and were provided with what the 'experts', including OTs, thought they needed.

Moment 1

DHBs emerged as a solution to a number of perceived problems with healthcare delivery in New Zealand. Siloed departments were replaced by interconnecting services, and quality improvement frameworks began to emerge. Legislation from the HPCAA impacted occupational therapy practice as professional discourse filtered through to DHB OTs via the OTBNZ and also through the construction of professional governance frameworks in the DHBs. Quality improvement discourses, such as those preferring quality, safety, financial prudence and client-centredness acted to circulate preferred knowledge through DHBs thus constructing named objects 'professional governance' and 'quality improvement'. The focus was on establishing, embedding and normalising fundamental organisational and services rules, regulations and practice procedures from top down into medical services and through to practitioners. OTs were now directly governed professionally and by DHBs, but while some occupational therapy practices were discontinued and core practices emphasised, other opportunities emerged to make visible and showcase practices through documentation and outcomes.

Dominant quality improvement discourses of the time constructed a docile body: a behaviourally compliant, responsible and accountable practitioner who engaged in practices associated with economic responsibility, safe practice, client-centredness and cultural responsiveness. The enduring belief that participation in occupation is necessary for health was also dominant and was a constant presence in the practices of OTs, particularly prominent when entrepreneurial and resistive behaviour surfaced within occupational therapy practice. Patients/clients were

constructed as now being capable of making their own healthcare decisions, as a result of prominent neoliberal discourses foregrounding autonomy and self-responsibility. However, for some OTs, the 'Welfarism', caring discourses (that rendered patients as docile bodies needing to be cared for), were still evident. This was clear in the use of underground practices, as other avenues were closed by, for example, funding restrictions or narrowing of scope of practice within DHBs.

Moment 2

There was a shift of oversight across some DHBs who followed Auckland DHB's lead and constructed allied health as a service in its own right. Directors of Allied Health emerged and were named, holding senior management level positions. Allied health increasingly shifted from being situated within medical services to be constructed as a full stand-alone service. OTs were now represented by clinical leadership structures emphasising a multiple direction (up, down and across) communication flow, professional-managerial partnerships and the appearance of discourses circulating the preferred truth that there were all kinds of leaders within DHBs, not only those in official positions (*In good hands*). The dominant focus was on establishing, embedding and normalising clinical leadership, allied health service rules, regulations and practice procedures with practitioner involvement. Economic, leadership, and quality and safety of patient care discourses, for instance, were now claimed and named as clinical governance discourses, entering the subjectivities of OTs. Additionally OTs were provided with opportunities to resist practices through counter-conduct, by speaking up; and to take up positions involving research and development of services.

Clinical governance discourses circulating at this time normalised the subject positions of the behaviourally compliant, responsible and accountable practitioner who engaged in practices associated with economic responsibility, safe practice, client-centredness and cultural responsiveness. As in Moment 1, the enduring belief that participation in occupation is necessary for health also remained dominant and was a constant presence in the practices of OTs; again, particularly prominent when opportunistic and underground behaviour surfaced within occupational therapy practice. As allied health services constructed their network of relationships, they were able to provide practitioners with opportunities for participation in patient experience initiatives, quality improvement projects, research and higher education. At the same time, though, more protocols were produced that standardised practices and behaviour so that risk was further minimised and productivity emphasised. Patients/clients were constructed as consumers capable of making their own healthcare decisions and expected to take on responsibility for their own health and healthcare as a result of neoliberal discourses foregrounding autonomy and self-responsibility. The consumers were provided with education and home programmes to be able to make their own decisions as to what action to take thereafter. Practitioners were warned not to engage in certain types of counter-conduct, particularly 'gaming' the system (Ministry of Health,

2012, p. 4) in order to provide services that patients/clients were not officially deemed eligible for through policy.

Implications for theory and practice

I have identified six prominent emerging themes and one enduring theme in my study that, I believe, make visible how clinical governance discourses have influenced occupational therapy practices in DHBs. OTs are:

1. Multi-governed, clinically-led
2. Discursively proactive
3. Holders of 'two roles'
4. Lifelong learners
5. Quiet influencers: Holders of hidden power
6. Biculturally responsive
7. Enduring 'claimers of occupation'

Multi-governed; clinically led

Clinical governance frameworks could be considered to be a neoliberal Orwellian dichotomy of 'freedom equalling restraint'. While national decentralisation had resulted in a reduction of direct governance by the New Zealand government via the Ministry of Health, the DHBs had been accorded that power, each producing their own version of clinical governance, facilitated to deliver healthcare services in a particular, controlled way. Using Foucault's 'Rules of Formation' (see Chapter 3), we can understand how multiple quality of healthcare discourses were enabled to flow from government agencies and, via 'surfaces of emergence' such as DHB executive leadership teams and HR services, enter the DHBs. The discourses eventually aligned within an umbrella construction named 'clinical governance'. The appointed 'authorities of delimitation' such as service delivery managers within DHBs were enabled to place limits on how clinical governance was known and enacted. For example, in Moment 1, in certain DHBs, annual plan documents written by some service delivery managers referred to 'quality improvement' or 'professional governance' rather than clinical governance *per se*. The effect was that in some DHBs, discourses such as economic, safety and clinician competency discourses were preferred, while others such as clinical leadership and patient experience discourses were somewhat backgrounded. However, realising that clinical governance had not been fully constructed and taken up, within many DHBs, the Ministry of Health, another powerful authority of delimitation, named clinical governance within a new round of documents where clinical leadership and patient experience discourses were foregrounded as essential constituents of clinical governance. In Moment 2, therefore, a shift is seen to occur and clinical governance is more visible. Foucault's final rule, the 'grids of specification', describes the ways of classifying clinical governance. As it is an umbrella term for a collection of particular discourses, it can be organised and grouped into

in to multiple systems. For instance, safety discourses run through clinical governance. Within the grids of specification, safety could be loosely grouped into patient safety and clinician safety. Patient safety could then be further classified as environmental safety in the hospital, risk reduction techniques associated with patient care; safe, competent practice provided by clinicians, and so on. The relationships between the three rules of formation provide crucial insights into how power circulates and changes behaviour.

When this collection of discourses was examined closely, it appeared to me that the relations between the discourses supported the argument that OTs working in publicly-funded healthcare organisations at this time were actually governed more than they were at other moments. Through local concentration of power circulating from the New Zealand government into the DHBs, producing clinical governance frameworks, practitioner behaviours could be more closely scrutinised and shaped through technologies of discipline, to conform with DHB preferences. Power acting on OTs also extended beyond the immediate workplace remit because the 2003 HPCAA professional discourse had also filtered into the DHB space. As a consequence, clinical governance frameworks had shifted to include professional governance, overseen by clinical leaders, within their remit, intensifying gaze on practice. Likewise, Treaty of Waitangi discourses concerning bicultural practices were also taken up and executed within clinical governance frameworks.

With so many regulations, some occupational therapy practitioners may believe their practice freedoms have been limited. As Foucault (1982b) questions, “What happens when individuals exert (as they say) power over others?” (p. 217), later answering, “To govern... is to structure the possible field of other people” (p. 221). It raises the question of whether occupational therapy practitioners were and are governed too much, and, more importantly, I ask whether the continuing close surveillance of their practice is actually effective. I also wonder if and how governance practices could be simplified so that client-centred care discourses are favoured and that time spent engaging in activities with patients is recognised as a core practice. I would argue that practitioners spending more direct time with clients, rather than engaging in the chore of satisfying multiple demands and behaving in the preferred DHB way, would ultimately be more beneficial to the client. One possible area for future consideration might be for professional boards and DHBs to collaborate and define the extent of their roles, with the aim of avoiding duplication of surveillance and disciplinary practices, potentially opening up opportunities for practitioners to engage more fully with clients.

Discursively proactive

I contend that my research necessarily demonstrates the fluidity of OTs’ subject positions. Occupational therapy practitioners have to be discursively proactive and take up subject positions that are not static, but change in response to societal, economic and political discourses entering

and circulating the DHBs through clinical governance frameworks. Changing discourses can produce a change in subject positions accompanied by a change in practices. Some practices are backgrounded, as in the earlier discussion about supplying prefabricated splints in preference to making custom splints, demonstrating the OT's prudent use of limited resources. Some practices disappear, such as the use of weaving and basket-making as therapeutic interventions, which are no longer viable, due to shorter inpatient hospital stays. OTs' subject positions shift so that occupational therapy practices focus more on assessment, recommendations and discharge, rather than periods of long inpatient treatment. These are practices that discourses would suggest are better for the client and more cost effective for the DHB. Other practices emerge and become prominent, examples being specialised wheelchair, equipment and home modification assessment and supply, so that clients can remain in their own homes and be discharged more quickly from hospital, emphasising both good economic management and fiscal prudence, as well as a client-centred focus to interventions.

The confessional

In order to practice proactively, occupational therapy practitioners need to be aware of changing political, social and economic discourse and how this discourse has a roll-on effect to their DHB subject positions and to their practices. My research would suggest that this relationship should be made visible and explicit, so that practitioners know why they are doing certain things. I would advocate for training opportunities that support practitioners to understand clinical governance frameworks and why DHBs produce policy requiring them to behave and practice in certain ways. Additionally, both my research and personal experience lead me to believe that it is essential that there are opportunities to engage in safe reflection and discussion of changing practices. As Foucault (1985) intimates in *History of Sexuality*, use of the confessional is productive in that it is a practice that encourages self-transformation through self-examination (see Chapter 3 section: Ethical care of the self). Although DHB supervision policies usually do have a confidentially clause (Counties Manukau Health, 2014b, 2014c; Waitematā DHB, 2016e), there may not be trust in how the process works in practice. Access to highly skilled, external supervisors, where confidentiality is guaranteed, would appear to be a safer option in every way compared to supervision provided by peers, managers and leaders working in the same DHB. Personal experience shows that internal supervision can be subject to breaches in confidentiality due to the very way it is constructed within DHB clinical governance frameworks. The close relationships with managers and leaders, who often oversee its implementation, means that supervision can become a mechanism for surveillance and discipline. When there is limited trust, then supervision becomes a 'chatting place', rather than a space for serious reflection and development of ethical practices.

Holders of 'two roles'

Clinical governance discourses have produced more complex iterations of the DHB occupational therapy practitioner job description, as waves of prominent discourses are taken up and normalised into practice. Gauld echoed the original acknowledgement in *A First Class Service: Quality in the New NHS* (Department of Health, 1998a), that the introduction of clinical governance frameworks has produced two jobs for the practitioner: "improving the system for providing care as well as providing care" (Davies et al., 2014). From an examination of occupational therapy position descriptions after the introduction of clinical governance frameworks, I would contend that OTs are expected to participate in multiple practices involving both direct intervention with clients and additional indirect clinical governance practices that focus on DHB values and implementation of clinical governance policy.

While the two roles could be understood as coming together to initiate and produce the OT-client relationship, the real-world result of 'two roles' is that practitioners are commonly expected to continuously add practices to their working day, without consideration of whether there is a safety risk attached to the increased workload. This raises a number of questions. Firstly, is there an assumption that practitioners have unlimited capacity to continuously add the practices that emerge through clinical governance driven policy? Secondly, if occupational therapy practitioners are expected to engage in 'two roles' with minimum resistance, should they receive education and support to understand what is expected of them? Lastly, are role expectations realistic and acceptable to those who carry them out? Does the answer lie in the exploration of realistic caseloads and FTE hours for the additional role? This would necessarily involve all stakeholders, including frontline clinicians, to ensure that power is disbursed more evenly and promote good morale amongst practitioners.

Lifelong learners

Clinical governance discourses place prominence on the individual responsibility of practitioners to participate in professional development, a continuous learning process, often referred to as 'lifelong learning'. London (2011) stresses lifelong learning is concerned with change and defines it as:

> Lifelong learning is a dynamic process that varies depending on individual skills and motivation for self-regulated, generative learning and on life events that impose challenges that sometimes demand incremental/adaptive change and other times require frame-breaking change and transformational learning. (p. 1)

Cast in Foucauldian terms, lifelong learning can actually be considered as "a neoliberal art of government", and "a technology of control" (Olssen, 2006, p. 216). Occupational therapy professional development discourses were present in Moment 1, emerging from both clinical governance and OTBNZ competency requirements. However, Moment 2 brought professional

development discourses to prominence when opportunities within allied health services began to be opened up for practitioners to engage in post-graduate papers, workshops and research projects. Although lifelong learning can be construed as a way of controlling individuals, in that they are obliged to engage in some forms of professional development to maintain their registration status, it is also an opportunity to explore different practices that might construct a pathway to other roles in academia and research or, indeed, act to improve quality of occupational therapy interventions for patients. As examples of these improvement activities across both Moments, opportunities to engage in professional development were cited in Chapter 6, where OTs developed their own assessment documentation (Blijlevens & Murphy, 2003), and Chapter 7, where OTs were involved in a project that streamlined an allied health community referral process (Bishop & Brott, 2019). These actions provided them with professional autonomy situated within a clinical governance dominated DHB environment.

Quiet influencers: Holders of hidden power

Foucault (1982a) suggests "not everything is bad but that everything is dangerous, which is not exactly the same as bad. If everything is dangerous, then we always have something to do" (pp. 231-232). What I understand Foucault to mean by this statement is that there is an instability connected with the dispersion of power and all discourses have the potential to work in both productive and counter-productive ways. Foucault warns that we must be vigilant in what we do to actively ensure we do not engage in behaviour that is possibly harmful to other individuals. It may be argued that within a clinical governance framework, OTs hold discursive power in that they are often placed in positions of hidden influence when it comes to patient outcomes. OTs are a "governmental mechanism of bodily regulation that produces subjects" through their practices (Gutiérrez Monclus & Pujol Tarrès, 2016, p. 68). They therefore need to ensure their behaviour and resulting effects avoid undue harm to others. Some may engage in what may be construed as a positive form of "counter-conduct" (Foucault, 2007a, p. 201) by pushing back or resisting discourses that limit what they are able to do, such as seeking extra funding for equipment that benefits their clients through demonstration of their reflective and clinical reasoning skills. OTs' advice is frequently requested for safe discharge of clients into the community, but delays are seldom favoured by the rest of the team because of the economic pressures to empty beds. 'Positive counter-conduct' is also evident in the need to engage in ethical reasoning, sometimes leading to recommendation of a delay to discharge if there are safety concerns, but for the patient, the risk of being unsafe at home is minimised. On the other hand, OTs can also recommend clients be discharged home with community services and equipment in place for safety, even in the face of opposition from the team or family, supporting a patient's autonomy to make their own decisions.

However, there is another subject position produced by the economic clinical governance discourse that construct OTs as gatekeepers and guardians of resources and information: "agent(s)

of social control" (Pollard et al., 2009, p. 11). It is important to note that in Foucauldian terms, this position is neither good nor bad, but OTs need to tread carefully. OTs are obliged to take ownership of how they delegate resources to patients. For instance, they must demonstrate that they are wisely issuing equipment and recommending only necessary home modifications, a part of their role to ensure that DHB populations are being effectively and equitably governed. Continuing with the example, as an alternative, they might provide education and home programmes which encourage clients to take responsibility for their own recovery, by engaging in self-help practices (Rimke, 2000), such as providing a falls prevention checklist for clients to use at home (Accident Compensation Corporation, 2003), or advising clients where they might purchase their equipment privately.

OTs are also trained skilled observers and measurers of behaviour, collecting information which is recorded, reported, discussed, acted upon and stored for both individual interventions and, where indicated, for collective statistical data. These behaviours are crucial to OT practices within clinical governance frameworks. An example of useful collection of information by OTs would be collection of data concerning a patient's home environment which might open up opportunities to provide options for home modification. In my experience, OTs have to decide where to draw the line between collecting essential data for patient treatment and recording other personal data not directly required for OT interventions, which may be construed as an invasion of privacy. Engaging in Foucauldian 'technologies of the self' within supervision by employing 'care of the self' (Foucault, 1988d) reflective skills helps to ensure OT behaviours are not 'dangerous'.

Pollard et al. (2009), advocate that OTs should hold political subject positions and use effective communication skills to actively challenge the rules that limit their practices as OTs. Their "3P dialectical triangle" (p. 10) is a reflective tool to aid political reasoning, exploring the OT's political values through personal, professional and political lenses. If "not everything is bad, but everything is dangerous", then the implication is that occupational therapy practitioners should reflect upon clinical governance discourses, challenging the discourses where necessary through careful use of counter-conduct, but also using them opportunistically in order to achieve change; particularly access to occupational engagement and participation for clients.

OTs do hold power to be quiet influencers, and one such example is the feedback OTs gave to the implementation of an algorithmic Equipment and Modification Services (EMS) Prioritisation Tool (Ministry of Health, 2012). The tool was constructed with the aim of managing government funding of equipment more fairly within a capped budget. While the tool was mostly completed by EMS assessors (mainly OTs, in yet another role), there was one specific component, named the *Impact on life* (p. 1), which was a questionnaire that clients completed themselves, and was included in the scoring by the algorithm. I would argue that it was controversial from the moment it was implemented because the language used for the *Impact* (i.e. quality of life) component did

not appear to OTs to be client friendly, and it was difficult to introduce it into initial assessment meetings. The algorithm also diminished practitioner reasoning behind why an EMS assessor would seek equipment for their clients.

In what we now recognise as an example of such counter-conduct, OTs provided collective feedback to the Ministry of Health (Orton, 2014, personal collection), who agreed to make some changes to the wording in the questionnaire and associated leaflets. The tool, in practice, turned out to be challenging to 'do' with clients "creating more bureaucracy and checks and balances by Accessable, leading to annoyance for them and DHB therapists" (Counties Manukau Health, 2014a, p. 1). The *Impact on life* questionnaire was eventually removed when the Prioritisation Tool was replaced by 'The Equipment and Modification Services (EMS) Portal' in 2019 (Ministry of Health, 2019). EMS assessors were now again able to provide 'rationales' for their equipment requests. My personal experience with this issue leads me to believe that regular, quiet[80] feedback from the EMS assessors who used the tool produced a change in the original Prioritisation Tool because it was perceived to be not as efficient and fair as at first thought. OTs *"always have something to do"*, it seems, to ensure they are both behaving in the interests of their patients and that they are not 'dangerous'.

Biculturally responsive

From the late 1980s onwards, increasing disparities were identified between the health of Māori and that of European New Zealanders (Robson, 2007). Partly as a result, in Moment 1, discourses circulated within DHBs brought forward "the special relationship between Māori and the Crown under the Treaty of Waitangi" (Ministry of Health, 2003a, p. viii). The Treaty of Waitangi was to act as the foundation of equality within the New Zealand health system through the principles of participation, partnership and protection. As a result, bicultural competency became an expectation of a quality service which emphasised practices that are "people centred" and incorporated "equity and access, safety, efficiency, and effectiveness" (Ministry of Health, 2003a, p. 10). The knowledge supporting these practices could be acquired through opportunities to attend training offered by Māori Services. For OTs, bicultural safety discourses were also circulated by OTBNZ through their CCFR, which required OTs to set professional development goals aimed at demonstrating engagement in bicultural practices.

In Moment 2, the Health, Quality & Safety Commission re-emphasised "cultural safety" (Health Quality & Safety Commission, 2017, p. 13) as part of ensuring consumer engagement and participation within its clinical governance framework as well as re-acknowledging the role of the Treaty of Waitangi as a foundation for the "key dimensions of quality" (p. 7) outlined in the original Ministry of Health document (Ministry of Health, 2003a). OTs in the DHBs were encouraged to consult with Māori services where appropriate, as when writing policy and within

[80] Carried out discreetly

their CASP professional development goals (Auckland Region District Health Boards, 2018) and OTBNZ ePortfolio requirements (Occupational Therapy Board of New Zealand, 2015c) that were also often used as a basis for the DHB professional development plan, aimed to further practitioner knowledge and understanding of Māori culture and history. As Māori construct and establish services within DHBs, texts suggest that an increase in Māori OT practitioners in DHB workforces would be a preferred outcome (Auckland and Waitematā District Health Boards, 2017). In April 2021, the New Zealand Labour government announced plans to dismantle the District Health Boards and replace them with a new national body, Health New Zealand, and a new Māori Health Authority, that will sit alongside it, signalling a new shift in bicultural discourse and the power relationship between Māori and the Crown. The aim is to work in true partnership with Māori as the Māori Health Authority will "have the power to directly commission health services for Māori" (Quinn, 2021, para. 8).

Enduring claimers of occupation

Discourses that remain prominent in occupational therapy professional beliefs are those that construct the OT subject position that occupation is essential for health. They run alongside, cross and intersect with clinical governance discourses, and still dominate the construction of OT subject positions and practices that prompt OTs to seek ways of providing "occupation, enablement and justice" (Whiteford & Townsend, 2011, p. 65) for their clients. The authors write:

> Occupation is as necessary for human existence as air, food and water, and that the power of occupational engagement can be used therapeutically to heal the body, form community connections, and organise what people do. In recognizing the centrality of occupation for humans, occupational therapists and occupational scientists have begun to advocate that societies define and protect occupational rights. (p. 67)

Above all else, occupational therapy practitioners look for opportunities that will enable their clients to participate in doing occupations that people want or need to do, because OTs believe that occupation is a human right (World Federation of Occupational Therapists, 2012). Clinical governance paradoxically both limits and provides opportunities for occupational justice events to occur. It sets boundaries on what can be provided economically, given regulations pertaining to the issue of equipment, particularly small items, like dressing equipment, which clients usually need to purchase privately, despite any limited financial means to do so. Instead, though, OTs educate their clients in the use of the recommended equipment and provide them with information as to where the items may be bought, rented or donated. In a neoliberal world, the latter method of intervention would be considered preferable, as the client is enabled to autonomously manage and participate in their own recovery by seeking their own equipment. It also demonstrates (in a small way) how OTs seek multiple solutions for occupation participation problems. OTs activate their reflective and problem-solving subject positions to uncover legitimate, and sometimes

underground, practices in order to achieve participation in occupation for their clients, within, and sometimes outside of, the boundaries of clinical governance frameworks.

Monitoring clinical governance

In 2010, research was conducted in New Zealand DHBs to ascertain to what extent were DHBs implementing *In good hands* (Brown et al., 2009) through the application of a newly developed tool, the *Clinical Governance Development Index* (CGDI) (Gauld & Horsburgh, 2012). Of concern in the 'allied health/other' category was the lack of familiarity of clinical governance amongst clinicians and worse, the perceived lack of support from DHBs for this cohort to be able to engage in clinical leadership activities. Davies et al. (2014), in a UK clinical governance conference, claimed that allied health was often a "poor cousin" and in some cases "a belated addition" to the traditional 'doctors and nurses' view of the provision of health systems. Even more recently, allied health has also been described as an "afterthought" (Allied Health Professions Australia, 2021, para. 1). These statements suggested that power is not distributed equally throughout DHBs and that the nursing and medical professions are still holding power to the detriment of allied health. The CDGI findings recommended that *all* health professions should be involved in clinical governance, thus having "the capacity to influence decision-making" (Gauld & Horsburgh, 2015, p. 7). Despite these shortcomings, Davies et al. (2014) argued that overall, New Zealand was actually making fair progress in the implementation of clinical governance frameworks and acknowledged that due to its complexity, practices associated with its implementation would take time to become a normalised part of the New Zealand health organisational structure. However, when the CGDI was repeated in 2017, little further progress had been made suggesting that there may be some resistance at play.

In 2020, the *Health and disability system review - Final report – Pūrongo whakamutunga*, chaired by Heather Simpson, was released (New Zealand Health and Disability System Review, 2020). The *Simpson Report* identified four key themes: "consumers at the heart of the system; culture change and more focussed leadership; more effective Te Tiriti-based partnerships; integrated system" (p. 3). The client-centred, leadership, bicultural and systems discourses glimmering within these themes alone suggest that clinical governance has not impacted the DHBs as hoped, and so I would question whether devolution to DHBs and the attempt at rolling out multiple clinical governance frameworks have, in fact, improved the quality and equity of healthcare delivery. The recommendations suggest that "A new crown entity, Health NZ, should be established to lead delivery of health and disability services across the country ...all DHBs should be required to operate as a cohesive system subject to Health NZ leadership" (p. 63), "A Māori Health Authority should be established to lead strategic policy with respect to Māori health" (p. 63) and that "the Ministry of Health assumes a stronger leadership role in population health" (p. 244).

One other statement stands out for me: “The future system will not be successful unless the workforce is planned and managed more effectively than has been the case in the past” (p. 248). It leaves me wondering what future iterations of the health system will emerge from these discourses and, in particular, what subject positions and practices OTs will take up. Finally, the report signals that the Māori voice and perspective of health appears to have been listened to and considered:

> the entire report is aimed at addressing health inequity for all New Zealanders. It has specific, consistent references to equity and Māori woven through every recommendation and chapter. (Parahi, 2020)

The outcome of this report was that in April 2021, Andrew Little, the Minister of Health, announced plans to “create a truly national public health service ...giving true effect to *tino rangatiratanga* and our obligations under Te Tiriti o Waitangi” (Little & Henare, 2021, para. 9) and through the creation of a Māori Health Authority. This raises the question of whether this new construction will effectively become a ‘super DHB’ with the opportunity to standardise the delivery of healthcare across New Zealand, and so avoid a ‘postcode lottery’ of care (Russell, 2021), while also ensuring that Māori receive equity of care. A more pessimistic possibility is that a nationwide organisation will likely act to narrow the opportunities afforded by smaller (and potentially more nimble) organisations to experiment with novel care modalities, resulting in another period of time where ‘core practices’ are favoured.

Limitations

It is occasionally argued that Foucault’s work offers no formulaic method of discourse analysis to work from (Hook, 2001a), and there are no defined theories “of anything” (McHoul & Grace, 1998, p. vii). Likewise, Foucauldian methodology may be read both critically as well as descriptively (Hook, 2001a). Applied critically, the Foucauldian understanding of discourse can be understood as a way of constituting knowledge that, in turn, produces practices which exercise and circulate power by discipline and resistance within social systems (Diamond & Quinby, 1988; Hook, 2001a, 2001b; Weedon, 1997). Foucauldian discourse analysis is effectively an alternative reading of social history and opens up opportunities to appraise traditional accounts of history from a different viewpoint (McHoul & Grace, 1998).

As a descriptive methodology, however, the emphasis is on locating and describing what, within the texts, “can be said” (McHoul & Grace, 1998, p. 31). Foucault uses what McHoul and Grace term “interrogative practice” (p. viii) by asking many questions about certain phenomena produced within historical moments. Foucault mixes history and philosophy together to understand life in the present: “The philosopher and historian of otherwise” (p. viii). He does not search for ‘the truth’, arguing instead that there are multiple truths due to differences in interpreting the meaning of discourses within texts (Powers, 2001). Additionally, what is ‘true’ is

relative and constrained to the conditions of particular temporal moments, and so it is not generalisable to other contexts (Powers, 2001).

An important limitation to my research is that I can only present my analysis and findings from a *tauiwi*[81] perspective as I am non-Māori and an immigrant from the UK, settling in New Zealand in 2004. I cannot speculate on whether Māori OTs have the same perspectives as myself given that health is framed differently within Māori culture. As Foucault maintains, there is a plurality of 'truths' (See Chapter 3). My 'truth' is only one of many. There are further truths yet to be revealed from other sources.

There can also be limitations placed upon getting access to documents, so the study needed to be planned to take that possibility into consideration by placing limits on the scope of the research focus (Gauld, 2001). Areas of interest that are not within the scope of this study, such as how OTs working in private practice are governed, would need to be a future study in itself. Following Foucauldian methodology as a researcher, it is not my role to predict what may be true in the future; nor apply my findings to other contexts. I can only describe 'archaeologically' what has happened in the past, critique how power has played out at certain moments in time and how certain past events have relationships with present practices. A Foucauldian approach to recommendations, therefore, would be to lay out the findings emerging from within the texts and leave it to others to contemplate the implications and construct their own conclusions. Therefore, I should not make recommendations, but instead highlight some questions that may need to be asked and consider some future directions this study may point to.

Possible future directions

For research

There are a number of directions worthy of further research. One possibility is to study the experiences of occupational therapy practitioners who have worked within clinical governance frameworks (or future iterations of New Zealand healthcare delivery governance) to gain further understanding of what they believe has opened up or become closed to them when engaging in occupational therapy practice in DHBs. This might have the additional value of introducing the occupational therapy clinician voice to clinical governance research.

Other groups may be interested in researching the impact clinical governance has had on their experience of New Zealand healthcare delivery, particularly Māori practitioners who may hold a quite different perspective, since being non-Māori myself, I can only properly comment on bicultural practice and the Treaty of Waitangi from a *tangata tiriti* perspective rather than *tangata*

[81] Foreigner, European, non-Māori; ancestry from another land

whenua. Another group may be patients themselves, who receive clinician services and so experience the 'action upon action' effect of clinical governance.

A further area of useful research would be to extend the study to the many OTs working in private practice outside DHBs. This would identify the governance mechanisms that they are subjected to, and their similarities to, and differences from, what has emerged from this study of DHB occupational therapy practice.

Lastly, it is possible, even likely, that OTs across New Zealand have been subject to an uneven level of governance, and further research to understand how much governance OTs *really need* might lead to improvements in the profession's effectiveness and efficiency.

For education

Foucault (1997) argues that people subject themselves to "games of truth" (p. 281), which are practices of the self, involving the production of the subject. Pollard et al. (2009) noted that "the games people play are largely at an unconscious level" (p. 7). Both appear to be alluding to relations of power. If we make the assumption that clinical governance is concerned with relations and games of power that are largely unconscious, and the ability to take up opportunities wherever possible, it would seem reasonable to suggest that OTs are skilled in political competences, defined by Pollard et al. (2009) as:

> A dynamic set of critical knowledge, skills, and attitudes that enables one to engage effectively in situations of conflict and co-operation that are about responding to people needs and demonstrating the relevance of the profession. Examples of political competences are: political reasoning (pADL), strategic planning and decision-making, networking, lobbying, debating. (p. 21)

So, a possible further direction for education might be to consider the open presentation and discussion of the complexities of clinical governance and leadership in occupational therapy student training programmes. Skills in political competence that may better prepare future students to work effectively on behalf of their clients within modern systems of governance - where every opportunity needs to be negotiated - would seem worthy of consideration.

For policy and practice

Clinical governance and its effects on practice are not always visible to those subjected to it, because it is complex, subject to change and not always named as 'clinical governance'. The question therefore arises: if practitioners are not aware of, or do not understand, the system within which they work, how can they be expected to fully participate in it? Is there not also 'danger' in being unaware of the 'games' and relationships of power that are present and circulate in the workplace, preventing choices from consciously and actively being made about what practices to engage in?

The arc of discourses from Moment 1 to Moment 2 highlights that practitioners still do not seem to be provided with opportunities (education, time, participation, reflection) to gain full understanding of the nature and functioning of clinical governance. Because the framework reacts to changing political, social and economic discourse, its fluidity impacts the construction of OT subject positions and practices from moment to moment. The occupational therapy profession is well positioned, for example, to provide educational workshops via their conferences and workshops, as are DHB allied health services, where clinical governance discourse foregrounds the importance of learning and education opportunities. However, reflecting on the clinical governance framework in *Clinical governance: Guidance for health and disability providers* (Health Quality & Safety Commission, 2017), it is clear to me that:

- There are still gaps within practice, particularly in the area of an "engaged effective workforce" (2017, p. 19).
- Representation, the ability to speak out, expression of how an OT 'feels' about what they do and the provision of realistic time and resources still appear to be less prominent than the production of rules and regulations to discipline individuals.
- Engagement of OT clinicians actively and freely participating in clinical governance quality initiatives is still limited, due to the time that needs to be specifically allocated to any work that is not directly concerned with patient treatment.
- Discourses from the UK *Francis Report* (Francis, 2013) and *Berwick Report* (National Advisory Group on the Safety of Patients in England, 2013) concerning professional disengagement and its remediation, including opportunities for staff to engage in continual learning and improvement of patient care, have not been totally heeded in New Zealand. The enabling of front-line clinician participation is still at the discretion of managers, and now clinical leaders within directorates.

It may simply be unreasonable and counterproductive to expect clinicians to engage in governance and leadership work within time originally allocated for clinical work, if the caseload is not reduced. The question then remains whether realistic staffing, funding, education and training will be future considerations to attract OTs to engage in quality initiatives.

Finally, opportunities continue to emerge outside DHBs possibly due to neoliberal-inspired deregulation "creating a highly fragmented and complex health system" (Adams & Carryer, 2020) and the emphasis on DHB/private partnerships. There has been a gradual decline in the percentage of OTs working in DHBs; with a notable shift to 50% registered OTs in 2003, and only 46% of OTs reported as working in DHBs in 2020 (see Appendix I). This decline may have a number of root causes, but neoliberal-influenced clinical governance has surely had a part to play. It is an open question whether the ideal clinical governance model (i.e. including deep clinician engagement) can survive and flourish in a for-profit environment.

Conclusion

How knowledge is constructed, circulated, selected and taken up into practice seems to be an important concept for practitioners to understand, and like other (even non-medical) professions, practitioners should always ask questions about the dissemination of knowledge and what the discourses constructing knowledge will do to their practices and, more importantly, what it will do to, and for, their clients. An intimate knowledge and understanding of the processes contributes to the 'art of practice' (Pollard et al., 2009, p. 25), aiding the effective management of client interventions and "an opportunity for political activism" (Silcock, 2020, p. 37).

Finally, when working within a complex clinical governance framework, I would suggest that questioning policy and engagement in reflective practice before 'doing' is essential so that the occupational therapy practitioner knows why they are behaving and practicing in particular ways, because clinical governance does influence occupational therapy practice via circulating preferred DHB discourses and through relationships of power. Growing skills to be "political actors" (Pollard et al., 2009, p. 31), while following their own hearts into ethical practices, may enable OTs to hold power to exercise client visions, validate and/or question policy and promote occupational justice, social justice and bicultural equity within Health NZ and the Māori Health Authority – the planned next construction of the New Zealand healthcare delivery system.

Afterword

> One writes to become other than who one is.
>
> – *Michel Foucault, Death and the Labyrinth*

I did not realise the size and wide range of the project I had taken on. Initially, my question seemed quite straightforward, but not having previously studied philosophy, and particularly Foucault's view of the world, I found myself starting from scratch. For me, the style of Foucault's writing is a challenge to read and understand, especially in (sometimes variable) translation, so I used many secondary texts alongside his original writing in an attempt to grasp the concepts he was advancing. As he draws heavily from philosophical ideas throughout history, I also found myself researching his influences, again with the goal of putting his writing in context in an attempt to understand it. Chapter 3 reflects my challenge to understand Foucault's methodology and how he constructed his ideas by manipulating and building upon the ideas of not only past philosophers, but also his European (primarily French) academic contemporaries.

Another challenge was building up an understanding of clinical governance, how, where and why it initially emerged in the UK healthcare system, to eventually surface in New Zealand DHBs. Collecting the data to enable me to follow the trail involved multiple searches across both academic and grey literature and reading documents from multiple sources. I produced a standard literature review, later realising that the approach was incorrect for Foucauldian Discourse Analysis research. More importantly, though, was the crucial insight that although clinical governance was a significant concept in my thesis, occupational therapy practice was really the crux of my question, and so 'occupational therapy' and 'occupational therapists' needed to be the focus of 'a history of the present', the Foucauldian alternative to a literature review.

I therefore turned to documents concerned with early occupational therapy practice to write 'a history of the present'. Initially applying archaeological tools, I revealed how the early subject positions of OTs were constructed. Use of genealogical tools then provided a way of explaining how the effects of power produced subject positions that informed the way early clinicians practiced occupational therapy. It was this chapter where I first consciously applied Foucauldian tools, a task in itself that, for me, was frightening, yet challenging and something I wanted to become proficient in over the course of the thesis.

On reflection, had I realised the potential extent of what I had inadvertently planned for myself, I think I would have taken more seriously the limitations placed on the allocated time frame of the study more closely. The research was limited to two years, plus an initial three semesters where papers were completed to guide philosophy, the literature review and to write the research proposal, forming the basis of the methods chapter.

Looking back, I would have ensured that my study design contained clear limits as to how much text gathering to undertake, but I left it somewhat open-ended. As a result, I felt the need to continually conduct literature searches throughout the study period, rather than keeping to a defined selection of texts for 'the history of the present' and for each moment. I also continually looked for literature that explained Foucault's methodology and methods so that I could better understand his concepts and then confirm and apply what I thought I understood. Engaging in such a large quest for knowledge was, for me, interesting and enlightening, but perhaps not necessary for the overall small size of the study.

However, I have to note here, that other than answering the research question, my whole approach in undertaking a DHSc., was not to achieve its completion as quickly as possible, but to enjoy the journey, while developing my thinking, knowledge and writing skills beyond the level I started with. Being an older person, my clinical career behind me, there was no urgency to hold another qualification. It was a personal challenge, and fully enjoyed, most likely because I did allow myself to venture beyond what was really required for the study.

References

Accessable. (2003). *Specialised assessor equipment manual. A modified version of the original equipment manual for the Auckland and Northland Regions*.

Accident Compensation Corporation. (2003). *ACC Thinksafe. Fall prevention: Home safety checklist* [Worksheet leaflet].

Accident Compensation Corporation. (2014a). *1972 - The Accident Compensation Act*. Retrieved 23 December, 2020, from https://www.acc.co.nz/about-us/who-we-are/our-history/#1972--the-accident-compensation-act

Accident Compensation Corporation. (2014b). *What we do*. Retrieved 23 December, 2020, from https://www.acc.co.nz/about-us/who-we-are/what-we-do/

Adams, S., & Carryer, J. (2020). How the institutional and policy context shapes the establishment of nurse practitioner roles and practice in New Zealand's primary healthcare sector. *Policy, politics and nursing practice*, *22*(1), 17-27. https://doi.org/10.1177/1527154420965534

Adhanom Ghebreyesus, T. (2017). *Health is a fundamental human right*. World Health Organization. Retrieved 30 November, 2020, from https://www.who.int/news-room/commentaries/detail/health-is-a-fundamental-human-right

Agger, B. (1991). Critical theory, post-structuralism, postmodernism: Their sociological relevance. *Annual Review of Sociology*, *17*, 105-131. https://doi.org/10.1146/annurev.so.17.080191.000541

Aimer, P. (2015). *Labour Party – First Labour government, 1935 to 1949*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 30 November, 2020, from https://teara.govt.nz/en/labour-party/page-2

Alcoff, L. (1993). Foucault as epistemologist. *Philosophical Forum*, *25*(2), 95-124.

Alcoff, L. (2013). Foucault's normative epistemology. In C. Falzon, T. O'Leary, & J. Sawicki (Eds.), *A companion to Foucault* (pp. 205-225). Blackwell. https://doi.org/10.1002/9781118324905

Allied Health Professions Australia. (2021). *Advocacy priorities*. Allied Health Professions Australia. Retrieved 24 January 2021, from https://ahpa.com.au/advocacy-priorities/

Andersen, L. T., & Reed, K. L. (2017). *The history of occupational therapy. The first century*. Slack.

Andrews, P. (1955). Occupational therapy as one physiotherapist sees it. *Occupational Therapy*, *10*(4), 9-10.

Archives New Zealand. (n. d.). *Te Tiriti o Waitangi/The Treaty of Waitangi*. Archives New Zealand,. Retrieved 29 November, 2020, from https://archives.govt.nz/discover-our-stories/the-treaty-of-waitangi

Armstrong, A. (2019). *Michel Foucault: Feminism*. The Internet Encyclopedia of Philosophy (IEP). Retrieved 15 November, 2020, from https://www.iep.utm.edu/foucfem/

Arribas-Ayllon, M., & Walkerdine, V. (2008). Foucauldian discourse analysis. In C. Willig & W. Stainton-Rogers (Eds.), *The SAGE handbook of qualitative research in psychology*. Sage.

Ashton, T. (1996). Health care systems in transition: New Zealand, Part I. *Journal of Public Health Medicine*, *18*(3), 269-273.

Auckland and Waitematā District Health Boards. (2017). *Māori health plan Auckland and Waitemata District Health Boards*. https://www.waitematadhb.govt.nz/assets/Documents/health-plans/2017-18-Maori-Health-Plan-Auckland-and-Waitemata-DHBs.pdf

Auckland Correspondent of the New Zealand Freelance. (1940, October 16th). Student tutors selected: Occupational training at Avondale. *New Zealand Freelance*.

Auckland DHB. (2002). *District annual plan for the year ending 30 June 2003*.

Auckland DHB. (2003a). *District annual plan for the year ending 30 June 2004*.

Auckland DHB. (2003b). *Tikanga: Recommended best practice policy*.

Auckland DHB. (2012). *An executive perspective. ADHB's clinical governance framework* [PowerPoint slides].

Auckland DHB. (2014). *Our values* [Staff leaflet]. https://wellbeingforhealth.nz/assets/Resources/Culture-and-Values/Values/Values-Leaflet.pdf

Auckland DHB. (2015). *2016/17 annual plan*.

Auckland DHB. (2016). *Allied health occupational therapy professional leader* [PowerPoint slides].

Auckland DHB. (2018). *Our shared values and what they mean to us*. https://wellbeingforhealth.nz/assets/Resources/Culture-and-Values/Values/ADHB-Our-Shared-Values.pdf

Auckland Region District Health Boards. (2018). *Allied, public health & technical multi employer collective agreement*. Public Service Association Te Pūkenga Here Tikanga Mahi. https://www.wdhbcareers.co.nz/assets/PDF/8cfdc84b9a/18-12-05-PSA-APHT-MECA-2018-20-AKLD-Final-min-1.pdf

Australian Commission on Safety and Quality in Health Care. (2017). *National model clinical governance framework*. https://www.safetyandquality.gov.au/sites/default/files/migrated/National-Model-Clinical-Governance-Framework.pdf

Bacchi, C. (2012). Why study problematizations? Making politics visible. *Open Journal of Political Science*, *2*(1), 1-8. https://doi.org/10.4236/ojps.2012.21001

Bachelard, S., Dagognet, F., Canguilhem, G., Foucault, M., Guéroult, M., Henry, M., Laplanche, J., Pariente, J., & Serres, M. (1971). *Hommage à Jean Hyppolite*. Presses Universitaires de France.

Ballinger, C., & Cheek, J. (2006). Discourse analysis in action: The construction of risk in a community day hospital. In L. Finlay & C. Ballinger (Eds.), *Qualitative research for allied health professionals: Challenging choices* (pp. 200-217). John Wiley & Sons.

Bargh, M. (2007). Māori development and neoliberalism. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism*. Huia Publishers.

Barry, A., Osborne, T., & Rose, N. (Eds.). (1996). *Foucault and political reason*. Routledge.

Batalden, P. B., & Davidoff, F. (2007). What is "quality improvement" and how can it transform healthcare? *Quality and Safety in Healthcare*, *16*(1), 2-3. https://doi.org/10.1136/qshc.2006.022046

Belgrave, M. (2011a). *Primary health care*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 29 November, 2020, from http://www.TeAra.govt.nz/en/primary-health-care

Belgrave, M. (2011b). *Primary health care - Reforming the system, 1970s–21st century*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 21 December, 2020, from http://www.TeAra.govt.nz/en/primary-health-care/page-5

Belgrave, M. (2012, 10-11 December 2012). *Social policy history: Forty years on, forty years back.* Affording our Future Conference, Wellington.

Berger, P., & Luckmann, T. (1966). *The social construction of reality. A treatise in the sociology of knowledge*. Penguin Books.

Bishop, A., & Brott, T. (2019). Why the wait? A new approach to community occupational therapy waiting list management. *New Zealand Journal of Occupational Therapy*, *66*(1), 19-23. https://www.otnz.co.nz/download/32/nzjot-archived/5032101/volume-66-issue-01.pdf

Blijlevens, H., & Murphy, J. (2003). Washing away SOAP notes: Refreshing clinical documentation. *New Zealand Journal of Occupational Therapy*, *50*(2), 3-8. https://www.otnz.co.nz/download/32/nzjot-archived/1227/volume-50-issue-02.pdf

Bollard, A. (2009). Economic recovery. *Reserve Bank of New Zealand: Bulletin*, *72*(3). https://www.rbnz.govt.nz/-/media/reservebank/files/publications/bulletins/2009/2009sep72-3bollard.pdf

Boyd, M. (1990). Reflections on occupational therapy [From Journal of New Zealand Association of Occupational Therapy, 28(2)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 38-40. (Original work published 1973)

Brennan, N. M., & Flynn, M. A. (2013). Differentiating clinical governance, clinical management and clinical practice. *Clinical Governance: An International Journal*, *18*(2), 114-131. https://doi.org/10.1108/14777271311317909

Bristol Royal Infirmary Inquiry. (2001). *The report of the public inquiry into children's heart surgery at the Bristol Royal Infirmary 1984-1995: Learning from Bristol*. Department of Health (UK). Retrieved 28 December, 2020, from http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4005620

Brott, T., & Bishop, A. (n.d.). *The digital age of occupational therapy home visits*. National Allied Health Conference. Retrieved 26 January 2021, from http://www.nahc.com.au/2646

Brown, J., Connolly, A., Dunham, R., Kolbe, A., Pert, H., & Pocknall, H. (2009). *In good hands: Transforming clinical governance in New Zealand*. Ministerial Task Group on Clinical Leadership: Department of Health. http://www.asms.org.nz/wp-content/uploads/2014/08/In-Good-Hands-2009_151202.pdf

Brunton, W. (1998). *Gray, Theodore Grant*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 21 January 2021, from https://teara.govt.nz/en/biographies/4g19/gray-theodore-grant

Buchanan, M. (1990). The beginning ['The early days of occupational therapy in New Zealand', Journal of New Zealand Association of Occupational Therapy 23(1)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 7-8. (Original work published 1972)

Butler-Bowdon, T. (2013). *50 philosophy classics*. Nicholas Brearley Publishing.

Calhoun, C. (2002). Structuralism. In C. Calhoun (Ed.), *Dictionary of the social sciences*. Oxford University Press.

Carabine, J. (2001). Unmarried motherhood 1830-1990: A genealogical analysis. In M. Wetherall, S. Taylor, & S. Yates (Eds.), *Discourse as data. A guide for analysis* (pp. 267-310). Sage.

Carroll, N. (2012). *Structural change in the New Zealand economy 1974 - 2012. Draft paper for the long-term fiscal panel*. The Treasury, New Zealand Government.

Cartwright, S. (1988). *The report of the committee of Inquiry into allegations concerning the treatment of cervical cancer at National Women's Hospital and into other related matters 1988*. G. P. Office. https://www.nsu.govt.nz/health-professionals/national-cervical-screening-programme/legislation/cervical-screening-inquiry-0

Chadwick, M. (2017). *Allied Health Directorate: Strategic intent 2017*. Director of Allied Health, Counties Manakau Health.

Cheek, J. (2000). *Postmodern and poststructural approaches to nursing research*. Sage.

Chester, M. (2014). *Desk file for Associate Director of Allied Health (occupational therapy)*. Counties Manukau Health.

Chester, M., & Kennedy, S. (2009). *Occupational therapy's contribution to Counties Manukau District Health Board's triple aim and district strategic plan*. Counties Manukau DHB.

Clinical Leaders Association of New Zealand and Nga Ngaru Hauora O Aotearoa. (2002). *Working together. Face to face communication*, CLANZ and Nga Ngaru Hauora O Aotearoa.

Counties Manukau DHB. (2005). *District strategic plan 2006-11*.

Counties Manukau Health. (2014a). *Allied Health quarterly report*.

Counties Manukau Health. (2014b). *Policy: Professional supervision*.

Counties Manukau Health. (2014c). *Professional and cultural supervision guide for practice*.

Counties Manukau Health. (2014d). *Rotational occupational therapist position description* [Job vacancy 2014].

Counties Manukau Health. (2015a). *Annual plan 2015/6: Incorporating the statement of performance expectations 2015/16 and statement of intent 2015/16 - 2018/19*. http://www.countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Annual-reports-and-plans/2015-16-CMDHB-Annual-Plan.pdf

Counties Manukau Health. (2015b). *Maaori health plan 2015-16*. https://www.countiesmanukau.health.nz/assets/About-CMH/Reports-and-planning/Maori-and-pacific-health/a4d379aaf3/2015-2016-Maori-Health-Plan.pdf

Counties Manukau Health. (2016). *Implementation document: Implementing a career framework and meeting the requirements of the Allied Health designated positions in accordance with the PSA MECA*.

Counties Manukau Health. (2017). *MH&A clinical governance notes* [Minutes from 'Mental Health & Addictions' meeting 18/4/17].

Counties Manukau Health. (2019a). *He pou oranga (Allied Health enabling locality): Task service analysis and Venn diagram*. Retrieved 28 December, 2020, from https://countiesmanukau.health.nz/for-health-professionals/primary-care-information/localities/he-pou-oranga-allied-health-enabling-locality/

Counties Manukau Health. (2019b). *Ko Awatea - About us*. Retrieved 26 January 2021, from https://koawatea.countiesmanukau.health.nz/home/about-us/

Counties Manukau Health. (2020). *Ko Awatea - Capability building*. Retrieved 26 january 2021, from https://koawatea.countiesmanukau.health.nz/capability-building

Creek, J. (2010). *The core concepts of occupational therapy*. Jessica Kingsley Publishers.

Crotty, M. (1998). *The foundations of social research*. Sage.

Cull, H. (2001). *Review of processes concerning adverse medical events*. Ministry of Health.

Cusack, L., & Sealey-Lapeš, C. (2000). Clinical governance and user involvement. *British Journal of Occupational Therapy*, *63*(11), 539-546. https://doi.org/10.1177/030802260006301107

Dalrymple, P. (2008). 'Patricia Robson'. In B. Gordon, S. Riordan, R. Scaletti, & N. Creighton (Eds.), *Legacy of occupation: Stories of occupational therapy in New Zealand 1940-1972*. The Bush Press.

Davies, G., Grant, M., Gauld, R., & Dixon, A. (2014). *Clinical governance and leadership: Invented in the UK, exported to New Zealand. New Zealand developments that can contribute to the NHS*. Presentation at Institute of Commonwealth Studies, University of London School of Advanced Study. https://www.sas.ac.uk/videos-and-podcasts/politics-development-and-human-rights/clinical-governance-and-leadership https://www.youtube.com/watch?v=Je1Cm4vI5mI

De Beauvoir, S. (1973). *The second sex*. Vintage Books.

Dean, M. (2010). *Governmentality: Power and rule in modern society* (2nd ed.). Sage. https://www.google.co.nz/books/edition/Governmentality/HgZdBAAAQBAJ?hl=en&gbpv=1

Deere, D. (2014). Truth. In L. Lawler & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 517-527). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

Department of Education. (1988). *Education: A professional issue. Report on the review of occupational therapy education* [Occupational therapy collection, Archives New Zealand, Wellington].

Department of Health. (1974). *A health service for New Zealand. White paper prepared by the Department of Health*. (Presented to the House of Representatives by Leave) https://www.moh.govt.nz/notebook/nbbooks.nsf/0/05D7CBD25241DF9A4C2565D7001869DE/$file/a%20health%20service%20for%20nz.pdf

Department of Health. (1988). *Occupational therapy workforce profile 1987-88*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/1114C129E0A7BA5B4C2565D7000DDF58/$file/Occupational-therapy-workforce.pdf

Department of Health. (1997). *The new NHS: modern dependable*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/266003/newnhs.pdf

Department of Health. (1998a). *A first class service: Quality in the new NHS*. https://webarchive.nationalarchives.gov.uk/20110322225724/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4006902

Department of Health. (1998b). *A first class service: Quality in the new NHS. 3. Delivering quality standards*. https://webarchive.nationalarchives.gov.uk/20110322225724/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4045152.pdf

Department of Health. (2006). *Good doctors, safer patients: Proposals to strengthen the system to assure and improve the performance of doctors and to protect the safety of patients*. Retrieved 28 December, 2020, from http://webarchive.nationalarchives.gov.uk/+/dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4137232

Department of Health. (2008). *High quality care for all: NHS next stage review final report*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228836/7432.pdf

Department of Health Workforce Development Group. (1988). *Occupational therapy: Roles and functions*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/0717727FA441DBD94C2565D7000DE834/$file/Occupationl-%20therapy.pdf

DePoy, E., & Gitlin, L. N. (2005). *Introduction to research: Understanding and applying multiple strategies* (3rd ed.). Elsevier/Mosby.

Diamond, I., & Quinby, L. (Eds.). (1988). *Feminism and Foucault: Reflections on resistance*. Northeastern University Press.

Dingle, J., & Hooper, L. (2000). Establishing a journal club in an occupational therapy service: One service's experience. *British Journal of Occupational Therapy*, *63*(11), 554-556. https://doi.org/10.1177/030802260006301109

Discipline. (n.d.). In *Merriam-Webster's online dictionary*. https://www.merriam-webster.com/dictionary/discipline

Doolan-Noble, F., Barson, S., Cullinane, F., Gray, J., Lyndon, M., Stokes, T., & Gauld, R. (2016). *Quality improvement at Counties Manukau Health: A case study evaluation*. Centre for Health Systems, University of Otago. https://www.otago.ac.nz/healthsystems/otago616861.pdf

Dreyfus, H., & Rabinow, P. (1982). *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed.). University of Chicago Press.

Durie, M. (1998). *Whaiora: Maori health development*. Oxford University Press.

Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Oxford University Press.

Easton, B. (2002). The New Zealand health reforms of the 1990s in context. *Applied Health Economics and Health Policy*, *1*(2), 107-112. https://www.eastonbh.ac.nz/2002/06/the_new_zealand_health_reforms_in_context/

Editorial: Health rehabilitation. [Editorial]. (1943). *The New Zealand Nursing Journal*, *XXXVI*(12), 279-280.

Elden, S. (2016). *Foucault's last decade*. Polity Press.

Emery, G. (1956). Patient, therapist, practitioner; the team. Rehabilitation; the goal. *Occupational Therapy*, *11*(3), 3-7.

Eribon, D. (1991). *Michel Foucault* (B. Wing, Trans.). Faber and Faber.

Fadyl, J. K., Nicholls, D. A., & McPherson, K. M. (2013). Interrogating discourse: The application of Foucault's methodological discussion to specific inquiry. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine*, *17*(5), 491-507. https://doi.org/10.1177/1363459312464073

Farazmand, A. (2004). Sound governance in the age of globalization: A conceptual framework. In A. Farazmand (Ed.), *Sound governance: Policy and administrative innovations* (pp. 1-23). Praeger.

Farge, A. (2013). *The allure of the archives*. Yale University Press.

Fischer, D. H. (2012). *Fairness and freedom. A history of two open societies: New Zealand and the United States*. Oxford University Press.

Fisher, J. A. (2007). Coming soon to a physician near you: Medical neoliberalism and pharmaceutical clinical trials. *Harvard Health Policy Review*, *8*(1), 61-70. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3092550/pdf/nihms236286.pdf

Flynn, T. (2003). Foucault's mapping of history. In G. Gutting (Ed.), *The Cambridge companion to Foucault* (2nd ed., pp. 29 - 48). Cambridge University Press. https://doi.org/10.1017/CCOL9780521403320

Foucault, M. (1954). *Maladie mentale et personnalité*. Presses Universitaires de France.

Foucault, M. (1961). *Folie et déraison: Histoire de la folie à l'âge classique*. Libraire Plon.

Foucault, M. (1962). *Maladie mentale et psychologie*. Presses Universitaires de France.

Foucault, M. (1963a). *Naissance de la clinique: Une archéologie du regard médical*. Presses Universitaires de France.

Foucault, M. (1963b). *Raymond Roussel*. Éditions Gallimard.

Foucault, M. (1966). *Les mots et les choses: Une archéologie des sciences humaines*. Éditions Gallimard.

Foucault, M. (1969a). *L'archéologie du savoir*. Éditions Gallimard.

Foucault, M. (1969b). Qu'est ce qu'un auteur? [Lecture and discussion]. *Bulletin de la Société Française de Philosophie*, *1969*(63), 73-104. http://1libertaire.free.fr/MFoucault349.html

Foucault, M. (1970). *The order of things: An archaelogy of the human sciences*. Vintage Books.

Foucault, M. (1971). *L'ordre du discours*. Éditions Gallimard.

Foucault, M. (1972). *The archaeology of knowledge* (A. Sheridan Smith, Trans.). Routledge.

Foucault, M. (1973). *The birth of the clinic* (A. M. Sheridan, Trans.). Routledge.

Foucault, M. (1975a, 21 February). *«Des supplices aux cellules» (entretien avec R.-P. Droit)* [Interview]. Le Monde. http://1libertaire.free.fr/MFoucault447.html

Foucault, M. (1975b). *Surveiller et punir: Naissance de la prison*. Éditions Gallimard.

Foucault, M. (1976a). *Histoire de la sexualité I: La volonté de savoir* (Vol. 1). Éditions Gallimard.

Foucault, M. (1976b). The political function of the intellectual. *Radical Philosophy*(17), 12-14. https://www.radicalphilosophyarchive.com/issue-files/rp17_article2_politicalfunctionofintellectual_foucault.pdf

Foucault, M. (1977a). *Discipline and punish: The birth of the prison* (A. Sheridan, Trans.). Penguin Books.

Foucault, M. (1977b). Language to infinity (D. Bouchard & S. Simon, Trans.). In D. Bouchard (Ed.), *Michael Foucault. Language, counter-memory, practice: Selected essays and interviews* (pp. 53-67). Cornell University Press. https://monoskop.org/images/1/13/Foucault_Michel_Language_Counter-Memory_Practice_Selected_Essays_and_Interviews_1977.pdf

Foucault, M. (1977c). Panopticism. In *Discipline and punish: The birth of the prison* (pp. 195-228). Penguin Books.

Foucault, M. (1977d). A preface to transgression (D. Bouchard & S. Simon, Trans.). In D. Bouchard (Ed.), *Michael Foucault. Language, counter-memory, practice: Selected essays and interviews* (pp. 29-52). Cornell University Press.

Foucault, M. (1978). *The history of sexuality. Volume 1: An introduction* (R. Hurley, Trans.). Vintage Books.

Foucault, M. (1980a). *Power/knowledge: Selected interviews and other writings 1972-1977* (C. Gordon, L. Marshall, J. Mepham, & K. Soper, Trans.). Pantheon Books.

Foucault, M. (1980b). Prison talk. In C. Gordon (Ed.), *Power/knowledge: Selected interviews and other writings 1972-1977*. Vintage Books.

Foucault, M. (1981). The order of discourse. In R. Young (Ed.), *Untying the text: A post-structuralist reader* (pp. 51-78). Routledge.

Foucault, M. (1982a). Afterword (1983): On the genealogy of ethics. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (pp. 229-252). University of Chicago Press.

Foucault, M. (1982b). Afterword: The subject and power. In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (2nd ed., pp. 208-226). University of Chicago Press.

Foucault, M. (1982c). Power and truth (personal communication) (R. Harvey, Trans.). In H. Dreyfus & P. Rabinow (Eds.), *Michel Foucault: Beyond structuralism and hermeneutics* (pp. 187). University of Chicago Press.

Foucault, M. (1982d). The subject and power. In J. Faubion (Ed.), *Essential works of Foucault* (Vol. 3, pp. 326-348). Penguin Books.

Foucault, M. (1984a). *Histoire de la sexualité II, L'usage des plaisirs* (Vol. 2). Éditions Gallimard.

Foucault, M. (1984b). *Histoire de la sexualité III, Le souci de soi* (Vol. 3). Éditions Gallimard.

Foucault, M. (1984c). Nietzsche, genealogy, history (D. Bouchard & S. Simon, Trans.). In P. Rabinow (Ed.), *The Foucault reader* (pp. 76-100). Pantheon Books. https://noehernandezcortez.files.wordpress.com/2011/04/nietzsche-genealogy-history.pdf

Foucault, M. (1984d). Space, knowledge, and power (C. Hubert, Trans.). In P. Rabinow (Ed.), *The Foucault reader* (pp. 239-256). Penguin Books.

Foucault, M. (1985). *The use of pleasure: Volume 2 of the history of sexuality* (R. Hurley, Trans.). Vintage Books.

Foucault, M. (1987). Maurice Blanchot: The thought from outside (B. Massumi, Trans.). In *Foucault/Blanchot* (pp. 7-60). Zone Books. https://monoskop.org/images/0/0a/Foucault_Michel_Blanchot_Maurice_Maurice_Blanchot_The_Thought_from_Outside_Michel_Foucault_as_I_Imagine_Him.pdf

Foucault, M. (1988a). *Madness and civilisation: A history of insanity in the age of reason* (R. Howard, Trans.). Vintage Books.

Foucault, M. (1988b). Power and sex: An interview with Michel Foucault. In L. Kritzman (Ed.), *Michel Foucault: Politics, philosophy, culture: Interviews and other writings, 1977-1984*. Routledge.

Foucault, M. (1988c). The prose of Actaeon (S. Hawkes, Trans.). In *The Baphomet* (pp. xix-xxxviii). Eridanos Press. https://monoskop.org/images/4/47/Klossowski_Pierre_The_Baphomet_1988.pdf

Foucault, M. (1988d). Technologies of the self. In L. H. Martin, H. Gutman, & P. H. Hutton (Eds.), *Technologies of the self: A seminar with Michel Foucault* (pp. 16-49). Univerity of Massachusetts Press.

Foucault, M. (1991a). Questions of method. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault effect: Studies in governmentality with two lectures by and an interview with Michel Foucault* (pp. 73-86). University of Chicago Press.

Foucault, M. (1991b). *Remarks on Marx: Conversations with Duccio Trombadori* (J. Goldstein & J. Cascaito, Trans.). Semiotext(e).

Foucault, M. (1994). Prisons et asiles dans le méchanisme du pouvoir [Prisons and asylums in the mechanism of power] (C. O'Farrell, Trans.). In *Dits et écrits* (Vol. 2, pp. 521-525). Gallimard.

Foucault, M. (1996). How much does it cost for reason to tell the truth? An interview conducted by Geraud Raulet. First published in Spuren, 1 & 2, May & June 1983 (M. Foret & M. Martius, Trans.). In S. Lotringer (Ed.), *Foucault live. Collected interviews,1961-1984* (pp. 348-362). Semiotext(e).

Foucault, M. (1997). The ethics of the concern of the self as a practice of freedom (P. Aranov & D. McGrawth, Trans.). In P. Rabinow (Ed.), *Michel Foucault. Ethics, subjectivity and truth. Essential works of Foucault 1954-1984. Volume one* (pp. 281-301). Penguin Books.

Foucault, M. (1998a). On the ways of writing history. Interview conducted by Raymond Bellour, appeared in Les Lettres françaises 1187 (15-21 June 1967), pp. 6-9. In J. Faubion (Ed.), *Michel Foucault. Aesthetics, method, and epistemology. Essential works of Foucault 1954-1984. Volume two* (pp. 279-295). Penguin Books.

Foucault, M. (1998b). Structuralism and post-structuralism. An interview conducted by Geraud Raulet. First published in Telos 16:55, pp.195-211. In J. Faubion (Ed.), *Michel Foucault. Aesthetics, method, and epistemology. Essential works of Foucault 1954-1984. Volume two* (pp. 433-458). Penguin Books.

Foucault, M. (1999). About the beginning of the hermeneutics of the self. In J. Carrette (Ed.), *Religion and culture* (pp. 158-181). Routledge.

Foucault, M. (2000a). Interview with Michel Foucault (R. Hurley, Trans.). In J. Faubion (Ed.), *Michel Foucault. Power. Essential works of Foucault 1954-1984. Volume three* (pp. 239-297). Penguin Books.

Foucault, M. (2000b). So is it important to think? (R. Hurley, Trans.). In J. Faubion (Ed.), *Michel Foucault. Power. Essential works of Foucault 1954-1984. Volume three* (pp. 454-458). Penguin Books.

Foucault, M. (2000c). The subject and power (R. Hurley, Trans.). In J. Faubion (Ed.), *Michel Foucault. Power. Essential works of Foucault 1954-1984. Volume three* (pp. 326-348). Penguin Books.

Foucault, M. (2000d). Truth and power (R. Hurley, Trans.). In J. Faubion (Ed.), *Michel Foucault. Power. Essential works of Foucault 1954-1984. Volume three* (pp. 111-133). Penguin Books.

Foucault, M. (2003). *"Society must be defended": Lectures at the Collège de France 1975-76*. Picador.

Foucault, M. (2004a). *Death and the labyrinth: The world of Raymond Roussel* (C. Ruas, Trans.). Continuum.

Foucault, M. (2004b). *Naissance de la biopolitique. Cours au Collège de France (1978-1979)*. Éditions Gallimard.

Foucault, M. (2004c). *Sécurité, territoire, population. Cours au Collège de France (1977-78)*. Éditions Gallimard.

Foucault, M. (2006). *Psychiatric power: Lectures at the College de France, 1973–1974* (G. Burchell, Trans.). Palgrave Macmillan.

Foucault, M. (2007a). *Security, territory, population: Lectures at the Collège de France, 1977-78* (G. Burchell, Trans.). Palgrave Macmillan. https://doi.org/10.1057/9780230245075

Foucault, M. (2007b). What is critique? (L. Hochroth & C. Porter, Trans.). In S. Lotringer (Ed.), *The politics of truth* (pp. 41-81). Semiotext(e).

Foucault, M. (2008a). *The birth of biopolitics: Lectures at the Collège de France, 1978-79*. Palgrave Macmillan. https://doi.org/10.1057/9780230594180

Foucault, M. (2008b). *Introduction to Kant's anthopology* (K. Briggs, Trans.; R. Nigro, Ed.) [Posthumous publication]. Semiotext(e).

Foucault, M. (2014). *Wrong-doing, truth telling: The function of avowal in justice*. The University of Chicago Press.

Foucault, M. (2019). *Discourse & truth and Parresia* (N. Luxon, Trans.; H. Fruchaud & D. Lorenzini, Eds.). University of Chicago Press.

Francis, R. (2013). *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary*. Mid Staffordshire NHS Foundation Trust Public Inquiry. http://webarchive.nationalarchives.gov.uk/20150407084003/http://www.midstaffspublicinquiry.com/report

Frederiksen, K., Lomborg, K., & Beedholm, K. (2015). Foucault's notion of problematization: A methodological discussion of the application of Foucault's later work to nursing research. *Nursing Inquiry*, *22*(3), 202-209. https://doi.org/10.1111/nin.12094

French, S., Old, A., & Healy, J. (2001). *Health care systems in transition: New Zealand*. The European Observatory on Health Care Systems, World Health Organisation. http://www.euro.who.int/__data/assets/pdf_file/0008/95138/E74467.pdf?ua=1

Garland, D. (2014). What is a ‘‘history of the present’’? On Foucault's genealogies and their critical preconditions. *Punishment and Society*, *16*(4), 365-384. https://doi.org/10.1177/1462474514541711

Gauld, R. (1999). Beyond New Zealand's dual health reforms. *Social Policy & Administration*, *33*(5), 567-585.

Gauld, R. (2009a). *The new health policy*. Open University Press.

Gauld, R. (2009b). *Revolving doors* (2nd ed.). Health Services Research Centre Institute of Policy Studies, Victoria University of Wellington.

Gauld, R. (Ed.). (2013). *Governance of the New Zealand health system* [PowerPoint slides]. Institute of Public Administration New Zealand. https://ipanz.org.nz/Folder?Action=View%20File&Folder_id=84&File=Robin%20Gould:%20Gov%20of%20NZ%20Health%20System.pdf.

Gauld, R., & Horsburgh, S. (2012). *Clinical governance assessment project: Final report on a national health professional survey and site visits to 19 New Zealand DHBs.* Centre for Health Systems, University of Otago. http://m.nzdoctor.co.nz/media/2098290/cgap-final-report.pdf

Gauld, R., & Horsburgh, S. (2015). Are some health professionals more cognizant of clinical governance development concepts than others? Findings from a New Zealand study. *Journal of Public Health*. https://doi.org/10.1093/pubmed/fdv045

Gauld, R., & Horsburgh, S. (2017). *Health professional perceptions of clinical governance and the quality and safety environment in New Zealand DHBs: Report on the 2017 national survey* [Report to HQSC. April, 2018]. https://www.otago.ac.nz/healthsystems/projects/publications/otago690608.pdf

Gauld, R., & Horsburgh, S. (2020). Did healthcare professional perspectives on the quality and safety environment in New Zealand public hospitals change from 2012 to 2017? *Journal of Health Organization and Management*, *34*(7). https://doi.org/10.1108/JHOM-11-2019-0331

Germov, J. (2007). Imagining health problems as social issues. In B. Deed (Ed.), *Health in the context of Aotearoa New Zealand*. Oxford University Press.

Gibbs, G. R. (2015). *Discourse analysis part 2: Foucauldian approaches* [Video lecture]. University of Huddersfield. https://www.youtube.com/watch?v=E_ffCsQx2Cg

Gordon, B. (1990). Clinical affiliation – a learning experience. [From Journal of New Zealand Association of Occupational Therapy. 26(2)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 47-48. (Original work published 1976)

Gordon, B., Riordan, S., Scaletti, R., & Creighton, N. (Eds.). (2009). *Legacy of occupation: Stories of occupational therapy in New Zealand 1940-1972*. The Bush Press.

Gottwald, M., & Lansdown, G. E. (2014). *Clinical governance: Improving the quality of healthcare for patients and service users*. Open University Press.

Graham, L. J. (2005). *Discourse analysis and the critical use of Foucault.* Paper presented at the Australian Association for Research in Education 2005 Annual Conference, Sydney. http://eprints.qut.edu.au/2689/1/2689.pdf

Grbich, C. (1999). *Qualitative research in health*. Sage.

Greckhamer, T., & Cilesiz, S. (2014). Rigor, transparency, evidence, and representation in discourse analysis: Challenges and recommendations. *International Journal of Qualitative Methods*, *13*(1), 422-443. https://doi.org/10.1177/160940691401300123

Guilfoyle, M. (2016). Subject positioning: Gaps and stability in the therapeutic encounter. *Journal of Constructivist Psychology*, *29*(2), 123-140. https://doi.org/10.1080/10720537.2015.1034815

Gutiérrez Monclus, P., & Pujol Tarrès, J. (2016). Occupational therapy: Autonomy, governmentality and subjectification [Doctoral research project, "Terapia Ocupacional: una disciplina para la autonomía. Prácticas y discursos de subjetividad y gubernamentalidad en torno a una ciencia emergente." English version retrieved 8 May 2021 from https://journals.openedition.org/revestudsoc/9951]. *Revista de Estudios Sociales*(57), 68-77. https://doi.org/10.7440/res57.2016.05

Gutting, G. (1989). *Michel Foucault's archaeology of scientific reason*. Cambridge University Press. https://doi.org/10.1017/CBO9781139172141

Gutting, G. (1990). Foucault's genealogical method. *Midwest Studies in Philosophy*, *15*, 327-343. https://doi.org/10.1111/j.1475-4975.1990.tb00221.x

Gutting, G. (2001). *French philosophy in the twentieth century*. Cambridge University Press. https://doi.org/10.1017/CBO9780511806902

Gutting, G. (Ed.). (2003). *The Cambridge companion to Foucault* (2nd ed.). Cambridge University Press. https://doi.org/10.1017/CCOL9780521403320.

Gutting, G. (2005). *Foucault: A very short introduction*. Oxford University Press.

Gutting, G. (2011). *Thinking the impossible: French philosophy since 1960*. Oxford University Press.

Gutting, G., & Oksala, J. (2018). *Michel Foucault*. Metaphysics Research Lab, Stanford University. Retrieved 20 November, 2020, from https://plato.stanford.edu/archives/spr2019/entries/foucault/

Hacking, I. (2006). Foreword. J. Khalfa, Ed. & Trans. In *History of madness* (pp. ix-xii). Routledge.

Hall, S. (2013). The work of representation. In S. Hall, J. Evans, & S. Nixon (Eds.), *Representation: Cultural representations and signifying practices* (pp. 1-47). Sage.

Hammell, K. W. (2015). If human health is impacted by occupational opportunities (and it is), what are we doing about poverty? *Occupational Therapy Now*, *17*(5). https://www.caot.ca/document/7347/OTNow_Sept_15.pdf

Harding, A. (1990). Then and now [Excerpt from Journal of New Zealand Occupational Therapy Association, 24(1)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 37-38. (Original work published 1973)

Hardy, N. (2010). Foucault, genealogy, emergence: Re-examining the extra-discursive. *Journal for the Theory of Social Behaviour*, *41*(1), 69-91. https://doi.org/10.1111/j.1468-5914.2010.00446.x

Havis, D. (2014). Discipline. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 110-119). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

Haworth, N. A., & Macdonald, E. M. (1946). *The theory of occupational therapy* (3rd ed.). Balliere, Tindall.

Haxby, E., Hunter, D., & Jaggar, S. (2010). *An introduction to clinical governance and patient safety*. Oxford University Press.

Hayes Fleming, M., & Mattingly, C. (1994). The underground practice. In C. Mattingly & M. Hayes Fleming (Eds.), *Clinical reasoning: Forms of inquiry in a therapeutic practice* (pp. 295-315). F. A. Davis Company.

Hayward, J. (2012a). *Biculturalism: Story summary*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 25 December, 2020, from https://teara.govt.nz/en/biculturalism

Hayward, J. (2012b). *Biculturalism. Page 1. From bicultural to monocultural, and back*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 25 December, 2020, from https://teara.govt.nz/en/biculturalism/page-1

Hazeldine, C. (1980). *The history of occupational therapy in New Zealand* [Unpublished paper]. Central Institute of Technology, School of Occupational Therapy. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington.

Health and Disability Services (Safety) Act 2001. https://www.legislation.govt.nz/act/public/2001/0093/latest/whole.html#DLM119975

Health Navigator New Zealand. (2021). *Patient and person-centred care*. Health Navigator Charitable Trust. Retrieved 26 January 2021, from https://www.healthnavigator.org.nz/clinicians/p/patient-centred-care/#Overview

Health Practitioners Competence Assurance Act 2003. https://www.legislation.govt.nz/act/public/2003/0048/latest/whole.html#DLM203312

Health Quality & Safety Commission. (2017). *Clinical governance: Guidance for health and disability providers*.

Health Quality & Safety Commission. (2021a). *Mō mātou. About us*. Retrieved 24 January 2021, from https://www.hqsc.govt.nz/our-programmes/building-leadership-and-capability/about-us/

Health Quality & Safety Commission. (2021b). *Putanga me ngā rauemi. Publications & resources*. Retrieved 24 January 2021, from https://www.hqsc.govt.nz/our-programmes/building-leadership-and-capability/publications-and-resources/

Heap, N. (2019). *A contestable professional development fund: Interpretations of the applicant experience* [Master of Health Science, AUT]. http://hdl.handle.net/10292/12208

Hook, D. (2001a). Discourse, knowledge, materiality, history: Foucault and discourse analysis. *Theory and Psychology*, *11*(4), 521-547. https://doi.org/10.1177/0959354301114006

Hook, D. (2001b). The 'disorders of discourse'. *Theoria: A Journal of Social and Political Theory*, *48*(97), 41-68. http://www.jstor.org/stable/41802158

Hook, D. (2005). Genealogy, discourse, 'effective history': Foucault and the work of critique. *Qualitative Research in Psychology*, *2*(1), 3-31. https://doi.org/10.1191/1478088705qp025oa

Inman, M. (1940). Occupational therapy. *The New Zealand Nursing Journal*, *XXXIII*(11), 354-355.

Institute for Healthcare Improvement. (2021). *Initiatives: The IHI Triple Aim*. Retrieved 24 January 2021, from http://www.ihi.org/Engage/Initiatives/TripleAim/Pages/default.aspx

Inter-DHB Working Group. (2004). *Health Practitioners Competency Assurance Act: Policy development guidelines for DHBs* [Unpublished].

Johnson, F. (1945). *War experience as the occupational therapist with the 4th New Zealand general hospital, New Caledonia* [Unpublished memoir. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington].

Johnston, R. J., Gregory, D., & Smith, D. M. (Eds.). (1994). *The dictionary of human geography* (3rd ed.). Blackwell.

Kate Malcomess Consultancy Limited. (2016). *Care aims: well-being, outcomes, collaborative*. Retrieved 22 January 2021, from https://careaims.com

Kelly, M. (2014). *Foucault and politics: A critical introduction*. Edinburgh University Press.

Kelly, M. (2016). *The internet encyclopedia of philosophy: Michel Foucault (1926-1984)*. The Internet Encyclopedia of Philosophy. Retrieved 28 December, 2020, from http://www.iep.utm.edu/foucault/

Kendall, G., & Wickham, G. (1999). *Using Foucault's methods*. Sage.

Kielhofner, G. (2004). *Conceptual foundations of occupational therapy*. F. A. Davis.

King, A. (2000). *The New Zealand health strategy*. Ministry of Health, New Zealand Government. https://www.health.govt.nz/system/files/documents/publications/newzealandhealthstrategy.pdf

King, A. (2001). *Quality improvement strategy for health sector* [Press release]. https://www.beehive.govt.nz/release/quality-improvement-strategy-health-sector

King, A. (2004). *ASMS annual conference: Achieving clinical leadership*. Ministry of Health, New Zealand Government. https://www.beehive.govt.nz/speech/asms-annual-conference-achieving-clinical-leadership

King, M. (2003). *The Penguin history of New Zealand*. Penguin Books.

Kooji, H. (2014). Object formation and subject formation: The innovation campus in the Netherlands. *Planning Theory*, 1-21. https://doi.org/10.1177/1473095214527278

Koopman, C. (2013). *Genealogy as critique: Foucault and the problems of modernity*. Indiana University Press.

Koopman, C. (2014). Problematization. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 399-403). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

Koopman, C. (2019). *How we became our data*. University of Chicago Press.

Kreis, S. (2012). *Nietzsche, Dionsus and Apollo*. Steven Kreis. The History Guide. Retrieved 29 December, 2020, from http://www.historyguide.org/europe/dio_apollo.html

Lambie, M. (1956). *My story: Memoirs of a New Zealand nurse*. N. M. Peryer Limited.

Laugesen, M., & Gauld, R. (2012). *Democratic governance and health: Hospitals, politics and health policy in New Zealand*. Otago University Press.

Law, M., Baptiste, S., Carswell, A., McColl, M. A., Polatajko, H., & Pollock, N. (2005). *Canadian Occupational Performance Measure* (4th ed.). CAOT Publications ACE.

Lemke, T. (2001a). "The birth of bio-politics" – Michel Foucault's lecture at the Collège de France on neo-liberal governmentality. *Economy and Society*, *30*(2). https://doi.org/10.1080/03085140120042271

Lemke, T. (2001b, September 21-24, 2000). *Foucault, governmentality, and critique.* Paper presented at the Rethinking Marxism Conference, University of Amherst (MA). http://www.thomaslemkeweb.de/publikationen/Foucault,%20Governmentality,%20and%20Critique%20IV-2.pdf

Lemke, T. (2019). *Foucault's analysis of modern governmentality: A critique of political reason*. Verso.

Lincoln, Y., & Guba, E. (1985). Establishing trustworthiness. In *Naturalistic inquiry*. Sage.

Little, A., & Henare, P. (2021). *Building a New Zealand health service that works for all New Zealanders [Beehive speech]*. https://www.beehive.govt.nz/speech/building-new-zealand-health-service-works-all-new-zealanders

London, M. (2011). Lifelong learning: Introduction. In M. London (Ed.), *The Oxford handbook of lifelong learning*. https://doi.org/10.1093/oxfordhb/9780195390483.013.0013

Lorenzini, D. (2015). What is a 'regime of truth'? *Le Foucaldien*, *1*(1). https://doi.org/10.16995/lefou.2

Lorenzini, D. (2018). Governmentality, subjectivity, and the neoliberal form of life. *Journal for Cultural Research*, *22*(2), 154-166. https://doi.org/10.1080/14797585.2018.1461357

Lynch, R. (2014). Foucault's theory of power. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 13-26). Routledge.

Maani, K., & Cavana, R. Y. (2007). *Systems thinking, system dynamics: Managing change and complexity* (2nd ed.). Pearson Education New Zealand.

Macdonald, E. M. (1960). *Occupational therapy in rehabilitation. A handbook for occupational therapists and others interested in this aspect of rehabilitation*. Balliere, Tindall.

MacDonnell, D. (1986). *Theories of discourse: An introduction*. Basil Blackwell.

Mackey, H. (2011). Foucault, power and professional identities. In F. Kronenberg, N. Pollard, & D. Sakellariou (Eds.), *Occupational therapy without borders. Volume 2: Towards an ecology of occupation-based practices* (pp. 133-141). Churchill Livingstone Elsevier.

Malcolm, L., Wright, L., Barnett, P., & Hendry, C. (2002a). *Clinical leadership and quality in District Health Boards in New Zealand*. Clinical Leaders Association of New Zealand. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/82544E2F11F29181CC256D48007CFBF9/$file/DHBsqualrptfinal.pdf

Malcolm, L., Wright, L., Barnett, P., & Hendry, C. (2002b). *Clinical leadership and quality in primary care organisations in New Zealand*. Clinical Leaders Association of New Zealand. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/C061A4D9C9E9471ACC257833007AD61E/$file/PCOqualrptfinal.pdf

Malcomess, K. (2005). *Care Aims Model: Presentation to occupational therapists WDHB*, Waitematā DHB.

Maling, J. (1944). *Occupational thesis* [Unpublished thesis]. Queen Mary Hospital, Hanmer Springs.

Mambrol, N. (2016). *Saussurean structuralism*. Nasrullah Mambrol - Literariness.org. Retrieved 20 November, 2020, from https://literariness.org/2016/03/20/saussurean-structuralism/

Mann, J. (1994). A gentle introduction to structuralism, postmodernism, and all that. *Philosophy Now*, *10*(Autumn). https://philosophynow.org/issues/10/A_Gentle_Introduction_to_Structuralism_Postmodernism_And_All_That

Marahey, S. (2000). *Social welfare in New Zealand. Address by the Minister of Social Services and Employment*. https://www.beehive.govt.nz/speech/social-welfare-new-zealand

Mattingly, C., & Hayes Fleming, M. (1994a). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. F. A. Davis Company.

Mattingly, C., & Hayes Fleming, M. (1994b). Interactive reasoning: Collaborating with the person. In C. Mattingly & M. Hayes Fleming (Eds.), *Clinical reasoning: Forms of inquiry in a therapeutic practice* (pp. 178-196). F. A. Davis Company.

Mauriora. (n. d.). *Treaty of Waitangi: Maori history and health (video transcript)*. Mauriora Health Education Research,. Retrieved 29 November, 2020, from https://members.mauriora.co.nz/video-transcript-maori-history-and-health-2/

May, T. (2014a). Governmentality. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 175-181). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

May, T. (2014b). Subjectification. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 496-501). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

May, T., & McWhorter, L. (2016). Who's being disciplined now? Operations of power in a neoliberal world. In V. Cisney & N. Morar (Eds.), *Biopower: Foucault and beyond* (pp. 245-258). University of Chicago Press, Ltd.

McGregor, S. (2001). Neoliberalism and health care. *International Journal of Consumer Studies*, *25*(2), 82-89. https://doi.org/10.1111/j.1470-6431.2001.00183.x

McHoul, A., & Grace, W. (1998). *A Foucault primer. Discourse, power and the subject.* University of Otago Press.

McNay, L. (1994). *Foucault: A critical introduction*. Polity Press.

McQuillan, C. (2010). Philosophical archaeology in Kant, Foucault and Agamben. *Parrhesia*(10), 39-49. http://www.parrhesiajournal.org/parrhesia10/parrhesia10_mcquillan.pdf

McSherry, R., & Pearce, P. (2011). *Clinical governance: A guide to implementation for healthcare professionals* (3rd ed.). Blackwell Publishing Ltd.

Mendieta, E. (2014). Biopower. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 44-49). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

Miller, P., & Rose, N. (2008). *Governing the present*. Polity Press.

Mills, S. (2003). *Michel Foucault*. Routledge.

Mills, S. (2004). *Discourse* (2nd ed.). Routledge.

Minister of Health. (2009). *Implementing the New Zealand Health Strategy 2009*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/implementing-nzhs-2009.pdf

Minister of Health. (2016a). *New Zealand health strategy: Future direction*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-futuredirection-2016-apr16.pdf

Minister of Health. (2016b). *New Zealand health strategy: Roadmap of actions 2016*. Ministry of Health. https://www.health.govt.nz/system/files/documents/publications/new-zealand-health-strategy-roadmapofactions-2016-apr16.pdf

Ministry for Culture and Heritage. (2014). *New Zealand and the United Nations*. Retrieved 30 November, 2020, from https://nzhistory.govt.nz/politics/new-zealand-and-the-united-nations

Ministry for Culture and Heritage. (2020). *Treaty of Waitangi*. Retrieved 29 November, 2020, from https://mch.govt.nz/treatyofwaitangi

Ministry of Health. (2001). *Discussion paper: Quality improvement strategy for public hospitals*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/70EEC585421E63AFCC25770B0071B0C3/$file/Quality-improvement-strategy-for-public-hospitals-discussion-doc.pdf

Ministry of Health. (2002a). *He korowai oranga. Māori health strategy*. https://www.health.govt.nz/system/files/documents/publications/mhs-english.pdf

Ministry of Health. (2002b). *Te pai me te oranga o ngā iwi. Health for all people*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/7F8B7A230A0B22E2CC256BA60072D1BA/$file/TEPAIMETEORANGA.pdf

Ministry of Health. (2002c). *Toward clinical excellence: An introduction to clinical audit, peer review and other clinical practice improvements*. https://www.health.govt.nz/system/files/documents/publications/moh_tce_2002.pdf

Ministry of Health. (2003a). *Improving Quality (IQ): A systems approach for the New Zealand health and disability sector*. https://www.health.govt.nz/system/files/documents/publications/improvingqualitysystemsapproach.pdf

Ministry of Health. (2003b). *New Zealand health and disability sector overview*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/283a543d960a798bcc256e4b007d4c40/$FILE/NewZealandHealthAnOverviewJuly03.pdf

Ministry of Health. (2011). *Primary health organisations*. Retrieved 25 December, 2020, from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/primary-health-organisations

Ministry of Health. (2012). *Equipment and Modification Services - Evaluation of the Prioritisation Tool pilot* [Summary of findings and recommendations of the report prepared by Synergia Limited - October 2011].

Ministry of Health. (2014a). *Equipment and Modification Services. Equipment manual*. https://www.health.govt.nz/system/files/documents/pages/equipment-manual-nov2014.pdf

Ministry of Health. (2014b). *The guide to he korowai oranga: Māori health strategy 2014*. https://www.health.govt.nz/system/files/documents/publications/guide-to-he-korowai-oranga-maori-health-strategy-jun14-v2.pdf

Ministry of Health. (2014c). *Treaty of Waitangi principles*. Retrieved 29 December, 2020, from http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga/strengthening-he-korowai-oranga/treaty-waitangi-principles

Ministry of Health. (2016). *Funding: Vote health funding allocation*. Retrieved 23 December, 2020, from https://www.health.govt.nz/new-zealand-health-system/overview-health-system/funding

Ministry of Health. (2018). *Background for the New Zealand health and disability system review 2018*.

Ministry of Health. (2019). *Equipment and Modification Services (EMS): Changes to the Prioritisation Tool and introduction of the EMS portal*. https://www.disabilityfunding.co.nz/__data/assets/pdf_file/0008/169289/Communication-to-EMS-Assessors-re-EMS-Portal-February-2019.pdf

Ministry of Health. (2020). *District health boards (2020)*. Retrieved 18 November, 2020, from https://www.health.govt.nz/new-zealand-health-system/key-health-sector-organisations-and-people/district-health-boards

Mirams, S. (1972). Untitled. *Occupational Therapy*, *23*(1), 9.

Molineux, M. (2010). The nature of occupation. In M. Curtin, M. Molineux, & J. Supyk-Mellson (Eds.), *Occupational therapy and physical dysfunction: Enabling occupation*. Churchill Livingstone.

Molyneux, R. (2006). *Evaluation quality action plan 2006. Occupational therapy* [Unpublished internal draft].

Morris, A. (1990). Occupational therapist workforce [From New Zealand Journal of Occupational Therapy 30(2)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 53. (Original work published 1979)

Morris, M., & Patton, P. (Eds.). (1979). *Michel Foucault: Power, truth, strategy*. Feral Publications.

Mueller, J., & Neads, P. (2005). Allied health and organisational structure: massaging the organisation to facilitate outcomes. *New Zealand Journal of Physiotherapy*, *33*(2), 48-54.

Murphy, T. (2006). *Te pumaomao: Nationhood-relationship building* [Course book]. Te Pumaomao Nation Building Seminars.

National 20 DHB Talent Management and Leadership Development Group. (2018). *A shared approach to developing our people. A resource to guide implementation of the State Services Commission Talent and Leadership Framework in District Health Boards*. https://tas.health.nz/assets/Workforce/3b-A-Shared-Approach-to-Developing-Our-People.pdf

National Advisory Group on the Safety of Patients in England. (2013). *A promise to learn – a commitment to act. Improving the safety of patients in England* [The Berwick Report]. Department of Health (UK). https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/226703/Berwick_Report.pdf

National Health Committee. (2001). *Safe systems supporting safe care: A discussion document on quality improvement in health care*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/BFFAFC4D01038BDCCC256AE00079798B/$file/Safe-systems-supporting-safe-care.pdf

National Health Committee. (2002). *Safe systems supporting safe care: Final report on health care quality improvement in New Zealand*. https://www.moh.govt.nz/notebook/nbbooks.nsf/0/EA63030373205199CC256BD7000CEB3A/$file/SafeSystemsSupportingSafeCare.pdf

National Library of New Zealand. (n. d.). *Buchanan, Henry Meredith (Dr), 1887-1974*. Retrieved 30 November, 2020, from https://natlib.govt.nz/records/22572868

A new practice: Treatment of returned men. (1941, May 9th). *Evening Post*. https://paperspast.natlib.govt.nz/newspapers/EP19410509.2.83?items_per_page=10&query=occupational+therapy&snippet=true&title=EP

New Zealand Guidelines Group. (2003). *Best practice evidence-based guideline: Assessment processes for older people*. https://www.health.govt.nz/system/files/documents/publications/assess_processes_gl.pdf

New Zealand Health and Disability System Review. (2020). *Health and disability system review - Final report - Pūrongo whakamutunga.* https://www.systemreview.health.govt.nz/assets/Uploads/hdsr/health-disability-system-review-final-report.pdf

New Zealand Health Information Service. (2004). *Occupational therapy workforce. Summary results from the 2004 health workforce annual survey*. Ministry of Health. https://www.health.govt.nz/system/files/documents/pages/occupational-therapy-2004.pdf

New Zealand Health Information Service. (2007). *Occupational therapists workforce. Summary results from the 2007 health workforce annual survey*. Ministry of Health. https://www.health.govt.nz/system/files/documents/pages/occupational-therapists-2007.pdf

New Zealand Health Information Service. (2008). *Occupational therapists workforce. Summary results from the 2008 health workforce annual census*. Ministry of Health. https://www.health.govt.nz/system/files/documents/pages/occ-therapy-workforce-results-2008-survey.pdf

New Zealand Occupational Therapy Board. (1990). *Competencies for registration as an occupational therapist*.

New Zealand Parliament. (2009). *New Zealand health system reforms*. Retrieved 24 December 2020, from https://www.parliament.nz/en/pb/research-papers/document/00PLSocRP09031/new-zealand-health-system-reforms

New Zealand Public Health and Disability Act 2000. http://legislation.govt.nz/act/public/2000/0091/latest/whole.html

New Zealand Public Health and Disability Amendment Act 2010. https://www.legislation.govt.nz/act/public/2010/0118/32.0/DLM2901027.html

New Zealand. Health innovation awards. (2003). *International Journal of Health Care Quality Assurance*, *16*(6). https://doi.org/10.1108/ijhcqa.2003.06216fab.014

Nicholls, D. A. (2008). Putting Foucault to work: An approach to the practical application of Foucault's methodological imperatives. *Aporia*, *1*(1), 30-40. http://hdl.handle.net/10292/1792

Nicholls, S., Cullen, R., O'Neill, S., & Halligan, A. (2000). Clinical governance: Its origins and its foundations. *British Journal of Clinical Governance*, *5*(3), 172-178. https://doi.org/10.1108/14777270010734055

O'Farrell, C. (1989). *Foucault: Historian or philosopher?* The Macmillan Press Ltd.

O'Farrell, C. (2005a). Appendix 2: Key concepts in Foucault's work. In *Michel Foucault* (pp. 129-161). Sage.

O'Farrell, C. (2005b). *Michel Foucault*. Sage.

O'Farrell, C. (2021). *Michel Foucault: Key concepts - archaeology*. Retrieved 21 March 2021, from https://michel-foucault.com/key-concepts/

O'Leary, T., & Falzon, C. (Eds.). (2010). *Foucault and philosophy*. Wiley-Blackwell.

O'Malley, P. (1996). Risk and responsibility. In A. Barry, T. Osborne, & N. Rose (Eds.), *Foucault and political reason* (pp. 189-207). Routledge.

O'Reilly, D., & Reed, M. (2011). The grit in the oyster: Professionalism, managerialism and leaderism as discourses of UK public services modernization. *Organization Studies*, *32*(8), 1079-1101. https://doi.org/10.1177/0170840611416742

Occupational Therapy Act, 1949. http://www.nzlii.org/nz/legis/hist_act/ota19491949n9252/

Occupational Therapy Board. (1950). *Minutes of meeting of the Occupational Therapy Board, held at the boardroom, Department of Health, Wellington on Thursday, 15th August 1950* [Meeting minutes]. Archived by OTBNZ.

Occupational Therapy Board. (1956). *Minutes of meeting of the Occupational Therapy Board, held at the boardroom, Department of Health, Wellington on Tuesday, 6th March 1956* [Meeting minutes]. Archived by OTBNZ.

Occupational Therapy Board. (1957). *Minutes of meeting of the Occupational Therapy Board, held at the boardroom, Department of Health, Wellington on Wednesday 18th September, 1957*. Archived by OTBNZ.

Occupational Therapy Board. (1958). *Minutes of meeting of the Occupational Therapy Board, held at the boardroom, Department of Health, Wellington on Wednesday 17th September 1958*. Archived by OTBNZ.

Occupational Therapy Board of New Zealand. (2004a). *Code of ethics for occupational therapists*.

Occupational Therapy Board of New Zealand. (2004b). *Competencies for registration as an occupational therapist*. http://www.otboard.org.nz/wp-content/uploads/2015/07/Competencies-for-Registration-2004.pdf

Occupational Therapy Board of New Zealand. (2004c). *Continuing competence framework for recertification: Practitioner handbook*.

Occupational Therapy Board of New Zealand. (2011). *Annual report 2011*. https://www.otboard.org.nz/wp-content/uploads/2015/04/2011-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2012). *Annual report 2012*. https://www.otboard.org.nz/wp-content/uploads/2015/04/2012-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2013). *Annual report 2013*. https://www.otboard.org.nz/wp-content/uploads/2015/04/2013-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2014). *Annual report 2014*. https://www.otboard.org.nz/wp-content/uploads/2015/04/2014-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2015a). *Annual report 2015*. https://www.otboard.org.nz/wp-content/uploads/2015/10/2015-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2015b). *Code of ethics for occupational therapists*. https://www.otboard.org.nz/wp-content/uploads/2015/04/CodeofEthics_April2015-1.pdf

Occupational Therapy Board of New Zealand. (2015c). *Competencies for registration and continuing practice*. https://www.otboard.org.nz/wp-content/uploads/2015/04/Competencies_April20151.pdf

Occupational Therapy Board of New Zealand. (2016a). *Annual report 2016*. https://www.otboard.org.nz/wp-content/uploads/2016/10/OTB-AOG-16831-Annual-Report-2016-v7-WEB.pdf

Occupational Therapy Board of New Zealand. (2016b). *Policy statement: ePortfolio audit policy. Reviewed June 2018*. https://www.otboard.org.nz/wp-content/uploads/2018/01/ePortfolio-Policy-June-2016.pdf

Occupational Therapy Board of New Zealand. (2017). *Annual report 2017*. https://www.otboard.org.nz/wp-content/uploads/2018/02/2017-Annual-Report.pdf

Occupational Therapy Board of New Zealand. (2018a). *Annual report 2018*. https://www.otboard.org.nz/wp-content/uploads/2018/11/Annual-report-2018.pdf

Occupational Therapy Board of New Zealand. (2018b). *What do we do?* Retrieved 27 December, 2020, from https://www.otboard.org.nz/what-do-we-do/

Occupational Therapy Board of New Zealand. (2018c). *What is the Occupational Therapy Board of New Zealand (OTBNZ)?* Retrieved 27 December, 2020, from https://www.otboard.org.nz

Occupational Therapy Board of New Zealand. (2018d). *Your requirement to be competent and fit to practice*. Retrieved 18 November, 2020, from https://www.otboard.org.nz/your-requirement-to-be-competent-and-fit-to-practise/

Occupational Therapy Board of New Zealand. (2019a). *Annual report 2019*. https://www.otboard.org.nz/wp-content/uploads/2019/11/Annual-Report-2019.pdf

Occupational Therapy Board of New Zealand. (2019b). *The Occupational Therapy Board of New Zealand's use of professional supervision as a condition on scope of practice*. https://www.otboard.org.nz/wp-content/uploads/2019/05/Supervision-as-standard-condition-on-scope-of-practice-FINAL.pdf

Occupational Therapy Board of New Zealand. (2020a). *Annual report 2020*. https://www.otboard.org.nz/wp-content/uploads/2020/09/OTBNZ_Annual-Report-2020_FINAL_WEB_21-Sept.pdf

Occupational Therapy Board of New Zealand. (2020b). *Supervision requirements for occupational therapists practising in Aotearoa New Zealand*. https://www.otboard.org.nz/wp-content/uploads/2018/01/Supervision-Requirements-for-Occupational-Therapists.pdf

Occupational Therapy Board of New Zealand. (n.d.). *Complaint process outline*. https://www.otboard.org.nz/wp-content/uploads/2015/04/OTBNZ-Complaint-Process-Outline-Final.pdf

Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa. (2015). *OTNZ - WNA Te Tiriti/Treaty relationship governance model*. Retrieved 25 May 2021, from https://www.otnz.co.nz/occupational-therapy/te-tiriti-treaty-relationship-governance-model/

Occupational Therapy New Zealand - Whakaora Ngangahau Aotearoa. (2021). *What is occupational therapy?* Retrieved 8 March 2021, from https://www.otnz.co.nz/occupational-therapy/what-is-occupational-therapy/

Office for Disability Issues. (2016). *New Zealand disability strategy 2016-2026*. Ministry of Social Development. https://www.odi.govt.nz/assets/New-Zealand-Disability-Strategy-files/pdf-nz-disability-strategy-2016.pdf

Office of War Information. (1942). *The United Nations fight for the Four Freedoms: The rights of all men – everywhere*. United States Federal Government.

Oksala, J. (2011). Sexual experience: Foucault, phenomenology, and feminist theory. *Hypatia*, *26*(1 (Winter)), 207–223. https://doi.org/10.1111/j.1527-2001.2010.01153.x

Oksala, J. (2012). Post-tructuralism: Michel Foucault. In S. Luft & S. Overgaard (Eds.), *Routledge companion to phenomenology* (pp. 258-259). Routledge.

Olssen, M. (2003). Structuralism, post-structuralism, neo-liberalism: Assessing Foucault's legacy. *Journal of Education Policy*, *18*(2), 189-202. https://doi.org/10.1080/0268093022000043047

Olssen, M. (2006). Understanding the mechanisms of neoliberal control: Lifelong learning, flexibility and knowledge capitalism. *International Journal of Lifelong Education*, *25*(3). https://doi.org/10.1080/02601370600697045

Olssen, M. (2014). Discourse, complexity, normativity: Tracing the elaboration of Foucault's materialist concept of discourse. *Open Review of Educational Research*, *1*(1), 28-55. https://doi.org/10.1080/23265507.2014.964296

Onie, R. (2012). *What if our healthcare system kept us healthy?* [Video]. https://www.ted.com/talks/rebecca_onie_what_if_our_healthcare_system_kept_us_healthy

Orton, Y. (2013). *How occupational therapists in Aotearoa/New Zealand have taken up ideas in the international occupational therapy literature* [MHSc., AUT]. Auckland.

Oxford English Dictionary. (1989). *Philosophy*. Oxford University Press. Retrieved November 20th, 2020, from https://www-oed-com.ezproxy.aut.ac.nz/view/Entry/142505?rskey=ZvQwbG&result=1#

Palmer, D. (1997). *Structuralism and post structuralism for beginners*. For Beginners LLC.

Parahi, C. (2020, 16 June 2020). *The Māori Health Authority plan that divided health review panel*. Stuff. Retrieved 10 May 2021, from https://www.stuff.co.nz/national/health/300035517/the-mori-health-authority-plan-that-divided-health-review-panel

Paras, E. (2006). *Foucault 2.0: Beyond power and knowledge*. Other Press.

Parker, I. (1992). *Discourse dynamics. Critical analysis for social and individual psychology*. Routledge.

Patton, P. (1979). Of power and prisons. In M. Morris & P. Patton (Eds.), *Michel Foucault: Power, truth, strategy* (pp. 109-147). Feral Publications.

Patton, P. (2014). Technology (of discipline, governmentality and ethics). In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 503-508). Cambridge University Press.

Patton, P. (2016). Power and biopower in Foucault. In V. M. Cisney & N. Morar (Eds.), *Biopower: Foucault and beyond* (pp. 102-117). University of Chicago Press.

Penalver, P. (1994). Archaeology, history, deconstruction: Foucault's thought and the philosophical experience. In R. Miguel-Alfonso & S. Caporale-Bizzini (Eds.), *Postmodern studies. Reconstructing Foucault: Essays in the wake of the 80's* (Vol. 10). Rodopi.

Peters, M. (1999). (Posts-) modernism and structuralism: Affinities and theoretical innovations. *Sociological Research Online*, *4*(3). http://www.socresonline.org.uk/4/3/peters.html

Phillips, C., Pearce, C., Hall, S., Travaglia, J., De Lusignan, S., Love, T., & Kljakovic, M. (2010). Can clinical governance deliver quality improvement in Australian general practice and primary care? A systematic review of the evidence. *The Medical Journal of Australia*, *193*(10), 602-607. https://doi.org/10.5694/j.1326-5377.2010.tb04071.x

Phillips, J. (2011). *Class*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 25 May 2021, from https://teara.govt.nz/en/class/print

Piper, D. (2017). Experiencing patient's struggles all part of hospital empathy zone in Auckland. *Stuff*. Retrieved November 19th, 2020, from https://www.stuff.co.nz/national/health/92033294/experiencing-patients-struggles-all-part-of-hospital-empathy-zone-in-auckland

Pollard, N., Sakellariou, D., & Kronenberg, F. (Eds.). (2009). *A political practice of occupational therapy*. Churchill Livingstone.

Portillo, M. (1998). The Bevan legacy. *BMJ*. https://doi.org/10.1136/bmj.317.7150.0

Poster, M. (1982). Foucault and history. Social research. *Modern Masters*, *49*(1), 116-142. https://www.jstor.org/stable/40970855

Powers, P. (2001). *The methodology of discourse analysis*. Jones and Bartlett Publishers.

Powers, P. (2007). The philosophical foundations of Foucaultian discourse analysis. *Critical Approaches to Discourse Analysis Across Disciplines*, *1*(2), 18-34. http://www.lancaster.ac.uk/fass/journals/cadaad/volume-1-2/

Quinn, R. (2021). *Major health sector shake-up: DHBs scrapped and new Māori Health Authority announced*. RNZ. Retrieved 8 May 2021, from https://www.rnz.co.nz/news/political/440903/major-health-sector-shake-up-dhbs-scrapped-and-new-maori-health-authority-announced

Quiroga, V. (1995). *Occupational therapy: The first 30 years 1900 to 1930*. American Occupational Therapy Association.

Rabinow, P. (Ed.). (1984). *The Foucault reader*. Penguin Books.

Raskin, J. (1984). A last interview with French philosopher Michel Foucault. *City Paper*, *8*(3), 18. https://progressivegeographies.files.wordpress.com/2015/05/foucault-1984-a-last-interview-with-french-philosopher-michel-foucault.pdf

Redfern, M., Keeling, J., & Powell, E. (2000). *Royal Liverpool Children's Inquiry: Report*. The Stationery Office Ltd. https://www.gov.uk/government/publications/the-royal-liverpool-childrens-inquiry-report

Reed, K. (2008). *Resituating the meaning of occupation in the context of living* [Unpublished thesis]. Auckland University of Technology. https://openrepository.aut.ac.nz/handle/10292/398

Reed, K., & Sanderson, S. (1980). *Concepts of occupational therapy*. Williams & Wilkins.

Research. (n.d.). In *Cambridge Dictionary*. Cambridge University Press. https://dictionary.cambridge.org/dictionary/english/research

Revel, J. (2014). History. In L. Lawlor & J. Nale (Eds.), *The Cambridge Foucault lexicon* (pp. 187-199). Cambridge University Press. https://doi.org/10.1017/CBO9781139022309

Rice, G. (2011). *Epidemics*. Te Ara - The Encyclopaedia of New Zealand. Retrieved 29 November 2020, from https://teara.govt.nz/en/epidemics/print

Richardson, I., Ballin, A., Bruce, M., Cook, L., Durie, M., & Noonan, R. (1988a). *The April Report: Report of the Royal Commission on social policy. Te kōmihana a te karauna mō ngā āhuatanga-ā-iwi* (Vol. IV Social perspectives). The Royal Commission on Social Policy. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE17394709

Richardson, I., Ballin, A., Bruce, M., Cook, L., Durie, M., & Noonan, R. (1988b). *The April Report: Report of the Royal Commission on social policy. Te kōmihana a te karauna mō ngā āhuatanga-ā-iwi* (Vol. I New Zealand today). The Royal Commission on Social Policy. https://ndhadeliver.natlib.govt.nz/delivery/DeliveryManagerServlet?dps_pid=IE17394709

Rimke, H. M. (2000). Governing citizens through self-help literature. *Cultural Studies*, *14*(1), 61-78. https://doi.org/10.1080/095023800334986

Rivett, G. (2015). *National Health Service history: A guide to the NHS*. Retrieved 25 May 2021, from http://www.nhshistory.net/a_guide_to_the_nhs.htm

Robertson, L., Jeffrey, H., Reay, K., & Benfield, A. (2019). *Considering a new way to foster skills for evidence-based practice* [Otago Polytechnic research project]. Ako Aotearoa. https://ako.ac.nz/assets/Knowledge-centre/Teaching-occupational-therapy-students-how-to-integrate-evidence-for-better-clinical-outcomes/Considering-a-new-way-to-foster-skills-for-evidence-based-practice.pdf

Robson, B. (2007). Economic determinants of Māori health and disparities. In M. Bargh (Ed.), *Resistance: An indigenous response to neoliberalism* (pp. 45-61). Huia.

Rodgers, J. (1998). *Lambie, Mary Isabel*. Te Ara - The Encyclopedia of New Zealand. Retrieved 28 November, 2020, from https://teara.govt.nz/en/biographies/4l2/lambie-mary-isabel

Roosevelt, F. D. (1941). *State of the Union address to Congress, 1941: The Four Freedoms speech*. United States Federal Government. Retrieved 25 May 2021, from https://en.wikisource.org/wiki/The_Four_Freedoms_speech

Rose, N. (1996). Governing "advanced" liberal democracies. In A. Barry, T. Osbourne, & N. Rose (Eds.), *Foucault and political reason* (pp. 37-62). Routledge.

Rose, N. (1999). *Governing the soul: The shaping of the private self* (2nd ed.). Free Association Books.

Rosser, J. K. (1956). *A short history of occupational therapy in New Zealand. Compiled for the New Zealand Registered Occupational Therapists' Association Incorporated by the Honorary Editor of the Journal* [Typewritten submission. Published in Occupational Therapy Dec. 1956. NZAOT Archives]. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington.

Rosser, J. K. (1990). Occupational therapy in New Zealand [From Occupational Therapy 11(4)]. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 18-21. (Original work published 1956)

Roth, M. S. (1981). Foucault's "History of the present". *History and Theory*, *20*(1), 32-46.

Russell, E. (2021, 22 April). Health system reforms: Grieving families speak out on end of 'postcode lottery' care. *New Zealand Herald*. https://www.nzherald.co.nz/nz/health-system-reforms-grieving-families-speak-out-on-end-of-postcode-lottery-care/MJDDF6V4JX7EISSV4KNNTFFK6I/

Rutherford, F. (1972). *A brief history of the New Zealand School of Occupational Therapy, 1940-1972* [Unpublished history notes. NZAOT Archives]. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington.

Rutherford, F. (1976). *History of the New Zealand School of Occupational Therapy* [Typewritten unpublished paper. Nov. 1976. NZAOT Archives]. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington.

Ryle, J. (1996). *City of words: A visit to the Panopticon*. Retrieved 3 April 2021, from https://johnryle.com/?article=a-visit-to-the-panopticon

"A sacred duty". Disabled soldiers: Government's pledge. (1943, June 30th). *Evening Post*. https://paperspast.natlib.govt.nz/newspapers/EP19430630.2.18?items_per_page=10&page=3&query=occupational+therapy&snippet=true&title=EP#print

Saghafi, K. (1996). The "passion for the outside": Foucault, Blanchot, and exteriority. *International Studies in Philosophy*, *28*(4), 79-92.

Scally, G., & Donaldson, L. J. (1998). Clinical governance and the drive for quality improvement in the new NHS in England: . *BMJ*, *317*(7150), 61. https://doi.org/10.1136/bmj.317.7150.61

Schirato, T., Danaher, G., & Webb, J. (2012). *Understanding Foucault: A critical introduction* (2 ed.). Allen & Unwin.

Schwann, S., & Shapiro, A. (2011). *How to read Foucault's discipline and punish*. Pluto Press.

Scragg, J. (2003). A critique of the review of process concerning adverse medical events (The Cull Report). *Canterbury Law Review*, *9*. http://kirra.austlii.edu.au/nz/journals/CanterLawRw/2003/2.html

Sealey, C. (1999). Clinical governance: An information guide for occupational therapists. *British Journal of Occupational Therapy*, *62*(6), 263-268. https://doi.org/10.1177/030802269906200610

Searle, B. (1990). A unique experience. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 16.

Senellart, M. (2008). Course context. In A. Davidson (Ed.), *The birth of biopolitics: Lectures at the Collège de France, 1978-79*. Picador.

Servicemen's needs. (1943, March 29th). *Evening Post*. https://paperspast.natlib.govt.nz/newspapers/EP19430329.2.41

Silcock, E. M. (2018). *Street-level bureaucracy and occupational therapy practices in Aotearoa New Zealand. A genealogical critique* [PhD Thesis, University of Waikato]. Hamilton. https://hdl.handle.net/10289/12148

Silcock, E. M. (2020). Street-level decision making and practising with de-colonial intent: Practice is political action. *New Zealand Journal of Occupational Therapy*, *67*(3), 31-39.

Silcock, M., Campbell, M., & Hocking, C. (2016). How Western structures shape our practice: An analysis of the competencies for registration for occupational therapists in Aotearoa New Zealand 1990-2014. *New Zealand Journal of Occupational Therapy*, *63*(2), 4-12. https://www.otnz.co.nz/download/32/nzjot-archived/1177/volume-63-issue-02.pdf

Simmons Carlsson, C., & Herkt, J. (2012). *Supervision review report for the Occupational Therapy Board of New Zealand*. http://www.otboard.org.nz/wp-content/uploads/2014/12/Supervision-Review-Report-for-the-OTBNZ.pdf

Simon, J. K. (1971). A conversation with Michel Foucault. *Partisan Review*, *38*(2), 192-201.

Sinclair, K. (1959). *A history of New Zealand*. Penguin Books.

Skilton, H. (1981). *Work for your life*. Self-published. Hudlo Printers.

Skilton, H., Hobcraft, N., & Johnson, F. (1990). The first executive: Barton, Hobcraft, Johnson. *New Zealand Journal of Occupational Therapy: Commemorative Issue 1940-1990*, *41*(1), 8-12.

Smart, B. (1983). *Foucault, Marxism and critique* (Vol. 4). Routledge.

Smith, J. (2005). *Reports: The Shipman Inquiry 2002 - 2005*. UK Government Web Archive: The Shipman Inquiry. Retrieved 25 May 2021, from http://webarchive.nationalarchives.gov.uk/20090808154959/http:/www.the-shipman-inquiry.org.uk/reports.asp

Som, C. (2009). Sense making of clinical governance at different levels in NHS hospital trusts. *Clinical Governance: An International Journal*, *14*(2), 98-112. https://doi.org/http://dx.doi.org/10.1108/14777270910952252

Spencer, F. (1943). Rehabilitation, or applied occupational therapy. *The New Zealand Nursing Journal*, *XXXVI*(12), 281-284.

Staniland, K. (2009). A sociological ethnographic study of clinical governance implementation in one NHS Hospital Trust. *Clinical Governance: An International Journal*, *14*(4), 271-280. https://doi.org/10.1108/14777270911007782

Stanton Woods, R. (1946). Foreword. In *The theory of occupational therapy*. Balliere, Tindall.

Statistics New Zealand. (n. d.). *The New Zealand official year-book, 1960*. Retrieved 25 May 2021, from https://www3.stats.govt.nz/New_Zealand_Official_Yearbooks/1960/NZOYB_%201960.html#idchapter_1_45623

Stevenson, L. E. (2014). *Anxious times: A discourse analysis of women's and health professionals' constructions of the experience of breast cancer* [PhD Thesis, Auckland University of Technology]. Auckland. http://hdl.handle.net/10292/8444

Stokes, F., & Dixon, H. (2018). *The occupational therapist workforce: Making sense of the numbers*. Occupational Therapy Board of New Zealand. https://www.otboard.org.nz/wp-content/uploads/2018/10/OTB-18299-Making-sense-of-the-numbers-report-WEB.pdf

Stonehouse, D. (2013). *Clinical governance* [PowerPoint slides]. Slideshare.net. http://www.slideshare.net/stonehod/clinical-governance-16154899

Tamboukou, M. (1999). Writing genealogies: an exploration of Foucault's strategies for doing research. *Discourse: Studies in the Cultural Politics of Education*, *20*(2), 201-217. https://doi.org/10.1080/0159630990200202

Taylor, C. (2010). Biopower. In D. Taylor (Ed.), *Michel Foucault: Key concepts* (pp. 41-54). Acumen Publishing. https://doi.org/10.1017/UPO9781844654734.004

The Chief Medical Officer. (1999). *Clinical governance: Quality in the new NHS*. Department of Health. http://webarchive.nationalarchives.gov.uk/20130107105354/http:/www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4012043.pdf

These convalescent American servicemen in New Zealand are not aiming at R.A. standards. (1943, February 1st). *Evening Post*. https://paperspast.natlib.govt.nz/newspapers/EP19430201.2.71.2.1

Thompson, P. (2011). *A Foucauldian approach to discourse analysis*. Thompson, P. Retrieved 25 May 2021, from https://patthomson.net/2011/07/10/a-foucaldian-approach-to-discourse-analysis/

Thomson, G., & Gauld, R. (2001). Finding the unseen, listening to the unheard: Using primary sources for research in the New Zealand health sector. *Social Policy Journal of New Zealand*(17), 183-199.

Timus, G. (1946). Work at Makari chest hospital and Pleasant Valley sanatorium. *New Zealand Occupational Therapy Newsletter*(1).

Townsend, E. (1999). Enabling occupation in the 21st Century: Making good intentions a reality. *Australian Occupational Therapy Journal*, *46*(4), 147-159. https://doi.org/10.1046/j.1440-1630.1999.00198.x

Townsend, E. (Ed.). (2002). *Enabling occupation: An occupational therapy perspective* (Rev. ed.). CAOT Publications.

Townsend, E. A., & Polatajko, H. J. (2007). *Enabling occupation II: Advancing an occupational therapy vision for health, well-being, & justice through occupation*. CAOT Publications.

Travaglia, J. F., Debono, D., Spigelman, A. D., & Braithwaite, J. (2011). Clinical governance: A review of key concepts in the literature. *Clinical Governance: An International Journal*, *16*(1), 62-77. https://doi.org/10.1108/14777271111104592

Turner, B. (2011a). Citizenship. In J. Beckert & M. Zafirovski (Eds.), *International encyclopaedia of economic sociology* (pp. 58-61). Routledge.

Turner, B. (2011b). Keynes, J. M. In J. Beckert & M. Zafirovski (Eds.), *International encyclopaedia of economic sociology* (pp. 382-384). Routledge.

Turpin, M., & Iwama, M. K. (2011). *Using occupational therapy models in practice: A field guide*. Churchill Livingstone Elsevier.

United Nations General Assembly. (1945). *Universal declaration of human rights*. http://www.un.org/en/documents/udhr/

United Nations Office of the High Commissioner for Human Rights. (2016). *Fundamental freedoms*. United Nations. Retrieved November 30th, 2020, from https://2covenants.ohchr.org/Fundamental-Freedoms.html

University of Otago. (2019). *Māori ki Te Whare Wānanga o Ōtākou - Māori at the University of Otago*. University of Otago. Retrieved 26 January 2021, from https://www.otago.ac.nz/maori/world/te-reo-maori/mihi-introductions/index.html

Valentine, S., McLean, S., & Rahiman, F. (2017). *Strategic workforce services workforce assessment report: DHB occupational therapy (whakaora ngangahau) workforce*. Central Region's Technical Advisory Services Limited. https://tas.health.nz/assets/SWS/Workforce/WFA-Reports/Occupational-Therapy-Workforce-Assessment-July-2017.pdf

Waitematā DHB. (2003a). *ATR occupational therapist: Position description* [Job vacancy]. Te Wai Awhina.

Waitematā DHB. (2003b). *District annual plan 2003-4*.

Waitematā DHB. (2003c). *Maori values and concepts (tikanga)*. Māori Health Services.

Waitematā DHB. (2004a). *Home and Older Adults Service quality and risk plan 2004 – 06*.

Waitematā DHB. (2004b). *Waitemata District Health Board competency framework*.

Waitematā DHB. (2005a). *AT&R occupational therapy - initial assessment* [Patient assessment sheet].

Waitematā DHB. (2005b). *District strategic plan 2005-2010: Making a healthy difference*.

Waitematā DHB. (2005c). *Home visit AT&R occupational therapists (HOAS)* [Clinical practices - HOAS manual].

Waitematā DHB. (2005d). *Initial assessment documentation, occupational therapy* [Clinical practices document].

Waitematā DHB. (2005e). *Setting steps* [PowerPoint slides handout (HOAS + COPM)].

Waitematā DHB. (2005f). *Splinting, upper limb guidelines for patients with stroke; Therapy Services*.

Waitematā DHB. (2005g). *Steps / Goals in your rehabilitation* [Patient worksheet]. Te Wai Awhina.

Waitematā DHB. (2005h). *Welcome to our team: Making a healthy difference* [Orientation document]. Te Wai Awhina.

Waitematā DHB. (2006). *Tū Ngātahi: Practically implementing the Treaty in your workplace* [1-day workshop]. Te Wai Awhina.

Waitematā DHB. (2010a). *Allied health structure and function consultation paper*.

Waitematā DHB. (2010b). *Professional supervision for Allied Health staff in Waitemata District Health Board*.

Waitematā DHB. (2012). *Breakfast group - assessment treatment & rehabilitation (AT&R) wards* [WDHB policies and procedures].

Waitematā DHB. (2013). *Breast surgery post op occupational therapy guidelines* [WDHB policies and procedures]. Medicine & Health of Older People Service.

Waitematā DHB. (2014a). *Our shared values and behaviours* [Staff leaflet]. https://wellbeingforhealth.nz/assets/Uploads/WDHB-values.pdf

Waitematā DHB. (2014b). *Standard operating procedures - occupational therapy*.

Waitematā DHB. (2016a). *2016/17 annual plan*.

Waitematā DHB. (2016b). *Driving assessment guidelines for occupational therapists* [WDHB policies and procedures]. Medicine & Health of Older People Service.

Waitematā DHB. (2016c). *Home visits - occupational therapy* [WDHB policies and procedures].

Waitematā DHB. (2016d). *Professional development fund* [Human Resources internal document].

Waitematā DHB. (2016e). *Professional supervision for Allied Health staff in Waitemata District Health Board*.

Waitematā DHB. (2016f). *Wheelchair assessment and provision* [WDHB policies and procedures].

Waitematā DHB. (2017a). *Patient experience gets boost through staff initiatives* [Press release]. https://www.waitematadhb.govt.nz/assets/Documents/news/media-releases/2017/DP-Patient-Experience-Week-2017.pdf

Waitematā DHB. (2017b). *Waitemata DHB Hospital Advisory Committee meeting 29/11/17* [Meeting minutes published internally]. https://www.waitematadhb.govt.nz/assets/Documents/board/2017/WDHB-HAC-OPEN-November-2017.pdf

Waitematā DHB. (2018). *Quality improvement lead (Allied Health): Position description* [Job vacancy].

Waitematā DHB. (2019). *Becoming a GROWTH coachee*. Retrieved 19 November, 2020, from https://koawatealearn.co.nz/enrol/index.php?id=2546

Waitematā DHB. (2021). *Our promise and values*. Retrieved 31 January 2021, from https://www.waitematadhb.govt.nz/about-us/our-promise-values/

Waitematā DHB. (n.d.). *Peer review and live supervision tool* [Review and feedback workbook - under revision].

Waitematā DHB Corporate Clinical Governance Team. (2010). *Clinical governance*.

Walden, J. (1941). What is occupational therapy [Typed article archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington]. *New Zealand Journal of Physiotherapy*, *1*(1941).

Walsh, K. (2014). Clinical governance: Costs and benefits. *International Journal of Health Policy and Management*, *2*(149). https://doi.org/10.15171/ijhpm.2014.30

Wang, D. (2017). Foucault and the smart city. *The Design Journal*, *20*(sup1), S4378-S4386. https://doi.org/10.1080/14606925.2017.1352934

Weedon, C. (1997). *Feminist practice and poststructuralist theory* (2 ed.). Blackwell.

Weir, L. (2008). The concept of truth regime. *Canadian Journal of Sociology*, *33*(2). https://doi.org/10.29173/cjs608

Welch, A. (2002). The challenge of evidence based practice to occupational therapy: A literature review. *The Journal of Clinical Governance*, *10*(4), 169-178.

Wepa, D. (2005). *Cultural safety in Aotearoa New Zealand*. Pearson Prentice Hall Health.

Whiteford, G. (2000). Occupational deprivation: Global challenge in the new millennium. *British Journal of Occupational Therapy*, *63*(5), 200-204. https://doi.org/10.1177/030802260006300503

Whiteford, G., & Townsend, E. (2011). Participatory Occupational Justice Frameowork (POJF 2010): Enabling occupational participation and inclusion. In F. Kronenberg, N. Pollard, & D. Sakellariou (Eds.), *Occupational therapy without borders - Volume 2. Towards an ecology of occupation-based practices* (pp. 65-84). Churchill Livingstone Elsevier. https://doi.org/10.1016/B978-0-7020-3103-8.00017-1

Whiteford, G., & Wright-St Clair, V. (2005). *Occupation & practice in context*. Elsevier Churchill Livingstone.

WHO Working Group. (1989). The principles of quality assurance. *Quality Assurance In Health Care*, *1*(2/3), 79-95. http://intqhc.oxfordjournals.org.ezproxy.aut.ac.nz/content/intqhc/1/2-3/79.full.pdf

Wilcock, A. (2001). *Occupation for health. Volume 1: A journey from self health to prescription*. Royal College of Occupational Therapists.

Wilcock, A. (2002). *Occupation for health. Volume 2: A journey from prescription to self health*. Royal College of Occupational Therapists.

Wilcock, A., & Hocking, C. (2015). *An occupational perspective of health* (3rd ed.). Slack.

Wilkinson, J., Powell, A., & Davies, H. (2011). *Are clinicians engaged in quality improvement?* http://www.health.org.uk/sites/default/files/AreCliniciansEngagedInQualityImprovement.pdf

Wilks, L., & Boniface, G. (2004). A study of occupational therapists' perceptions of clinical governance. *International Journal of Therapy and Rehabilitation*, *11*(10). https://doi.org/10.12968/ijtr.2004.11.10.17193

Willard, H. S., & Spackman, C. S. (1954). *Principles of occupational therapy* (2nd ed.). J. B. Lippincott.

Willard, H. S., & Spackman, C. S. (1963). *Occupational therapy* (3rd ed.). Lippincott.

Willig, C. (2015). Discourse analysis. In J. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (3rd ed., pp. 143-167). Sage.

Women's Health Action. (2014a). *Cartwright Inquiry*. Retrieved 28 December, 2020, from https://womens-health.org.nz/the-cartwright-inquiry/

Women's Health Action. (2014b). *Gisborne cervical smear inquiry*. Retrieved 28 December, 2020, from https://womens-health.org.nz/gisborne-cervical-smear-inquiry/

Woodwork Instructor Rotorua Hospital. (Circa 1945). *Occupational therapy* [Unpublished thesis: Name unknown]. Archived at Occupational Therapy New Zealand Collection, Archives New Zealand, Wellington.

World Federation of Occupational Therapists. (2012). *About occupational therapy*. Retrieved November 18th, 2020, from https://wfot.org/about/about-occupational-therapy

World Health Organization. (1946). *Constitution of the World Health Organization*. https://www.who.int/about/who-we-are/constitution

Wright, J., & Hill, P. (2003). Clinical governance: Principles into practice. In *Clinical governance* (pp. 19-35). Churchill Livingstone. http://www.us.elsevierhealth.com/media/us/samplechapters/9780443071263/9780443071263.pdf

Wright, L., Barnett, P., & Hendry, C. (2001). *Clinical leadership and clinical governance: A review of developments in New Zealand and internationally*. Clinical Leaders Association of New Zealand. http://www.moh.govt.nz/notebook/nbbooks.nsf/0/AAB2DD0163B4F434CC257833007A8818/$file/CLANZlitreviewfinal.pdf

Youngson, R. (2012). *Compassion in healthcare* [Video lecture]. Stanford University. https://www.youtube.com/watch?v=7PskIJAc-gk

Zamora, D. (2014). Can we criticize Foucault? *Jacobin*, (12). https://www.jacobinmag.com/2014/12/foucault-interview/

Zamora, D., & Behrent, M. C. (Eds.). (2016). *Foucault and neoliberalism*. Polity Press.

Abbreviations

ADHB	Auckland District Health Board Metropolitan DHB covering Auckland city centre and immediate suburbs
DHB(s)	District Health Board(s) Created by the New Zealand Public Health and Disability Act 2000
CLANZ	Clinical Leaders Association of New Zealand (extant 1998 – c.2003)
CMH	Counties Manukau Health Rebrand of Counties Manukau DHB – covering Southern Greater Auckland
COPM	Canadian Occupational Performance Measure
HPCAA	Health Practitioners Competence Assurance Act 2003
HQSC	Health Quality & Safety Commission Created by the New Zealand Public Health and Disability Amendment Act 2010
NZAOT	New Zealand Association of Occupational Therapists Professional association renamed from original NZROTA
OT Board	(New Zealand) Occupational Therapy Board Created by Occupational Therapy Act, 1949 until 2003 rename
NZJOT	New Zealand Journal of Occupational Therapy NZAOT/OTNZ-WNA monthly association journal. Successor to the 1948-50s newsletter
NZROTA	New Zealand Registered Occupational Therapists Association Inc. Incorporated 28th June 1948 after Department of Health acceptance of constitution
OTBNZ	Occupational Therapy Board of New Zealand Occupational Therapy Board continued by HPCAA (2003), renamed from NZBOT
OTNZ-WNA	Occupational Therapy New Zealand – Whakaora Ngangahau Aotearoa Association rename (2015) of the NZAOT
PDR	Performance Development Review
WDHB	Waitematā District Health Board Metropolitan DHB covering Auckland North Shore and suburban West

Appendices

Appendix A: A corpus of work. Foucault publications as tools

Michel Foucault's books were written within the context of French history and philosophical approaches popular in France at the time he was writing, such as Marxism, phenomenology and structuralism. His primary audience was other French academics who were well aware of French politics and each other's philosophical perspectives (Schwann & Shapiro, 2011). For that reason, Foucault's writing rarely explains the historical circumstances of his thought, because of the assumption that his French readers were immersed in the context. Schwan and Shapiro suggest those with limited knowledge of French history may miss Foucault's message: Societal behaviour is contingent on both the discursive construction of the 'preferred truth' and the individual's or populations response to this version of truth, relative to particular moments of history. Societal behaviour can change as a response to the autonomy of an individual to resist societal rules and regulations (Schwann & Shapiro, 2011). According to Foucault, individuals are turned into 'subjects' through the action of power relations, and, more specifically, what they do to themselves, through use of technologies of the self, which may involve confession, supervision, reflection and how they will behave under certain defined conditions (Foucault, 1982b).

In an early publication, *Maladie mentale et personnalité (Mental illness and personality)* (1954), Foucault was influenced by psychology, psychoanalysis, phenomenology and, arguably, Marxism. Of this latter influence, he said: "I often quote concepts, texts and phrases from Marx, but without feeling obliged to add the authenticating label of a footnote with a laudatory phrase to accompany the quotation" (Foucault, 1980a, p. 52). We can assume that Marxist thinking is at least present in his early writing, although not attributed, even though Foucault himself says that he was never a Marxist (Foucault, 1996, p. 350; 1998b, p. 437). In any case, over time he moved away from such philosophy and developed his own ideas regarding power and oppression.

An interest in language and discourse can be seen as early as the 1960s, when Foucault wrote a number of literary essays on writers who were also philosophical thinkers: the mystic Georges Bataille (1897-1962), the libertine Donatien Alphonse François, Marquis de Sade (1740-1814); the commentator Pierre Klossowski (1905-2001) and the literary theorist Maurice Blanchot (1907-2003). Like Foucault, many of these men were also influenced by the ideas of Friedrich Nietzsche (1844-1900) or Martin Heidegger (1889-1976). During this time, he also wrote *Raymond Roussel* (published in English as *Death and the labyrinth: The world of Raymond Roussel*) (Foucault, 1963b), an examination of the life and works of this experimental writer who investigated language and its relationship with non-linguistic objects (Kelly, 2016). This interest in discourse soon became the foundation for the next phase of his work, archaeology, and is the starting point of Foucauldian discourse analysis.

Archaeology

Foucault published three major works in the 1960's, each developing on its predecessor, resulting in his concept of 'archaeology'. In the first, *Folie et déraision: Histoire de la folie à l'âge Classique* (1961), translated as *Madness and civilization* (1988a), Foucault discussed his interpretation of the terms 'rationality' and 'irrationality' and how reasoning is not necessarily tantamount to the truth, pointing out that there were examples of social control that were based on rational thinking but actually acted as a repressive mechanism in society. He was also clear to point out that caution should be applied to any censure of reason because that could lead to irrational social actions (O'Farrell, 2005b). The tensions between what is rational and irrational were similar to Nietzsche's theoretical concepts based in ancient Greek mythology; Apollo, the god of reason and the rational, versus Dionysus, the god of the irrational and chaos (Kreis, 2012).

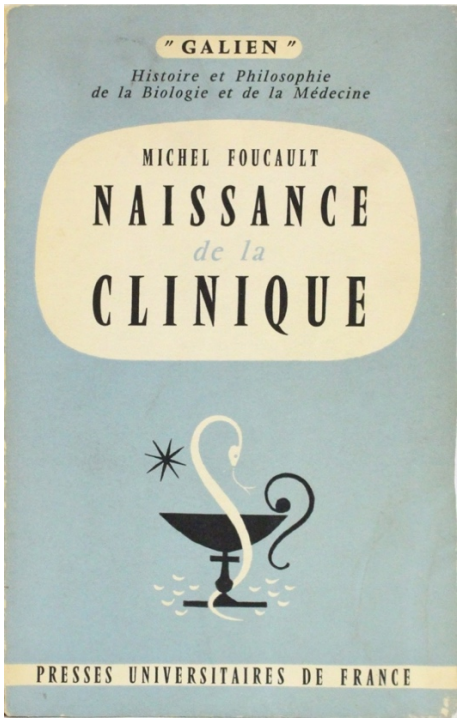


Figure 19. 1963 first edition of *Naissance de la Clinique.* Reproduction permission granted.

In his third book, *Naissance de la clinique: Une archéologie du regard médical* (*The birth of the clinic: An archaeology of the medical gaze*) (1963a), Foucault focused only on describing discourses in their historical setting, not attempting to provide any explanation, beginning a move away from his earlier flirtation with Heidegger and phenomenology. The content of *The birth of the clinic* signals Foucault's interest in contingent events shaping history by his claim that knowledge suddenly changed in the 1700s due to a number of seemingly unrelated events. Furthermore, Foucault's concept of the 'medical gaze'[82] is described, effectively an investigation into the effects of power on the body. He argues that patients, when under the care of the

[82] As in the titles of some of his books, Foucault's original French is sometimes only imperfectly translated into English, for example "medical gaze" is originally "*regard médical*", where the French *regard* has connotations of looking, seeing, staring, perception and gazing, i.e. an active and intentional action.

physician, become dehumanized, their bodies becoming separated from their identity, signifying the power of the physician over the patient. His following book, *Les motes et les choses. Une archéologie des sciences humaines (The order of things: An archaeology of the human sciences)* (1966), realizes 'archaeology' as a methodology and cements it as one of Foucault's major ideas.

Genealogy and discourse

In his next major work, *L'ordre du discours (The order of discourse)* (1971), Foucault examined 'how' discourses are constructed through the application of his method of genealogy. This deals with a random 'field of objects' to be discovered and encountered, focusing on uncovering discursive/non-discursive practices as a series of events, 'the discursive field' (Penalver, 1994). Genealogy enabled Foucault to study discourses within a historical social setting to make transparent the hidden strands of power, revealing real influences on phenomena of interest (Mills, 2003).

How discourses occur

Foucault's inaugural Collège de France lecture introduced a political dimension to his work by questioning "how" discourses occur. He used his method of genealogy to locate the study of discourses within an historical setting and make hidden strands of power transparent, thus revealing the real influences on phenomena of interest (Mills, 2003). Foucault was intrigued with the techniques of power and how it in turn influenced events in history, eventually leading to change in the current time. The publication of *Surveiller et punir: Naissance de la prison (Discipline and punish: The birth of the prison)* in 1975 latterly laid out both his concept of genealogy as a methodology, built on archaeology, and his argument that knowledge and power are interrelated.

Collection of tools

In a February 1975 Le Monde interview with Roger-Pol Droit, Foucault is quoted as saying: "All my books… are, if you will, little toolboxes. If people are willing to open them and use a sentence, an idea [or] a study, as a screwdriver or spanner to short-circuit, discredit or break systems of power, including perhaps the very ones that my books come from... well, that's good!" (Foucault, 1975a). Foucault's 'toolbox' referred to his philosophical thoughts, ideas, and research processes, which he freely offered to readers, suggesting that they find their own way to use and adapt in their own research. He considered that his writing provided examples of "experience" rather than "truth" and that he often did not know where his work would take him, indicating that only when he reflected on the completed work did he see the method he should have used (Foucault, 2000c).

Table 13. Publications, moments and tools within the Foucauldian corpus

One body of work; multiple stages (Dreyfus & Rabinow, 1982) producing three historical approaches that overlap: Archaeology; genealogy and the history of thought (O'Farrell, 2005b).	
Publications, theses and lectures	Notes
Formation of ideas from philosophy, literature, sciences exploring Heidegger	
Maladie mentale et personnalité (Mental illness and personality), (Foucault, 1954) *Wrote introduction to Binswanger's Dream and existence in 1954; influence: existentialism and phenomenology* *Over 20 literary essays written between 1962-66 (Saghafi, 1996) concerned with philosophy, language and discourse (Kelly, 2016), including:* *Bataille: A preface to transgression, 1963 (Foucault, 1977d)* *Klossowski: The Baphomet Introductory essay The prose of Actaeon, 1964 (Foucault, 1988c)* *Blanchot: Maurice Blanchot: The thought from outside, 1966 (Foucault, 1987)* *Raymond Roussel Death and the labyrinth: The world of Raymond Roussel, 1963 (Foucault, 2004a)* *De Sade Language to infinity, 1963 (Foucault, 1977b)* *Presentation of primary doctoral thesis, History of madness, published as Maladie mentale et psychologie (Mental illness and psychology) (Foucault, 1962)* *Presentation of secondary doctoral thesis, 1961, Introduction to Kant's Anthropology, published posthumously (Foucault, 2008b)*	Prolific reader of the sciences, literature and history (Eribon, 1991). Studied philosophy and psychology Philosophical influences included: Marxism (Louis Althusser); psychology, psychoanalysis (Lagache; Freud); Marxism and phenomenology (Hegel, via Jean Hyppolite) (Eribon, 1991); Existential phenomenology, hermeneutics (Heidegger); existential analysis (Binswanger) (Eribon, 1991); Phenomenology, the body as a source of knowing the world, language (Merleau-Ponty) (Eribon, 1991); History and philosophy of the sciences; contingency, epistemological break (Gaston Bachelard via Georges Canguilem), (Gutting, 1989); Linguistics and semiotics (signs) (Barthes); Classical history, historical breaks and ruptures (Nietzsche); Paradigm shifts, discontinuity, structures (Kuhn) (Garland, 2014); Philosophy and power (Dumezil); Enlightenment, ethics, aesthetics, epistemology - knowledge (Kant); Identity and difference (Deleuze). Structuralism, phenomenology, hermeneutics (interpretation of human actions through text) (Dreyfus & Rabinow, 1982). Literary influences included (Eribon, 1991): Bataille; Art, eroticism, philosophy Maurice Blanchot: language, literary theory, philosophy Klossowski: Marquis de Sade and Nietzsche Marquis de Sade: Eroticism Roussel: investigated language and its relationship with non-linguistic objects (Kelly, 2016) Experiences: working in a hospital and prison (Eribon, 1991).

Publications, moments and tools within the Foucauldian corpus (contd.)

Archaeology: Descriptive methodology (structuralist) oeuvre	
Folie et déraision: Histoire de la folie à l'âge classique (The history of madness in the classical age) (1961)	History of madness introduces problematization Construction of what is abnormal compared with what is normal; exclusion of those displaying abnormal behaviour from rest of group; naming; of the abnormal behaviour analysis of abnormal behaviour
Naissance de la Clinique: Une archéologie du regard medical (Birth of the clinic – an archaeology of the medical gaze) (1963a)	Governmentality; regulation of spaces and bodies; surveillance - the gaze – both body and state - statistics; classification; signs, symptoms, disease; role of patient and doctor;
Les mots et les choses: Une archéologie des sciences humaines (The order of things: An archaeology of the human sciences) (1966)	Archaeology as a methodology. How knowledge and theory is constructed through the way the human sciences are unconsciously ordered and normalised within particular moments in time; or episteme.
L'archéologie du savoir (Archaeology of knowledge) (1969a)	History of ideas; A description of the archaeological method used in previous three publications. Terms: Episteme; statements; discursive formations; rules of formation
Qu'est-ce qu'un auteur? (What is an author?) Lecture and discussion (1969b)	Problematization of the author. Authors as discursive formations, their relationship to texts; author function, recognition of the extent of their work; influence on other authors; the system of constraints acting upon them.
Genealogy: Cause and change	
L'ordre du discours (The order of discourse) (1971), Foucault's inaugural lecture at the Collège de France. *Surveiller et punir: Naissance de la prison (Discipline and punish: The birth of the prison) (1975b)* *Sécurité, territoire, population (Security, Territory, Population) (2004c) Collège de France lectures* *Naissance de la biopolitique (The birth of biopolitics) (2004b) Collège de France lectures*	Building on archaeology History of the present Knowledge and power related How discourses linking power and knowledge can be mapped; produced by rules and procedures What is true and what is false Social criticism on the prison system
Problematization. **Ethics** – Analysis and formation of the subject; care of the self	
Histoire de la sexualité I: La volonté de savoir (The history of sexuality: The will to knowledge) (1976a) *Histoire de la sexualité II, L'usage des plaisirs (The history of sexuality : The use of pleasure) (1984a)* *Histoire de la sexualité III, Le souci de soi (The history of sexuality : The care of the self) (1984b)*	Disciplinary power; biopower; ethics Technologies of the self: Care of the self Practices used to by subjects to transform their mode of being. Construction and modification of self through practices History of thought

Appendix B: Foucault the philosopher-historian

Foucault combines philosophy with history, a practice that was frowned upon by American philosophical purists (Poster, 1982), but was not uncommon amongst the French philosophers influencing Foucault's work, including Jean-Paul Sartre (1905-1980), Fernand Braudel (1902-1985) of the Annales School of history, Gaston Bachelard (1884-1962) and Foucault's doctorate sponsor, Georges Canguilhem (1904-1995) (Gutting, 2001).

By pairing philosophy and history together, he constructed his own methodology to understand problems of the present by examining the past. Foucault acknowledged that his use of philosophy combined with history was unconventional and often signalled that he did not consider himself a philosopher; "I am not an analytic philosopher. Nobody is perfect" (Foucault, 1999, p. 160); "I myself am not a philosopher, and barely a critic" (Foucault, 2007b, p. 49). However, in spite of his protestations, he is recognised as a philosopher, as his body of work shows a deep commitment to philosophical ideas, particularly of the self, experience, transformation; philosophy of politics and philosophy of dialogue (O'Leary & Falzon, 2010).

"I am not a philosopher"

Despite his assertions about being a non-philosopher, Foucault's thinking is seen as having been influenced by a number of prominent philosophers including Aristotle, Plato, Immanuel Kant, Gilles Deleuze, Charles Baudelaire as well as Nietzsche and Heidegger (O'Leary & Falzon, 2010). Kant, who pioneered the philosophical critique of knowledge (Gutting & Oksala, 2018), was a particular influence in Foucault's development of his methodology of archaeology (McQuillan, 2010), and continued to be so later in Foucault's life, when he turned to exploration of the genealogy of ethics and critique (O'Leary & Falzon, 2010). Foucault confirmed his use of Kantian ideas when he said, "If one abandons the work of Kant, one runs the risk of lapsing into irrationality" (Foucault, 1984d, p. 248).

Foucault's work is trans-disciplinary, combining ideas from history, sociology, psychology, and philosophy, thus, the 'human sciences' are a particular focus of his writing rather than the natural sciences of biology, chemistry and physics. Foucault conducts an analysis of the human sciences in his book, *Les mots et les choses* (1966). He argues that while the natural sciences take the stance of 'man' as being part of the natural world, where 'man' is understood to be already formed as a subject, the human sciences open up a different way of understanding how the formation of subjects is enabled (Gutting, 1989, 2005). Positioning his work within the human sciences, Foucault claims that there is no such thing as the natural occurrence of objects such as "man" or "god", but that objects are constructively produced and named through discourse (Palmer, 1997). Furthermore, human objects are constructed as subjects by underlying networks of power relations that run invisibly below the surface of society. Subjects are produced by "technologies" or "microphysics" of power acting within societal institutions. Everyday behaviours desired and

favoured by a society at a particular moment are thus produced through the effects of prominent discourse, science and knowledge (Poster, 1982).

Appendix C: Requests for information, and approvals

20/2/17

To: Geraint Martin, CEO, Counties Manukau DHB

Kia ora Geraint,

My name is Yasmin Orton, and I am a Doctor of Health Science candidate at Auckland University of Technology. The connection is that I found your presentation to my class in 2015 to be the single most useful thing of that course and of the year: the information you shared and the references you recommended were invaluable in my background work towards formulating my research question, which has now been approved.

I don't want to take up any more of your time than is necessary, so I'll come straight to the point. I am writing to ask for your help in obtaining permission to gather relevant CMDHB documents to use as data for my research.

My research question working title is: "A post-structural discourse analysis of how clinical governance has shaped occupational therapy practice in Aotearoa/New Zealand". My understanding is that clinical governance should be embedded in healthcare and is concerned with accountability, regulation and control of clinical performance, including:

- Patient safety, standards of care (quality assurance) and patient health outcomes
- Integrated ways of working; clinical leadership and decision-making at all levels
- Prudent and effective use of resources and spending
- Consumer participation
- Improved information systems (IS)

I am seeking your permission to access organisational, service and practice specific documents designed to guide allied health and occupational therapy practice.

Examples might include:

- Any direct and indirect clinical governance work documented within the DHB (via minutes, reports, working notes, letters, leadership structure diagrams, descriptions, values statements, annual plans)
- Position statements, policy / practice, SOPs, supervision, audit, peer review guides
- Project planning and quality initiatives (terms of reference, memos, reports, pamphlets)
- Any documents that indicate possible constraints or limits to practice
- Documents pertaining to patient collaboration and feedback
- Documents related to working at top of scope; resource allocation, carrying out work effectively and safely – supports; hinderances
- The use of IS systems for interventions, communication, documenting, etc.
- Clinical leadership; promoting and hindering implementation
- Job descriptions/ adverts, interview questions, key role components

I am also asking if you would permit me to visit CMDHB to access and search *limited areas* of information storage systems and make copies of relevant documents to study. I am **not** interested in or seeking patient private personal information or interventions.

If you are able to help, would need more information or can refer me on to others in the DHB who can grant permission/set up access for me, please would you contact me:

Email: yasmin@orton.com

Phone: 0277 589 588

Thank you in advance.

Kind regards,

Yasmin Orton

Doctoral Candidate, Auckland University of Technology (AUT)

Academic supervisors: Professor Clare Hocking; Professor Deborah Payne (AUT)

COUNTIES MANUKAU HEALTH

CM Health Research Office
Counties Manukau Health
Esme Green Building
Room 109, Level 1
Middlemore Hospital

18 April 2017

Dear Yasmin,

Thank you for the information you supplied to the CM Health Research Office regarding your research proposal:

Research Registration Number: **283**

Research Project Title: **A post structural discourse analysis of how clinical governance has shaped occupational therapy practice in Aotearoa / New Zealand.**

As determined via the NZ Online Forms for Research screening questionnaire, and as stated in correspondence from the Health and Disability Ethics Committee, your study does not require HDEC ethical approval as it is outside the scope of review. This scope is described in section three of the *Standard Operating Procedures for Health and Disability Ethics Committees,* May 2012.

I am pleased to inform you that the CM Health Research Committee and Director of Hospital Services have approved this research with you as the CM Health Co-ordinating Investigator.

Your study is approved until **1 March 2019.**

Amendments: Any amendments to your study must be submitted to the Research Office for review. Please note that failure to submit amendments may result in the withdrawal of CM Health Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

S. Karatela

Dr Shamshad Karatela
Research Manager
Counties Manukau Health
Under delegated authority from CMH Research Committee and Director of Hospital Services

Waitemata
District Health Board

Best Care for Everyone

Director Allied Health Scientific and Technical Professions
Board Office
15 Shea Terrace
Takapuna, Auckland 0622
Private Bag 93 503, Takapuna
North Shore City 0740
Telephone: 09 486 8900
Facsimile: 09 486 8924
www.waitematadhb.govt.nz

2 March 2017

Yasmin Orton
Doctoral Candidate
Auckland University of Technology (AUT)

Via email: yasmin@orton.com

Dear Yasmin,

Re Official Information Act Request

Thank you for your Official Information Act request to Waitemata District Health Board received 20 February 2017. Please find below our responses to your request.

Waitemata DHB is the largest DHB in New Zealand with a population of 598,000 and 7000 staff over four major facilities and over 80 community bases throughout the Auckland region. We are a regional provider of child disability, forensic psychiatry, alcohol and drug and school dental services. We are a national provider of hyperbaric medicine and we have New Zealand's largest secondary general medical department. Eighty per cent of our workforce are healthcare professionals, with 1768 (1515 fte) of those sitting in the Allied Health, Scientific and Technical (AHS&T) group.

The information below, as per your request, is predominantly aligned with the occupational therapy workforce within the adult physical services, situated operationally within the Specialist Medicine and Health of Older People Division. The exceptions to this are the Professional Development Fund and the Professional Supervision for Allied Health Staff in Waitemata District Health Board policies, which reach across the District Health Board.

	Item Requested	Document Name Provided	Comments
1	1 – 2 examples of Allied Health clinical governance group meetings minutes	1a - Allied Health Clinical Governance Forum, 7 November 2016 1a - Allied Health Clinical Governance Forum, 5 December 2016	
2	Allied Health quality plan (or similar title)	Nil	There is no current Allied Health Quality plan. An Allied Health Scientific and Technical Action Plan is currently in progress
3	Occupational Therapy plans/strategy (if they exist)	Nil	All Allied Health disciplines will be included in the AHS&T Action Plan

Letter for NZBOT to publish requesting docs 3 Feb 2017

Kia Ora, Occupational Therapists,

I am interested in how the concept of clinical governance has influenced current occupational therapy practice and am hoping that you might be able to help me locate documents that will assist my research into this topic.

Clinical governance is concerned with:

- Accountability, regulation and control of clinical performance
- Effective patient/client health outcomes
- Prudent and effective use of resources and spending
- Patient safety
- Promoting the highest standards of patient care (quality assurance)
- Consumer participation via collaboration and communication with service users
- Improved information systems (IS)
- Integrated ways of working,
- Support for organisational learning and clinician professional development
- Partnership between clinicians and managers with emphasis on clinical leadership and joint decision-making at all levels, including front-line care

I am currently looking for documents that will enable me to identify what aspects of clinical governance are affecting the way occupational therapists are able to provide service and interventions to their patients/clients. I hope to source material from New Zealand/ Aotearoa healthcare providers, such as DHBs, PHOs and special schools. I am also interested in the implementation of clinical governance strategies within private companies, including contracted Ministry of Health agents for equipment supply and housing modifications as well as companies contracted to carry out ACC-derived work – anywhere occupational therapists practice within healthcare in New Zealand.

I am interested in both the benefits and the constraints of clinical governance and the contingent nature of occupational therapy practice. To do this, I will be gathering and analysing documents from a Foucauldian discourse analysis viewpoint, which is essentially, identifying the power/knowledge/resistance interplay and the hidden mechanisms related to clinical governance, that shape current occupational therapy practice with a view to understanding how the occupational therapy profession has responded to the application of clinical governance in the workplace.

As clinical governance is a wide ranging concept, it encompasses practices that might not always be clearly labelled as clinical governance, but articulated in various other ways, such as procedures, rules, regulations, monitoring and disciplinary processes associated with practice, peer review, ePortfolio and APC processes; quality projects, best value/outcomes, high quality care, supervision, audit, patient satisfaction and feedback, population health initiatives, leadership roles, in-services and ability to attend courses or participate in post-grad education. It is these activities that clinicians are more likely to be involved in and it is the documents associated with this work that I am interested in locating for potential analysis in my study.

If you have participated in or are familiar with any clinical governance type work in your organisation such as that mentioned above, I would love to hear from you.

I am interested in accessing documents such as:

- Policy documents/practice guides/standard operating procedures, supervision, audit, peer review
- Project planning and quality initiatives
- Key role component descriptions
- Patient and clinician safety
- Any documents that indicate possible constraints or limits to practice
- Terms of reference, memos, minutes, reports, pamphlets, photos, newsletters, diary, journal or blog entries
- Governance / leadership structure diagrams or descriptions

- Job descriptions, adverts for positions, interview questions
- Patient satisfaction questionnaires, quality and consumer feedback documents
- Values statements, annual plans overarching organisational or service documents
- Research, training, further education and professional development initiatives
- Documents pertaining to working at top of scope in practice and supports to achieve this
- Costs, budgeting, fiscal prudency
- Resource allocation to be able to carry out work effectively, including IS systems
- Integrated ways of working, communicating, liaison in/outside organisation

These documents could be organisational, related to an allied health service, or most importantly, specifically designed to guide occupational therapy practice.

I am not interested in or seeking individual patient/client information, or anything related to individual client interventions / personal information, nor am I wishing to interview anybody. I am simply seeking access to documents that pertain to the take up of clinical governance by occupational therapists within the New Zealand healthcare system.

If the documents are not in the public domain, permission to use them from the originating source will be sought.

If you can help me locate any relevant documents, Please contact me, Yasmin Orton:

Email: yasmin@orton.com

Phone: 0277589588

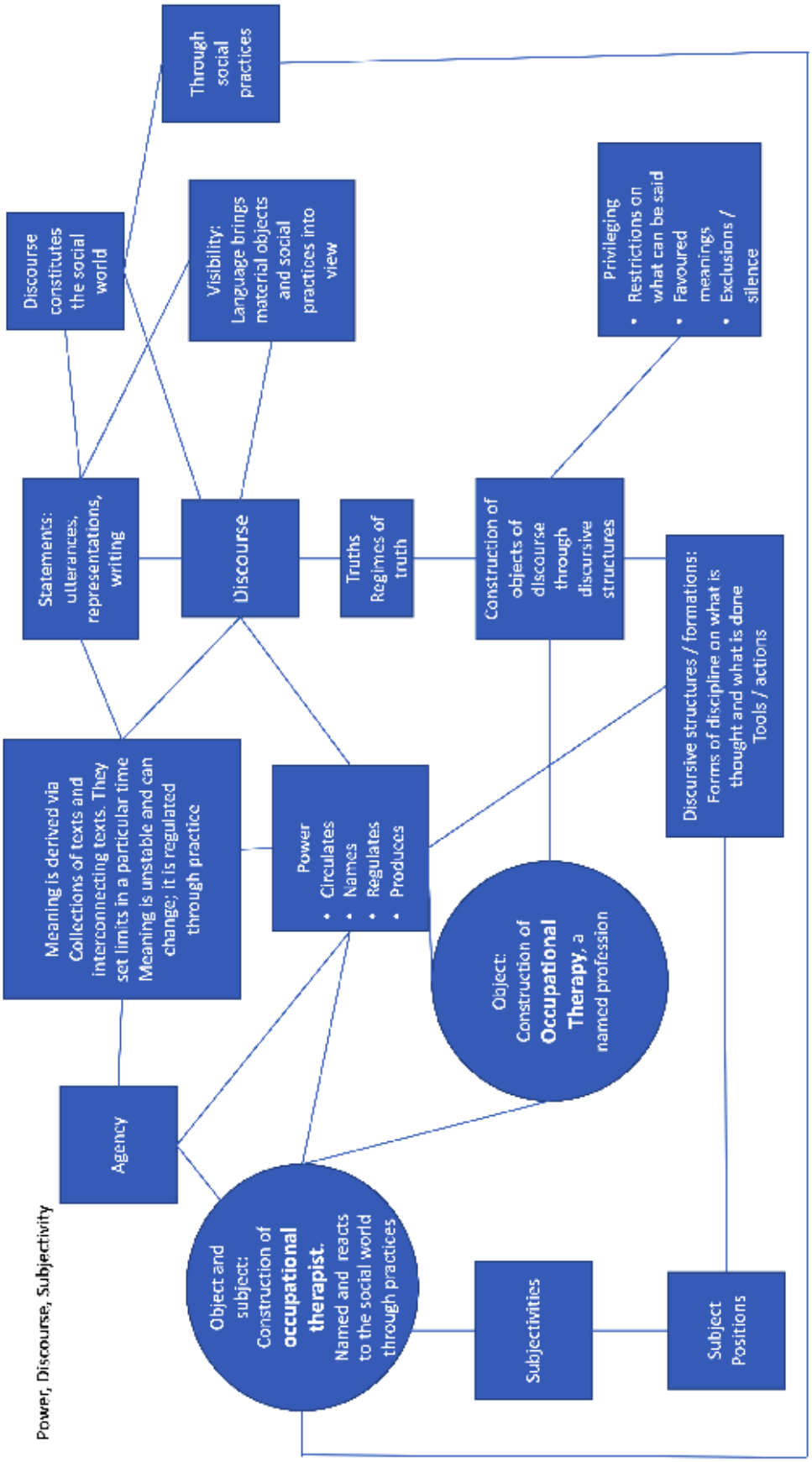
Thank you.

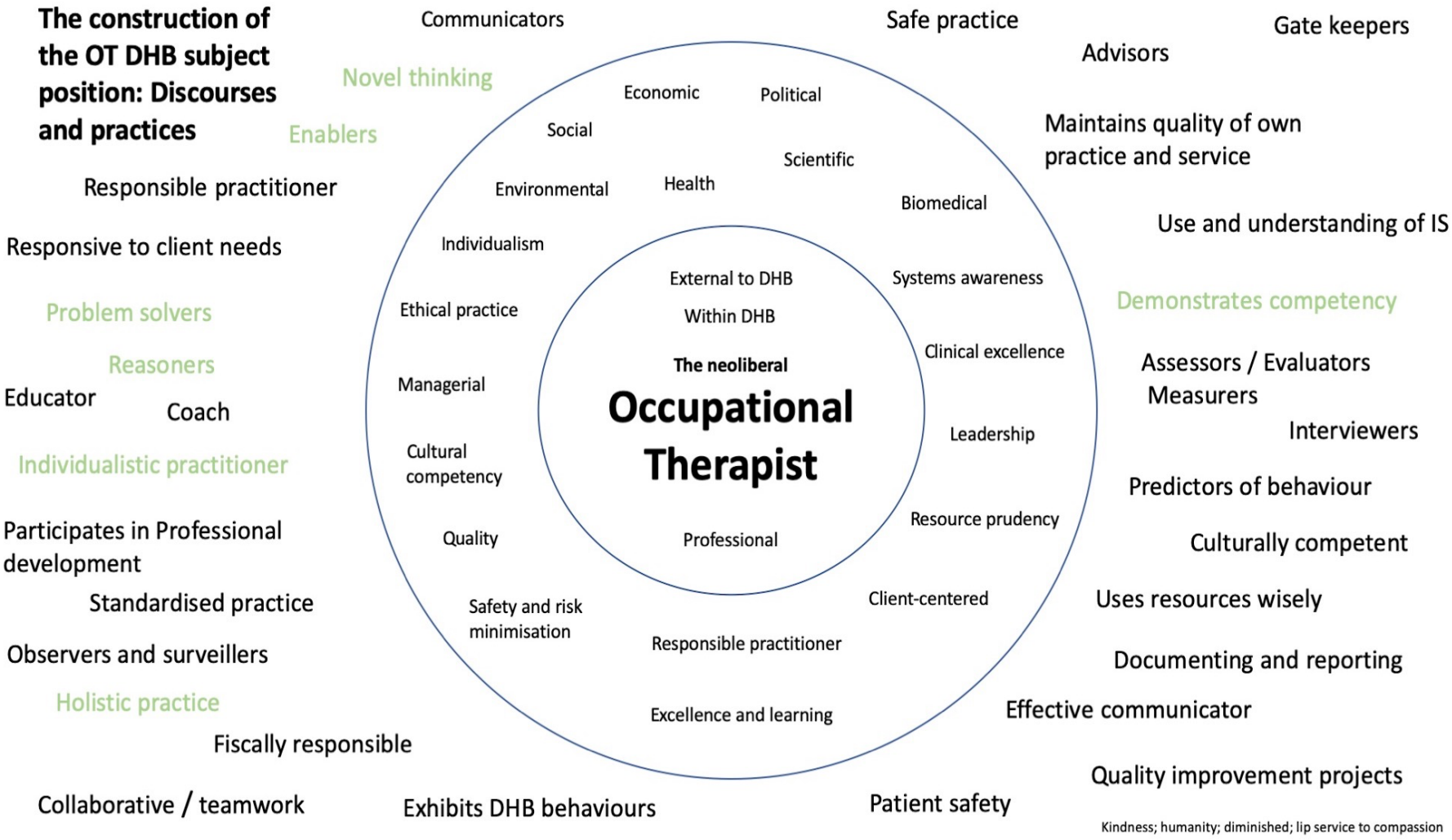
Yasmin Orton

Doctoral Candidate, Auckland University of Technology (AUT)

Academic supervisors: Professor Clare Hocking; Professor Deborah Payne

Appendix D: 'Powerpoint thinking': Power, discourse, subjectivity




The construction of the OT DHB subject position: Discourses and practices
Communicators
Safe practice
Gate keepers
Advisors
Novel thinking
Enablers
Maintains quality of own practice and service
Responsible practitioner
Use and understanding of IS
Responsive to client needs
Demonstrates competency
Problem solvers
Assessors / Evaluators
Measurers
Reasoners
Interviewers
Educator
Coach
Predictors of behaviour
Individualistic practitioner
Culturally competent
Participates in Professional development
Uses resources wisely
Standardised practice
Documenting and reporting
Observers and surveillers
Effective communicator
Holistic practice
Quality improvement projects
Fiscally responsible
Collaborative / teamwork
Exhibits DHB behaviours
Patient safety
Kindness; humanity; diminished; lip service to compassion
Economic
Political
Social
Scientific
Environmental
Health
Biomedical
Individualism
External to DHB
Systems awareness
Ethical practice
Within DHB
Clinical excellence
The neoliberal
Occupational Therapist
Managerial
Leadership
Cultural competency
Resource prudency
Quality
Professional
Client-centered
Safety and risk minimisation
Responsible practitioner
Excellence and learning

Done to OTs: The political technology of the body and soul

Power relations / object relations

A microphysics of power within institutions
A strategy – dispositions, manoeuvres, tactics, techniques, functioning: A network of relations, in tension and activity. Power is excised rather than possessed…the overall effect of its strategic positions. Power invests those who are dominated and is transmitted by them and through them, just as they struggle against it to resist the hold it has on them (Foucault, D&P, 1991, p. 26-7) . Power produces domains of objects and rituals of truth (p. 194).

Examples of techniques that shape OT behaviour
Both constraining and productive

- DHB Behavioural expectations (written)
- Wearing uniform and personal appearance
- Productivity: KPIs; caseload requirements,
- Rules, regulations; political rituals, procedures; regulated use of instruments, habits, orders, secrecy, diary, planners, time-table, prioritization guidelines; caseload guidelines; practice guidelines / policy; OT SOP; PL desk diary,
- Demonstration of competency: APCs and PDRs; peer review, observations, live audit, documentation audit
- PIPs, coaching, training and correction, dismissal, resignation
- Constructive dismissal; reporting to OTBNZ
- Supervision, confession, reflection
- Surveillance: Panopticon – individuals adjust to conforming behavior as they come to believe they are being constantly observed. In effect, they self-monitor.
- Rules around authority and permission to use objects

Techniques of: Discipline Punishment

Power relations and domination on the body
Confinement; correction; invest it ; mark it; train it; torture it; force it to carry out tasks; to perform ceremonies; to emit signs. (Foucault, D&P, 1991, p.25)

Productive outcome through a system of subjection

The Body

The Soul

Achieving outcomes with rules

"Trust the process" (HR, 2015)

Truth – Power relationship produces knowledge:
New mission statements; values, behavioural expectations, service departments, role positions and processes developed to address the new clinical governance and leadership framework, while others are discontinued. Development is over many years

What is done to a non-compliant practitioner?

Resistance is essential for power relations to operate

Technologies of the self

Care of the self

- Secrets
- Confession
- Supervision
- Reflection
- Action

Yasmin Orton 2019
Done to OTs
Discipline and Punish, Foucault, M.

What is done to the non-compliant practitioner?

Rules of Punishment:

1. Minimum quality: Punishment must just be enough to make it not worth committing the crime again.
2. Sufficient ideality: Memory of the punishment is sufficient to deter re-offence.
3. Lateral effects: Punishment should deter others from committing the crime.
4. Perfect certainty: The link between the crime, the punishment and the other consequences associated with the punishment, e.g. loss of job = loss of incomes = failure to support family
5. Common truth: There must be evidence that a crime has been committed, it is the truth.
6. **Optimal specification**: All behaviours that constitute a crime must be defined so that it is known when a crime has been committed.

Hence, it is not only the body but also the mind that needs to be subjected to punishment

Three organising technologies of power to punish:

1. Monarchical law: Power of the Sovereign.
2. Juridical law: Power of a society on its subjects through administrative procedures, signs, representation.
3. Prison: Re-training the body to change behaviour

(Foucault, D&P, 1991, p.130-1)

Practitioners:

Monarchical law: practitioners are subjects – of Government, DHBs, OTBNZ
Judicial Law: Policy, rules, protocols, procedures – these need to be followed and application demonstrated.
Prison (re-training) / punishment: Those who are non- compliant are subject to re-training to change behaviour – coaching, supervision, discussion, preceptors. If their behaviour still does not meet requirements, then further disciplinary action taken – punishment – investigations, dismissal, OTBNZ notification.

Yasmin Orton 2019
Punishment Foucault, M. D&P

Disciplining Techniques – the body as an object

Disciplining Docile bodies through coercion, working on the body's capacity to achieve desired behaviours. Must be corrective. Can be positive - reward
A microphysics of power – its in the detail. Micro-powers exercised at the level of daily life.
A well disciplined body - Movements: marching; body position – the signs of an OT in demeanour – listening pose; gaze, attention, body language; where and how we sit / approach patient, attitude, poker face, silence – what to say and what not to say – know place, handwriting, physical use of equipment – ergonomics, safe handling practices etc.
Supervision – of conduct of individuals
Regulations, hierarchies – surveillance from top to bottom, bottom to top, and laterally – a whole network, an apparatus that produces power
Inspection,
Organisation: Orders the 'dangerous' masses through classification and designation. Designated spaces – hospitals, offices, collective space; interview rooms, meeting rooms, gym, kitchen, bathroom, ward space, garden, departments, wards, clients homes, workshops. Rules associated with space – infection control; maori patient space round bed, out-of-bounds space; locking up equipment in space – restricted access
Partitioning - own place – desk, compartment- organisation of space for the individuals within it
Movements of individuals – in / out; where, time, who, regulation - working hours, breaks, leave, training leave; patients seen and time with them, what was done; documenting. Distributing individuals in space – ward assignments – duties, monitoring by senior / manger; reporting when sick and handing over
Use of materials and equipment – safety, designations, training,
Monitoring quality of work, classifying against other OTs – skill, speed, capability, experience, competency, to the rules
Observations, assessments, recording progress, achievements, training log
Rank for person – NG, senior, specialty, CASP level, recognition of achievements / hierarchy of knowledge / ability - rewards – a network of relations
Tables: Both a technique of power and procedure of knowledge. Economic tables: observe, supervise, regularise, register, distribution, division of space and duties, classify into specialities – ortho, older adults, MH, paeds, medical, surgery, etc
Tactics, special ordering of people, taxonomy, regulated movement of wealth,
Tables allow individuals to be characterised and multiple things to be organised and ordered
Time table: orders the day, sets the rules and quality of the use of time including what must not be done; non-idleness
OT training – apprenticeship; practice of skills specific to OT – to learn and improve upon them
(Effective) **Productive workforce** – working together – team work – an efficient machine. Hospital a machine for healing? Learn the codes and signs associated with hospitals - to change behaviour tables, movement, exercises tactics.
The examination: observation, gaze, the norm – standardised practices – can then set standards against the norm and examinations – a visible exercise of power – objectifies subjects a case; whereas disciplinary power is invisible, yet makes its subjects visible to demonstrate its hold over them.

Yasmin Orton 2019
Techniques of power (Foucault, D&P, 1991)

Appendix E: Snapshots from Yasmin's thoughts; an ongoing log

10.8.17 From reading Carabine (2001): Unmarried mothers 1830-1990: A genealogical analysis in Discourse as data: A guide for analysis. Eds Wetherall, Taylor, Yates; Thousand Oaks, Sage**.** Beginning to understand genealogical approach and what discourses are. Have tried to apply to CLANZ clinical governance document 2001. Making notes about the context around the document as well as what may be implied from knowing the context. I believe I am now focusing in on what I need to select from Foucault's tools for this study. Also read Fadyl, Nicholls, McPherson (2013) Interrogating discourse: The application of Foucault's methodology for discussion to specific inquiry. This article then goes into the specifics of using discourse and the terms Foucault used to analyse discourse. Need to make a chart to guide me.

Just completed a review of the 2003-05 OTBNZ minutes. Was a busy period as the HPCAA bill was passed and the Board needed to put in place a competency system to fulfil the requirements. Work involved examining other systems around the world, writing documents re. ethics, scope, competency to practice as well as the actual registration process and the online platform. Throughout, the board needed to address discipline/complaints and decide upon the appropriate action to take. Surveillance, gathering information, reporting, collaborating, disciplining, auditing, generation of statistics were all prominent in this work. Some work was completed (CCFR documents); other work was ongoing (discipline/complaints managements); new work was taken up (Recognition of biculturalism: Use of Te Reo Māori in documents; driving assessment). Some things were discontinued (removal of 'old' documents); others were given new names (cultural essay – cultural assessment for overseas applicants).

28.12.18 Safe places

Are there actually mechanisms that enable clinicians to actually speak out and tell the truth about their practices? I suggest not, surveillance and punishment curtail this practice. Environments are not safe. Supervision affected by this; managers participate in supervision; relations are messy and grey. Supervision should be external to the DHB / organization with an impartial party, if there is to be complete confidentiality as described in the OTBNZ documents. Cost…..yes, this is a problem. OTs should be paid more or receive an allowance for supervision so that they can choose a supervisor themselves.

Technology sshmology

Governance emphasizes the development and **take up of technology** to enhance and improve clinician interventions. Evidence shown in leadership governance meetings where 'apps' discussed and plans for a policy in the use of apps to be written. Skyping also being considered as alternative to real live meetings in the home or healthcare facility. Seen as an effective and economic means of providing interventions to clients to be able to be responsible for and own their own recovery pathway, thus moving the responsibility over to clients to 'do' the rehabilitation themselves. Technology could be seen as providing measured, limited interventions; depersonalizes - arguably reducing the humanistic component of being actually there; removes the emotion and connectedness associated with a clinic / home visit and the relationship that is built between the clinician and the client. About rationalizing practice, making the most of time available and productivity – part of a machine – in its extreme. What does this do to the clinician and the practice? Will a different type of person – less focused on humanism and caring - attract and take up what is called OT? On the other hand, some clients might prefer this approach – more convenient, able to track themselves, go at own pace, select what they want to do, etc.

How do we know what is true – time of post truths – multiple truths – unscientific truths – what we want the truth to be and not to be. How do we know what is normalized into practice is 'the truth'?

22.1.19 Transferrable skills

OT has a large transferable skill set, do we need to be doing work at root cause of health problems rather than bandaging the aftermath? Should we think of ourselves more as occupation specialists rather than therapist? Therapist gives us such a narrow field of work and implies that we should be in organisations such as DHBs, working with individuals, when the profession could be involved in more strategic health care planning and execution. Move away from medical model - provision of equipment- can be done by others - would question whether this is our true role in the current

healthcare arena - holding on to something from the past. What other opportunities are out there? Remember, not on set pathway, all about taking up opportunities that present themselves when they arise

6.2.19 **Walking the walk talking the talk** - what the doing does. The observed moment where that phrase made sense to me. A nurse 'doing' with her patients in a culturally appropriate way. Hongi and using language they understood, making a way for them and their family to be comfortable in hospital. Seeing their reactions and the animated way they participated - what the doing does.....Provision of real patient centred health care. Te Tapa Wha. Holistic. Cultural. Compassionate. Beautiful.

7.2.19 Nebulous creatures

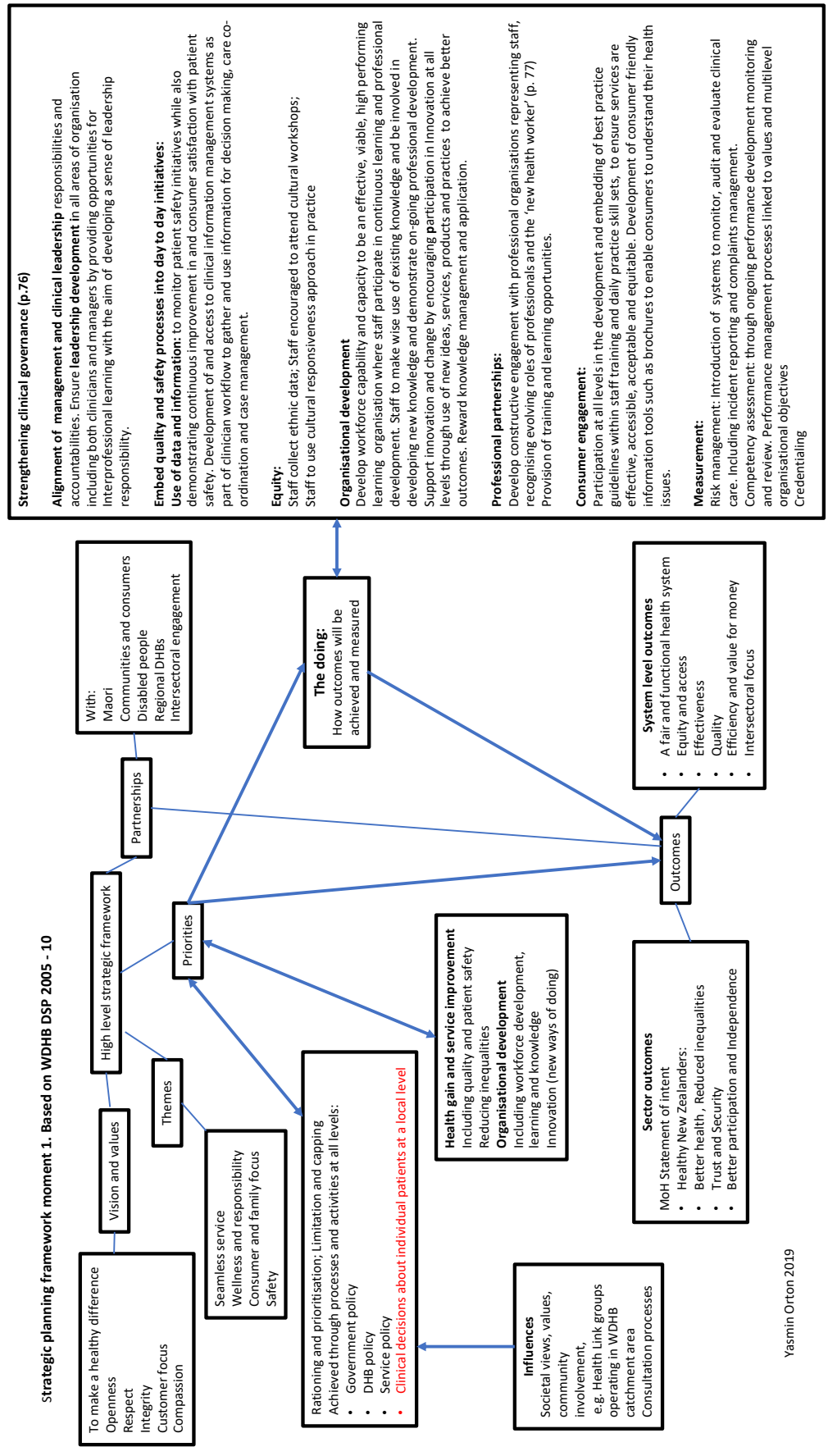
So, when working in DHBs, where the discourses are biomedically predominant, OTs have to look really hard to justify their presence and what they do. So much of what an OT does is not visible. So much goes on through observation – standing quietly to see what a person does or says, and then, thinking about that observation, reflecting, imagining the possibilities, and feeding back potential solutions. OTs are a catalyst for doing. OTs do not require to be seen to be 'hands-on doing' themselves. It is contradictory to their philosophy, although it could be argued that some practitioners feel the need to be seen to be doing something. Hence, the attraction of wheelchairs, and possibly, standardised assessments, not specifically designed for OTs to administer. OTs could be seen as the "producers" in a team – visualising, imagining, planning, directing, co-ordinating, editing, finding financing, liaison, - towards a client's ultimate occupational goal. All are nebulous, rather than concrete, but as a whole, can create an effective and desired outcome for the person involved at the centre of the work.

Appendix F: Moment 1 pointers to emerging clinical governance in a DHB

The table summarizes pointers I sought in the Moment 1 (2003 – 2005) documents that would signify to me the presence of an applied clinical governance framework.

Clinical governance framework	Systems awareness	Teamwork	Communication	Ownership	Leadership
Clinical effectiveness	Quality initiatives Safety Value for money Outcomes Interconnecting services	MDT / IDT Outcomes Seamless service	Use of information systems; openness; transparency	Individual and collective responsibility at all levels to achieve safe, quality outcomes that are value for money	Clinical leadership; Everyone a leader
Risk management awareness	Development of processes to promote safe, competent practice and minimize risk Use of audit Interconnecting services	Consider risks as a team and practice risk minimization	Training in use of processes designed to minimize risk and promote safety	Individual and collective responsibility for competent, safe and ethical practice	Supporting processes and procedures designed to minimize risk at all levels
Communication effectiveness	At all levels; across services; with patients / whanau Interconnecting services	Reporting; Documenting; sharing information appropriately	2-way process, so also from ground up Collaboration Feedback / outcomes	Individual and collective responsibility; including patient / whanau	2-way process, so also from ground up
Patient experience	Inclusive, patient-centred care; partnerships Interconnecting services	Teamwork inclusive of patient	Easily understood shared knowledge and information Lay people elected to DHB board Client panels	Individual and collective responsibility; including patient / whanau	Support patient experience practices at all levels
Resource effectiveness	Value for money Interconnecting services	Value for money Avoid duplication of services	Use of information services for efficient use of time and resources	Prudent use of budget and resources at all levels	Support prudent use of budget and resources at all levels
Strategic effectiveness	Value for money Interconnecting services	Structure for professional and cultural diversity in teams for best outcomes	Feedback mechanisms	Individual and collective responsibility to provide services with best outcomes for patients	Support effective ways of working at all levels
Learning effectiveness	Learning organisation Interconnecting services Learning opportunities for staff	Working together to develop new, efficient ways of working	Organizational communication at all levels	Individual responsibility to engage in lifelong learning, Skills development and knowledge acquisition	Support provision of selected knowledge acquisition at all levels Promote wise use of knowledge

Appendix G: Moment 1 DHB strategic planning framework



Appendix H: The author's CASP reflection (2014)

CASP Objective 1

Evidence 5

Reflection: How Māori participants can be made to feel comfortable during an interview and how their information and knowledge needs to be handled and respected in research (32)

Before completing my research, I read and referred to the work of Linda Tuhiwai Smith (1999), who indicated that the effects of colonisation and the 'research' completed during this period, have had ongoing effects on Māori and that many Māori consider research warily. Therefore, it was imperative that when I conducted my research, the three principles of the Treaty of Waitangi, partnership, participation and protection were followed. With respect to partnership, it was important to acknowledge that a researcher's personal values do impact on communication with Māori participants, and so the researcher needs to be aware of this and minimise that influence by careful preparation.

I hoped that I would have Māori participants in my study, but in the end, this was not achieved. Still. I carefully prepared so that I had the knowledge to make sure any participant would feel comfortable completing an interview with me. In the literature, for cultural awareness, Sporle and Koea (2004) suggested obtaining advice. Therefore, I prepared for participation of Māori clinicians by initially seeking a conversation with [advisor 1] (Ngāti Maniapoto, Ngāti Kauwhata), NZROT. [Advisor 1] had completed research in the past and agreed to share some insights that assisted with making my approach acceptable to potential Māori participants. I also met with [advisor 2], Māori Research Advisor at WDHB, who suggested I pay particular attention to the coding of information and that I offer to hand write notes during an interview as an alternative to using a tape recorder. [Advisor 1] talked about the importance of respecting knowledge. She said that Māori often consider that their knowledge is not personally owned by them - that it belongs collectively to their whanau and iwi. This may include Tikanga and local practices, what they know from others in their family, their community. From [advisor 1], I understood that client-centredness, from the Māori perspective was about 'me and my family'.

This concept is an important aspect of cultural awareness and meant that if information was shared with me, the researcher, I needed to make sure that the information was verified as correct and enable the participant the opportunity to remove or withdraw any information they were subsequently uncomfortable with. Additionally, the remaining information needed to be used carefully so as not to cause distress to the participant or wider family. [Advisor 1] indicated that traditionally, Māori have a strong oral tradition, and many have special roles in their community as orators and welcomers to the Marae. Therefore, because the spoken word might be the preferred means of communication for some participants, I was prepared to offer to read the transcripts, as

required. Sporle and Koea (2004) recommended that when conducting a research project it was important to obtain informed consent from the individual or wider collective. This was particularly important if Māori traditional knowledge was involved. In actual fact, as my study was about ideas from occupational therapy literature, I did not anticipate that Māori traditional knowledge would be a subject of discussion. Another recommendation was that for the purposes of confidentiality, any identifiable information should not be used. This was particularly important with Māori participants, as they may have requested that the research information to be disseminated beyond themselves to their whanau/family. So, in my study, I used pseudonyms to represent participants. I also asked participants to check the transcript to make sure that the information was correct which provided them with the opportunity to have any information removed that they felt uncomfortable about. Additionally, I gave them copies of the transcript and offered to provide a summary of the outcome of the research, so that they could choose to share with others if they so wished.

One of the last pieces of advice [advisor 1] gave me was to understand that Māori are not supposed to talk about their own achievements. In Māori communities, others do that for you. She gave an example of how, in interviews, family traditionally accompany the applicant, and it is they who tell of the applicant's accomplishments. Therefore, when I wrote the participant information sheet, I made sure participants knew that they could bring a supporter, if they wanted. My overall reflection was that by taking time to consider cultural aspects associated with research, with respect to Māori participation, I was well prepared. I believe the insights set up a good approach for the participants I actually did interview, although not Māori.

Appendix I: Proportion of OTs working in DHBs/Health Authorities

Compared with overall workforce of registered OTs over time: shows gradual decline, while private practice/ education/ other increases)

Date	DHB/HAs	Reference
Unable to find statistics prior to 1979		Legacy of Occupation (Gordon et al., 2009) notes that until the late 1960s, new graduate OTs were still bonded for first two years to pay for their education, after which it was common for them to do their OE and travel/work abroad. From the accounts collected in the book, it would appear that the main workplaces from 1950s – 1970s were government funded general and mental hospitals and sanitoriums. There was some acknowledgement of working in the not-for-profit private sector, such as in blind institutions, children's farm schools, aged care, as well as for the Multiple Sclerosis Society, the Crippled Children Society and the Asthma Society. One practitioner worked for the prison service. Some also left the profession and used their skills working in generic roles. The assumption, then, is that the majority of OTs worked for government-funded organisations – the equivalent of DHBs of the time.
1979	87%	Occupational therapy workforce (Morris, 1979/1990)
1988	74%	Occupational therapy workforce profile (Department of Health, 1988, p. 12) This is the second one – first completed in 1985 (unavailable)
2003	56.8% (APC application survey)	Clinical training agency (2003). Disability workforce analysis report. Ministry of Health. Wellington. p.15 (Survey undertaken in 2002 – figures from 2001)
2004	50.4%	(New Zealand Health Information Service, 2004)
2007	52.8% (APC application survey – only 44.5 response rate)	(New Zealand Health Information Service, 2007)
2008	51%	(New Zealand Health Information Service, 2008)
2011	59%	(Occupational Therapy Board of New Zealand, 2011, p. 17) First time annual report includes organisations (incl. DHBs) OTs worked for
2012	53%	(Occupational Therapy Board of New Zealand, 2012, p. 17)
2013	57%	(Occupational Therapy Board of New Zealand, 2013, p. 15)
2014	51%	(Occupational Therapy Board of New Zealand, 2014, p. 19)
2015	49%	(Occupational Therapy Board of New Zealand, 2015a, p. 19)
2016	49%	(Occupational Therapy Board of New Zealand, 2016a, p. 19)
2017	49%	(Occupational Therapy Board of New Zealand, 2017, p. 19) Also reproduced in: (Valentine et al., 2017, p. 34)
2018	48% 49%	(Occupational Therapy Board of New Zealand, 2018a, p. 19) Also in: (Stokes & Dixon, 2018, p. 43)
2019	46%	(Occupational Therapy Board of New Zealand, 2019a, p. 19)
2020	46%	(Occupational Therapy Board of New Zealand, 2020a, p. 22)

Appendix J: Waitematā DHB Values leaflet 2014

Our shared values and behaviours

Our values and behaviours will shape:

- The way we plan and make decisions
- The way we behave with patients, service users, whānau and with each other
- How we recruit, induct, appraise and develop staff
- How we measure and keep improving everyone's experience

Waitemata District Health Board
Best Care for Everyone

v7 - 6 March 2014

"best care for everyone"

This is our promise to the Waitemata community and the standard for how we work together.

Regardless of whether we work directly with patients/clients, or support the work of the organisation in other ways, each of us makes an essential contribution to ensuring Waitemata DHB delivers the best care for every single patient/client using our services."

About our values and behaviours

Our values and behaviours were developed by over 1,000 patients, whānau and members of staff. They describe how we aim to be with the people we serve and with each other, and set out our ambition to provide an "best care for everyone". Here's what patients said about our care in In Your Shoes meetings.

"They looked after me like my own children would have."

"The surgeon clearly explained the pros and the cons of surgery. I could make a choice."

"The contact from the clinical nurse specialist in the hospital, at home, made me feel cared for, loved and cherished."

"I felt like safe, as a consistent system was being used. It was clear to everyone if I needed assistance."

How we aim to be with patients and each other

Waitemata District Health Board
Best Care for Everyone

"everyone matters"

Every single person matters, including patients, clients, family members and staff members.

- **Welcoming** and friendly
- **Respect** each individual
- **Listen** and understand
- **Speak up** for others

"connected"

We need to be connected with our community. We need to be connected within our organisation – across disciplines and teams. This is to ensure care is seamless and integrated to achieve the best possible health outcomes for our patients / clients and their families.

- **Communicate** to keep people informed
- **Explain** clearly
- **Teamwork** with patients, whānau, and colleagues
- Give and receive **feedback**

"better, best, brilliant"

We seek continuous improvement in everything we do. We will become the national leader in health care delivery.

- **Positive** we can make a difference
- **Improve** services and ourselves
- **Safe** practice
- **Efficient** and organised

"with compassion"

We see our work in health as a vocation and more than a job. We are aware of the suffering of those entrusted to our care. We are driven by a desire to relieve that suffering. This philosophy drives our caring approach and means we will strive to do everything we can to relieve suffering and promote wellness.

- **Compassion** for your suffering
- Attentive and **helpful**
- Protects your **dignity**
- **Reassuringly** professional

	Our standards	**Our behaviours.** How we are with service users and colleagues.		
		☆ Love to see	Expect to see	Don't want to see
Everyone matters	**Welcoming** and friendly	• Makes everyone feel positively welcomed and valued	• Is courteous and polite, engages people, makes eye contact, smiles • Introduces themselves using 'the 3Ms in welcome'	• Ignores or avoids patients or colleagues • Is aggressive, rude or impolite
	Respect each individual	• Brings the best out of others by recognising their different abilities	• Remembers people's names • Welcomes different views / cultures	• Makes assumptions, is judgmental or disrespectful of other people • Gossips
	Listen and understand	• Motivates others by making time to listen to their views and feelings	• Is interested in what others say	• Talks over people, doesn't let them ask questions or express views
	Speak up for others	• Encourages colleagues to speak up on behalf of others	• Speaks up every time they see poor or unsafe care or behaviour	• 'Walks by' or ignores poor or unsafe care or behaviour
With compassion	**Compassion** for your suffering	• Is thoughtful about other people and takes time to 'put themselves in other people's shoes'	• Checks in to see people are OK • Notices pain, and does everything they can to reduce it	• Is dismissive of other people's concerns, feelings or pain
	Attentive and **helpful**	• Always wants to make a difference for other people, even if it means putting themselves out	• Asks people if they need help or if they are in pain • Proactively offers to help people or finds someone else who can	• Stands back until someone asks for help - "not my patient / job" • Walks past people in obvious need
	Protects your **dignity**	• Encourages everyone to support the privacy and dignity of patients, families and colleagues	• Always acts if they see someone's dignity or privacy being harmed • Is gentle	• Does / says things that make people feel unsafe, unvalued or bullied
	Reassuringly professional	• Is calm and patient even when under pressure	• Is aware of the impact of things they say and do on other people	• Takes their stress out on others via tone, language or behaviour
Connected	**Communicate** keep people informed	• Connects teams and services, inside and outside our organisation, so they can work better together	• Keeps people informed so they know what's happening • Is prepared, reads notes in advance	• Keeps information that other people need to themselves
	Explain clearly	• Follows up to check that people have understood what's happening	• Explains clearly, using appropriate language, so people can understand	• Uses jargon or confusing language others have trouble understanding
	Teamwork with patients, whānau, and colleagues	• Involves people to make informed choices about things that affect them	• Involves patients, families and colleagues in everything they do	• Silo-working. Acts without involving people in issues that affect them • Lets hierarchy get in the way of care
	Give and receive **feedback**	• Encourages feedback from their service users	• Appreciates good work, says *"thanks"* • Speaks up when people don't live up to our values or give their best	• Is not open to hearing or acting on feedback about themselves • Blames other people
Better, best, brilliant	**Positive** we can make a difference	• Is positive about what we can achieve, has high standards, and motivates others to meet them	• Uses best practice to deliver the best outcomes whatever their role • Celebrates and shares success	• Uses negative, pessimistic language • Accepts poor performance
	Improve services and ourselves	• Inspires others to be creative in finding better ways to do things • Supports other people's learning	• Reviews performance and evidence to look for better ways to do things • Proactively finds ways to improve their own knowledge and skills	• Resists change for the better • Doesn't look to learn or improve their own skills or knowledge
	Safe practice	• Shares lessons learned and supports others to improve safety	• Follows safe practice, is vigilant about risks, and challenges unsafe practice	• Covers up errors • Doesn't follow agreed safe practice
	Efficient and organised	• Stays responsive to patients and colleagues when under pressure	• Is on time, organised and efficient • Respects other people's time	• Is regularly late

Figure 20. Waitematā DHB Leaflet 2014 *Our shared values and behaviours*. (Waitematā DHB, 2014a). Copyright WDHB 2014. Reproduction permission granted.

Appendix K: Table and figure reproduction permissions

Table 7 and 8

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Blijlevens, H., & Murphy, J. (2003). Washing away SOAP notes: Refreshing clinical documentation. *New Zealand Journal of Occupational Therapy, 5*(2), 3-8.
Table 1: Client-centred note writing framework - page 6
Table 2: Progress note foprmat - page 7
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Thank-you for your interest in NZs Journal of Occupational Therapy publications.

Kind Regards,
Grace O'Sullivan
(Editor)

Grace O'Sullivan PhD., NZROT

Private practice: Health of older people
Editor: New Zealand Journal of Occupational Therapy

Email: sullies@xtra.co.nz
Phone: 64 9 410 9541

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Therefore, could I also have permission to use Table 2: Progress note format (p. 7)?
I have attached a copy of the journal containing this article for easy reference.
Many thanks.
Kind regards,
Yasmin

Yasmin Truelove Orton
0277 589 588
yasmin@orton.com
http://www.scopeplus.co.nz

--
Kindness in words creates confidence.
Kindness in thinking creates profoundness.
Kindness in giving creates love.
- *Lao-Tzu*

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Figure 2. Prisoners assemble outside their open cells in a Presidio Modelo Panopticon, Isla de Pinos, Nueva Gerona, Cuba. Photograph circa 1940s. ***Orphaned work***

Figure 3. Early formative mind map. ***Author's work.***

Figure 4. Thinking visually using Powerpoint. ***Author's work***

Figure 5. Sample prescription forms for sanatorium and physical disability use showing medical doctor direction of the purpose of treatment and decision on the desired outcomes. (Haworth & Macdonald, 1946, p. 133 & 127). ***Orphaned work***

Figure 6. Economic discourse upholding the value of occupational therapy practice recognised through plans of NZRSA to acquire more funds that would provide further interventions to servicemen. (Evening Post, 1943b, p. 4). Copyright Fairfax Media. ***Creative Commons New Zealand BY-NC-SA licence.***

Figure 7. Hierarchy in the OT department: OT – Assistants – Volunteers – Patients. (Evening Post, 1943c). Copyright Fairfax Media. ***Creative Commons New Zealand BY-NC-SA licence****.*

Figure 8. Sample record sheet and report revealing treatment plans for rehabilitation of physical injuries (Haworth & Macdonald, 1946, pp. 128-129). ***Orphaned work***

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Figure 18. Overview: Multi-governance Moment 1 (2003-2005 and Moment 2 (2015-2017) produced by multiple discourses from multiple sources. ***Author's work.***

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Figure 10.

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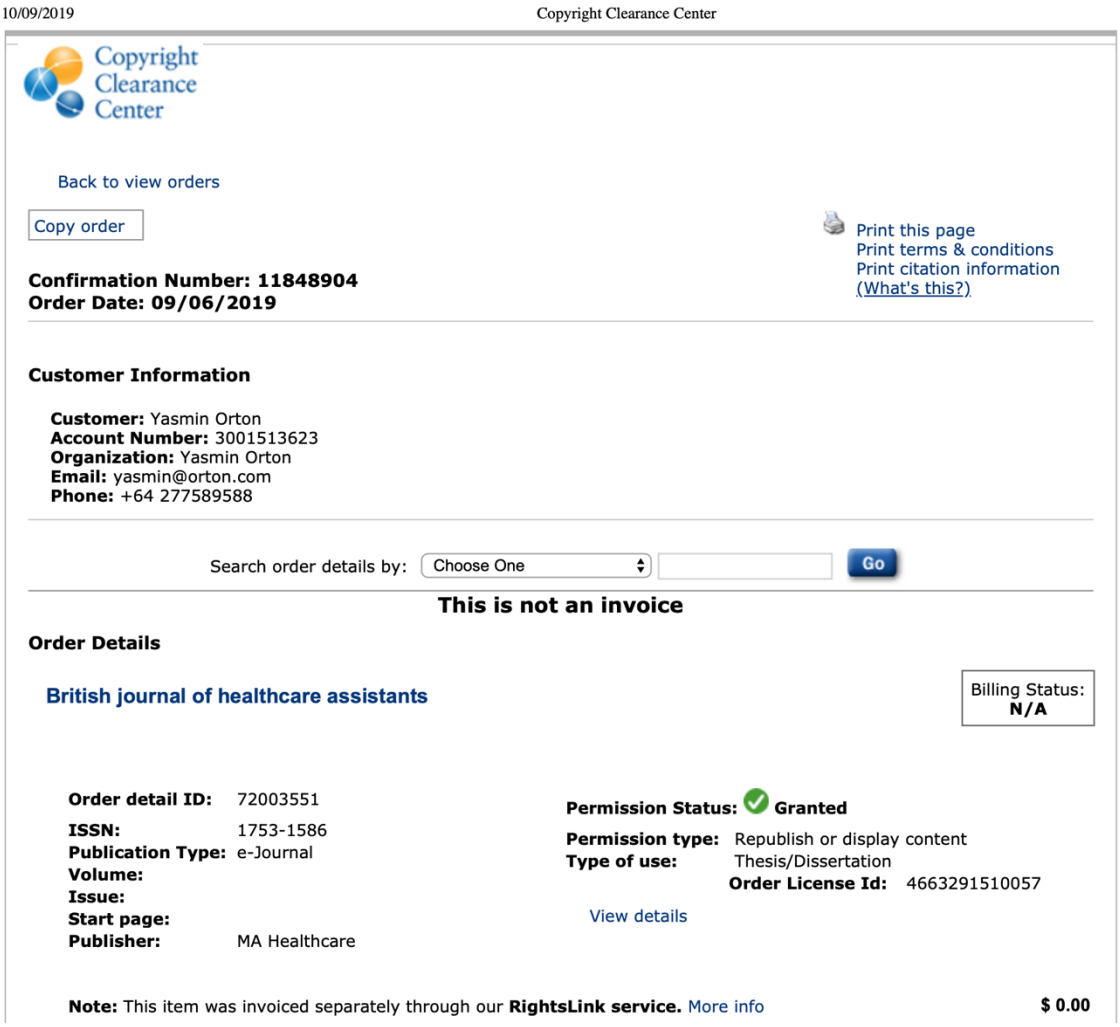

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-
I am a doctoral candidate at AUT, Auckland, and my research is 'How clinical governance has shaped occupational therapy practice within a DHB setting'.
My supervisors are Professor Clare Hocking and Ass. Professor Deb Payne.

I am requesting permission to reproduce a diagram from the document "Clinical governance: Guidance for health and disability providers" 2017.
The diagram is labelled, "The key component of the clinical governance framework" (figure 1, page 12).

Would you let me know if I may have permission granted to use this diagram in my thesis?
It is for educational purposes only.

Many thanks,
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Doctoral Candidate
Faculty of Health and Environmental Sciences, AUT

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0277 589 588
yasmin@orton.com
http://www.scopeplus.co.nz

--
Kindness in words creates confidence.
Kindness in thinking creates profoundness.
Kindness in giving creates love.
- Lao-Tzu

Figures 16 and 20

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Date: 10 May 2021 at 09:56:05 NZST

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The thesis is a Foucauldian discourse analysis of how clinical governance has influenced occupational therapy practice within DHBs.

I would like to reproduce the attached leaflet, “Our shared values and behaviours (2014)” within the thesis, as I refer to it in certain chapters as an example of changing behaviours.

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Figure 19

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My AUT supervisors are Professor Clare Hocking and Ass. Professor Debra Payne.

Please let me know if you require further information to support this request.

Thank you for considering my request.

Kind regards,

Yasmin Orton

MHSc. OTR, NZROT

Doctoral Candidate

Faculty of Health and Environmental Sciences, AUT