Shifting accountabilities: Patient-citizen voices and contested governance in public-private hybrid healthcare

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Abstract

Context

Public-Private Partnerships (PPPs) are increasingly ubiquitous in Canadian healthcare and across the world. They have seen poor consequences for patient care and failures in democratic accountability. Literature has highlighted fundamental differences in the logics that govern accountability between private and public organizations. Whilst the espoused role of the state in a public system is to advance the welfare of its citizens, private companies are ultimately concerned to increase the wealth of their shareholders. Despite this recognition, little is known about how these apparently contradictory patterns of accountability function at the micro-level of healthcare governance. The experiences of patients and citizens are notably absent from the literature.

Objectives

Without better understanding the interplay of these apparently contradictory accountability logics, we lack guidance for how to protect democratically-governed, publicly-accessible healthcare. This thesis aims to identify the consequences for accountability in public-private hybrid healthcare, exploring how accountability is enacted on the front lines of healthcare governance. Specifically, it examines the positioning of patient-citizens, seeking to understand how they enact their interests in this context.

Methods

This thesis adopted a critical ethnographic research design to explore enactments of accountability at a Canadian PPP hospital, using a combination of observational activity and interviews. An ethnographic approach involved direct observation of how PPP policy was translated at a micro-level of healthcare governance and, in line with the aims of this thesis, enabled foregrounding the voices and experiences of patient-citizens.

Results

Particular accountability positions and cultures were reflected in the perspectives, agendas and strategies of three central stakeholder groups in the PPP arrangement: private sector representatives, healthcare managers and patient-citizens. The formal PPP contract had a central role in shaping how private sector representatives and healthcare managers enacted governance and accountability. In contrast to the transactional accountability that was inscribed in the technologies of the formal contract, patient-citizens sought to enforce a socially-based accountability that reflected interdependence between individuals and their overarching systems of influence (culture), and their “real-life” embodied contexts.

Conclusion

This thesis introduces the concept of *accountability cultures* to studying public-private hybridity in healthcare, as a way to understand the interplay of macro, meso and micro-level practices that condition enactments of accountability. Despite commitments of governance bodies for public administration in publicly-funded healthcare institutions, public-private hybridity has profound and contradictory ramifications for public accountability. Attending to micro-practices at the forefront of PPP governance, and *epistemic activism* enacted by patient-citizens entails envisioning and advocating for practices of accountability that foreground the needs of the public. In doing so, this thesis provides the basis for urgently-needed redress of accountability practices in increasingly privatized public healthcare governance.

Résumé

Contexte

Les partenariats public-privé (PPP) deviennent omniprésents dans les services de santé canadien et à travers le monde. Ils ont entraîné de mauvais résultats au niveau des soins des patients et de l'imputabilité démocratique. La littérature a mis en évidence des différences fondamentales dans les logiques qui gouvernent l'imputabilité entre les organisations privées et publiques. Alors que le rôle attendu de l'État dans un système public est d'améliorer le bien-être des citoyens, les entreprises privées sont en bout de ligne soucieuses d'accroître la richesse de leurs actionnaires. Cependant, malgré cette reconnaissance, on en sait peu sur la manière dont ces structures d'imputabilité apparemment contradictoires fonctionnent au niveau local de la gouvernance des services de santé. Les expériences des patients et des citoyens notamment, sont absentes de la littérature.

Objectifs

Sans une meilleure compréhension des interactions entre ces logiques d'imputabilité *a priori* contradictoires, nous manquons d'orientation sur comment protéger un système de santé démocratique et accessible publiquement. Cette thèse vise à identifier les conséquences sur l'imputabilité dans les services de santé hybrides privé-publics, en explorant comment cette imputabilité est performée dans les premières lignes de la gouvernance des services de santé. Plus particulièrement, elle examine le positionnement des patients-citoyens en cherchant à comprendre comment ils réalisent leurs intérêts dans ce contexte.

Méthodes

Cette thèse a adopté un modèle de recherche ethnographique critique afin d'explorer les exécutions d'imputabilité dans un hôpital PPP canadien, en utilisant une combinaison d'observations et d'entretiens. Une approche ethnographique a permis une observation directe de comment les politiques PPP étaient traduites à niveau micro de la gouvernance des services de santé et, dans la continuité des objectifs de cette thèse, a permis de mettre de l'avant les voix et expériences des patients-citoyens.

Résultats

Des positions et des cultures d'imputabilité particulières ont été reflétées dans les perspectives, les intentions et les stratégies de groupes centraux d'acteurs impliqués dans l'agencement PPP : les représentants du secteur privé, les gestionnaires des services de santé et les patients-citoyens. Le contrat formel PPP a un rôle central dans la conception de la gouvernance et de l'imputabilité des représentants du secteur privé et des gestionnaires des

services de santé. Contrairement à l’imputabilité transactionnelle inscrite dans les technologies du contrat formel, les patients-citoyens cherchaient à faire appliquer une imputabilité basée sur le social qui reflèterait l’interdépendance entre les individus, les systèmes d’influences qui les englobe (la culture), et leur contextes incarnés de la «vie réelle».

Conclusion

Cette thèse introduit le concept de *cultures d’imputabilité* à l’étude de l’hybridité publique-privée dans les services de santé, pour permettre de comprendre les interactions entre les niveaux macro, meso et micro des pratiques qui conditionnent l’exécution de l’imputabilité. Malgré les engagements des entités de gouvernance pour l’administration publique dans les institutions de santé publiquement fondées, l’hybridité public-privé a de profondes et contradictoires ramifications pour l’imputabilité publique. Traiter des micro-pratiques en première ligne de la gouvernance PPP, et de *l’activisme épistémique* performé par les patients citoyens, implique d’imaginer et de préconiser des pratiques d’imputabilité qui au premier plan les besoin du public. Ce faisant, cette thèse fourni les bases pour une correction plus que nécessaire des pratiques d’imputabilité dans la gouvernance des services de santé publics qui sont de plus en plus privatisés.

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List of Abbreviations

NPM	New Public Management
PPP	Public-Private Partnership
P3	Form of PPP that refers specifically to infrastructure projects
SEG	South-East General hospital
SGIG	Southeast General Infrastructure Group

Glossary of key terms

Accountability	An ongoing accomplishment that denotes the answerability of actors through use of accounts, as well as explanations or justifications of practice. To be ‘accountable’ for one’s activities involves both to explicate the reasons for them and to supply the normative grounds through which they are justified.
Culture	The customs, behaviors and norms enacted by a group of people, as well as values and assumptions about social reality that structure and normalize their practices.
Democracy	A philosophical ideal, a political strategy, and an instrument of economic well-being. As a system of rule, democracy denotes the organization whereby power is vested in the people and exercised directly or indirectly through a system of representation.
Enactment	The practices, activities and techniques and events that make an object or concept visible, tangible and knowable.
Governance	The processes by which organizations are directed, controlled and held to account. Denotes various structures, approaches and tools that clarify the responsibilities of different actors involved and coordinate between them.
Neoliberalism	The resurgence of principles of classical liberalism. In particular, defense of the free economy, advocating renewal of enterprise culture and the pursuit of market solutions to social and political problems.
Patient-citizen	A term that describes the dual role occupation of healthcare users in a publicly-funded system. This term recognizes that in a publicly-funded system no typical user of healthcare services is only a patient, users also have distinct relations and responsibilities as citizens.
Public-private Hybridity	The mixing of public and private sector elements in service provision. Often seen in Public-Private Partnerships (see below).

Public-Private Partnership	Formal collaboration between public agencies and private enterprises in providing a public asset or service.

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This thesis follows a traditional format.

Chapter one

Introduction and literature review

This thesis is written in the flux of irreversible change to public healthcare systems worldwide. Over the past decades, private organizations have become increasingly involved in the provision of publicly-funded healthcare internationally (El-Gingihy, 2015; McGregor, 2001). Private companies are now strongly embedded in the provision of healthcare services in many clinical fields, such as general practitioner services, diagnostics tests and surgery (El-Gingihy, 2015), as well as in infrastructure (Whiteside, 2011) and support services (Zuberi, 2011). There is little debate that the numbers will continue to rise (El-Gingihy, 2015).

In the context of increased private involvement in public healthcare, repeated concerns for patient safety and democratic governance have emerged (Chang, 2015; El-Gingihy, 2015). Private organizations have been beset by allegations of cost-cutting, insufficient staffing and sub-standard care (El-Gingihy, 2015) and scholars have highlighted the worrying lack of checks and balances entailed by the semi-autonomy of privately contracted services (Chang, 2015; Collier & Scally, 2015; El-Gingihy, 2015; Leys, 2015; Manuel & Crowe, 2014). Involving patients, caregivers and citizens in health care and health policy has been a contemporary concern of organizations internationally (Forster & Gabe, 2008; Jones & Pietilä, 2017; Staniszweska, 2009). The involvement of private companies in public healthcare poses a significant threat to these efforts, as accountability slips out of the public purview.

Following from these concerns over accountability, this thesis seeks to understand the negotiations of stakeholders in a Canadian Public-Private Partnership (PPP) hospital, as private organization involvement becomes increasingly ubiquitous in healthcare in Canada, and across the world. In particular I examine the implications for ‘patient-citizens’. There is an increasingly urgent need to understand the consequences for patient stakeholders and democratic governance, as growing private involvement fundamentally restructures the ways in which public healthcare is provided and governed.

In this thesis I use the term *accountability cultures* to conceptualize the relationship between logics of accountability on broader macro and organizational levels, and micro-level practices at the frontlines of healthcare governance. In the four chapters that follow, I develop an analysis of accountability practices that is inherently cultural, in the sense of deciphering what values and assumptions about social reality, as well as meanings and symbolisms, naturalize certain ways of thinking about and enacting accountability. I argue that understanding accountability *culturally* enables us to better understand the impact of private sector involvement on the everyday practices of public healthcare governance and untangle the ‘non-neutrality’ of accountability relationships in this context (Almquist, Grossi, van Helden & Reichard, 2013). More specifically, a cultural perspective on accountability supports the potential means to address the negative consequences of private sector involvement in public healthcare, to the benefit of patient-citizens.

To introduce the subject of this thesis, the literature review that follows starts by reviewing general roles and principles of publicly-funded healthcare systems. This serves to introduce themes of public accountability and democratic governance in healthcare as the foundations on which my inquiry is built. I go on to consider the threat posed to these principles by growing neo-liberalization in public healthcare. I show Public-Private Partnerships (PPPs) to present a case-in-point of this threat, with conflicting logics of accountability being brought to the fore of healthcare governance. I explore literature that has investigated the subject of accountability in healthcare PPPs, as well as reviewing conceptual and methodological literature on accountability before turning to the research questions that follow from this review.

Healthcare and democratic governance

Publicly-funded, free-at-the-point-of-access healthcare is considered a cornerstone of a successful welfare state (Moran, 2000). Along with education and social welfare, healthcare is often considered one of the three pillars of social policy, as a key tenant to the protection and enhancement of human life and dignity (McGregor, 2001). Built on principles of equal opportunity, public responsibility and equitable distribution, public healthcare systems follow the assumption that healthcare is a right for all citizens. These values stem from both economic and social logics. As taxpayers, all citizens pay into a publicly-funded system. As such, ownership and rights of access apply to the whole population contributing or potentially contributing to the fund, which is usually managed by a central government. This organization is based on Keynesian economic theories which prescribe constructive state involvement in the economy (Fierlbeck, 1998). It is assumed that the role of the state is to actively provide accessible healthcare using taxpayers' money: that there exists a social contract between the state and its citizens. Socially, the provision of publicly-funded healthcare in a welfare state implies that no typical user of healthcare services is only a patient – users have distinctive relations and responsibilities as citizens (Sorell, 2001). Weiner (1993) uses the term 'citizen-patient' to describe this dual role occupation. In the context of a publicly-funded system, the notion of 'patient-citizenship' underlines the inextricable fusion between civic consciousness and one's position at the receiving end of healthcare, either as a current or potential patient (Sorell, 2001).

The Canadian healthcare system, which provides the context for this study, typifies the values of publicly-funded, free at the point of access, universal healthcare. In Canada, access to healthcare based on need, rather than ability to pay was the founding principle of the healthcare system and this has been identified as a defining national value (Martin *et al.,* 2018). Canadian Medicare, commenced in 1947, established taxation-based, publicly-funded programs that cover core medical and hospital services and are free at the point of delivery. The Canadian Health Act of 1984 is considered to have consolidated these standards across provinces (Martin, *et al.,* 2018) and has remained formally tied to principles of universality, accessibility, portability, public administration and comprehensiveness (Whiteside, 2011).

In Canada's publicly-funded healthcare system and in comparable systems, the principle of public accountability is a defining feature (Church, Gerlock & Smith, 2018; Forrer, Kee, Newcomber & Boyer, 2010). Accountability, broadly, denotes the answerability of actors through use of accounts, as well as explanations or justifications of practice. To be 'accountable' for one's activities involves both an explication of the reasons for particular actions and articulation of the normative grounds through which they are justified (Giddens, 1984). In a publicly-funded healthcare system, public accountability requires engagement with citizens who expect value for money and equitable access to services (Martin *et al.,* 2018). This means that each citizen has the right to know the drivers of decision-making processes and to be an active participant in these processes (Daniels & Sabin, 1998). Public accountability concerns the relationship between elected politicians and citizens, as well as the relationship between politicians and public managers (Almquist, *et al.,* 2013). At a macro level this relationship implies a democratic and transparent process in which society, through its elected representatives, participates in making decisions related to healthcare (Nunes, Brandão & Guilhermina, 2011). As a principle of public healthcare provision, democratic governance is built on the idea that public services are paid for by the people and therefore should be shaped extensively by them. It also responds to the notion that public involvement will make services more responsive to the individuals and communities that use them (Florin & Dixon, 2004). Thus, ensuring democratic governance is imperative to a successful public healthcare system.

Mechanisms of governance give practical meaning to public accountability obligations through denoting the processes by which public entities are directed, controlled and held to account (Loh & Lorenz, 2019). Thus, the governance of publicly-funded healthcare systems is built on principles of democracy, transparency and accountability and, theoretically, seeks to protect these values and codes of conduct (Loh & Lorenz, 2019). Public sector governance is concerned with accountability with regards to service delivery, but also pertains to the impact of policies on communities and society at large (Almquist, *et al.,* 2013). On a practical level, governance of public healthcare entities involves the steering and coordination of various actors and defines the relationships between the senior management, the board, governmental actors, stakeholders and integrity bodies (Almquist, *et al.,* 2013). As such, the governance of public healthcare entities includes various structures, approaches and tools that clarify the responsibilities of different actors involved.

In accordance with principles of democratic governance, public accountability and transparency, patient and public involvement has become a central tenant of public healthcare policies internationally (Staniszewska, 2009; Forster & Gabe, 2008; Hardyman, Daunt & Kitchener, 2015; Jones & Pietilä, 2017). Public healthcare entities increasingly seek to emphasize ‘patient centredness’ (Kitson, Marshall, Bassett & Keitz, 2013) and democratic governance (Caperchione, Demirag & Grossi, 2017). The active engagement of current or potential users in governing healthcare services is considered an integral strategy to promoting transparent decision-making and flattening power balances between healthcare systems and those whom they claim to serve (Goodridge, Isinger & Rotter, 2017). This emphasis is reflected in the legal mandate for patient groups in healthcare entities in Canada and many other publicly-funded healthcare systems. Criteria of accreditation and audit bodies that conduct assessments of healthcare institutions, such as Accreditation Canada, seek to enforce and reinforce such principles (see Di Carlo, 2019). Across the spectrum, from individual healthcare providers to national and international levels of policy-making, the agenda for direct patient and public involvement in the governance and design of healthcare delivery is being promoted (see Florin & Dixon, 2004).

Despite the growing prevalence of patient and public involvement in healthcare service development, relatively little is known about the enactment or success of such democratizing initiatives (Staniszewska, 2009; Florin & Dixon, 2004; Renedo & Marston, 2015). The implementation of meaningful patient and public engagement remains a challenge (Goodridge *et al.,* 2017) and improvements to practice remain slow and variable (Hardyman *et al.,* 2015). Concerns have been raised that patient engagement policies can be tokenistic and more concerned with "box-ticking" than with genuine engagement (Goodridge *et al.,* 2017). In accordance with the values that underpin public healthcare systems, for public management to demonstrate effectiveness, decisions relating to healthcare 'must contribute to the value experienced by its multiple stakeholder groups' (Wright, Chew & Hines, 2012: 441). The sense is that involvement of patient and public representatives in healthcare policy must be enacted in ways that enable true civic engagement. To uphold the role and principles of publicly-funded, universal healthcare, it is imperative to examine the function of such mandates for democratic governance.

This thesis follows from the understanding that universal healthcare that is free-at-the-point-of-access, in democratic terms, can be considered a fundamental right, and that democratic and transparent governance is a cornerstone of a successful publicly-funded healthcare system. Canada, alongside most countries with comparable systems, takes great national pride in its universal, publicly-funded healthcare (Martin, *et al.,* 2018). With the goal of protecting universal healthcare, principles of democratic governance, transparency and public accountability must serve to protect the sanctity of healthcare systems, rather than obscure processes that might seek to undermine them. With this understanding, I turn next to the threat posed to democratic governance of public healthcare entities by increasing private sector involvement.

Neoliberal threats to public healthcare governance

Healthcare is one of the highest priorities for any government. It follows that healthcare is highly politicized and driven as much by ideology as by evidence or effectiveness (Gillies, 2003). In this section I explore how, over the past decades, healthcare policies worldwide have been reshaped based on a neoliberal worldview. After exploring a common mind set shaping healthcare service reform in many modern welfare states, I consider the threat the neoliberal infiltration poses to principles of democratic governance, transparency and public accountability in publicly-funded healthcare systems.

Since the 1980s, neoliberalism has been seen to emerge as the dominant government paradigm across many modern welfare states (Church *et al.*, 2018). During the 1990s, concerns about ballooning public costs incurred substantial efforts to reform the organization and delivery of public services in western democracies (Church *et al.*, 2018). This trend has been noted to be particularly evident in the UK, Canada, the US, Australia and New Zealand (Donelan, Blendon, Schoen, David & Binns, 1999). A central hallmark of neoliberal public policy has been its emphasis on market-based provision of services once financed and provided through the welfare state (Whiteside, 2015). The perceived failure of the welfare state has led to increased outsourcing of public services to private organizations, following the central tenants of neoliberalism, comprising deregulation, promotion of the free market via privatization and individualism (McGregor, 2001). Advocates of the neoliberal model argue that private company outsourcing fosters innovation and, freed from state bureaucracy, increases cost effectiveness (Alonso, Clifton & Diaz-Fuentes, 2016; El-Gingihy, 2015; McGregor 2001; Mindell, Reynolds, Cohen & McKee, 2012; Modi, Clarke & McKee, 2018). However, ample evidence has demonstrated that such reforms incur increased costs to the public purse and that efficiency is most often achieved by cutting wages and compromising quality at the front lines of public service delivery (El-Gingihy 2015; Mindell *et al.* 2012; Modi, *et al.*, 2018).

Both the public and private sectors play important roles in neoliberal reform to public services[1] (Savas, 2000). Neoliberal reform involves both the extension of market rule through deregulation and privatization and the adoption of market-like rules by the public sector (Whiteside, 2015; Church *et al.*, 2018). As such, the idea of New Public Management (NPM) has been a central tenant of neoliberal reform, as a way of applying principles and technologies developed in the private sector to governance in the public sector. Developed during the ascendance of key neoliberal politicians – Margaret Thatcher in the UK and Ronald Reagan in the US – NPM aimed at ‘reinventing government’ through the adoption of market-like rules applied to the public sector (Whiteside, 2015: 22). NPM aims to run public sector organizations in a business-like manner, which is generally regarded as relatively more

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[1] It should be noted that enabling neoliberal reform to public services has relied heavily on the political support of public sector actors. Whilst this support can be considered to be in part ideological, scholars have noted how the ideology is encouraged and sustained by a ‘revolving door’ between politician and senior civil service posts, and corporate sinecures (Mindell *et al.* 2012; El Gingihy, 2015).

orientated than public services had been towards performance, cost and efficiency (Diefenbach, 2009). In doing so, this style of governance operates to reorient public sector decision-making in a way that routinizes, institutionalizes and depoliticizes private appropriation – indeed dispossession – of public resources (Whiteside, 2015). The application of NPM in public healthcare governance has been well documented (see Church *et al.,* 2018; McGregor, 2001; Whiteside, 2015). Language and metaphors reflecting neoliberal philosophy prevail in private and public sector discourse on healthcare policy, in descriptions of spending cuts, competitiveness, cost efficiencies, as well as "truth claims" about apparently unfortunate necessities and justifiable sacrifices (McGregor, 2001; Whiteside, 2015).

Neoliberal infiltration into healthcare has received particular critical attention, given that private sector involvement has important implications for the health and wellbeing of the population. Reforms have significantly impacted healthcare delivery, both in financing and services (McGregor, 2001). The neoliberal agenda for healthcare reform includes cost cutting for efficiency, decentralizing from national to local levels and, critically, evolving healthcare as a private rather than public good (McGregor, 2001). This means that the healthcare delivery is increasingly aligned with the generation of profit. A major aim of neoliberalists is the deregulation and privatization of public and state-owned entities (McGregor, 2001). As such, re-regulation has involved re-working laws to enable more power to be given to the private sector and extensive outsourcing of public healthcare services to private organizations. Private companies are now strongly embedded in the provision of healthcare services across modern welfare states, in many clinical fields, such as general practitioner services, diagnostics tests and surgery (El-Gingihy, 2015), as well as in infrastructure (Whiteside, 2011; El-Gingihy, 2015) and support services (Zuberi, 2011; El-Gingihy, 2015).

Neoliberal reforms have profound effects for healthcare policy (Mindell *et al.,* 2012) and public accountability (Church *et al.,* 2018). Research has demonstrated troubling effects for democratic accountability incurred by private organization involvement in the governance of public healthcare delivery (Church *et al.,* 2018; El-Gingihy, 2015; Mindell *et al*., 2018; Whiteside, 2015). Private profit from public services, without corresponding accountability has concerning implications for populations across western democracies. Accountability failure in this context has been linked to poor outcomes for patient safety – that is, the extent of harm that is done to patients using healthcare services, much less the improvement to their health (Church *et al.,* 2018; El-Gingihy, 2015; Modi, *et al.,* 2018). It has been recognized that private organizations providing public healthcare services occupy an uncertain position between representing public and private interests (Collier & Scally, 2015; El-Gingihy, 2015). Whilst public sector organizations are publicly-funded and controlled, private sector organizations are run by individuals and companies, with the intention of making profit for individual owners or shareholders.

The implications for accountability incurred by neoliberal reforms of the public sector extend to the heart of the relationship between the state and business. Whilst the state is charged with protecting and advancing the welfare of its citizens, the purpose of private organizations is to increase the wealth of their shareholders (Mindell *et al,*. 2012). When private organizations become involved in public healthcare services, complications and resultant costs continue to be covered by central government funding, but private organizations' primary legal accountability remains to their own company management, and to their shareholders (Collier & Scally, 2015; El-Gingihy, 2015; Mindell, *et al.,* 2012; Whiteside, 2015). As such, responsibility and answerability in public-private hybridity is a thorny and multifaceted issue. Accountability for public health governance has become fundamentally linked to the specific relationship, obligations and contractual agreements formed between governments and private firms (Forrer, *et al.,*2010).

In this neo-liberalizing context, effective accountability to the public has become a central concern (Church, *et al.,* 2018). Involvement of private sector companies in public healthcare provision involves the transfer of rights, authority and power over important social concerns away from the public sphere, into the hands of private companies with wholly different accountability agendas (Church, *et al.,* 2018; Whiteside, 2011). In public healthcare provision, this has considerable implications for democratic governance and quality of care. Whilst politicians remain accountable to their constituents through the polls, traditional notions of accountability that stem from the welfare state have been challenged, as lines of accountability become multiple, tangled and obscured (Tuohy, 2003). Accountability is understood in varied ways: political, bureaucratic, legal, moral, professional (Church *et al.,* 2018). When governmental bodies delegate authority and responsibility to an increasing array of private sector organizations, democratic accountability comes up against other types of accountabilities, which may not be consistent with each other, such as new legal and professional accountabilities between governmental bodies and private sector organizations. As the role of the state moves from one of 'rowing' in the post-war welfare state, to 'steering' healthcare service delivery from a distance (Pfeiffer, 2019; Church *et al.,* 2018; Tuohy, 2003), the established relationship between the state and its citizens is tested.

Researchers have argued that market reforms to healthcare systems must be carefully scrutinized in order to protect values and norms for social cohesion (Nunes, *et al.*, 2011). Neoliberal encroachment on public healthcare delivery threatens the democratic values on which publicly-funded healthcare systems are built. Indeed, there is a contradiction between principles of publicly-funded, democratically-governed healthcare that are formally retained modern welfare states, and the complicity of the state in neoliberal reforms that are serving to dismantle such systems. In this context, we must specifically attend to how the neoliberal reform of publicly-provided healthcare raises questions about public accountability and the spaces available for activism and citizen voices. As healthcare initiatives worldwide increasingly seek to emphasize 'patient-centredness' (Kitson, *et al.* 2013) and democratic governance (Caperchione, *et al.* 2017), it is critical to explore the implications for such initiatives in the flux of increasingly private sector involvement, and consider the agency of patient-citizens in this context.

Public-private hybridity in healthcare

Thus, it is broadly recognized that there are fundamental differences in the logics that govern accountability between private and public healthcare organizations (Collier & Scally, 2015; El-Gingihy, 2015; Kirkwood & Pollock, 2016). Despite recognition of the apparent threat of private interests to the democratic governance of healthcare, not enough is known about how multiple logics for accountability intersect and are negotiated as they move between broader organizational levels and micro-levels of practice (Bishop & Waring, 2016; Marsilio, Cappellaro & Cuccurullo, 2011; Waring, Currie & Bishop, 2013; Waring & Bishop, 2018). In the previous section I explored problems for public accountability that emerge in the growing neo-liberalization of public healthcare. In this section I introduce Public-Private Partnerships (PPPs) and, more specifically, P3 projects as illustrations of this problem and as the case study for this research. I begin by introducing P3 projects as examples of public-private hybridity. I go on to provide an overview of literature that has addressed PPPs and P3s, focusing particularly on how accountability, as the central tenant of this thesis, has been addressed in this field. I follow this section with a brief review of research on accountability, focusing particularly on conceptual and methodological approaches that have important implications for investigating stakeholder behaviors on the frontlines of public-private hybrid healthcare.

PPPs are a prevalent example of how private organizations have become increasingly involved in the provision of public healthcare (Bishop & Waring, 2015; El-Gingihy, 2015;

Whiteside, 2011; Whiteside, 2015). PPPs involve a formal collaboration between public agencies and private enterprises in providing a public asset or service (Roehrich, Lewis & George, 2014). What is involved in this collaboration is varied: PPPs can entail one or all of the planning, construction and management of public services (Forrer, *et al.,* 2010; Koppenjan, 2005). Consistent with arguments for neoliberal reform of public services, advocates argue that PPPs enable risk-sharing in the financing and delivery of public goods and serve to unlock innovation (Forrer *et al.* 2010; Roehrich *et al.* 2014). Consistent with broader arguments against neoliberal reform in public sectors, critics have demonstrated that PPPs create high costs to the public purse, dilute public accountability, and transfer decision-making away from public interests (El-Gingihy, 2015; Mindell, *et al.,* 2012; Whiteside, 2011; Whiteside, 2015). Despite these controversies, over the past decade or so the use of PPPs in healthcare fields has grown almost five-fold worldwide (PWC, 2010). PPPs now hold a strong global presence in delivering healthcare infrastructure, technology systems and clinical services, as well as maintenance, security and management services (Barlow, Roehrich & Wright, 2013; Roehrich, Barlow & Wright, 2013; Roehrich *et al.* 2014). As a widespread manifestation of neoliberal reform in public healthcare delivery, PPPs provide a valuable case study for examining issues of accountability that have arisen through these changes. PPPs are particularly interesting because they combine the distinct organizing logics and cultures of the public and private sectors in an explicit 'hybrid' form (Waring & Bishop, 2018; Bishop & Waring, 2016).

This thesis examines a particular type of PPP, known as the 'P3' model. P3 projects pertain specifically to the provision of infrastructure and denote the involvement of private organizations to privately design, build, finance and operate (DBFO) public infrastructure (Whiteside, 2015). The origins of the global P3 model can be found in the emergence of Private Finance Initiative (PFI) in the UK. As part of neoliberal reforms in the 1990s, PFI projects emphasized the mobilization of private finance for public infrastructure and service funding (Whiteside, 2015). PFI projects were rebranded as 'P3s' following the election of a Labour government in 1997, as a way of shifting the emphasis towards 'partnership' with the private sector, and downplaying the privatization dimension (Whiteside, 2015). In contrast to traditional public hospitals, whereby design, construction and support services are provided through public services, P3 projects entail contracting these services to private firm consortia, often multinational (Whiteside, 2015). Thus, as well as building, P3 contracts entail private companies' involvement in the day-to-day running of hospitals, clinics and community centers, through activities such as laundry, cleaning, security and maintenance of infrastructure (Whiteside, 2011). As such, P3 projects establish binding long-term contracts incorporating the private sector into the provision of public healthcare services, with the course of contract typically lasting around 30 years (Jones, 2018; Whiteside, 2011).

P3 projects are an increasingly central component of healthcare infrastructure across the world (Forrer, *et al.* 2010). In Canada, P3 use has grown unabated since the mid-1990s. Healthcare infrastructure has been particularly targeted for P3 use (Whiteside, 2015). In recent years, Canadian provinces have increasingly employed private sector organizations to finance and construct large-scale infrastructure projects in healthcare through P3 projects (Whiteside, 2015). Whilst Ontario leads the country in the quantity of P3 hospital projects, followed by British Columbia, Quebec, where this research is set, is not far behind, as the province with the third highest number of P3 hospital projects in the country (Truchon, 2013). As such, P3s are an increasingly integral component of Canadian healthcare infrastructure and service delivery.

P3 healthcare projects have been seen to exemplify the negative repercussions of private sector involvement in public healthcare provisions. As well as allegations of cost-cutting and corruption (see Whiteside, 2015; Whiteside, 2011), there have been repeated concerns of eroded accountability and transparency in P3 projects (Whiteside, 2011). Conflicting logics of accountability have been brought to the fore, as P3s transfer rights and control away from the public sphere, vesting greater authority, power and decision-making in private companies with wholly different accountability agendas. Evidence from the UK suggests that the P3 model may have deleterious effects on the operation of hospitals and the quality of care provided (Fussell & Beresford, 2009; El Gingihy, 2015). P3 projects have been beset by issues of poor patient safety and significant lapses of accountability, as well as mounting public debt (El Gingihy, 2015; Whiteside, 2015). Existing projects have already left a legacy of delays, higher costs and hidden fees, and well as more ground-level issues of inadequate training of privatized support services, poor hygiene control and cuts to wages and benefits (Whiteside, 2011). As such P3s are typical cases of the broader challenge of neoliberal reform to public healthcare. They exemplify the contradiction incurred by public systems that are premised on public governance and the de-linking of ability to pay from the receipt of services, yet enable the erosion of these principles through for-profit involvement.

On PPPs in healthcare

In line with my aim to address issues of accountability in public-private hybrid healthcare, I draw on current evidence from literature on both PPPs in healthcare and P3 healthcare projects. As much of the literature uses ‘PPP’ and ‘P3’ interchangeably depending on the country of source, I refer to mainly to PPPs. I focus primarily on empirical studies and reviews, drawing from fields of social sciences, accounting, health services management and policy.

Despite the worldwide prevalence of PPPs, they have rarely been subjected to in-depth empirical investigation and conceptualization (Roehrich, *et al.,* 2014; McKee, Edwards & Atun, 2006; Saussier, 2013). Broadly, literature on PPPs in healthcare has highlighted them as controversial policies (Bishop & Waring, 2015; Hodge & Greve, 2007), with mixed reviews about their effectiveness (Saussier, 2013; Caperchione *et al.* 2017; Roehrich, *et al.* 2014; Barlow, *et al.* 2013; Hodge & Greve, 2007). Although existing research has come from across various disciplines, perspectives from accountancy, finance and public management predominate (Roehrich, *et al.* 2014).

Accordingly, much of the research concerning PPPs in healthcare has been concerned to investigate macro-level analyses of PPP policy and the economic performance of PPPs (Caperchione, *et al.,* 2017; Roehrich, *et al.,* 2014; Cui, Lui, Hope & Wand, 2018; Hodge & Greve, 2007; McKee, *et al.,* 2006). Many have questioned the long-term value for public money that is created by these partnership agreements (Bishop & Waring, 2015; Caperchione, *et al.,* 2017; Barlow, *et al.,* 2013; Cui, *et al.*, 2018; Forrer, *et al.,* 2014). Scholars have also shown concern about how risks are being diffused between the public and private sectors (Roehrich, *et al.,* 2014; Barlow, *et al.,* 2013; Forrer, *et al.,* 2010; Burke & Demirag, 2017). A number of studies have shown PPP infrastructure projects in healthcare to involve inequitable sharing of risk between public and private sectors (Burke & Demirag, 2017), poor value for money and to involve high levels of debt incurred by the public sector (Bishop & Waring, 2015; Smyth, 2019; Hodge & Greve, 2007; McKee, *et al.,* 2006).

Research has also been invested in understanding and assessing the efficiency of PPPs and how they impact healthcare performance (Saussier, 2013; Bishop & Waring, 2015; Roehrich, *et al.,* 2014; Barlow, *et al.,* 2013; Cui, *et al.,* 2018; Forrer, *et al.,* 2014). A significant number of studies raise questions about outcome quality in healthcare PPPs, with particular concerns raised about the emphasis on cost-reduction over quality of care (Bishop & Waring, 2015; Hebson, Grimshaw & Marchington, 2003; Roehrich, *et al.,* 2014; Hodge & Greve, 2007). Related concerns about flexibility, complexity and innovation have also been conveyed (McKee, *et al.,* 2006; Bishop & Waring, 2015; Barlow, *et al.,* 2013).

As such, it can be said that literature on PPPs has tended to focus on structural or ‘upstream’ issues, such as partnership configuration, financial contracting and risk management (Bishop & Waring, 2016). Beyond dominant economic concerns, scholarship from social sciences, accounting and management has recognized accountability as a central issue arising from the implementation of PPPs (Caperchione *et al.*, 2017; Forrer, *et al.*, 2010). Such literature on PPPs has highlighted the potentially contradictory implications of incorporating capital-seeking entities into a public healthcare system (Jones, 2018; Chang, 2015; Collier & Scally, 2015; El Gingihy, 2015; Leys, 2015; Manuel & Crowe, 2014; Bishop & Waring, 2015; Whiteside, 2015; Whiteside, 2011). Not only, then, has a considerable amount of academic debate questioned private interests in public healthcare delivery; a growing body of literature has specifically focused on accountability and governance in relation to PPPs. Alongside other neoliberal healthcare reforms, PPPs have been argued to undermine the moral principles of public organizations, by promoting economic rationality above other values (Bishop & Waring, 2015; Fevre, 2003; Davies, 2014; Forrer, *et al*., 2010). Scholars have highlighted fundamental differences in the logics that govern accountability between private and public healthcare organizations and contradictions incurred by their combination in PPPs (Bishop & Waring, 2015; Bishop & Waring, 2016; Collier & Scally, 2015; El Gingihy, 2015; Kirkwood & Pollock, 2016). Public and private sectors are associated with having distinct funding arrangements, client relations and modes of working, with accountability systems that function accordingly (Bishop & Waring, 2015). Whereas public sector organization is characterized by an ethos of political accountability and public interest, private sector work is informed by competitiveness, profitability and accountability to shareholders (Bishop & Waring, 2015). Public and private sectors are associated with having distinct funding arrangements, client relations and modes of working, with accountability systems that function accordingly (Bishop & Waring, 2015). Although public sector reforms have arguably blurred these distinctions, there remain apparently intractable differences in the principles that guide these sectors (Bishop & Waring, 2015). The differences that condition these distinct sectors have been characterized by some as particular ‘cultures’, in the sense that they manifest in systems of meanings, beliefs, values, norms and routines, which are shaped and reinforced through mutual interactions among those in the same sphere of activity (Bishop & Waring, 2015). As such, scholars have broadly recognized the difficulties of overcoming institutional differences between public and private organizations in PPPs, to enable ‘true’ partnership (Bishop & Waring, 2015; Caperchione, *et al.,* 2015).

Consequently, a growing number of scholars have examined governance arrangements in relation to public accountability of PPPs (Forrer, *et al.,* 2010; Baru & Nundy, 2008; Bishop & Waring, 2015; Cui, *et al.*, 2018; Shaoul, Stafford & Stapleton, 2012). For example, recognizing that involvement of private sector organizations in public healthcare provision requires a degree of authority to be devolved outside of public bureaucracy, scholars have been concerned to investigate the operation of governance in healthcare PPPs (Bishop & Waring, 2015; Shaoul, *et al.* 2012). Through such investigations, scholars have sought to unravel different components and mechanisms of governance in the operation of PPPs (Bishop & Waring, 2015; Forrer, *et al.*, 2010; Shaoul, *et al.*, 2012). It has been identified that PPPs pose unique challenges to public managers, because public entities must consider how they account to and for their private partners, as well as to their citizens (Forrer, *et al.*, 2010; Shaoul, *et al.*, 2012). Accordingly, some literature has sought to explore stakeholder relations, which attend to organizational level management of PPPs (see Burke & Demirag, 2017; Caperchione, *et al.*, 2017; Wong, *et al.*, 2015; Roehrich, *et al.*, 2014). More broadly, scholarship concerned with the neo-liberalization of the public sector has highlighted the growth of audited technologies of accounting in public organizations (see Strathern, 2000; Power, 1994). Overall, research has demonstrated concern over the multiplicity of accountability relations created by PPPs (Forrer, *et al.*, 2010; Baru & Nundy, 2008; Shaoul, *et al.*, 2012)

Despite the growing body of research into PPPs, concerns for accountability and governance have tended towards analyses on macro and organizational levels of PPP implementation (see Forrer, *et al.*, 2010; Shaoul, *et al.*, 2012). Following the understanding that there exist important differences in the logics that guide accountability between the public and private sectors, recent scholarship has demonstrated interest in exploring the ‘genealogical parenthood’ (Oliver & Montgomery, 2000) of accountability practices, to better understand the influence of these divergent understandings of accountability and risk at the sharp end of PPP environments (Bishop & Waring, 2016; Durdy & Bradshaw, 2014; Kirkwood & Pollock, 2016; Mindell *et al.*, 2012; Waring, *et al.*, 2013). Accountability failure in neoliberalized healthcare environments has been recognized as often the result of interrelated factors at the individual, organizational and system levels (Church, *et al.*, 2018). Despite this emergent interest, few studies have examined the intra-organizational or ‘downstream’ issues of PPPs, and a ‘top-down’ institutional perspective prevails (Bishop & Waring, 2016; Waring, *et al.*, 2013).

As such, there is limited empirical research that has explored the micro-level effects of PPPs and how distinct public and private sector accountabilities function at the frontlines of healthcare governance and delivery. Where scholarship has explored the micro-level effects of PPPs, it has tended to be focused on the experiences of the workforce, either on healthcare managers (Waring, *et al.*, 2013; Bishop & Waring, 2016; Hebson, *et al.,* 2003) or clinical and non-clinical staff (Alonso, *et al.,* 2016; Waring & Bishop, 2018; Bishop & Waring, 2016). Such literature has demonstrated concerns about the values promoted by PPPs, with some empirical literature suggesting that PPP contracts limit the capacity for public workers to work in the public interest (Bishop & Waring, 2015; Hebson, *et al.*, 2003).

Exploring the experiences of staff involved in healthcare PPPs in the UK's National Health Service (NHS) Bishop & Waring (2015) identified four prominent points of cultural difference between NHS staff and their private sector partners (see also Waring, *et al.* 2013). The first relates to the perceived goals and purposes of the service, with public sector clinicians advocating patient care as an end to itself. Contrarily, clinicians perceived that their private partners understood patient care as a means of making profit. Relatedly, Bishop & Waring (2015) found that public sector clinicians perceived the ideology of care as a public good, whereas they experienced the PPP as advancing private value ahead of public good. Thirdly, clinicians described a shift in the norms of day-to-day work, with collegial and local team-based practices being replaced with more standardized ways of working, reflecting little regard for local circumstances. This reflected the fourth difference, whereby workers experienced changes in patterns of accountability and responsibility, with emphasis given to contractual obligations and performance indicators, ahead of professional judgement (Bishop & Waring, 2015).

Therefore, where scholarship has explored the frontlines of healthcare PPP environments, significant impacts on people and practices have been highlighted. Some studies from architecture have also emphasized that PPP healthcare projects profoundly affect care environments by shaping the contexts care work is produced (Jones, 2018). Importantly, such changes in workplace cultures and environments in healthcare provision would seem to indicate that there might be equally significant impacts on the experiences of patients. Despite this, minimal research has been conducted that addresses this level of experience. This literature review found only two studies that addressed some aspect of patient experiences (see Waring & Bishop, 2018; Wong, *et al.*, 2015). Bishop & Waring (2018) consider how 'hybrid spaces' of PPPs transform the practices and identities of professionals and service users in healthcare environments. They found that there was a degree of incongruence between what patients expected from NHS care and what they experienced in the public spaces of public-private hybrid organizations (Bishop & Waring, 2018). However, it is notable that the data collection for Bishop & Waring's (2018) study included no interviews with patients and where it did address patient behaviors, used ethnographic observation to focus primarily on their use of space. Wong, *et al.* (2015) explored the practice of PPPs at the inter-organizational (meso) level and interpersonal (micro) level in the Hong Kong health sector. Whilst their data collection included interviews with patient support groups and patient representatives, amongst others, conclusions focussed primarily on a 'realist evaluation' of PPP function. Patient input was therefore structured into a 'context, mechanism and outcome' model, which might be considered to miss important dimensions of their experiences.

Overall, although failures in democratic accountability have been a central facet of PPP healthcare literature and existing empirical studies have highlighted significant impacts for workplace culture incurred by healthcare PPPs, the voices and experiences of patients and citizens are notably absent from the literature. Appeals have been made for research in this field to re-focus on everyday work (Bishop & Waring, 2016; Caperchione, *et al.,* 2017; Waring, *et al.*, 2013), and attend to the role of new forms of 'dialogic' accounting and accountability incurred by public-private hybridity (Caperchione, *et al.*, 2017). There exists a strong imperative for research to address the experiences of patient-citizens in PPP healthcare environments with the aim of advocating democratic governance, transparency and citizen participation.

On Accountability

Accountability has received interest as an object of investigation across many different fields, including public administration, law, political science, psychology, organizational studies and sociology (Dubnick, 2003; Yang & Dubnick, 2016). The dominant approaches to studying accountability in these fields, particularly in psychology and organizational studies, have tended to treat it as a cognitive process; as a 'state of mind'; as a mechanism of governance, or as a goal-orientated set of rules (Dubnick, 2003). As such, the concept of accountability remains contested across the literature. Dubnick & Justice (2004) consider the "chameleon-like" nature of the term, denoting the way in which accountabilities constantly move simultaneously along several dimensions of governance. The coupling of accountability and governance in investigations on both individual and organizational levels may be seen to run through much of the research: there has been a tendency to characterize accountability in strictly organizational terms, privileging study of formal accountability systems over other, non-administrative ways in which accountability is enacted (Dubnick & Justice, 2004; Hor, 2011).

Where research has gone beyond investigation of formal accountability systems, it has nonetheless tended to dichotomize 'formal' governance and 'informal' everyday practices (Hor, 2011). In response, there has been a recent concern in the literature to uncouple accountability from governance, widening the purview of accountability to studying accountability *practices* (Aveling, Parker & Dixon-Woods, 2016; Hor, 2011; Yang & Dubnick, 2016). Yang & Dubnick (2016) identify a shift that has occurred from the macro-analysis of accountability structures, to micro-analysis of the actors involved in these systems. They consider that the implication is that to better understand accountability systems and their effects, we must carefully understand how actors make sense of the systems (Yang & Dubnick, 2016).

Moreover, there is recognition that accountability practices are subject not only to internal institutional logics, but are also influenced by structuring effects of broader institutional and socioeconomic contexts. However, work to link micro-practices in healthcare with wider social, political and economic logics is not well developed (Aveling, *et al.,* 2016; Chang, 2015). Overall, available research on accountability has struggled to link macro and meso-level logics with micro-level accountability practices and so is, in this respect, methodologically underdeveloped. A notable effort to address these different levels of accountability practices might be seen in Hor (2011), who suggests that there is a need to match complexity with complexity, exploring *multiple accountabilities* in order to engage the multiplicity of practices involved in healthcare work. The need to engage the multiplicity of accountability practices in healthcare suggests an imperative to understand the various cultures in which these practices are embedded. This is particularly pertinent to the context of public-private partnerships in healthcare, legitimating examination of how 'different sources of justification… come from different rationalities' (Hor, 2011: 65; see also Aveling, *et al.*, 2016). Accordingly, this thesis responds to a pressing need to understand the complexity of accountability, and the interplay of conditions that contribute to accountability practices.

Aim: Investigating *accountability cultures* and patient-citizen voices

This thesis is guided by the need to better understand how the presence of multiple logics for accountability is enacted on the frontlines of healthcare governance and the effects of such enactments for patient-citizen voices. Without understanding the interplay of public and private interests at the frontiers of healthcare governance, we lack guidance for how to protect publicly-funded, accessible healthcare. Underpinning concerns of poor accountability in PPP healthcare projects are more fundamental concerns about democratic governance, transparency and citizen participation (Caperchione, *et al.,* 2017). What is meant by public and patient participation in this context is often unclear and open to multiple interpretations and rationales (Renedo & Marston, 2015). As private sector involvement in public healthcare services makes access to democratic accountability increasingly problematic, researchers must attend to new forms of communication that are created in this context, paying attention to the range of practices through which patient and citizen participation is negotiated and enacted (Renedo & Marston, 2015). There is a danger that without careful scrutiny, the values that underpin public healthcare systems will not only fail to protect them, but also in fact serve to obscure the very processes that are dismantling them.

It has become apparent that we must understand the relationship between accountability on macro and organizational levels, and practices on the micro-level of P3 healthcare environments, to address consistent concerns of eroded accountability that have emerged in the outsourcing of services to private company providers (Waring, *et al.,* 2013). This research seeks to address these needs by tracing *accountability cultures* through stakeholder negotiations at P3 hospital in the Canadian province of Quebec. Following from the above review of conceptual and methodological approaches to studying accountability, the term *accountability cultures* presents a way of making explicit links between the structuring effects of broader macro-level logics and micro-level practices. Framing these links culturally enables foregrounding 'the tacitly known scripts and schemas that organize ordinary activities' (Ybema, Yanow, Wels & Kamsteeg, 2009: 2). As such, a cultural approach to accountability practices in healthcare PPPs enables exposure of the 'non-neutrality' of such practices by explicating the values, logics and structures through which they are naturalized. Importantly, a cultural approach to accountability practices also attends to multiple forms of accountability. In doing so, it serves to provide opportunities to redress how governance is enacted in neoliberalized healthcare environments, with the aim of benefitting of patient-citizens.

Specifically, then, this research seeks to understand how stakeholders negotiate their interests between *accountability cultures* created by the involvement of profit-making organizations in public healthcare services. In line with the need to attend to patient-citizen participation in this context, I investigate what happens to patient stakeholder voices in PPP hospital governance, with emphasis on producing engaged, critical research in healthcare. In accordance with these concerns, the primary research question examined in this research is **'How is accountability enacted in PPP healthcare projects?'** The secondary research question is **‘How do patient-citizens enact their interests in the context of PPP healthcare projects?’**

Chapter two

Methodology

In the previous chapter, I reviewed current research on healthcare PPP projects and accountability, arguing a need for critical research to investigate micro-practices of accountability and experiences of patient-citizens at the sharp end of PPP healthcare environments. In this chapter, I continue this discussion by explaining my research design and demonstrating how my approach is necessitated by the broader aims of this research. I convey how the methods employed were chosen to critically explore *accountability cultures* in the context of a healthcare PPP and capture the accountability practices of different stake-holding groups. I consider the theoretical perspectives that underpin my research design, discussing the relationship between ethnography, policy, space and accountability. I discuss the setting for this research and why it should be considered as a typical case of the broader problems that this research seeks to address, as well as exploring how identity was conceptualized with regard to participants. This is followed by a description of data collection and analysis, and a reflexive discussion of ethical considerations in the field.

Research design

Ethnography

Ethnography as a research methodology has been described in many different ways over time, but has consistently been understood to involve ethnographer's 'direct engagement with the world they are studying' (Reeves, Kuper & Hodges, 2008: 512). Ethnography is best suited to studying the 'culture' of a group by getting close to everyday practices in natural settings (Finn & Waring, 2006; Goodson & Vassar, 2011). This is achieved through systematic and long-term observation of a social setting, usually involving a combination of observational activity and conversation with the social actors involved (Payne & Payne, 2004). Systematic observation of a social setting presents a compelling way of studying accountability practices in a PPP healthcare setting. Examining *accountability cultures* at the frontlines of stakeholder negotiation is framed conceptually by an understanding that culture is central in shaping behavior, institutions and processes in an organizational context (Alvesson, 2013), and that a culture can only be deciphered as it is enacted (Schein, 2013). Ethnographic methods in organizational settings can be used to explore 'how that organizing organizes people' (Ybema, *et al.,* 2009). Ethnographic methods, therefore, offer an effective methodological framework for exploring how macro-level logics of accountability in PPP policy are translated by stakeholders at the micro-level in P3 healthcare environments. Direct observation makes available the values and assumptions about social reality that underpin behaviors related to a healthcare PPP, as well as meanings and symbolisms that naturalize *accountability cultures*. This also comprises a distinct epistemological move beyond studies of healthcare PPPs that have tended towards economic and institutional perspectives (see Caperchione, *et al.,* 2017; Bishop & Waring, 2015; Waring, *et al.,* 2013).

Methodologically, doing ethnography at an institution has important effects on how the research is carried out. The organizational processes and professional practices that characterize an institution shape the manner in which the researcher can engage with the site, as well as its actors. This poses specific methodological challenges (Ybema, *et al.,* 2009). In the next sections, I explore how I conceptualized and carried out this research, responding to policy, institutional settings and stakeholders with whom fieldwork was conducted.

Critical policy ethnography

This research project adopted a critical ethnographic research design, responding to my central concerns to investigate accountability practices in PPP healthcare contexts and to centralize the voices and priorities of patient stakeholders. Ethnographic fieldwork is a powerful methodological tool in the critical interpretivist project of deconstructing visions of the social world that are generally held as true. Critical ethnography is distinguished by a desire to denaturalize taken-for-granted assumptions, by highlighting underlying operations of power and control (Madison, 2012). This may be considered to stem from the recognition that, whilst policies are often cloaked in neutral language, they are fundamentally political

(Wedel, Shore, Feldman & Lathrop, 2005). The ethnographer's task in this context may be considered to unmask the political from its cloak of neutrality, by exploring the cultural and philosophical underpinnings of policy (Wedel, *et al.*, 2005). By analyzing how macro-level policy is translated in social processes and actions, ethnography denaturalizes policies, treating them as contested political spaces (Shore & Wright, 1997). This is particularly imperative when PPP contracts are notoriously non-transparent (Jones, 2018; Whiteside, 2013). Power relations can be determined through careful ethnographic analysis of whose voices prevail in and across sites and how particular discourses are made authoritative (see Wright & Shore, 1995). Such analyses also provide opportunities for ethnographers to probe behaviors that challenge dominant discourses, searching for possibilities that could change inequitable social conditions and unequal power relations (Wright & Shore, 1995). In this way, an ethnographic design was imperative to the critical goals of this research project, as the processes entailed by P3 projects operate to effectively submerge political decisions and motivations, obscuring their very status as political (Jones, 2018; Whiteside, 2015). The denaturalization of neoliberal involvement, through tracing the mundane and less obvious aspect of stakeholder negotiations, is key to distinguishing rhetoric from reality in the implementations of PPPs in healthcare and to advancing the democratic agenda of the participants with whom I worked.

Material environments of care

A critical ethnographic design can also illuminate understanding the way P3 policies can shape how healthcare users interact with the built environment of hospitals. Scholars have recognized that attending to accountability in P3 healthcare projects must involve recognition of the structural contexts in which material environments of care are produced (Jones, 2018). Closely-observed ethnographic analyses that locate participants in the built environment of P3 healthcare infrastructure can illuminate how architecture can be incorporated in provisions of care, situating the architecture of the hospital in its political place (Jones, 2018). The critical design of this research project responds to a need to recognize the built environment of a P3 site as inherently political, by simultaneously investigating the social and political discourses that underpin P3 policy through the actors that enact them, as well as by illuminating how these discourses condition the physical environment of the hospital (Jones, 2018). As such, the use of an ethnographic methodology enabled investigation of accountability practices in P3 healthcare projects through connecting policy, actors and spaces.

Accountability cultures

From a pragmatic research perspective, ethnographic methodology is an effective way to investigate accountability practices within organizational cultures (Aveling, *et al.,* 2016; Dixon-Woods, 2003; Dixon-Woods, Suokas, Pitchforth & Tarrant, 2009; Dixon-Woods & Bosk, 2010; Dubois, 2014; Hor, 2011; Rosen, 1991). It does this by seeking to understand the points of view of the people observed and their meaning-making activities (Dubois, 2014). In studying *accountability cultures*, ethnography can capture 'winks, sighs, head shaking and gossip that may be exceptionally powerful, but which more formal methods will miss' (Dixon-Woods, 2003: 327). Accountability is not based on one formal system or another, but in interactions between parties involved, and should be considered an 'ongoing accomplishment' (Garfinkel, 1967, quoted in Hor 2011). This understanding shows why stakeholder negotiations provide a useful entry point to studying *accountability cultures* involved in P3 healthcare projects. Tracing stakeholder negotiations ethnographically enables researchers to understand the possibility of dissonance between different rationalities. Transforming the question of 'accountability' into 'how accountability is enacted' involves a move beyond the contested boundaries of the concept. By using participant observation to explore the micro-practices of stakeholder negotiations, ethnographic methodology can explore multiple levels of accountability practices, gleaning deeper understanding not only of internal institutional logics, but also of the structuring effects of broader contexts. This is particularly important in the task of linking micro-practices of accountability with wider social, political and economic logics, following an understanding that 'different sources of justification… come from different rationalities' (Hor, 2011: 65; see also Aveling, *et al.*, 2016).

Patient voices

That ethnographic work puts researchers in close and continued proximity to their participants makes it an effective methodology for highlighting patient voices, by foregrounding their experiences of, and responses to, a P3 healthcare institution. Internationally, healthcare providers are increasingly required to involve patients and citizens in decision-making processes (Forster & Gabe 2008; Jones & Pietilä 2017). However, the means used to measure such involvement is most often ill-suited to the nature of 'engagement' and has been accused of amounting to tokenism and box-ticking (Goodridge, Isinger & Rotter, 2017). In this context, ethnography is a powerful tool to probe into areas where measurement is not easy or possible, and where issues are sensitive and multifaceted

(Dixon-Woods, 2003). Ethnography can produce more nuanced descriptions of what 'patient engagement' actually involves, by drawing attention to the social and material realities of healthcare institutional contexts (see Liberati, *et al.*, 2015).

Concurrent with my focus on accountability, this methodology reflects a broadly participatory agenda. Although not formally a "participatory action research" project, it aligns the nature of the research with the agenda of the Patients' Committee with whom I worked. This is also in line with the critical framework of this research, and the goal to further the involvement of citizen voices in healthcare (Groot *et al.*, 2018). Participant observation, the main tool for data collection in ethnographic studies, puts the researcher in intimate contact with the groups they study. This can be fruitful for collaborative and participatory modes of research that implicate bringing about social change as part of the research (Hansen, Kline, Holmes & Lindemann, 2013). The use of ethnographic methods in combination with a participatory agenda also follows a call for research into PPPs that explores citizen participation, accountability and governance (Caperchione, *et al*. 2017). Before the start of this study, as well as throughout and following fieldwork, there was ongoing consultation with the Patients' Committee about their priorities and interests and how the research project could be conducted to best benefit them. This follows an essential concern of this research – to centralize the priorities of participants in the conduct of ethnographic work, simultaneously seeking to further their agenda, and learn something in the process (see Tax, 1975). The intention was that the analysis that resulted from this fieldwork would involve clearer understanding of the priorities and accountabilities of different parties involved, with specific emphasis on how these negotiated interests might be better redressed to the benefit of patient stakeholders.

Setting and participants

Site selection

The site for this research project was a large Canadian 'super-hospital', the South East General (SEG). Specifically, fieldwork, comprising observations, interviews and document analysis, was conducted at the SEG Meadow site, which comprises two hospitals of the five which make up the 'super-hospital': the Princess Anne hospital and the South East Pediatric hospital. The SEG Meadow site was built in 2014 as a P3 project involving multiple private partners, dominated by two of the world's largest private infrastructure investment groups, BHC Reliance and Lakeston Tide. The P3 project at the SEG is based on a Design-Build-

Operate-Finance (DBFO) contract, meaning that the private companies involved have ongoing involvement in the operation and maintenance of the site. These firms are represented by a consortium, the Southeast General Infrastructure Group (SGIG), which is responsible for managing the hospital centre's assets and ensuring its upkeep until the contract terminates in 2044 – thirty years after the hospital's construction. Since its opening in 2015, the Meadow site project has been beset with controversy surrounding hospital maintenance, accumulating debt and unsatisfactory negotiations between stakeholders[2]. Most recent of the controversies has been an out of court agreement between BHC Reliance and the SEG, following a lawsuit for $340 million filed by BHC Reliance against the SEG and the provincial government, claiming compensation for additional costs incurred during the design and construction of the SEG Meadow site, among other issues. The confidentiality of the agreement is typical of non-transparency entailed in procurement agreements between private companies and state bodies in P3 projects (see Jones, 2018; Whiteside, 2015). Indeed, the structuring and resultant issues that are seen at the SEG Meadow P3 project exemplify those seen in PPP healthcare projects, demonstrating it to be a relatively typical case of the broader issues that this research seeks to address.

Accessibility issues

One of the most prevalent problems, and a typical example of poor patient safety incurred by healthcare P3s (see Whiteside, 2011; Whiteside, 2015), relates to issues of poor accessibility that have arisen in the building of the SEG Meadow site. Since the opening of the site, issues have been identified with toilet access, seating, elevator timing, way-finding and push-button access, amongst others. Although a mandate for a 'patient-centered approach' was stated in the building of the SEG Meadow site, preparatory discussions with research stakeholders showed that the Princess Anne Patients' Committee was shut out of important infrastructure consultations and accused site administration of disregarding patient safety. As patient stakeholders mobilize to address these issues, they come up against the complex decision-making processes that arise from PPPs, whereby changes to the infrastructure of the hospital cannot be carried out without permission of the private partner, and most often require lengthy negotiations between the two sides (see Whiteside, 2011; Whiteside, 2015). As such, the processes involved in addressing these accessibility issues are a working example of how involvement of private sector companies in public healthcare provision entails transferring

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[2] These controversies have been well-documented in local and national media, although no references to media coverage are included in this thesis to avoid explicitly identifying the sites.

rights, power and authority over healthcare governance away from the public sphere (Whiteside, 2011). The way that patient stakeholders navigate issues of accessibility at the site is an empirical lens onto *accountability cultures* in public-private hybridity. Following this understanding, I chose to focus my investigation on the negotiations of different stakeholders to address issues of accessibility at the SEG Meadow site. This choice corresponds with the orientation of this research towards linking broader logics with micro-level accountability practices.

Participants

This research project investigated how patient stakeholders enact their interests in the context of PPP healthcare projects through engagement with the Princess Anne Patients' Committee and its offshoot organization, the Accessibility Committee. The Accessibility Committee was formed in 2016 in response to multiple perceived problems of access resulting from infrastructure decisions made in the building of the SEG Meadow site. At the time of conducting this research, the Accessibility Committee was mobilizing to address a multitude of accessibility issues, through negotiations with healthcare managers and the Board of Directors. As such, the Committee provides a compelling entry point through which to better understand the experiences of patient-citizens in public-private hybrid healthcare.

Alongside participant observation at the hospital, eleven participants were interviewed. Interviewees comprised:

- Seven members of the Patients' Committee. Of these, six members also sat on the Accessibility Committee and one sat on the Board of Directors representing the SEG users' committee.
- Two SEG healthcare managers
- Two representatives from BHC Reliance: the head of communications and the vice-president of capital.

These interviewees represented three categories of stakeholder: patient stakeholders, public healthcare managers and private company stakeholders. Healthcare managers were selected for their relationship with the Princess Anne Patients' Committee and Accessibility Committee, as these groups aim to affect change within the hospital. Both healthcare manager participants were points of contact for the two Committees and play an intermediate role in bringing these concerns to higher organizational levels and negotiating changes to the hospital space with the private partners. They had direct and frequent contact with the two committees and were present for most Accessibility Committee meetings. Participants from

BHC Reliance were interviewed in order to contextualize the patient voices within a broader picture of the PPP policy. As representatives of the main firm involved with the SEG Meadow site, they enabled better understanding of the accountability practices of private organizations in the context of a healthcare P3. In accordance with the critical aims of this research, interviews with patient committee members comprised the bulk of interview data. The research aims and design of this study placed strong emphasis on patient-citizen voices. In the section that follows, I briefly explore the categorization of 'patient-citizen' participants and its coherence within the broader epistemological and ontological groundings of this research.

Patient-citizen identity and representation

Following the work of the Patients' and Accessibility Committees entails conceiving 'patient voice' in a 'collective form' (Forster & Gabe, 2008). The choice to engage with a legally-mandated committee, as opposed to individual users of the hospital, should be considered to correspond to the aims of this research by way of linking concerns for patient safety and democratic accountability that have arisen in the implementation of P3 projects (see Whiteside 2011; Whiteside 2015; Whiteside 2018). The identity of 'patients' as seen in this research was constituted from a combination of discourses, including: legal discourses which mandate a Patients' Committee; institutional discourses that configured Patients' Committee members as patient representatives; the self-identification of members as users of hospital services. Whilst 'patient' identity accurately captures the relational identity produced within the institutional context of the hospital, these participants may also be understood as 'patient-citizens' (Weiner, 1993). The notion of 'patient-citizen' reflects the dual role of the Patients' and Accessibility Committees in representing not only patient voices, but also citizens, as potential patients, and whose membership of 'the public', including payment of taxes, underwrites and legitimizes public services. It has been recognized that in welfare states, such as Canada, occupiers of the patient as well as healthcare professional role also have distinctive relations and responsibilities as taxpayers for medical services (Sorell, 2001). My choice to follow the Patients' and Accessibility Committees follows the understanding that civic consciousness is inextricably fused with healthcare involvement in a welfare state. The term 'patient-citizen' (Weiner, 1993) captures the identity produced in welfare states that PPPs most significantly threaten to undermine. As such, conceptualizing the work of the Patients' and Accessibility Committees as the work of 'patient-citizens' follows from the critical orientation of this research, by showcasing the voices of those who are most profoundly affected by PPP policies.

Sampling

Sampling for interviews was *purposive*, in the sense of explicitly selecting interviewees from the field whom I considered would generate the most useful and insightful data (Green & Thorogood, 2014). The selection of interviewees followed the chain of decision-making processes starting with the interests of the Patients' Committee and correspondingly followed a snow-balling technique. Therefore, interviews were conducted with members of the Patients' Committee, then the healthcare managers with whom they met, and representatives of the main private partner company involved in the SEG Meadow P3 project. In this way, interviewees represented multiple faces of accountability enactment in a P3 healthcare project, enabling analysis between different levels and forms of social processes and actions. This comprises an approach to 'studying through' (Reinhold, 1994: 477), tracing relations of power between actors, institutions and discourses across spaces (Shore & Wright, 1997) through interview data.

Recruitment

Access to the site and to research participants was gained by reaching out to the SEG User committee representative, with an explanation of my research interests. Following meetings with the User committee representative and the Princess Anne Patients' Committee chair and co-chair about the project and how our interests might be aligned, I was given permission to attend Patient Committee and Accessibility Committee meetings as an observer and to interview members of these committees. In line with the participatory efforts of this research, I also became involved with the Patients' Committee in developing a 'socio-cultural' subcommittee at the request of the committee chair. This constituted an effort to form a reciprocal and accountable relationship with the Patients' Committee.

Data collection

The data collection for this research comprised approximately five months of ethnographic fieldwork. The fieldwork commenced May 2018, paused over Patients' Committee summer break, and resumed in September 2018. The bulk of the work took place between September and December 2018. From January 2019 I continued to attend Patients' Committee and Accessibility Committee meetings. In line with the focus on accountability practices in healthcare PPPs, data collection involved following specific organizational practices entailed in negotiating issues of accessibility at the Meadow site. Using ethnographic tools of participant observation and interview, I followed the negotiations of the Patients' Committee and Accessibility Committee as they tried to effect change to redress multiple problems of accessibility created in the building of the SEG Meadow site. This involved observing monthly meetings of the two committees, observing discussions with healthcare managers at the Meadow site, as well as attending SEG board meetings and informal meetings with Patients' Committee members. As such, most of fieldwork was conducted in conference rooms and involved making notes about the conversations, particularly noting language use, body language and interruptions as well as reflexive commentary. A 'walking interview' was conducted with one member of the Patients' Committee as way of more fully understanding the accessibility issues that that the Committee seeks to address. This involved the participant showing and discussing issues that related to bathroom accessibility created in the infrastructure of the site. The use of a walking interview in this context was well-suited to addressing the concerns of the Accessibility Committee. In addition, I followed a tour of bathrooms at the Meadow site, conducted by three members of the Accessibility Committee and management representatives, which was conducted in order to demonstrate poor bathroom accessibility and how improvements might be made for the benefit of users with disabilities. Both of these experiences presented opportunities to address the materiality of care environments (Adams, 2007), attending to the irreducible relationship between people, policy and spaces created in the implementation of P3 projects (see Jones, 2018).

Participant observation

The level of participation entailed in my 'participant observation' varied from meeting to meeting. At many meetings, particularly those with healthcare managers or board members, I remained further towards the 'outsider' experience of participant observation (see Spradley, 1980). However, in accordance with the wishes of the Patients' Committee chair for me to initiate a socio-cultural subcommittee, at some meetings I was a more active participant, providing updates on the progress of the committee. My position in these meetings might be considered as 'observant participation' (Wacquant, 2011: 87), a term that aptly summarizes my position as a participant foremost, and observer secondarily.

Semi-structured interviews

Parallel to participant observation, a total of ten semi-structured interviews were conducted, nine in English and one, with two participants together, in French. These do not include the walking interview. These interviews were conducted to compliment observational data, by gleaning more in-depth information about the meaning-making processes of stakeholders with regard to accountability at the SEG Meadow P3 site. I used topic guides to loosely structure the interviews, which were derived from interim analysis of the observations that I had made up to the point of interview (see Appendix A for patient participant interview guide; Appendix B for healthcare manager interview guide; Appendix C for private company participant interview guide). Of the interviews, nine were conducted face-to-face and lasted between thirty minutes and one hour. These were audio-recorded and transcribed by me. Interviews with patient participants were conducted at the SEG Meadow site in meeting rooms booked through the Patients' Committee. Questions related to their experiences of the P3 project at the SEG Meadow site and the work that they were doing to affect change to issues of accessibility. I also asked some participants to elaborate on conversations or comments I had observed at meetings. In order to accommodate the communication impairments experienced by one member of the Patients' Committee, one interview was conducted via email at the participant's request. After consulting the participant about her preferred form of interview, I sent questions to her in a Word document, to which she responded in writing. Follow-up questions were conducted by email. This form of interview followed the wishes of the participant and follows recognition that interviewing participants with communication impairments requires practical strategies and a flexible approach to data generation (Philpin, Jordan & Warring, 2005).

Interviews with healthcare managers also took place at the SEG Meadow site, in their respective offices. Questions in these interviews were concerned with how healthcare managers navigate P3 negotiations and their relationship with the Patients' Committee. I also asked these participants to elaborate on conversations or comments I had observed at meetings. Finally, interviewing representatives from BHC Reliance took the form of a group interview, at the request of the head of communications, who prearranged for the second interviewee to join us about twenty minutes into a one-hour interview. That this interviewee took a more active role in structuring the interview might be considered a symptom of 'studying up' (Pierce 1995, cited in Pope, 2005) in this context. That is to say, gaining access to representatives of this large and controversial company was a lengthy process in which I occupied a relatively less powerful role than my research participants (see Pope, 2005). As such, it was made clear to me that this interview would be conducted on the terms of the interviewees[3]. Questions in this interview were concerned with what participants understood the role of BHC Reliance to be in the running of the SEG Meadow site and their relationships with other stakeholders.

Feedback sessions

In accordance with the broadly participatory agenda of this study and central concern for accountability, feedback sessions were held following data collection and analysis. These sessions were a form of accountability, whereby the Patients' Committee held me accountable for my involvement in their environment for the previous months (see Hor, 2011). One session included a meeting with the chairs of the Princess Anne Patients' Committee, to discuss the outcomes of the research and the development of the findings into a 'Patient Engagement Tool' which could be used by patient representatives to advance their agenda for accountability (see appendix D)[4]. A second session was held towards the end of writing this thesis, in which I presented the findings of this study and the 'Patient Engagement tool' to the Princess Anne Patients' Committee.

Data analysis

To analyze these data, I adopted a thematic analysis approach. Thematic analysis is a useful approach for identifying the salient issues for particular groups of participants and identifying key themes in their accounts (Green & Thorogood, 2014). As such it is a well-suited approach to identifying how different stakeholders understood and enacted accountability at a healthcare P3 project. Thematic analysis involves identifying and analysing patterns of meaning (Joffe, 2011) and mapping regularities and variations across different accounts (Green & Thorogood 2014; see also Braun & Clark, 2014).

I conducted data analysis, as the sole researcher on this project. Interviews in both languages were transcribed into word files and participants de-identified and given pseudonyms. Each interview was analysed separately before combining interviews and ethnographic data to identity common themes. Thematic analysis was conducted inductively, meaning that themes and explanations were derived primarily from a close reading of the

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[3] Incidentally, I found that the group dynamic of this interview enabled insightful data, perhaps concurrent with the observation that this type of interview facilitates comfort with a topic through 'solidarity with friends' (Wilkinson 1998: 117).

[4] This 'Patient Engagement Tool' was developed from a subsection of the data set discussed in this thesis, which pertained to the relationship between patient representatives and healthcare managers and administrators. It comprises a criteria for guiding effective patient engagement through micro-level behaviours and for holding healthcare institutions accountable for their promises of patient engagement.

data, without trying to fit it into *a priori* concepts (Green & Thorogood, 2014). This constituted an effort to remain true to the intentions of the participants. The process began with identifying codes and themes in the data, coding the dataset and organizing codes and themes (Green & Thorogood, 2014). Coding involved several readings of transcripts and a comparative process of looking for regularities and divergences in the data. Identifying key themes in the data occurred through an iterative and reflexive process of comparing and contrasting an identified code across the dataset to see if it matched an existing category, warranted modification of an existing category or required the creation of a new category. Through this process of inductive analysis, patterned responses developed into themes, which retained strong links with the original dataset (Braun & Clark, 2006) and generated explanations grounded in the data (Dixon-Woods, 2003). This data-grounded process enabled focused insight into how accountability was understood and enacted by stakeholders, foregrounding how participants made sense of the P3 healthcare environment and their position and practices within it. Analysis of ethnographic fieldnotes followed same principles of inductive thematic analysis, entailing detailed and systematic reading of the data, identifying codes and themes in the data.

Ethical considerations

Institutional Review Board human research ethics approval for this research was obtained from McGill University (see Appendix E). However, in line with the critical focus of this research on accountability, I follow Hor's (2011) contention that ethical research is not produced solely in the acquisition and compliance to the conditions of formal ethics approval. Diligent ethnographic reflexivity was an ethical imperative of this research, as it navigated different stakeholder agendas. Indeed, it has been recognized that although formal ethics procedures are important, the crystallized code of ethics on which they rely is clearly insufficient for dealing with the shifting contexts of ethnographic fieldwork (Hor, 2011). As such, I tried to be highly reflexive about my relationship with participants and attuned to changes that might require ethical consideration and action as the research proceeded. This was particularly important in light of my own accountability to the Patients' Committee, following the participatory agenda of this research. The participatory concerns of this research also demanded particular attention to conflicting interests and power structures (Groot, *et al*., 2018). The varied positions of power occupied by participants and the relationships between them posed challenges to my conduct as a researcher. For example, it was necessary to put careful consideration into how I asked questions about one stake-holding group to another, in order to not exacerbate tensions between them. I followed the Participatory Healthcare Research (PHR) ethical criteria (ICHR 2013) to guide my researcher responsibilities in this regard. In accordance with the theoretical orientation of this research that takes accountability to be a practical and on-going accomplishment (Garfinkel 1967, in Hor, 2011), I also tried to ensure my own accountability to the Patients' Committee as an on-going process. To circumvent ethically dubious 'helicopter research' (Minn, 2015), whereby researchers enter a community, collect their research and leave without consultation or local outcome, I continued to attend and participate in Patient and Accessibility Committee meetings following five months of fieldwork, maintained contact with Patient Committee members, developed a locally relevant resource in the 'Patient Engagement tool', and arranged feedback sessions. This comprised an effort for accountable, 'slow research' (Adams, Burke & Whitmarsh, 2014), as much as possible within the framework of an MSc project.

Written consent was obtained preceding interviews, and it was made clear that participants were free to withdraw their consent at any point during the interview, or for the interview not to be audio-recorded (see Appendix F for consent form template). The longitudinal nature of ethnographic research poses challenges to the concept of consent, with the understanding that 'consent [is] not single events but involve[s]e a negotiated process' (Pope 2005: 1182). Whilst consent was obtained from key participants at the outset of the fieldwork, member checking was critical to ensure ongoing consent, and that my interpretations took account of the intended meaning of informants. Following Morse's (2018) guidelines for rigor in qualitative research, I paid close attention to differentiating between descriptive and interpretive data in my analysis, practiced member-checking (where appropriate) and consulted with participants, academic colleagues and advisors during data collection to guide ethical decision-making in the field, and during post hoc analysis. Research materials such as fieldnotes and interview transcripts were stored securely in a locked filing cabinet, and information stored in digital form secured on a password-protected computer. Participants are anonymized in this thesis and in any public dissemination of findings.

Chapter three

Results

What are the effects of public-private hybridity on healthcare environments and the people who use them? In this chapter I look closely at the different types of accountability that were enacted at the SEG Meadow site, and how these were pitted against one another by stakeholders. These different types of accountability mirror the roles of principle stakeholders – private company representatives, healthcare managers and patient-citizens – and I present them as such in this chapter. I start by examining the pivotal role of the P3 contract in shaping how governance and accountability were enacted by private sector representatives and healthcare managers. I show how the technologies of the contract produced a highly specific logic for defining accountability practices. I go on to address how patient-citizens contested this logic, working for recognition of their rights to socially-based accountability. The last section of this chapter attends to contested enactments of accountability. I explore how different types of accountability competed at the SEG Meadow site as stakeholders tried to assert their various agendas. In accordance with my secondary research question, I focus particularly on the strategies used by patient-citizens to enact their interests in a public-private hybrid healthcare environment.

‘Prescriptive’ technologies for accountability: the P3 contract

The conditions of the P3 contractual agreement were central point of reference in my observations of, and conversations about decision-making processes at the SEG Meadow site, with both representatives from BHC Reliance and healthcare managers. Representatives from BHC reliance repeatedly, and without prompting, used the term ‘prescriptive’ to describe the contract. This meant that beyond the point of ‘financial close’, when the contract was signed, they considered that there were few possibilities for change to the relationship between public and private actors, pertaining to who was responsible for what at the SEG Meadow site.

> *‘So there are discussions about adjustment until the time of financial close, when everything is frozen’* (M. Godard, BHC Reliance, Interview)

As such, representatives from BHC Reliance understood their responsibilities at the site, which would span a thirty-year contract, to be pre-determined by the ‘binding documents’ entailed in the contract signed at financial close, preceding the building of the site.

> *‘…Most of the sections are quite prescriptive. So if I’m, if I talk about communication, there’s a section that explains pretty well how they will talk together and how they will manage issues altogether’* (Mm. LeBlanc, BHC Reliance, Interview)

The contract itself was described as the product of competition between different bidders, followed by negotiations between the private companies that comprised SGIG and public sector representatives. From the private side, Mm. LeBlanc and M. Godard described the negotiations that formed the contract were heavily based in free-market competition and maximizing profit for BHC Reliance.

> *'Because we must not forget that [with] PPPs, what we also look for when the proposals are open, is the lowest bidder, who must nonetheless fulfil obligations. If it is the lowest, but he does not fulfil the obligations, it will surely be disqualified. If you fulfil the minimum of obligations, you are the lowest bidder… it is he who wins'* (Mm. LeBlanc, BHC Reliance, Interview)

BHC Reliance tried to negotiate a contract that fulfilled obligations to a minimum, concerned with minimizing risk and maximizing profit for their company. Amongst others, these obligations pertained to the building code, which determined how the Meadow site was to be built.

> *‘Well, the code, what you call the code, is basically its specs (specifications). The code, it goes without saying that it must be the code, the building codes, but the*

> *client gives you his set of specifications. This is the limitations you're going to have to work with'* (M. Godard, BHC Reliance, Interview)

Importantly, Mm. Leblanc and M. Godard emphasized the need for their 'client', the public sector, to be precise in their specifications for the building. They considered that a lack of foresight by public sector actors was responsible for much of the discord between the public and private sides of a P3 project. Monsieur Godard expressed this very clearly, commenting that *'if the specs are well defined by the client… there is no reason that there should be any extra [costs] there'* (Interview). Indeed, the freedom of choice accorded to the public side was considered by private sector actors to be of great benefit to the public sector: *'the great advantage of PPPs is the certainty that the client will receive what they have requested'* (M. Godard, BHC Reliance, Interview).

As such, responsibility for issues that arose in the building of the SEG Meadow site were understood as often due to a lack of experience and understanding from the public side in the creation of the contract. Representatives from BHC Reliance considered that their responsibility was to fulfil their obligations as defined in the contract, following its heavily prescriptive wording. Whilst both representatives acknowledged that sometimes grey zones existed in the contract, they considered that this often required more specific terms – as described by M. Godard: *'the further [the project] goes on, the more it converges on… much more precise language'* (Interview).

BHC Reliance representatives understood and enacted their accountability practices following the measures, techniques and technologies defined by the P3 contract. When problems arose, private companies turned to the contract to determine their obligations. Mm. LeBlanc emphasized this:

> *'…If they are facing issues and they don't arrive to a solution, it's in the contract. It's written in black and white what they have to do, and the path they have to follow'* (Mm. LeBlanc, BHC Reliance, Interview)

Both representatives from BHC Reliance described how the contract created measurable conditions for their obligations across several different domains: in the specifications of how the hospital would be built, in deadlines pertaining to the construction and operation of the site, as well as in how communications between the public and private sides were conducted. They described these obligations through 'specifications' 'schedules' and 'deliverables', as well as the prohibitive conditions of 'deadlines', 'completion dates' and ‘contractual penalties.’ Importantly, in following these highly specific principles and technologies to define their accountability, private sector organizations created conditions for how governance and accountability were enacted by their public sector counterparts at the SEG Meadow site.

‘Measurable progress’: How healthcare managers enact accountability

The procurement agreements and prescriptive contracts entailed by the P3 arrangement fundamentally affected how healthcare managers understood and enacted accountability at the SEG Meadow site. At a basic level, healthcare managers felt that the contract with private sector organizations constrained the way that they were able to deal with issues that arose at the hospital. This was clearly conveyed by Callum, who had frequent dealings with BHC Reliance through his work, and who often referenced the contract between SGIG and the hospital, both in meetings with the Patients’ Committee and in our interview.

> *‘Because it’s a PPP most of the [modifications to the building] that we decide to pursue are given to our private partners: because even if we were to bring in external contractors to do a project here, we still have the obligation of presenting it to our private partners and then they have the right to review it and comment and all of the time they spend on it technically they can invoice back to us… We’re going to have to pay them to have to review everything and to also do audits while we’re doing the work, and inspections afterwards…’* (Callum, healthcare manager, Interview)

Callum, as a healthcare manager, recognized that the prescriptive nature of the contract was pivotal to how he was able to approach issues at the hospital. The technologies of the contract were critical to determining how to approach issues of accessibility at the SEG Meadow site due to the heavy financial sanctions that accompanied making changes. At the time of this research, it was estimated that the changes needed to make the bathrooms accessible at the SEG Meadow site would cost between $7000 and $10,000 per bathroom. The prices were augmented as a result of being outside of the initial contractual arrangements. As such, the commercial interests of the private companies played an important role in what healthcare managers were able to achieve.

> *‘There was a lot of emphasis on codes and standards and, you know, if you write a contract and then say, “well, you need to make sure that you abide by all the*

> *codes and standards", you know, everybody's going to try to interpret those in such a way that's going to be better – best – for their bottom line'* (Callum, healthcare manager, Interview)

In practice, perceived constraints posed by the contractual agreements between SGIG and the SEG were evident in how healthcare managers approached hospital governance and the concerns of the Patients' Committee. Importantly, this was not only evident in explicit reference to the conditions of the contract, but in the logic through which healthcare managers approached problems. Whilst healthcare managers were often sympathetic to the concerns of patient representatives and in agreement with the issues that they raised, their lens on problems followed the logic and technologies of the contract in the same way as representatives of BHC Reliance. For example, healthcare managers discussed problems in language of 'measurable progress' (Board member, SEG), potential liability and budgetary limitations. This was particularly evident in discussions about addressing accessibility issues in the bathrooms at the SEG Meadow site, as illustrated by the following vignette from an Accessibility Committee meeting, in which Callum, a healthcare manager, discusses bathroom access with three members of the Patients' Committee.

> Callum: *In preparing for this meeting, Deidre came across something fairly interesting. There must be a turning room of 1500 mm. Building code requires a diameter of 1500mm to move within the space… Let me draw a diagram [Callum draws something, passes it to Annette]. The issue we have here is that we don't have door clearance [for wheelchair users]… Right now we are in a phase of code interpretation – was it built to code specifications at the time of PPP agreement? – to determine who is responsible.*
>
> Annette: *But what about common sense? We are back to talking about code?*
>
> Donna: *The bathroom set up, it boggles my mind… Are they taking manual or motorized wheelchairs?*
>
> Clara: *Things have changed for handicapped equipment dramatically. The average person doesn't know – they don't have that background… They should have had handicapped people [in discussions about building].*
>
> Annette: *They should have a code for hospitals… Why didn't they look at other hospitals?*

Callum: *If there is a specialist [you don't question it]*

(Observational Excerpt, SEG Meadow site)

Whilst members of the Patients' Committee, who in this case were all wheelchair users, discussed their lived experiences of using the bathrooms, Callum discussed the issue through the technologies of the code that were prescribed in the P3 contract. As the conversation continued, it became clear that, whilst Callum listened patiently to the patient representatives, decision-making about the bathrooms here would primarily pivot on the terms created by the contract. As such, the contractual agreements created by the PPP at the SEG Meadow site informed not only what healthcare managers were able to do, but how they approached issues at the hospital. Their approach fundamentally converged on the technologies of their contractual agreement with private sector organizations.

'Working backwards': Social accountability

Members of the Patients' Committee demonstrated that they understood well how the P3 contract conditioned the governance, priorities and accountability practices at the SEG Meadow site. Throughout my interviews and conversations with Patients' Committee members, *'profit over patients'* was a recurrent theme and members expressed much frustration that the primary accountability of the hospital seemed to be to rooted in a fiscal relationship with the private sector, which they considered to be to the detriment of patient care. This was explicitly expressed by several members of the committee, perhaps epitomized by Annette, the chair of the committee, who stated that, *'in PPPs, things are built on the back of patients to make money'* (Observational excerpt).

Amongst other issues, the Patients' Committee was particularly exasperated with the commercialization of the hospital space. This was particularly expressed towards spaces that were demarked for commercial use, which Patients' Committee members saw as being to the expense of the patient population: *'built to a business agenda'* (David, Patients' Committee, Interview). At one accessibility meeting it was wryly noted by Nadia that contra to the multitude of accessibility issues in the rest of the hospital, SGIG had managed to make the rentable spaces '*very accessible'.* At the heart of Patients' Committee members' frustrations with the building was a common sentiment that the code to which the site had been built was entirely unsuited to the needs of hospital users.

> *'the private partner cut a lot of corners and um, the private partners built a facility to some kind of standard or code that is not the optimal standard or code for a hospital'* (Nadia, Patients' Committee, Interview)

Specifically, the Patients' Committee expressed frustration that the 'code' to which the hospital had been built seemingly absolved the private partners from redressing important issues of accessibility at the SEG Meadow site.

> *'It is not acceptable for BHC Reliance and all these other companies to hide behind building code… The building code people protect their own'* (Joyce, Patients' Committee, Observational Excerpt)

As such, members of the Patients' Committee considered that the 'code' as technique of measurement for accessibility favoured protecting private sector companies. In this context, the Patients' Committee worked hard to reclaim the need for social accountability to patient-citizens, by working for recognition of their rights to the hospital institution, and their authority as patient users. Annette, the chair of the committee, articulated these efforts explicitly:

> *'In PPPs, patient voices are diluted. Therefore, patients have to assess what the needs are and work backwards to establish their rights.'* (Annette, Patients' Committee, Observational Excerpt)

The notion of 'working backwards' expressed by Annette captures well how Patients' Committee members conveyed that the SEG Meadow PPP diluted accountability to patients, but equally asserted the role for patient-citizens in this context to redress how accountability was being enacted. This was expressed by many patients through the rhetoric of patient 'rights', the understanding that hospitals are fundamentally for patients, as well as assertion of their civil rights as taxpayers.

> *'Patients, who are not just the users of the healthcare services: but they pay, they pay for it through the public system… They exemplify one of the highest levels of civic responsibility there is'* (Nadia, Patients' Committee, Interview)

As such, members of the Patients' Committee expressed their understanding of how accountability should be enacted as primarily *social*. As patient-citizens, they demanded accountability from healthcare governance that reflected their social contract with the state and contested the technologies of financial management that informed the accountability practices of healthcare managers and the private partners.

> *'…There is a certain inhumanity and I think it's shared by both administrations – both the administration and the private partner. You know, no matter – you know, you can't say that profits are more important than patients'* (David, Patients' Committee, Interview)

In the recognition that there was a shared logic to the accountability practices of both private sector actors and public healthcare managers, Patient Committee members felt that their voices were increasingly isolated. They considered that the impetus for social accountability was increasingly lost in the contractual agreements between the public administration and private partners. As described by one member, *'we are dealing with the patient still suffering and we have no recourse'* (David, Patients' Committee, Observational Excerpt). As such, they considered that a central component of their role was to redress the centralization of financial management that underpinned decision-making by healthcare managers at the SEG, to instead emphasise the rights of patient-citizens and the socially-based accountability that must follow.

Attending to contested accountabilities

I have discussed how private sector representatives and healthcare managers most often enacted accountability which followed from the logic of the P3 contractual conditions. Conversely, patient representatives battled for recognition of their rights to socially-based accountability. In this next section of my findings, I illustrate how these different accountabilities were pitted against one another by stakeholders. Using interview excerpts and vignettes from my fieldnotes, I start by examining the practices and rhetorical devices used by healthcare managers to contain patient-citizen's demands for social accountability. I go on to examine how patient representatives resisted these attempts to contain their voices, focusing particularly on their embodied assertions of authority.

Healthcare managers: Containing patient voices

'Beyond their mandate': Containing patient voices

One important way in which healthcare managers sought to contain patient-citizen claims for social accountability was by using the logic of financial management. In meetings and in interviews, some healthcare managers expressed frustration that the Patients' Committee was going *'further than their mandate'* (Jason, healthcare manager, Interview). In meetings, this was expressed in "truth claims" by healthcare managers that worked to undermine the competencies of Patients' Committee members. This was demonstrated quite clearly in an exchange between Nadia, a Patients' Committee member and M. Lessard, the interim head of the Department of Operations, which took place during an Accessibility Committee meeting:

> Nadia: *This is our hospital. This is a public hospital… A good start is to let patients show you where things should be…*
>
> M. Lessard: *Some things can be done, some things can't. You have this number of projects and only a certain amount of dollars… There is a difference between consulting [the Patients' Committee] and deciding. We will consult, but it is us who will decide.*
>
> (Observational Excerpt, SEG Meadow site)

In making a "truth claim" about financial scarcity, M. Lessard attempted to undermine Nadia's claim of patient expertise and demand for social accountability. By insinuating that she does not understand the financial reality of hospital governance, he worked to contain her contribution to the discussion, framing it as irrational through the logic of financial management.

'This is not a perfect world': Containing patient voices

A related way in which healthcare managers worked to limit patient voices was by positioning them as overly emotional and with '*expectations misaligned with reality'* (Jason, healthcare manager, Interview). This was witnessed in meetings when healthcare managers would express to Patients' Committee members that '*this is not a perfect world… This is a world based on dollars'* (Jason, healthcare manager, Interview). This was particularly evident in the language used by Jason in an interview, to describe the behaviour of some Patients' Committee members in meetings:

> *'…more of a problem would be the perception that um, people in the hospital work for them. Um, I've sat in meetings- you might even have been sitting in some of these meetings when someone's ferociously slamming their fist around demanding answers and results and er, thinking that they have some kind of authority and that the people who run these hospitals are all evil, mean people. No. They're good people who try as hard as everyone else to get things done in a big machine and sometimes things work out well- sometimes there's limits,*

> *sometimes there's problems, but you're supposed to be a collaborator, you are not supposed to be a confrontational adversary.'* (Jason, healthcare manager, Interview)

The image that Jason presented of Patients' Committee members here epitomized the notion that not only did Patients' Committee members lack understanding of the realities of running a hospital, but that they were emotionally immature. As such, he positioned them as adversarial to affecting positive change at the hospital, being delusional and aggressive.

'There will be timelines, there will be accountability': Containing patient voices

A third way in which hospital management worked to contain patient voices was by claiming authority over measures of accountability to patients. This was achieved by rhetoric of accountability stated publicly by upper-level managers and board members at the SEG, which was widely discredited by members of the Patients' Committee as tokenistic. The mandates propagated in SEG board meetings provided clear example of this rhetoric of accountability. A public board meeting in 2018, for example, included a Powerpoint presentation in which a mandate was described to *'build partnerships with patients, families and community partners, to improve the seamless coordination of care'*. The SEG Patients' Committee Annual Report featured a speech from the CEO of the SEG, who asserted that '*as stakeholders, the Patients' Committee should be considered as internal partners… Patients do come first'.* These claims of accountability were expressed in terms of measurable metrics. Emphasis by upper management was put on '*measurable progress'*, with one board member expressing that '*there will be timelines, there will be accountability'*. Quantification of problems was important to defining accountability: as described by Jason:

> *'Without lots of complaints from clientele, without data, nothing will happen'* (Jason, healthcare manager, Interview)

Such forms of accountability were often mismatched with how patient-citizens expressed and demonstrated problems that they experienced at the hospital. Next, I turn to how patient-citizens resisted attempts to contain their experiences and make them subject to institutional measures of accountability.

Patient-citizens: Negotiating social accountability

Patients' Committee members enacted many strategies as they worked to demand social accountability at the SEG Meadow site. They were aware of their own currency as subjects of accountability at the SEG, as accreditation bodies and government bodies increasingly mandate patient involvement in healthcare decision-making. As such, they were conscious that the institution tried to capitalize on their involvement in what they often viewed as being a tokenistic manner:

> *'There's been, um, a lot of the discussion in the literature and at the higher level of hospital accreditation, like Accreditation Canada and so on – you know you've heard a lot of buzzwords coming out about patient inclusion and patients as partners and patient engagement. So this whole notion of including patients in the discussions, in the decision-making about their hospitals – um, it's still a lot of talk and not enough action. A lot of the patient inclusion in discussions is really done for the optics and not for the actual input'* (Nadia, Patients' Committee, Interview)

As a result, much of the work enacted by the Patients' Committee involved resisting being made subject to institutional claims of accountability. This work entailed negotiating recognition of the Committee as a legally-mandated entity, born from a social contract between the state and its citizens. It also entailed negotiating recognition of its membership as patient-citizens, as holding rights to accountability based on the twinned precepts of being taxpaying citizens and as users of the hospital. The ways in which they worked to establish their identity to the hospital administration as such varied.

'We are here to collaborate': Enacting the professional patient

One way in which the Patients' Committee boosted their credibility and worked towards accomplishing social accountability at the SEG Meadow site was by learning the institutional discourse of the hospital and educating themselves about the contractual agreements between the private partners and the hospital.

> *'…We had to struggle to, as a Patients' Committee, to educate ourselves so that we could talk to the hospital administration who then could talk to the private partners.'* (David, Patients' Committee, Interview)

In this way, patient representatives strategically employed the institutional discourse of the hospital and the P3 arrangements, in order to expand their role and legitimacy in decision-making processes. This entailed attempts to destabilize the demarcation between professional and lay knowledge that healthcare managers imposed when they undermined Patients' Committee members' input for a supposed lack of competency and understanding of institutional workings. At times, advancing their negotiating capital through knowledge of the contract also involved identity performances that aimed to distance themselves from perceived weaknesses that some saw as denoted by patient identity. Following a meeting with a M. Lessard, a new healthcare manager at the SEG Meadow site, Nadia described how she tried to establish the credibility of the Patients' Committee:

> *'The concept is that the Patients' Committee is full of old, sick people, but that's not us. We are intelligent and constructive… We are a mixture of professions and talents… I kept trying to establish my credibility with that guy'* (Nadia, Patients' Committee, Observational Excerpt)

As such, by enacting a specifically 'professional patient' role, distinct from a perceived identity of 'old, sick patient', patient representatives tried to negotiate a form of professional legitimacy within the institutional discourse of the hospital and its contractual arrangements with the private partners.

'The power of free speech': Enacting broader civic duties

When collaboration with healthcare managers failed, the Patients' Committee often used local media as a platform to legitimate their concerns and make them known to the general public.

> *'We try to go first to the department… Then we'll go to the, if we have to, to the Director General – the CEO… But often the answer is, 'well our hands are tied by the government, our budgets have been tightened by the government; the partner – according to the contract we have with the partner, they don't, they aren't obliged to do this, dah dah dah dah' So, this is when we will use the media to raise these concerns and make the rest of the public aware, you know about this, ah, these unfair practices or ah, the unfairness of the situation'* (Nadia, Patients' Committee, Interview)

The use of the media was regarded by Patients' Committee members as an important strategy to assert their civic rights to SEG management and to the private partners. Particularly because the contractual agreement of the P3 obliged private partners to have contact with only a select few healthcare managers at the SEG, the Patients' Committee sought other avenues to make their voices heard. By publicizing issues that they experienced at the SEG Meadow site, such as poor accessibility and inadequate consultation with patient users in decision-making processes, as well as photographic evidence to accompany it, the Patients' Committee created a body of public material evidence. This in turn established demands for social accountability from both the hospital and the private partners, to patient-citizens at the SEG and the broader public that they represented.

'A picture says a thousand words': Embodying epistemic authority

An important way in which members of the Patients' Committee worked to resist being made subjects of institutional discourse was by asserting their embodied epistemic authority as users of the hospital. This means that they strategically used their experiences of using hospital facilities to claim legitimacy as stakeholders in decision-making at the SEG. This was particularly notable in their efforts to address issues of poor accessibility in the bathrooms at the SEG Meadow site. The Patients' Committee was frustrated that many bathrooms in the hospital displayed handicapped accessible signage, but were in reality extremely difficult to use for people with disabilities, particularly for wheelchair users who were represented by several members of the committee. As such, Patients' Committee members recognized an important gap between what was written on paper and the lived experiences of hospital users.

> *'You look at things on paper and you don't really see… it from the, you know when the patient is trying to actually use the space'* (David, Patients' Committee, Interview)

In order to contest these issues of accessibility, members of the Patients' Committee often used their own bodies to demonstrate the inefficacy of the bathrooms to healthcare managers. They recognized that, as patients, they possessed an understanding of using a hospital space that many able-bodied healthcare managers did not. Donna, who was a wheelchair user, described this lack of understanding succinctly:

> *'…This hospital was built and there was not a person sitting there with a disability. So they built this hospital for a person with no disability and not realizing that it's not an accessible building… You have to have someone that lives it and not somebody that's taking it from a standing point. And what gives the person that's walking, that has no mobility issues, the right to say, oh yeah*

> *that's an accessibility problem, oh no, that's not. Because they really don't understand the concept'* (Donna, Patients' Committee)

Following this recognition of their embodied understanding of accessibility issues, Patients' Committee members challenged efforts by healthcare managers to undermine their expertise and contain their voices. Such embodied demonstrations of epistemic authority were carried out in several capacities. Members conducted their own assessments of the bathrooms at the site and took photographs of the difficulties they experienced, which then were passed on to healthcare managers at relevant meetings. Annette described an instance of this in a conversation following an Accessibility Committee meeting:

> *'Has he [M. Lessard, healthcare manager] seen Clara's picture? A picture says a thousand words. Clara couldn't close the door so I said 'get on [the toilet], keep your pants on' and we got someone from the cafeteria to take a photo'* (Annette, Patients' Committee, Observational Excerpt)

On one important occasion, Clara, Annette and Donna, who were all wheelchair users, also conducted a tour of the bathrooms. They showed staff from Operations the difficulties that they experienced in using the bathrooms, as the following vignette shows:

> *At the bathroom at entrance of SEG Meadow site. Annette, Donna, Clara are present from Patients' Committee, as well as three healthcare managers: Claudette, Dean and Shaun. Donna, Annette and Clara line up outside bathroom; Donna remarks that push plate for accessing toilet is too high. Annette demonstrates to Dean that she is unable to reach push plate. Annette indicates where she can reach and Dean makes a mark on the wall.*
>
> Dean: *I think we should look at three feet*
>
> *Claudette, Dean, Shaun and Clara enter bathroom.*
>
> Clara: *The sink is not accessible, the soap is not accessible, and [the push plate] needs to be much lower…*
>
> Dean: *[to Shaun] The lady here says it needs to be lower and on the sides of walls, not here [indicates front of toilet]*
>
> (Observational Excerpt, SEG Meadow site)

By demonstrating the issues of accessibility using their bodies, in real time and space, the authority of patient representatives was demonstrated undeniably to healthcare managers. As such, using their embodied authority they shifted the burden of proof, and created demands for social accountability that at times worked to usurp the authority of the fixed P3 contract. This was demonstrated in the Accessibility Committee meeting that followed the bathroom tour:

> Callum: *So let's start with item one on the agenda… SEG public bathrooms. Basically, we met with the private partners to discuss the location of accessories, the directions of doors, etc…*
>
> Claudette [healthcare manager]: *They've already started to look into adding hygiene liquid dispensers… the meeting I had with them- the surprise to them is that not all wheelchairs are made the same…*
>
> (Observational Excerpt, SEG Meadow site)

As such, through taking photographs and demonstrating in-person the issues of accessibility that they experienced, Patients' Committee members established a body of evidence that in turn created demands for social accountability. Such actions were effective in drawing the attention of some healthcare managers to the lived reality of accessibility issues at the hospital and establishing bases for change.

> *'It's definitely opened my eyes to have more of a patient point of view. You know, certain things I would brush off and say this is not important and now really recognize how there's been an impact… also, sitting face-to-face with some of the [Patients' Committee] members who are, you know, who have disabilities- just seeing them coming into a room you can- witnessing someone struggling to go into a room through a door, that the door is hard to open, has more impact than just hearing about it'* (Callum, healthcare manager, Interview)

In this way, using their embodied epistemic authority as hospital users, Patient Committee members resisted being made subject of institutional measures of accountability. By creating evidence through photographs and tours of accessibility issues at the hospital, they established demands for social accountability and were able to affect changes that benefitted patient users.

Contested accountabilities in action

Meetings between patient representatives and healthcare managers, as well as my conversations with different stakeholders demonstrated that accountability at the SEG Meadow site was enacted as dynamic and contested. The conditions of the P3 contract produced highly specific technologies for defining accountability, around which the practices of private sector actors and public healthcare managers alike largely pivoted. It was evident that the P3 contract between public and private sector actors compelled an *accountability culture* whereby healthcare managers must answer to private companies through their contractual agreements. However, I have shown how patient-citizens contested this logic, working for recognition of their rights to a socially-based accountability by making their own claims to authority, entailed through their positioning as patient-citizens.

The practices of different stakeholders at the SEG Meadow site demonstrate how different accountabilities operate on a micro-level. These findings also show how patient-citizens navigate the accountabilities that are produced by public-private hybridity at the hospital: the constraints they experience and the resistances that they enact. After attending to micro-enactments of accountability at the SEG Meadow site and their relationship to meso-level organizing logics, the next chapter turns to the way broader macro structures – in the form of social, political and economic influences – are indivisible from accountability practices in public-private hybrid healthcare governance. I consider the positioning of patient-citizens within these broader structuring effects and the implications for accountability that follow.

Chapter four

Discussion and concluding remarks

This thesis draws the concept of *accountability cultures* into the study of public-private hybridity in healthcare environments. The contribution of this thesis is to show how broader organizational, social and economic logics intersect with micro-level accountability practices in public-private hybrid healthcare governance, compelling competing practices of accountability. Importantly, the findings of this thesis have demonstrated the uncertain positioning of patient-citizens in this context, exploring how constraints upon their agency are imposed, but equally the resistances that they enact to reclaim their rights for accountability.

Importantly, this thesis has demonstrated accountabilities to be mutually influential across macro, meso and micro-levels of practice. The term *accountability cultures* captures the way in which shared ways of thinking, believing and acting are indivisible across these levels of practice. Social accountability can be contrasted with a type of transactional accountability produced by private infiltration in public healthcare governance. The P3 contract produced accountability practices based on a transactional relationship between SGIG and the SEG. This exacerbated a need for the Patients' Committee to enhance social accountability in governance at the SEG. A social accountability perspective sees health as a public good that spans micro, meso and macro levels. The interests of patient-citizens in local environments are shared with the broader public good, in that they promote democratic possibilities and universal accessibility. As such, the findings of this thesis compel promoting social accountability for the preservation and protection of effective public healthcare.

In this final chapter, I elaborate on the main arguments of my thesis and the possibilities that they offer to studies of accountability, in increasingly neoliberal healthcare environments. Returning to my first research question, I find that accountability is enacted in PPP healthcare projects through *accountability cultures* that are produced by the infiltration of neoliberal values into healthcare governance. The neoliberal ethos operates to undermine local sovereignty and trouble patient representation in healthcare governance. In terms of my second research question, examining how patient stakeholders enact their interests in the context of PPP healthcare projects, I find that patient-citizens adopt particular legitimating strategies, including learning institutional discourse, outreach to local media and asserting their embodied authority as hospital users to challenge such neoliberal infiltration. The resistances enacted by patient-citizens in this context can be considered as a form of *epistemic activism*. They demonstrate that *accountability cultures* are not unidirectional: micro-practices exacerbate shifts in accountability on broader scales. I reflect on the implications of such practices for studies of accountability in contemporary healthcare environments. I conclude this chapter by considering how research in this field might envision and advocate for more socially democratic ways for accountability to be enacted, and for patient-citizens to give voice to their experiences.

Regulatory capture of accountability practices

In the introduction to this thesis I discussed the infiltration of a neoliberal agenda into public healthcare policy and the threat that this poses to democratic governance. In this section I discuss how my findings advance previous research by identifying links between broader socio-economic logics and micro-level practices of accountability at the frontlines of healthcare governance. This goes some way to answer calls for research in this field to better understand ‘downstream’ manifestations of accountability in public-private hybridity (see Bishop & Waring, 2016; Waring, *et al.*, 2013; Caperchione, *et al.*, 2017) and address concerns about democratic failure (Bishop & Waring, 2015; Fevre, 2003; Davies, 2014; Forrer, *et al.*, 2010). In particular, my findings traced how PPP contracts condition a particularly neoliberal accountability culture in micro-practices of healthcare governance. Following from a cultural understanding of accountability, this thesis underlines what values and assumptions, as well as artefacts and languages that serve to condition particular ways of thinking about and enacting accountability at the SEG, drawing attention to the non-neutrality of everyday work in healthcare governance.

This thesis showed how procurement agreements and prescriptive contracts entailed by the P3 agreement fundamentally conditioned how accountability was enacted at the SEG Meadow site, by creating the measures through which accountability was realized. The narratives and behaviours of many stakeholders on both the public and private sides of the contract emphasized its ‘prescriptive’ nature, the ‘performance requirements’ that it entailed, as well as the financial sanctions that were incurred by deviations from the agreement. The way in which the technologies of the P3 contract were privileged in accountability practices at the SEG Meadow site might be usefully understood as a form of ‘regulatory capture’, a term attributed to the work of Stigler (1971). This term broadly describes the process through which industries hijack or ‘capture’ regulatory processes (see Mindell, *et al.*, 2012). The ‘capture’ of the P3 contract by private sector organizations can be seen in how the technologies of the contract were enacted as ‘disciplinary tools’ through which the accountability practices of the SEG were conditioned (Pfeiffer, 2019: 53).

Anthropological literature from the field of global health has demonstrated how an increased reliance on metrics and evaluation has become integral to importing neoliberal logics into global health practices, resulting in a narrow siloing of public health practice and abandonment of support for public health sector services (Pfeiffer, 2019). The findings of this thesis have demonstrated the same to be true in public-private hybrid healthcare institutions, whereby the metrics of the P3 contract ‘indirectly become the micro-practices of neoliberalism’ (Adams, 2016: 39). What is constituted as ‘good evidence’ has direct implications for accountability practices. At the SEG Meadow site, processes for determining ‘good evidence’ were directly linked to the technologies of the P3 contract. The findings of this thesis saw how the criteria for accessibility were determined through the P3 contract and that changes came with hefty additional charges. In their approaches to accessibility issues at the SEG Meadow site, the behaviours of healthcare managers most often pivoted on the technologies of the contractual agreement with private partner organizations. The technologies of the contract, such as the building code, coupled with considerable financial sanctions for work that falls outside of the contract are disciplinary tools through which to control the governance of public healthcare. The calculation of profit, enabled by the rigid technologies of the contract, tied governance at the SEG Meadow site directly to neoliberal aspiration.

As such, the contract should be understood as an artefact that served to structure a neoliberalized accountability culture at the SEG, in the sense of advancing the interests of private capital. This follows an understanding that such documents are not just written materials, but ‘fields, frames and networks for action’ (Prior, 2003: 2, in Ahmed, 2007). The prescriptive nature of the contract created selective deployment and unequal application of principles of measurement and evaluation (see Pfeiffer, 2019). The finding of this thesis showed that the selective deployment of these principles feigned accountability, whilst in fact serving only a very specific framework for accountability that served the interests of the private sector. A slippage was incurred by the P3 contract between the political and the technical, whereby neoliberal values were recast as technical realities. This happened by taking politically-based decisions over codes, measurements and techniques of governance and recasting them in supposedly neutral language of a contractual agreement. Political technologies were presented in purportedly detached language of code and measurement, through the supposedly neutral ‘partnership’ arrangement. As such, slippage occurred in the ways that problems were identified and evidenced.

The way in which the P3 contract transferred accountability to the public sector, whilst maintaining control in the private sector was perhaps inadvertently surmised by M. Godard from BHC Reliance, is his comment that *‘if the specs are well defined by the client… there is no reason that there should be any extra [costs] there’* (Interview). Critically, private sector accountability was absolved through neoliberal discourses of autonomy, choice and self-regulation: the idea that *'the great advantage of PPPs is the certainty that the client will receive what they have requested'* (M. Godard, BHC Reliance, Interview). The framing of what is important to measure, through prescriptive contract and code empowers private companies to set the agenda for accountability in healthcare governance and simultaneously obscures their accountability for harmful impacts on healthcare access (see Pfeiffer, 2019).

The prevalence of private interests in public healthcare means that the governance of public healthcare becomes bound by the tools, discourses and mechanisms of neoliberal culture. The findings of this thesis showed how concepts and terms from the private sector, incorporated in the contract, were integrated into the lexicon of public healthcare governance, with upper managers and accountants usurping the role of actual experts in evaluating and measuring performance (see Pfeiffer, 2019). In the behaviours of healthcare managers, we saw how calculative practices of measurement, born from free-market competition, were institutionalized and used in the governance of a public healthcare organization. This was evident in discourse that frames patients as ‘clients’, and privileges ‘measurable progress’ and financial management, as well as Callum's preoccupation with the code in seeking to address issues of accessibility in the SEG Meadow bathrooms. These discourses structure a cultural process of reorienting the accountability of the healthcare organization: by depicting a particular reality, they in turn compel that reality to be remade. As such, neoliberal values become naturalized into the culture of healthcare governance. Despite broadly agreeing that the code was unsuitable, Callum was bound by its conditions and could only seek accountability within its logic, without incurring high costs for the public sector – even if this was damaging to SEG Meadow patient users. As neoliberal values infiltrate public healthcare governance, social accountability is constrained by how PPP contracts compel accountability from public healthcare management to their private sector partners.

The inscrutable logic of relying on metrics and prescriptive evaluative processes makes this accountability culture particularly insidious. Neoliberal rhetoric has been recognized to have 'a plausible ring to the uninformed' (McGregor, 2001: 83). The challenge is that pushes for less measurement and evaluation are unlikely to be galvanizing, as it is these principles on which the goal of advancing accountability is most often built (see Strathern, 2000). By shifting the responsibility for defining codes and conditions for the contract to public sector actors, private partner organizations become almost impossible to hold to account. As such, the prescriptive nature of the contract is in many ways a typical tool of the neoliberal project, by creating a situation where 'there is no alternative' (Fisher, 2009: 57). This was seen particularly in the behavior of healthcare managers who, though often recognizing the legitimacy of calls for social accountability by patient-citizens, were nonetheless bound by the constrictive logic of the P3 arrangement. Indeed, reluctantly or not, the way in which hospital managers privileged their accountability to their private sector partners is exemplary of the role of the state in neoliberal ideology: to ensure that the rules of the market economy are followed and ensure that the market can function efficiently (McGregor, 2001).

Local sovereignty in public-private hybrid healthcare

That the contractual arrangements of the P3 favoured the logic of the private sector pertains to the neoliberal agenda of contemporary public healthcare reforms (see McGregor, 2001). The benefit of contractual arrangements to private over public interests is also demonstrative of a divided enactment of 'public interest'. Corporate entities are being increasingly interlinked to the state and largely unaccountable to the public (Orelus &

Chomsky, 2014). The findings of this thesis suggest that the ‘public’ in public-private partnership only partially represents the interests of the citizens that it implies. There is a fragmentation of the ‘public’, whereby institutions are co-opted by business interests and patient-citizens excluded from the discourse. The particular regulatory capture incurred by PPP contracts works with the autonomy and choice of particular, privileged public sector actors in government and health institution management, but is non-responsive to the fluctuating needs of patient-citizens.

As such, this thesis suggests that the public-private distinction loses use value at the upper echelons of the public sphere as PPP contracts work to entrench inequalities between decision-makers at the top end of public sector governance, and patient-citizens at the bottom. This was demonstrated by how contested accountabilities were pitted against one another by healthcare managers on the one hand, and patient-citizens on the other, at the SEG Meadow site. The findings of this thesis suggest that public-private hybridity in healthcare environments incurs divisions between distal and proximal enactments of ‘public’. Rather than prioritizing the lived activities and priorities of patient-citizens at the sharp end of healthcare provision, the contractual arrangements of the P3 represent an institutional perspective that is distant and disembedded from the interests of patient-citizens.

At the SEG Meadow site, the accountability culture produced by public-private hybridity created a hostile environment for patient-citizen sovereignty by constraining the possibilities for how accountability could be enacted. Patient-citizens struggled to maintain a strong culture of social accountability in the face of a dominating transactional accountability that was inscribed in the state’s relationship with the private sector. The transactional accountability produced by the PPP arrangements not only privileged the institution over individuals, but held a particular notion of organizations which is monolithic and teleological (see Giri, 2000). The P3 contract posed constraints on agency at a local level, as the dominating accountability culture privileged prescriptive contractual technologies and the principles of fiscal management, at the expense of more experiential, socially-based ways of knowing enacted by patient-citizens. Healthcare managers enacted practices that attempted to cement the discourse of accountability within the terms created by the contract, rather than through the experience of the health users. As such, public-private hybridity was seen to weaken the accountability of the state to its citizens, by setting a new and fundamentally mismatched agenda for accountability practices in healthcare organizations.

The ways in which local sovereignty was undermined at the SEG Meadow site appears to comprise a form of ‘epistemic injustice’ (Fricker, 2007). In other words, there is an injustice that is done by undermining patient-citizen ways of knowing, such as through embodied experience, that has been shown in the findings of this thesis. Theorizing the relationship between social power and understandings of social experiences, Fricker uses this term to describe how relations of identity and power can create conditions in which ‘some social groups are unable to dissent from distorted understandings of their social experiences’ (Fricker, 2006: 96). Epistemic injustice operates through a person being ‘wronged specifically in her capacity as a knower’ (Fricker, 2007 quoted in Newbigging & Ridley, 2018). This understanding of the structural inequalities inscribed in epistemic practice has significant resonance with the experiences of patient representatives at the SEG Meadow site. Institutional and professional behaviours, shaped by the P3 contract and enacted by healthcare managers conspire to negate the epistemic agency of patient-citizens, comprising a form of ‘epistemic violence’ (Spivak, 1988). The ‘hermeneutical marginalization’ (Fricker, 2007) of patient-citizens in the PPP institution is evident in the frustrations of Patients’ Committee members as their experiences are obscured by the dominating epistemic logic of the P3 contract, as well as in their struggles to make their social experiences knowable to more powerful stakeholders. As described by one Patients’ Committee member, *‘we are dealing with the patient still suffering and we have no recourse’* (David, Patients’ Committee, Observational Excerpt).

Patient-citizen identity and representation

The conflicting *accountability cultures* entailed by public-private hybridity in healthcare institutions raise fundamental questions about patient identity and representation in contemporary healthcare institutions. In the context of public-private hybrid healthcare, patient-citizens must navigate an increasingly complex set of identity performances to assert their interests, as they confront the development of new norms for accountability practices. This thesis has shown how patient representatives fluctuate between attending to their embodied expertise and trying to intervene in expert discourses by enacting the professional patient. These oscillations in identity performance suggest that the corporatization of public health governance has incurred significantly more turbulent negotiations of patient identity in organizational and institutional settings, as choices are constrained in more complex and multileveled ways.

The limiting effects of public-private hybridity on patient voices are particularly concerning as healthcare initiatives worldwide increasingly seek to emphasize ‘patient-centredness’ (Kitson, *et al.,* 2013) and democratic governance (Caperchione, *et al.,* 2017).

The current moment has been called ‘the Age of Accountability’ (Dubnick, 2007), as institutions make increasing pushes for formalized mechanisms of accountability. The findings of this thesis suggest that pushes for formalized mechanisms of accountability are augmented by private sector involvement in contemporary healthcare governance. Concurrent with their frustration with the PPP arrangements, patient representatives considered that the SEG enacted patient engagement *‘for the optics and not for the actual input’* (Nadia, Patients’ Committee). Whilst the administration made consistent public commitments to patient engagement and praised the strength of their patient groups, behind the scenes the Patients’ Committee experienced a constant uphill battle to have their voices included in decision-making processes.

It has been noted that current mechanisms of public and patient involvement in decision-making regarding healthcare policy are weak and unsustainable (Hudson, 2018). An ‘ontologically shallow’ understanding of citizenship seems to prevail in patient and public engagement initiatives, which prevents patient-citizens from becoming legitimate spokespeople (Lehoux, Daudelin & Abelson, 2012). The opening up of public healthcare to private company involvement would seem to compound these issues. Indeed, there exist significant parallels between the epistemic injustices produced by the P3 contract, and epistemic marginalization that is incurred by the regulatory capture of patient involvement by healthcare institutions. The rhetoric of accountability to patient stakeholders and emphasis on the importance of patient involvement enables healthcare institutions to appear to be practicing democratic governance and involving patient users, whilst in fact limiting their capacity to affect change (Ahmed, 2007). By claiming authority over measurements for accountability to patients, patient involvement is in fact coopted by higher-level institutional interests. A similar process is incurred by the PPP arrangements. The metrics of the P3 contract appear to be measuring accountability, but in fact serve the interests of the private sector and operate to exclude patient voices from decision-making processes. As such, a twinned epistemic violence is done unto patient representatives. On the one hand the hospital capitalizes on patient involvement, making tokenistic efforts for patient engagement to advance their image as a democratically-governed, inclusive institution. On the other hand, PPP arrangements operate to limit the capacity for patient-citizen voices in decision-making. Together, these processes comprise a dual regulatory capture of accountability practices, creating distorted understandings of the lived experiences of patient-citizens and the social context of the healthcare environment.

The contradictions that are created by institutional commitments to patient involvement and accountability on the one hand, and proximal marginalization of patient voices on the other may be considered to inflict an ‘erosion of epistemic confidence’ (Fricker, 2006: 104). This erosion occurs as patient representatives struggle to locate themselves within institutional discourses that limit their capacity for significant impact whilst simultaneously capitalizing on their involvement. As such, contemporary patient groups are in an acute crisis of positioning. The existence of patient groups is intended to mitigate the excesses of professional behaviors and institutional regimes, by foregrounding the experiences of patient users. However, the professionalism of patient advocacy may be considered to counter this purpose by severing advocacy from its foundations in lived experience (see Newbigging & Ridley, 2018). The ‘professional patient’ has important parallels to the self-governing individual subject of neoliberal discourse: through the professionalization of their role, patient representatives are compelled to ‘participate in their own discipline’ (McGregor, 2001). As such, patient groups are caught in a problematic bind: increasingly being demanded to enact the subject role within institutional discourse, yet more than ever needing to foreground their agency to remain true to advocating patient experiences in healthcare governance. In the next section I turn to how the findings of this thesis offer some guidance for possibilities to protect and advance patient-citizen interests in the context of regulatory capture of accountability practices, and to strengthen the agenda for social accountability.

Epistemic activism and embodied resistance

The findings of this thesis showed the contested ways in which different stakeholders tried to assert different needs for accountability and simultaneously limit the capacity of others. These practices can be usefully understood as a form of ‘boundary work’ (Gieryn, 1983). Boundary work describes how healthcare managers and patient representatives employed practices and rhetorical devices to demarcate their roles and authority (see Allen, 2000). The concept of boundary work enables attention to the micro-processes of stakeholder contestations as inherently political, thus enabling linkages to be made between micro-level behaviours at SEG committee meetings and the broader context of PPP policies. As such, considering how boundary work was enacted by patient stakeholders and healthcare managers at the SEG involves tracing *accountability cultures* in action, exploring the dynamic processes through which these divergent forms of accountability were at times made to matter, whilst at other times contained by other stakeholders.

Importantly, the boundary work enacted by patient-citizens at the SEG Meadow site demonstrated that the transactional accountability culture produced by PPPs in healthcare and based in neoliberal values, was not homogenous and never fully naturalized. The dynamic and interactional nature of healthcare governance meant that what accountability culture dominated at one time could be subjugated at another. Accountability practices were seen as contested grounds at the SEG Meadow site and practices of boundary work never complete. As such, the way in which patient-citizens asserted their embodied epistemic authority as hospital users posed a notable challenge to transactional accountability, by establishing demands for socially-based accountability practices. Drawing on the notion of ‘epistemic activism’ (Hamraie, 2017) I suggest that the forms of resistance enacted by Patients’ Committee members at the SEG Meadow have much to offer as a means of challenging the regulatory capture of accountability practices posed by PPPs in healthcare environments.

Patient-citizens resisted epistemic injustices produced by the P3 contract by working to proliferate the epistemic bases for accountability practices at the SEG. Using their bodies and embodied experiences as users of the hospital space, Patients’ Committee members fought to shift a dominating discourse for accountability practices which privileged a transactional relationship with the private sector, to a socially-based logic for accountability. The notion of ‘epistemic activism’ has relevance as a way of theorizing the strategic and purposeful way in which the Patients’ Committee developed counter-narratives to the dominating institutional discourse. Whilst Hamraie uses epistemic activism to describe a form of activism that occurs in academic fields to shape norms and practices of accessibility (2017), I consider that the term has equal relevance to describe the boundary work enacted by Patients’ Committee members, through their embodied epistemic strategies of resistance at the SEG Meadow site. Epistemic activism attends to the purposeful and political ways in which the Patients’ Committee contested technocratic strategies for accountability, such as the code to which the SEG Meadow site was built, by considering the ‘relatively illegible spheres of knowledge production’ (Hamraie, 2017: 132) that occur in ‘seemingly mundane sites’ (Hamraie, 2017: 132). As such, it enables us to consider the specifically epistemic basis through which members mounted challenges to institutional practices that work to contain them as ‘non-knowers’ (Hookway, 2010). The notion also gives expression to the SEG Meadow as a site where norms are produced and resistances enacted. The seemingly mundane sites of the bathrooms, elevators and conference rooms at the SEG materialize the oppressive conditions of the P3 contract and thus can equally be understood as sites of active, political resistance.

Consequently, the actions of the Princess Anne Patients' Committee to contest sites where codes and technologies of governance were enacted, such as the SEG bathrooms, should be considered as intentionally negotiating recognition of their 'epistemic agency' (Newbigging & Ridley, 2018), towards the goal of accomplishing social accountability. When Donna, Annette and Clara, as wheelchair users, used their bodies to demonstrate the inaccessibility of these spaces, they made visible bodily experiences that the prescriptive technologies of the P3 contract work hard to contain. As such, they challenged technocratic epistemologies with ways of knowing which were bodily and proximal: tacit acts of epistemic activism and embodied, political resistance. Through taking photographs of how the built environment compromised their ability to use the bathroom with dignity, and through tours in which they demonstrated these experiences to healthcare managers, Patients' Committee members created evidence that in turn made demands for social accountability. Such evidence effectively shifted the burden of proof on to the hospital and private partners, by demonstrating the ineffectiveness of the code to determine accessibility. Importantly, through Patient Committee members' insistence on demonstrating the lived experience of using the hospital space, they 'create[d] space for different forms of knowledge within an unequal power dynamic that privileges professionals' authority over that of lived experience' (Newbigging & Ridley, 2018: 36).

Attending to the spaces that patient-citizens create for different forms of knowledge within the power asymmetries created by corporate capture of public healthcare institutions entails envisioning and advocating for alternative ways for accountability to be enacted. It does this by tracing the epistemic means through which the impetus for social accountability is achieved in a corporatized healthcare setting. Exploring practices of epistemic activism recognizes that *accountability cultures* are not unidirectional: whilst macro and meso-level logics produce micro-level practices, equally micro-level practices exacerbate meso and macro-level shifts in accountability. Epistemic activism operates through *'proliferat[ing] the meanings of access and producing momentum for achieving it* [emphasis added]*'* (Hamraie, 2017: 132). By creating counter-narratives concerning how accessibility is determined, the Princess Anne Patients' Committee proliferated the bases for accountability practices and produced momentum for achieving accountability to patient-citizens. Such strategies of resistance to hierarchy and control worked to increase the agency of patient-citizens in an epistemically marginalized environment. As such, this thesis has shown how patient-citizens have developed strategies for strengthening their agency, resisting the dominant discourse and seeking to produce alternative understandings of the hospital institution, in terms of use-value, ownership and accountability. In doing so, they make space for different forms of knowledge and resultant demands for accountability, within glaring power asymmetries.

Implications for accountability

Attending to epistemic activism enacted at the frontiers of increasingly neoliberalized healthcare governance involves envisioning and advocating for alternative ways for accountability to be enacted and for patient-citizens to give voice to their experiences. In considering the implications for further research entailed by this thesis I consider, what do these forms of resistance offer to studies of accountability in increasingly corporatized public systems? This thesis demonstrates the need to attend to how accountability practices are mutually influential across micro, meso and macro-levels. It is through the linkages between these levels of practice that we can discern *accountability cultures*, in the sense of deciphering what values and assumptions about social reality, as well as meanings and symbolisms, naturalize certain ways of thinking about and enacting accountability. As such, discerning *accountability cultures* also requires critical examination of what practices are denaturalized and become epistemically marginalized. We must attend to the epistemic inequalities that arise from dominating *accountability cultures* and are inevitably hard to detect.

This thesis has offered some possibilities for how studies of accountability might address epistemic injustices and enhance social accountability. By exploring people and environments at the frontlines of neoliberal policies we can better understand how certain *accountability cultures* operate to submerge and contain particular voices. Equally however, such research presents possibilities to forefront and thus advocate for marginalized voices. This thesis has shown that, despite the dominance of a transactional accountability culture in healthcare governance at the SEG Meadow site, *accountability cultures* are dynamic and contested. Validating the personal experiences, narrative and visceral forms of knowing of patient representatives can serve to secure the epistemological basis for social accountability practices. Increasing studies are needed in different settings, focusing on how people make spaces for alternative forms of knowledge in epistemically marginalized environments. In doing so, studies in accountability and healthcare governance alike can ‘foreground possibilities foreclosed by… dominant logics’ (Howarth, 2005: 319). In the context of increased neoliberal infiltration into public healthcare delivery, this thesis suggests the need for researchers to enact a form of ‘epistemic witnessing’ (see Newbigging & Ridley, 2018) with the goal of voicing and protecting the agency of the epistemically marginalized.

For patient representatives, working for recognition of their rights to social accountability might involve revisiting the means through which they enact their interests. This thesis has shown how better understanding the interplay of patient representation and institutional discourse could benefit patient representative groups. Whilst operating in the conditions created by PPPs has been shown to have profoundly negative consequences for patient-citizen voices and representative, this thesis has also shown that patient groups hold some unique advantages in healthcare governance. As patient-citizens, they have the freedom and impetus to circumvent the constraints of bureaucracy, by operating outside of administrative governance. The work of the Princess Anne Patients' Committee demonstrates strategies enacted outside of these realms can be effective for accomplishing social accountability. These insights are valuable. They comprise a call-to-arms for patient groups, who must equip themselves with new – arguably, old – tools to negotiate their interests, as neoliberal discourse in healthcare institutions increasingly operates to absorb and obscure their agency.

For those who profess to support patient engagement in healthcare governance, such as healthcare managers and policy makers, this thesis has shown the need to recognize, respect and make space for patient voices, in ways that are determined by patient-citizens. The patient engagement tool (appendix D) that was developed from the findings of this thesis presents an example of how this might be achieved locally, on a micro-level. Recognizing that healthcare managers in particular experience different, significant, constraints on how they can operate in contemporary healthcare governance, this tool focuses on small, actionable ways in which healthcare staff can make space for alternative ways for patient-citizen voices to be heard. It also comprises a means for patient representatives to hold institutions accountable to their commitments to patient engagement.

Finally, I consider that this thesis offers some theoretical and methodological contributions to the study of accountability. In and beyond healthcare, it has been considered that as organizations compete to maintain their footing in a neoliberal milieu, actors must negotiate increasingly ambiguous scopes of responsibility and involvement in their everyday conduct (Caldas-Coulthard & Iedema, 2008). The findings of this research have shown that that identity performances at the frontlines of neoliberalized healthcare environments are constrained in ever more complex ways, as patient-citizens struggle to locate themselves within institutional discourses that limit their capacity for significant impact whilst simultaneously capitalizing on their involvement. As such, patient-citizens enact multiple and sometimes contradictory roles, oscillating between asserting their interests within and outside of the dominating institutional discourse. Current study of accountability might be considered methodologically underdeveloped in capturing the complexity of such accountability performances as they move between multiple registers. Most research has tended to dichotomize between ‘formal’ governance and ‘informal’ everyday practices, or between structural and psychological approaches, and the epistemological and methodological complexities of actualizing study of accountability remain contested (Dubnick & Justice, 2004; Hor, 2011).

This thesis has demonstrated the potential of an ethnographic lens to address these shortcomings. Transforming the questions of ‘accountability’ into ‘how accountability is enacted’ involves an epistemological move beyond the contested boundaries of the concept. As neoliberal infiltration creates accountability practices as increasingly complex and multifaceted across public services, an increase in ethnographic inquiry of patient-citizen engagement provides the means to ‘match complexity with complexity’ (Hor, 2011) by probing into areas where measurement is not easy or possible, and where issues are sensitive and multifaceted (Dixon-Woods, 2003). By being in close and continued proximity to the people and environments at the sharp end of the policies that produce *accountability cultures*, ethnographic fieldwork can produce nuanced descriptions of accountability work, highlighting the dynamic and contingent nature of these practices. As such, it collapses unhelpful distinctions between ‘formal’ and ‘informal’ accountabilities by focusing the intersections between different *accountability cultures* and the contested spaces that emerge between them. An ethnographic approach to accountability may advance the effort by scholars of accountability to uncouple accountability from governance (Aveling, *et al.*, 2016; Hor, 2011; Yang & Dubnick, 2016) and engage with the multiplicity of accountability practices. The implications of these contributions extend beyond the context of my research, and ought to have application in critical inquiry of accountabilities across an array of social, political and organizational spheres.

Limitations and future research

In this brief section, I reflect on some of the limitations of this thesis: topics or issues that were not included, but which could enrich further research in this field. Beyond acknowledging the time constraints posed by an MSc program, I consider issues of identity, space and theory and how these might be productively evolved in future work.

Conceptualizing who qualifies to represent patient voices in this study was a central point of contention for me. Whilst I maintain that the identity of ‘patient’ is a relational category, it seems fair to say that chronic users of healthcare services may be more adept to represent patient voices than people who have infrequent interaction with healthcare services. Whilst I was aware of many members of the committee with whom I worked as long-term users of healthcare services, I do not know if this was the case for all representatives on the committee. Indeed, by way of being on the committee, patient identity in this study was to a large extent professionalized from the outset. Further studies of accountability in neoliberalized healthcare environments would perhaps benefit from exploring patient identity through different interactions and capacities in the healthcare space. The legal mandate for a Patients' Committee ensured at least some capacity for voice – It would be revealing to explore capacity for patient-citizen voices when this is not the case. Furthermore, a relatively small sample in one site raises issues of transferability, though it should be noted that the literature reviewed for this thesis suggests that the phenomena and challenges that I have addressed are widely shared.

Next, whilst I made some efforts to acknowledge and incorporate the material environment created by the P3 agreement into this thesis, it is arguable that this should have been more developed. Scholars from architecture and social sciences have demonstrated the inherently political nature of built environments. Although I have used the case study of a P3 project to demonstrate broader issues in public-private hybridity and neoliberalized healthcare, that P3 projects pertain fundamentally to the architecture of care environments was perhaps deserving of a more central place in this thesis.

Finally, I have chosen to explore the findings of this research using mid-level theoretical concepts, which I felt enabled fruitful analysis of the empirical data and some level of accessibility for researchers and interested parties across fields, academic or otherwise. This perhaps reflects my position as an anthropological researcher within a healthcare field. Many of the ideas underlying the concepts I have used here resonate with the work of Bourdieu, in particular his original ideas concerning how symbolic capital is validated within different fields (1986). Future papers that engage with *accountability cultures* might benefit from frameworks suggested by Bourdieu (1986) to sociologically frame enactments of boundary work and negotiations of structural power and agential possibilities represented in this thesis.

Concluding remarks

This thesis has demonstrated how values, artefacts and discourses of neoliberalism in public-private hybrid healthcare produce specific *accountability cultures* in the micro-practices of public healthcare governance. It has demonstrated that, despite commitments of governance bodies for public administration in publicly-funded healthcare institutions, public-private hybridity has profound ramifications for public accountability. As private organizations become increasingly involved in the provision of public healthcare, they create new norms for accountability in public healthcare governance.

The study of *accountability cultures* in public-private healthcare governance raises fundamental questions about the future for publicly-owned and accessible healthcare. The findings of this thesis have demonstrated that private sector involvement is clearly linked with conflict and uncertainty at the frontlines of accountability practices in public healthcare governance, and with weakened capacity for social accountability. Rigidity and technocratic metrics in PPP contracts have been shown as cultural codes that favour the private sector, rather than the fluctuating and evolving needs of public population. The narrowly construed means for accountability that are imposed by private sector involvement in public healthcare serve to distract from more comprehensive efforts for accountability, notably social-based accountability from the state to its citizens. As such, it incurs a systematic 'failing to measure what counts most' (Pfieffer, 2019: 59).

However, attending to epistemic activism enacted at the forefront of increasingly neoliberalized healthcare governance entails envisioning and advocating for alternative ways for accountability to be enacted and for patient-citizens to give voice to their experiences. The work of the Princess Anne Patients' Committee demonstrates that *accountability cultures* are indivisible across macro, meso and micro-levels: micro-level practices exacerbate shifts in what accountability is made to matter. At the heart of this critique of neoliberal healthcare are important epistemic questions about what knowledge counts and whose knowledge is recognized to matter, in the quest for accountability. This thesis demonstrates the need for patient representatives, governance bodies and researchers alike to promote non-standardized, proximal and embodied types of knowledge that are born from experiences of those operating on the sharp end of public-private hybrid healthcare, towards the goal of strengthening social accountability.

Healthcare policy-makers and managers are making efforts across multiple spheres to become more patient and citizen engaged. The implementation of PPPs in healthcare poses a significant threat to these efforts, as accountability slips out of the public purview. Understanding and denaturalizing *accountability cultures* in this privatizing context is paramount to the goal of publicly-accessible, democratically governed healthcare. In the absence of clear accountability in healthcare, we risk undermining the right for universal healthcare, and the involvement of the public voice to shape this. This thesis has shown not only what accountabilities are entailed by private involvement in public healthcare services, but how patient and public voices negotiate this. In doing so, it provides the basis from which to critique and improve accountability practices in increasingly neoliberalized healthcare environments.

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Appendix A: Patient participant interview guide

Shifting accountabilities: Patient-citizen voices and contested governance in public-private hybrid healthcare

Interview Guide for Patient Committee members

Briefly describe the project. Consent procedure.

1. When and how did you first become involved in the Princess Anne Patients' Committee?
2. What do you see the role of the Patients' Committee as being?
3. Why is the Patients' Committee important?
4. Can you tell me about the first time you heard the phrase 'public-private partnership'?
5. What do you see the role of the private companies being in the running of the SEG?
6. What has been your experience of the P3 here at the SEG?
7. What effects have you seen? (Can you give me an example?)
8. Have you been personally affected by these issues?
9. Has anything surprised you about P3 projects?
10. What are the consequences for patients of SEG being a P3?
11. Who is accountable for these issues?
12. What do you think the role of the Patients' Committee is in the face of these issues? (Why is the Patients' Committee important in the context of the SEG PPP right now?)
13. How do you try to address these issues?
14. Who do you work with to address these issues?
15. What challenges do you face in addressing these issues?
16. What do you think would make addressing these issues more effective?
17. Is there anything else you would like to tell me?

18. Can you suggest anyone else from or outside of the committee who might be good to talk to about these issues?

Thank you for your time and attention.

Appendix B: Healthcare manager interview guide

Shifting accountabilities: Patient-citizen voices and contested governance in public-private hybrid healthcare

Interview guide for healthcare managers

Briefly describe the project. Consent procedure

1) What is your title? How long have you been in this role?
2) Please describe your role.
3) Can you tell me about the first time you heard the phrase ‘public-private partnership’?
4) What do you see the role of the private companies being in the running of the SEG?
5) What has been your experience of the P3 here at the SEG?
6) What effects have you seen? (Can you give me an example?)
7) Has anything surprised you about P3 projects?
8) What are the consequences for patients of SEG being a P3?
9) Who do you think is responsible for these issues?
10) How do you try to address these issues?
11) Who represents the private partner in addressing these issues? How do you work with them?
12) What do you think the role of the Patients’ Committee is in the face of these issues? (Why is the Patients’ committee important in the context of the SEG PPP right now?)
13) What is your relationship with the Patients’ Committee? How would you characterize it?
14) How do you work together/apart to address these issues of accessibility?
15) What challenges do you face in addressing these issues?
16) What do you think would make addressing these issues more effective?
17) Is there anything else you would like to tell me?

18) Can you suggest anyone else who might be good to talk to about the PPP here?

Thank you for your time and attention.

Appendix C: Private company participant interview guide

Shifting accountabilities: Patient-citizen voices and contested governance in public-private hybrid healthcare

Interview guide for private company participants

Briefly describe the project. Consent procedure.

L'objectif de mon projet est de comprendre comment les différents intervenants communiquent et revendiquent leurs intérêts au sein de partenariats public-privé dans le secteur de la santé. Donc, je veux apprendre comment les problèmes posés par les PPP peuvent être traités plus efficacement au profit de tous les intervenants.

1) What is your title? How long have you been in this role?
   Quel est votre titre? Depuis combien de temps occupez-vous ce rôle?

2) Please describe your role.
   Pouvez-vous s'il-vous-plaît décrire votre rôle.

3) What do you think are the advantages and disadvantages of a PPP?
   Dans votre expérience, quel sont les avantages et désavantages d'un partenariat public-privé?

4) Do you think that healthcare PPPs are different from other PPPs? If so, how? (Have you seen consequences from the SEG being a healthcare PPP?)
   Pensez-vous qu'un PPP dans le domaine de la santé et des PPP dans d'autres contextes? Si oui, comment? (Est-ce que vous avez vu quelques conséquences du fait que le SEG soit un projet de soins de santé au lieu d'un projet d'infrastructure comme un pont ou une autoroute?)

5) What do you see the role of your company is in the running of the SEG?
   Quel est selon vous le rôle de votre entreprise dans la gestion de SEG?

6) What has been your experience of the SEG project?
Quel est votre expérience du projet du SEG?

7) Who do you see as the stakeholders in the SEG project?
Qui sont selon vous les intervenants dans le projet SEG?

8) What is your interaction with these other stakeholders?
Comment interagissez-vous avec les intervenants?

9) Is there anything that you find difficult about managing your relationship with stakeholders?
Qu'est-ce qu'il y a de plus difficile concernant la gestion de votre relation avec les intervenants?

10) What do you think would make addressing these issues more effective?
Qu'est-ce qui rendrait le traitement de ces problèmes plus efficace?

11) There has been some discussion of issues of accessibility at the SEG. What do you think BHC Reliance's responsibility is in addressing these issues?
Il a déjà été question de problèmes d'accessibilité au SEG. Selon vous, quelle est la responsabilité de BHC Reliance face à ces défis?

12) How has the company been involved in addressing these issues?
Comment l'entreprise a-t-elle été impliquée dans la résolution de ces problèmes?

13) Is there anything else that you would like to tell me?
Aimeriez-vous ajouter autre chose?

Thank you for your time and attention.
Merci pour votre temps.

Appendix D: Patient Engagement Tool [draft]

Patient engagement: Making the commitment actionable

My name is Anna Horton and I am a MSc student in the department of Family Medicine at McGill. My MSc research has been concerned with patient voice in the context of public-private partnerships in healthcare. As part of this research, I have spent five months observing meetings between patient committee members and hospital staff at the Royal Victoria hospital and conducting interviews with patients and hospital staff. I have been looking to better understand how patient engagement is enacted in decision-making processes at healthcare institutions.

For patient representatives, achieving true, equitable patient engagement in a hospital can often be extremely challenging. Whilst hospital managers and administrators might make verbal commitments to patient engagement or partnership, I have observed in meetings that too often these promises are not enacted when decisions are made that affect hospital users. With an understanding of these issues, a proposed tool has been created as an aid to help guide hospital managers and administrators on how their commitments to patient engagement might be better realized. It has been designed collaboratively, by patients and scholars, with the input of hospital managers.

The tool comprises two parts.

Part one is a suggested guide with criteria for patient engagement aimed at hospital managers and administrators. You can give this to staff at your hospital to help guide them in enacting patient engagement.

Part two is a questionnaire for patient representatives, aimed at assessing patient engagement in decision-making processes. The items on the questionnaire reflect the suggested criteria on the guide for staff. Once completed, feel free to share these questionnaires with hospital staff.

For any questions, please feel free to email me at anna.horton@mail.mcgill.ca

PART ONE

Patient engagement: Making the commitment actionable

Guide for hospital managers and administrators

This hospital has expressed a commitment to engaging patients in setting its institutional priorities and decision-making processes. This is reflected in the mandate of the hospital (cite), as well as in broader provincial and federal and accreditation policies (cite). However, managing patient engagement successfully can be challenging. Achieving truly collaborative decision-making processes between different stakeholders is not an easy task. This tool has been designed as a suggested guide to help achieve the goal of successful patient engagement.

Suggested criteria for achieving patient engagement

The first question to ask yourself is:

1) When a decision which affects users of the hospital needs to be made, are patient representatives being contacted to be involved?

It is a legal requirement to have a Patient/User’s committee at your healthcare institution. If you are in doubt about how to reach out to patient representatives, the Patients’ Committee will be able to help you. It is important that patient representatives are present in meetings and discussions about decisions that affect them.

However, having patients simply being present at meetings and discussions is not enough to constitute real patient engagement. Sometimes, without realizing it, healthcare managers and administrators can behave in ways that undermine patient voices. This might be because they have lots of different responsibilities that leave them feeling stressed and reluctant to answer to more people. This checklist comprises suggestions for simple actions that healthcare managers and administrators can enact in meetings, to make sure that patient voices are being heard and included in any appropriate decision-making process.

2) Staff can make written notes of patient representative contributions
3) Staff should not interrupt or cut off patient representatives when they are speaking
4) Patient representatives should be given opportunities to ask questions and clarify points
5) Staff should try not to leave during these meetings, unless absolutely necessary
6) Staff should try not take phone calls in the meeting
7) An agenda can be made for the meeting
8) Patient representatives should have opportunity to contribute to the agenda
9) The meeting can be minuted
10) Patient representatives should have access to the agenda in advance of the meeting and access to minutes after the meeting
11) Patient representatives should have access to any other relevant materials or documents
12) Patient representatives should be given room to voice their concerns in forms which are determined by them- eg. Photographs; videos; walking tours.

It is important to note that behaviours in these meetings will be exacerbated by existing social and cultural inequalities, such as those that result from gender, race, disability and social class. All participants in these meetings should be conscious about how social inequalities might contribute to some voices being made more powerful than others.

After a meeting, it is important that patient contributions are followed up.

13) Plans should be made for a follow-up meeting
14) There is ongoing consultation with patient representatives about the actions being taken to address the issue at hand.

If you have questions about patient engagement, reach out to the patient representatives at your hospital! They will be happy to help you find suitable ways to collaborate.

PART TWO

Patient engagement: Making the commitment actionable

Patient engagement assessment tool

1) How was your presence at this meeting determined?

   You contacted a staff member
   A staff member contacted you
   Other (please state)

2) Did staff members make notes during your contributions?
   Yes/No

3) Were you interrupted by staff members?
   Yes/No

4) Were you given the opportunity to ask questions or clarify points during this meeting?
   Yes/No

5) Were there any questions that you wanted to ask, but felt unable to do so?
   Yes (If yes, please elaborate)
   No

6) Did any staff members leave during the meeting?
   Yes/No

7) Did staff members take phone calls during the meeting?
   Yes/No

8) Was there an agenda sent to you preceding the meeting?
   Yes/No

9) Did you have input into this agenda?
   Yes/No

10) Was this meeting minuted?
    Yes/No

11) Were these minutes sent to you following the meeting?
    Yes/No

12) Were there any documents referenced in the meeting?
    Yes/No

13) Did you have access to these documents?
    Yes (if yes, please state if you had access before or after the meeting)

No

14) Did you discuss problems that you are concerned about?
Yes (if yes, please state how you evidenced the problem- eg. Personal account; written account; photographs; video)
No

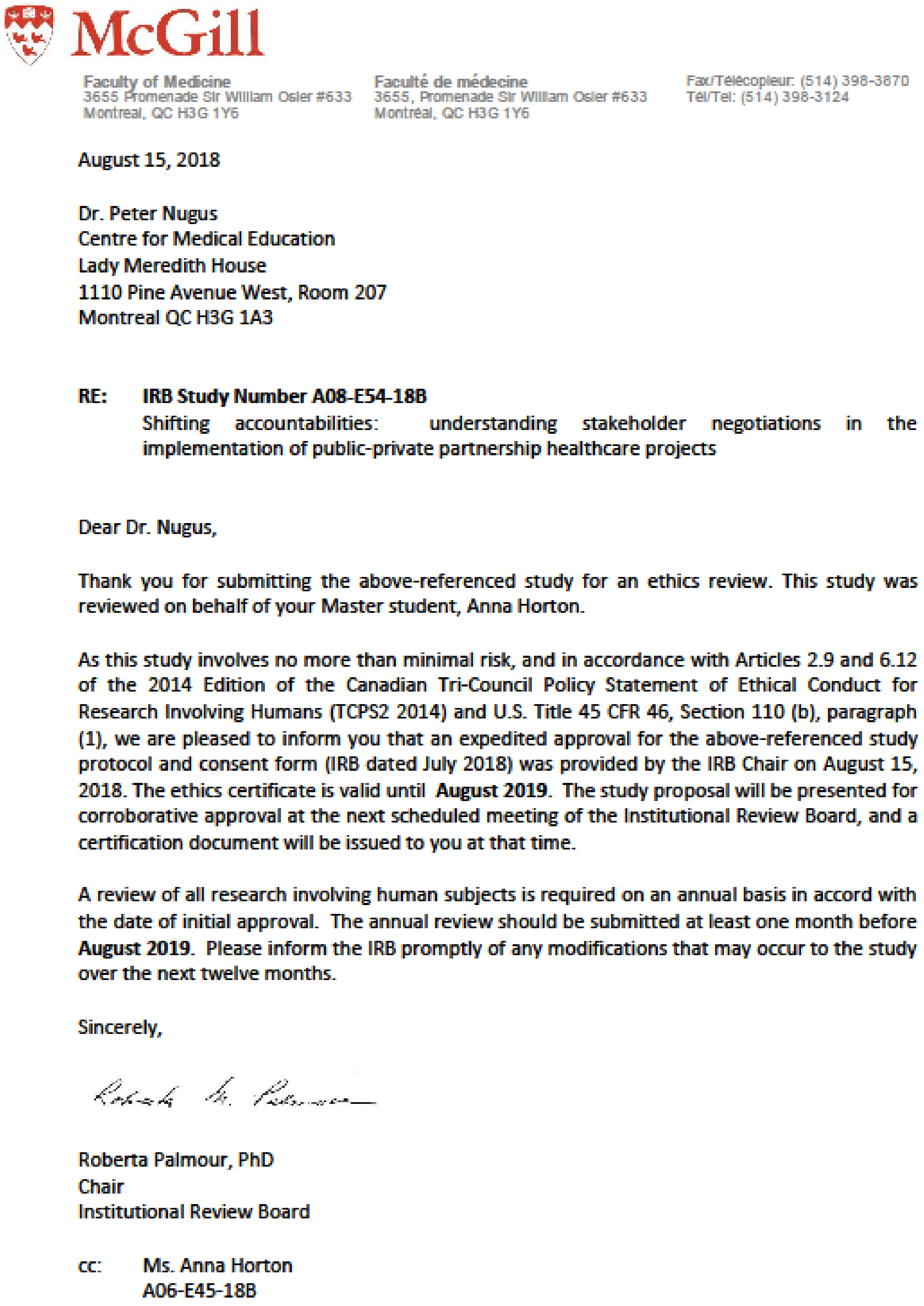
15) Did you feel heard in this meeting?
Yes/No
Please elaborate……………………

16) Were plans made for a follow-up meeting?
Yes/No

17) (If applicable) Have you since been consulted about the actions being taken to address the issue at hand?
Yes/NO

18) Do you have any other comments?

Appendix E: IRB study approval



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August 15, 2018

Dr. Peter Nugus
Centre for Medical Education
Lady Meredith House
1110 Pine Avenue West, Room 207
Montreal QC H3G 1A3

RE: **IRB Study Number A08-E54-18B**
Shifting accountabilities: understanding stakeholder negotiations in the implementation of public-private partnership healthcare projects

Dear Dr. Nugus,

Thank you for submitting the above-referenced study for an ethics review. This study was reviewed on behalf of your Master student, Anna Horton.

As this study involves no more than minimal risk, and in accordance with Articles 2.9 and 6.12 of the 2014 Edition of the Canadian Tri-Council Policy Statement of Ethical Conduct for Research Involving Humans (TCPS2 2014) and U.S. Title 45 CFR 46, Section 110 (b), paragraph (1), we are pleased to inform you that an expedited approval for the above-referenced study protocol and consent form (IRB dated July 2018) was provided by the IRB Chair on August 15, 2018. The ethics certificate is valid until **August 2019**. The study proposal will be presented for corroborative approval at the next scheduled meeting of the Institutional Review Board, and a certification document will be issued to you at that time.

A review of all research involving human subjects is required on an annual basis in accord with the date of initial approval. The annual review should be submitted at least one month before **August 2019**. Please inform the IRB promptly of any modifications that may occur to the study over the next twelve months.

Sincerely,

Roberta Palmour, PhD
Chair
Institutional Review Board

cc: Ms. Anna Horton
A06-E45-18B

JULY 2018

Shifting accountabilities: Understanding stakeholder negotiations in the implementation of public-private partnership healthcare projects

Peter Nugus & Anna Horton

DATE OF I.R.B.
APPROVAL
AUG 15 2018
Faculty of Medicine
McGill University

Appendix F: Consent form template

CONSENT FORM FOR INTERVIEW PARTICIPANTS

How do patient stakeholders enact their interests in the context of public-private partnership healthcare projects?

Investigators: Anna Horton, Dr. Peter Nugus

Introduction

The investigators are conducting a research study to understand how different stakeholders enact and negotiate their interests in the context of Public-Private Partnership (PPP) healthcare projects. You are invited to participate in the interview component of the study.

Study Procedures

If you volunteer to participate, one of the investigators will ask you to:

- Participate in an audio-recorded, semi-structured interview, conducted by an investigator about: your role and mandate in the context of the PPP project; your experiences of negotiating your role and mandate in a PPP context; your interactions with public and private representatives; your beliefs and opinions regarding the efficacy of PPPs in this healthcare environment.

The interview will take between 45-60 minutes. This will take place between August 2018 and December 2018.

Risks and Benefits

You will not benefit directly from your participation in this research. However, the findings of this research may be used to inform better communication practices and improvement of accountability in your healthcare environment. You will also be informed of the findings of this research. Please note that in the presentation of such findings, your name will not be used.

Withdrawal from the Study

You may withdraw your consent and discontinue participation at any time.

Cost

Apart from the time that you make available, there is no cost to you to participate in this study. If you withdraw from this study and discontinue participation, there will be no penalty to you, and no loss of benefits to which you were otherwise entitled.

Compensation

You will not be compensated for participating in this study.

Participants' Rights

- You can choose whether or not you want to be in this study, and you may withdraw your consent and discontinue participation at any time, without cost or prejudice.

- You may refuse to answer any questions that you do not want to answer and still remain in the study.
- The researcher will not record events, statements or conversations if you request them either not to be recorded or to be deleted during the interview or subsequently.
- You have the right to review, edit or erase the files of your participation in whole or in part.

Confidentiality

Any information that is obtained in connection with this study and that can identify you will remain confidential. It will be disclosed only with your permission or as required by law. You have the right to review, edit or erase the research tapes or transcripts of your participation in whole or in part.

Contact

If you have any questions, comments or concerns about the study, you can talk to the Principal Investigator, Dr Peter Nugus. Please contact Dr Nugus at: peter.nugus@mcgill.ca or on 514-754-0073.

If you have questions about your rights while taking part in this study, or you have concerns or suggestions and you want to talk to someone other than the PIs about the study, please call the Senior Ethical Administrator, McGill University Faculty of Medicine, at 514-398-8302 or write to:

Senior Ethical Administrator
McGill University Faculty of Medicine
IRB, Room 633, McIntyre Medical Building
3655 Promenade Sir William Osler
Montreal, Quebec H3G 1Y6

You will be given a copy of this form to keep.

Signature of participant

The study has been explained to me and my questions have been answered to my satisfaction. I agree to participate in this study. I do not waive any of my rights by signing this consent.

Name of participant	Signature of participant	Date
Name of person requesting Consent	Signature of person requesting consent	Date