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Evidensbasert praksis i nyliberal kontekst

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Opplegg

I. Evidenskonseptet

II. Hva er evidensen for evidensbasert psykoterapi

III. Det nyliberale samfunn

IV. Evidens og styringslogikker

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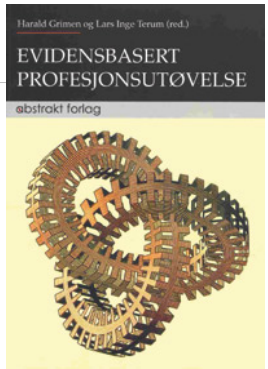

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Evidens – ein hype?

So what?

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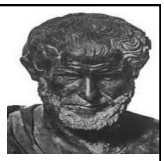

Aristoteles (384-322 f.Kr.):

- **Theôrêsis:** tilskuerkunnskap med teoretisk målsetting
- **Pathos:** påvirke, reaktivitet
- **Khrêsis:** brukskompetanse relatert til ytre objekt
- **Poiêsis:** omformings-produksjonskompetanse relatert til ytre objekt
- **Praxis:** utøverkompetanse, deltakerkompetanse
- **Theôria**: artikulert innsikt
- **Doxa:** uprøvet, spontan mening
- **Epistêmê**: forståelse, ferdig analysert, systematisert kunnskap
- **Phrónêsis:** artikulert evne til overveielse av rett og galt (normativt) i konkret situasjon, artikulert versjon av praksis
- **Tékhnê:** artikulert vurderingsevne innenfor poiesis
- **Súnesis:** artikulert evne til å vurdere konkret situasjon deskriptivt (sant/falskt)
- **Deinotes:** egenyttig kløkt
- **Dialogikk:** induktiv argumentasjon og artikulasjon
- **Didaktikk:** deduktiv argumentasjon og saksframstilling
- **Retorikk:** overtalelseskunst i forhold til handling/beslutning, primært relatert i forhold til forsamlinger

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Og i dag?

Evidensbasert kunnskap!!!!

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Evidens.....

- Nye internatsjonale og nasjonale organisasjoner som spesialiserer seg på å produsere og formidle systematiske kunnskapsoversikter, f. eks. Cochrane, Campbell, EPPI, SCIE...
- Ofte semistatlige med rådgivingsoppgaver (f.eks. Nasjonalt kunnskapssenter for helsetjenesten)

Nye begrep:

- Evidensproduksjon
- Kunnskapsmeglere
- Kompleksitetshåndtering
- Innsikt erstattes av algoritmer og prosedyrer

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Manifest for "evidensbasert medisin"

Et nytt paradigme for medisinsk praksis er under dannelse. Evidensbasert medisin legger mindre vekt på intuisjon, usystematisk klinisk erfaring og patofysiologiens rasjonale [medisinsk lærebokskunnskap] som tilfredsstillende grunnlag for å fatte kliniske beslutninger. Det vektlegger studium av evidens fra klinisk forskning. Evidensbasert medisin krever nye ferdigheter av legen, inkludert effektivt litteratursøk, og bruken av formale regler for evidens i evalueringen av klinisk litteratur.

(Evidence-Based Medicine Working Group, publisert 4.nov 1992, *The Journal of the Americal Medical Association*).

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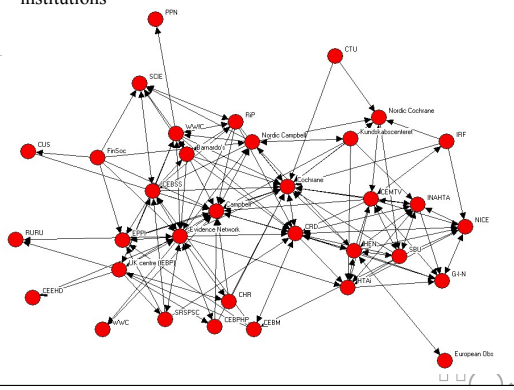
A global network of "evidence" institutions

Hanne Foss Hansen



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Bakgrunn i uhåndterleg kunnskapsvekst

- Informasjonsoverload og ofte konflikterende budskap
- Redusere gapet mellom mellom det forskerne vet, og det praktikeren gjør
- Rydde opp i uenighet, rot i kunnskapsarkivene etc
- Fjerne dårlig udokumentert praksis
- Behov for oversikter, sortering, syntetisering og formidling av kunnskapsstatus om gitte forhold, f.eks. effekten av ulike typer tiltak (medisinske, sosialpolitiske osv....)

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Evidensideologien "Vi må rydde i kunnskapsrotet….."

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Evidence based excitement

- **Government**
- **Politicians**
- **Managers and payers**
- **Researchers**
- **Clinicians and practiciens ?**

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Eksempel: Campbell review av Multisystemisk terapi (MST)

- Hva er effektene av MST?
- 95 relevante rapporter, 35 primærstudier, der 8 tilfredstilte inklusjonskriteriene (RCT'er).
- Metaanalyse.
- Konklusjon: der er ingen troverdig evidens for at MST er et bedre tiltak enn alternativene på de fleste resultatmål. Der er heller ingen evidens for at MST har skadelige virkninger.

Tromsø mars 2011

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Eksempel

Spørsmål:
Hvilken type kompetanse hos lærere bidrar mest til læring hos barn

Bestiller:
Kunnskapsdepartementet

Utfører:
Dansk Clearinghouse for Uddannelsesforskning (Nordenbo mfl. 2008)

Metode:
–Datsøk gir 6000 artikler
–Tematisk avgrensing: reduksjon til 70 artikler
–Metodisk seleksjon: reduksjon til 55 artikler

Resultat:
«For første gang vet vi med stor sikkerhet hvilke kompetanser en lærer må ha: Solid fagkunnskap og evnen til å formidle denne kunnskapen til elevene». (Kunnskapsdepartementet, 2008)

For øvrig:
Etter 800 internasjonale metaanalyser, kan vi også slå fast: Læreren utgjør hovedforskjellen på en god og en dårlig undervisning (Hattie, 2009)

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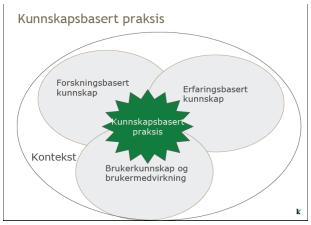
The ideal…

The integration of best research evidence with clinical experience and the users preferences



"….the conscientious, explicit, and judicious use of current best evidence in making decisions about the care og individual patients" (Sackett et al, 1996)

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Some questions:

- What is to be regarded as best evidence?
- How to handle conflicting knowledge?
- Who is authorized to handle conflicts?
- What do you do when user preferences contradict the evidence?
- What do you do when your professional experience contradict research?

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Two epistemological claims in EBP

- defining the criteria for what should count as knowledge
- predict that this knowledge will give "best" practice

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Hierarchy of evidence

- Meta analysis of RCT
- At least a RCT-study
- At least a controlled study without randominisation
- At least some kind of quasie -experimental study
- Non-experimental descriptive studies
- Expert rapports/consensus

(Geddes and Harrison, 1997)

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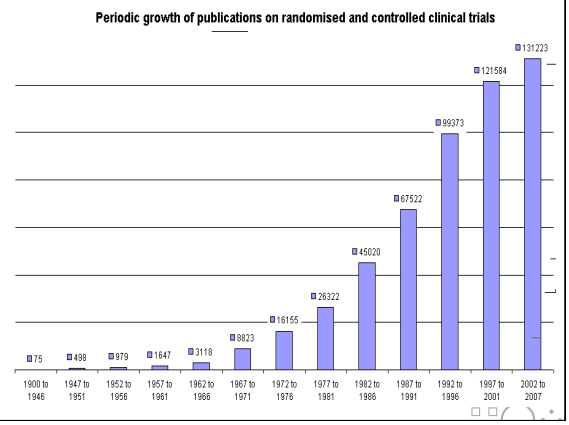

Randomphilia

- *RCT as the holy grail in the ebp-movement*

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The Logic of Evidence Based Practice

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What does it mean that an intervention is evidence based?

Evidence based knowledge:

- That a treated group of clients in ***average*** get better results compared to the ***average* effect** in a comparable group not getting the treatment (or another)

Evidence based practice:

- Implementing this knowledge through diagnose based procedures

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What`s new?

This is old:

Evidence based knowledge

- **The idealization of context-independent and universal knowledge**
- **The aspiration to transform knowledge into "technology"**

This is new:

Evidence based practice

- **Narrowed and authorized criteria of what counts as knowledge (gold standard)**
- **The use of evidence based knowledge are not a matter of professional autonomy alone, but come with manuals implemented in new strategies for governing**

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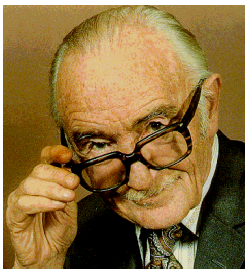
Archibald Leman Cochrane (1909 - 1988)



- Can it work?
- Does it work in practice?
- Is it worth it?

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……but:

Why does it work?

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Empirical pragmatism

"Kunnskapssenterets rolle vil særlig være knyttet til det å evaluere og måle og ikke det å forstå mer grunnleggende mekanismer eller fortolke opplevelser og sammenhenger."

(Nasjonalt kunnskapssenter for helsetjenesten, 2005)

(The Knowledge centers role will be to evaluate and measure, not to understand the more profound mechanism or meaning patterns)

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The unanswered questions

- No evidence-based explanaition of *why* treatment works and how the changes come about
- Demonstrating statistical causation is an *illusion* of an explanation
- Does *implemented* EBP work in natural practice?
  That is an empirical question

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Science is built up with facts as a house is with stone, but a collection of facts is no more a science than a heap of stones is a house

(Jules Henri Poincaré, 1854 -1912)

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Evidence based practice

EBP is foremost an empirical pragmatism, addressing "what works"

..a move from critical science to empirical pragmatism in the service of governmental efficiency

May foster pseudoscience……..

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The evidence paradox

- Finally, we do not have convincing studies showing that patients whose clinicians practice EBM are better off than those whose clinicians do not practice EBM: no one has done a randomized controlled trial of EBM with patient outcomes as the measure of success (Haynes (2002)
- s 5)
- "Thus, EBM has taken on the tones of a moral imperative. But it is premature to get very preachy about the ought of EBM , not that this has stopped EBMs more ardent advocates

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Some pioneering warnings…

"Between measurements based on RCTs and benefit….in thecommunity there is a gulf which has been much under-estimated (Cochrane, 1971)

At its best a trial shows what can be accomplished with a medicine under careful observation and certain restricted conditions. The same results will not invariably or necessarily be observed when the medicine passes into general use (Austin Bradford Hill, 1984)

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Alvan R. Feinstein (1926-2001) on RCT:

- "The reason we are in such profound trouble today is that the bloody models don`t fit what is going on clinically.
- Furthermore, because clinicians have not articulated what they are doing, they keep hoping that they will get an intellectual handout, either from the social scientists, the clinical epidemiologist, the statistician, or the biomedical researcher, Clinicians will be immensely grateful for anything that will keep them from having to think about what they are doing.
- I would have no model whatsoever. I think that we have been destroyed intellectually by all of these models (Feinstein, s. 104 I Daly (2005)
- …"the authorative aura accorded to evidence selected (….) for evidence-based medicine may lead to major abuses that produce inappropriate guidelines or doctrinaire dogmas for clinical practice" (Feinsten . s 105)

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David Sackett

"Progress towards truth is impaired in the presence of an expert especially when new evidence is rejected because it challenges the views of experts (…)"

As an expert on EBM David Sackett has taken the consequence of this view and stated that he would:

"..never again lecture, write, or referee anything to do with evidence-based clinical practice

(Sackett 2000, s. 1283, ref I Daly 2005, s 241)

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Some problems

- Standardization not efficient if "best treatment" is individualization
- Many health and social problems without evidence based treatment
- The average patient does not exist in practice
- "Absence of evidence is not evidence of absence"
- Weak relation between diagnose and therapy method
- Marginalization of other kinds of knowledge
- Increase the danger to objectify the patient
- Less creative practice
- Disguise the contextual difference between practice and research
- Research informed practice a better strategy than research governed practice

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EBM is out – PBM is the new game in town…..

…the crisis in medicine is worsening, not improving

… it is not the case that modern medicine is ineffective but rather that it has become depersonalised

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II. What about psychotherapy and social work?

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Boulder-konferansen 1949

"The scientist-practitioner model"

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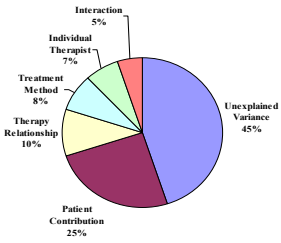
% of Psychotherapy Outcome Variance Attributable to Therapeutic Factors



Norcross, 2007
www.ebcrp.org/ccount/click.php?id=67

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Some hard evidence

- No particular treatment/approach are demonstrated superior to another, across disorders or within disorders
- The specific methods explain less than 10% of variance
- Placebotreatment (unspecific) almost as good as active treatment
- Therapists (as persons) contribute much more to outcome than the method
- The variability among providers are far greater than the variability among treatments
- When the cognitive component of CBT for depression is removed, the resulting treatment is as effective as CBT
- The "alliance" is the most robust predictor of outcome

What works in mental health services according to service-users? Implication from research outside the evidence paradigm

- Difficult to predict good outcome
- Equal efforts for the equal problems gives different experiences
- Formal treatment variables not so important
- Timing: small causes may give great effects (turning points)
- A sense of life – functional daily life
- A home, work – meaningful activities
- A sense of being – identity, respect and acceptance
- Involved, trustworthy and dedicated helpers
- Regaining responsibility – "a speaking I"

The great tragedy of Science – the slaying of a beautiful hypothesis by an ugly fact:

"Despite volumes devoted to the theoretical differences among different schools of psychotherapy, the result of research demonstrate negligible differences in the effects produced by different therapy types".
(Smith og Glass, 1977, s.760)

***"..., there is massive evidence that psychotherapeutic techniques do not have specific effects, yet there is tremendous resistance to accepting this finding as a legitimate one"* (Bergin & Garfield, 1994, "Handbook of Psychotherapy and Behavioral Change", s. 822).**

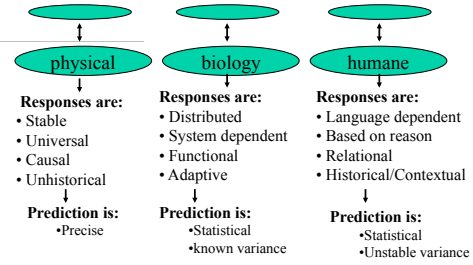
From science to "technology":

- Science: If A, then B (i.e. with *p*=x)
- Technology: If you want B, do A

Implicit premises:
- **Stable relation between A and B**
- **Can be replicated**
- **That the action (A) is independent of the acting person**
- **That the response (B) is independent of the person who is the target for the action**

When is this premises valid?

Intervention and prediction in different "worlds"



Do we have a map (epistemology) which fit the territory (ontology)?

Confusion create epistemological errors

Summing up….

- EBP are therapies which are relatively independent of context and therefore can be standardized (= technology):
  - **In medicine "evidence based" can function well when the diagnostic validity is high and the working theories are adequate**
- Empirical evidence on psychotherapy and social methods show that this is contextual methods and therefore should not be standardized (= praxis)
  - **The hypothesis "psychotherapy as technology" is falsified**
  - **There are no evidence for evidence based method in psy-**
  - **The effects of such methods are dependent on individual and contextual conditions**
  - **The practice should therefore be "tailor-made" rather than standardized**

Å male seg inn i eit hjørne

- *Unfortunately, the empirical validation strategy weakens support for psychotherapy as a mental health treatment rather that strengthen it. Why is it that researchers persist in attempts to find treatment differences, when they know that these effects are small in comparison to other effects …. or treatment versus no treatment comparisons….?*

  (Wampold et al 1997, p 211)

Nyliberal kontekst

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Det lange repet:

- *Differensieringsprosess*
- *Sekularisering*
- *Mobilitet*
- *Demokratisering*
- *Reproduksjonskontroll*
- *Likestilling*
- *Individuering*
- *Intimisering*

Nyliberale samfunn

Tradisjonssamfunn Modernitet Seinmodernitet

Kontinuitet og brudd…….

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Max Weber (1864-1920)

The Protestant Ethic and the Spirit of Capitalism .

..about the relations between structures in societies and structures in persons (character) ……..

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Neo liberal culture and governing

- From repression to expression
  - Identity: from given to a task
  - What's in it for me (self-branding)

"And, you know, there is no such thing as society."

(Margaret Thatcher, 1987)

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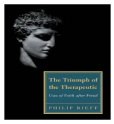
Character and culture, jf Philip Rieff

The religios culture
The religious man
- The outward self
- The goal of Life:

Salvation

(Become like us)



The therapeutic culture
The psychological man
- The inward self
- The goal of Life:

Self-realization

(Become your self)

(A vertical order is a mean)

(A vertical order is a barrier)

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From "Life of Brian"

"We are all different"

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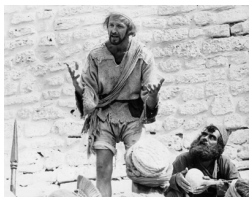

"I 'am not! "

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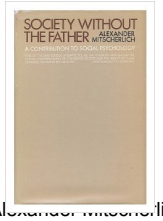
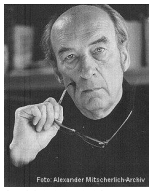
The ambition to be original in the same way

News report: This kids says that they dont want uniforms in school, because – *Its important to find your own style*

The downzising of vertical order





Alexander Mitscherlich (1908-82)

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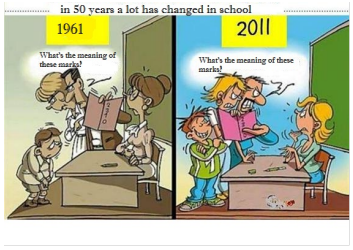

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From God to Gucci

Neoliberal subject:

- Liberated from tradition - and embeddedness in time and place
- Liberated from vertical order (institutional norms)
- Identity from a given to a task
- From "How to get there" to "Where should I go"
- Self-realization as an option and a cultural obligation
- The «Empty self» – must be filled and refilled:
  - **I buy – therefore I am**
  - **Identity markers as the new economy**
  - **Commercialization of life style**
  - **Commodification of relations (what's in it for me?)**
  - **Dependency on the gaze of the others**

Backside:

- Surviliance of the self - «self-stress»
- Ontological doubt – Am I good enough, accepted, respected, loved?
- Identity-wrecks – suffering and dignoais as a legitimate alternative

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Change in modal character?

The culture of repression

- Firmness
- Internalization of virtues
- Stability, discipline and loyalty
- Mild asceticism
- "Become like us (a citizen)"
- Modal personality: "Compulsiveness light"

The branding culture

- Flexible
- Sociable
- Goal-oriented
- Strategic attitude - "What`s in it for me"
- "Become yourself"
- Modal personality: "Psychopathy light"

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The Strategic beeing…

Well, those are my principles, and if you don`t like them, I`ll change them!

Groucho Marx

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Neo liberal culture and governing

- From repression to expression
  - **Identity: from given to a task**
  - **What's in it for me (self-branding)**
- From social problems to individual problems
  - **Governing of souls**
  - **Management of normality**

"And, you know, there is no such thing as society."

(Margaret Thatcher, 1987)

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Michel Foucault (1926-1984)

Empowerment som Governmentality:

- Conduct of conduct (*La conduite de la conduite*)

Niclas Rose

- **To live as free individuals through subordinate to a form of therapeutic authority and language, to construe our lives in psychological terms of adjustment, the art of self-scrunity, self-evaluation and self-regulation, not by an alien gaze but through a reflexive hermeneutics under the constant gaze of our own suspicious reflexivity, tormented by uncertainty and doubt.**

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«the idea of one's life as the enterprise of oneself» (Rose)

"we will assist you to practice your freedom as long as you practice it our way"

……..From "power to the people" to "therapy to the people"

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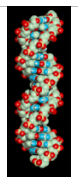
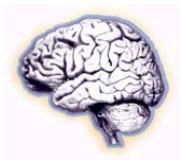
Blaming the brain?





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The dominating discourse

- Diagnosis
- Disorder
- Disease
- Disability
- Damage
- Deficit
- Dysfunction
- Delinquent

(Jacqueline Sparks,2002)

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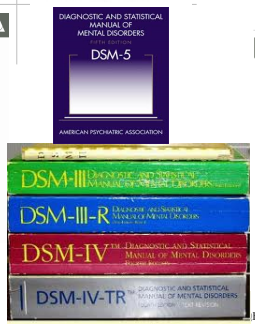
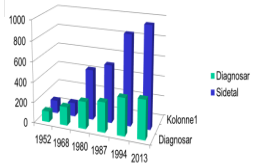


DSM - vekst og utvikling



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Hunting down the «normal» child

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NFK Hordaland

The new policy…..

Early detection……

Screen and intervene

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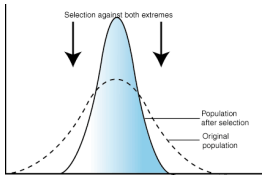
Changing normality?



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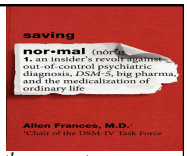
Allan Frances, tidligere leder av DSM IV-komiteen



"As chairman of the task force that created the current Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), which came out in 1994, I learned from painful experience how small changes in the definition of mental disorders can create huge, unintended consequences. (….)

Our panel (..) inadvertently contributed to three false "epidemics" - attention deficit disorder, autism and childhood bipolar disorder"

http://lacrossetribune.com/news/opinion/article_5434bbac-27e3-11df-bd13-001cc4c002e0.html

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From social problem to individual deficits

Individual:

- Delineation and identification (diagnosis)
- De-politisation
- Legitimate administration and social control
- Solutions: technology of the self (therapy, self-help, counseling, courses etc.)

Focus on context:

- Difficult to delineate
- Involving «others»
- Solutions: ends in politic

Thatchers *..and, you know, there is no such thing as society* has become an self-fulfilling prophecy

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Neo liberal culture and governing

- From repression to expression
  - **Identity: from given to a task**
  - **What's in it for me (self-branding)**
- From social problems to individual problems
  - **Governing of souls**
  - **Management of normality**
- From policy to market
  - **New public management**
  - **Health enterprise (business)**

"And, you know, there is no such thing as society."

(Margaret Thatcher, 1987)

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Julian Le Grand has been the Richard Titmuss Professor of Social Policy at the London School of Economics since 1993. From 2003 to 2005 he was seconded to No 10 Downing Street as Senior Policy Adviser to the Prime Minister.

The mistrust model—perhaps more familiarly known as command-and-control—can take various forms, but all versions of it have fundamental similarities: a hierarchy of control, with direction from the top, coupled with external rewards or penalties for those complying or failing to comply with the central directives. Under the mistrust model, staff cannot be trusted to do their job properly without outside intervention; they have to be provided with external incentives to do it.

International Public Management Journal 2010.13:56-71. downloaded from www.tandfonline.com

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Refleksiv styring

"…..en rejerings opgave i minde grad kommer til at dreje sig om at styre sociale og økonomiske processer, som er ydre i forhold til den selv, men snarere kommer til at handle om at sikre den sociale og økonomiske styrings egne institusjsoner og mekanismer." (Dean 2008:273)

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Reflexive government

- *refers to the situation where the activities of government turn upon themselves in an attempt to render governmental institutions, efficient, accountable, transparent and democratic*
- *by the employment of technologies of performance such as benchmarking, best practice schemes, performance indicators and auditing, mv*
- *..they are at the same time technologies of responsibilization and seek to make bureaucratic actors behave according to standards that ensure efficiency, quality and effectiveness measured in terms of fixed indicators*
- *… to make security mechanisms more effective, transparent and accountable by subjecting them to constant public scrutiny and evaluation.*
- *..a logical consequence of this is that an important part of reflexive government consists in the collection of information about the performance of systems and actors (i.e. professionals)* (Mitchell Dean)

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New Public Management

- Economical efficiency
- Economical terms/discourse superior
- Marketization
- Management and contracts
- Users as customers
- Clinical work as «production», and clinical data as data for:
  - *Documentation of production results*
  - *Reimbursement*
  - *Benchmarking*

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Why are RCTs still done?

- Controlled clinical trials, including randomized clinical trials and controlled singlesubject designs of psychosocial interventions are our strongest calling card in getting in and staying in the top tier of recommended treatments for mental disorders. We have to face it. To be in the market place we have to present data that is compelling to relevant stake holders. At the moment, randomized clinical trials are the currency that counts. No matter what we say or think, we will not get our treatments into the marketplace without data from clinical trials.

Marsha Linehan, 2007, The Clinical Psychologist, 60, 1, p. 4

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  - **Health enterprise (business)**
- From citizen to consumer
  - **What is my rights?**
  - **What do I pay for?**

"And, you know, there is no such thing as society."

(Margaret Thatcher, 1987)

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  - **Is it safe? Is it quality? Who is responsible?**
  - **Audit culture – quality control**

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The logic in Health Supervision

- Responsibility from rule-makers to rule-followers
- From professional autonomy to "accountability"
  - i.e. the professionals own responsibility to behave so that a third part could evaluate your practice
- From closed rooms to transparency
- From trust to mistrust and surveillance

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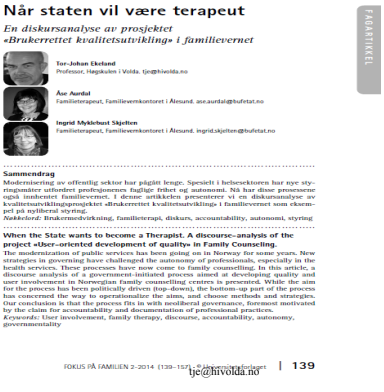

Når staten vil være terapeut

En diskursanalyse av prosjektet «Brukerrettet kvalitetsutvikling» i familievernet

FAGARTIKKEL

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Sammendrag
Modernisering av offentlig sektor har pågått lenge. Spesielt i helsesektoren har nye styringsmåter utfordret profesjonenes faglige frihet og autonomi. Nå har disse prosessene også inntentet familievernet. I denne artikkelen presenterer vi en diskursanalyse av kvalitetsutviklingsprosjektet «Brukerrettet kvalitetsutvikling i familievernet som eksempel på nyliberal styring.

Nøkkelord: Brukermedvirkning, familieterapi, diskurs, accountability, autonomi, styring

When the State wants to become a Therapist. A discourse-analysis of the project «User-oriented development of quality» in Family Counseling.

The modernization of public services has been going on in Norway for some years. New strategies in governing have challenged the autonomy of professionals, especially in the health services. These processes have now come to family counselling. In this article, a discourse analysis of a government-initiated process aimed at developing quality and user involvement in Norwegian family counselling centres is presented. While the aim for the process has been politically driven (top-down), the bottom-up part of the process has concerned the way to operationalize the aims, and choose methods and strategies. Our conclusion is that the process fits in with neoliberal governance, foremost motivated by the claim for accountability and documentation of professional practices.

Keywords: User involvement, family therapy, discourse, accountability, autonomy, governmentality

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Terapeuter som utøver et oppdrag for det offentlige må tåle mer overordnet inngripen og styring i behandlingssamtalen enn klienter. Sagt på en annen måte: Det som er bra for klienter oppleves ikke nødvendigvis bra for terapeutene, og i den grad det er kryssende interesse må terapeutene vike plass for klientene (Bufdir, 2009, p 15)

Therapists who practice a mission for the public must endure more general intervention and control in the treatment-process than the clients. Put another way: What is good for the clients is not necessarily good for the therapists and to the extent there are conflicting interests, therapists must give way to the clients

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Krav om "Accountability"

" …i første omgang opp til det enkelte kontor å avgjøre *hvordan* klientperspektivet på behandlingen innhentes,..(..) men sørge for at det skjer systematisk og at det dokumenteres i journal. Det bør være et krav at den terapeutiske alliansen følges nøye og tematiseres i hver samtale, og det bør være en evaluering av endring i problemopplevelsen i de tre første, og deretter minst hver tredje samtale."(s. 17)

Bufdir (2008): Bedre og bedre dag for dag

Et kunnskapsbasert familievern som driver forbedringsarbeid grunnlagt på brukernes perspektiv

Neo liberal culture and governing

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(Margaret Thatcher, 1987)

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- From confidence to risk management
  - **Is it safe? Is it quality? Who is responsible?**
  - **Audit culture – quality control**
- From professional discretion to rule based systems
  - **De-professionalization**
  - **Bureau-professionals (agents for policy)**

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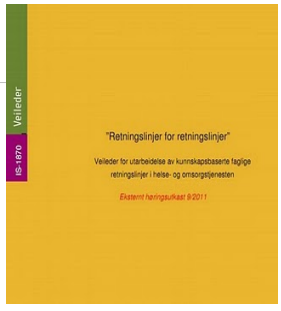
Modernisering

"Et enklere Norge"

Moderniseringsministeren

- 24. juni 1999: Regjeringen lanserer programmet "Et enklere Norge"
- Det er satt i gang en nasjonal dugnad for å rydde opp ….
- Regjeringen er klar over hvilken byrde innrapporteringen til det offentlige innebærer.
- Også helsesektoren er pålagt store innrapporteringsplikter.
- Helsepersonell skal behandle pasienter fremfor å fylle ut unødvendige skjema. Derfor vil regjeringen gjennomgå skjemabelastningen i helsesektoren.



(Guidelines about Guidelines – Guide for how to creater evidence based guidelenes)

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Reduction in autonomy

" Political measures has, together with new knowledge and technology, created profound changes in the health professions framework conditions. Reduction in professional autonomy is one of this." (Lian, 2003)

(*my translation*)

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Autonomi:

- Skilje mellom profesjonsautonomi (relasjon til samfunnet) og klinisk autonomi (relasjon til pasienten)
- Klinisk autonomi: at terapeut i samarbeid med pasient kan gjøre fornuftige val
- Pasientens autonomi er forutsatt av behandlarens autonomi
- Tradisjonelt grunngitt med:
  - Esoterisk kunnskap
  - Tilpasset behandling
  - Etikk – verne pasienten mot andre interessenter

Brukermedvirkning inneberer mer autonomi til brukeren.

Hvordan skal den realiseres i møte med hjelpere som har fått mindre autonomi?

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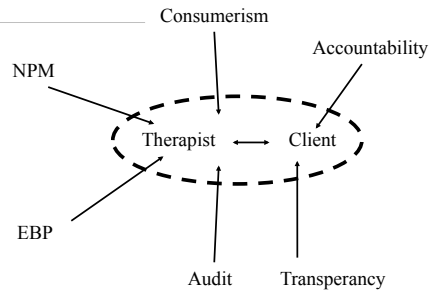
The new pressure from outside



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When the patient is still in the office…..

"Når du likevel har pasienten på kontoret…"

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The new governing of practice:

The logic of NPM
+
The logic of EBP
+
The logic of accountability
+
The logic of audit/ transparency

=

- Standardization
- Disciplinization
- Reduced clinical autonomy
- Reduced client autonomy

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Moderne dillemma

Systemverden: (Konfeksjon)
- nomotetisk
- evidensbasert
- kvalitetssikret
- produksjonseffektiv

Kommunikativ rasjonalitet

Standardisering → Praksisfeltet ← Individualisering

Teknisk-rasjonell instrumentalitet

Livsverda: (Skreddersøm)
- brukermedvirkning
- mestring og myndiggjøring
- individuell tilpassing

Standardisert brukermedvirkning?

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Moderne dilemma

Styring ⟷ Autonomi

For sterk styring:
- Regelstyrt profesjonsutøving

For mykje autonomi:
- Vilkårleg profesjonsutøving

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-Det enkle som svikter
-Opptrappingsplanens milliarder har ikke hjulpet stort på de enkle tingene, som å snakke med pasientene, de pårørende og å få tjenestene rundt pasientene til å samhandle, mener direktør i Helsetilsynet, Jan Fredrik Andresen.

Vil trygge tjenestene med styring og standard

Publisert: 03.04.14 - Sist endret: 03.04.14
Av: Per Halvorsen

Jan Fredrik Andresen
– Trygge helsetjenester, sier Jan Fredrik Andresen. Det er det samfunnet vil ha. Og da trengs mer faglig styring og standardisering enn vi har i dag.
Budskapet var entydig da Helsetilsynets øverste leder møtte psykologer i ledelse 3. april.

«Individualiseringsmyra»

Andresen ønsker seg mer standardisering i helsevesenet. Det gjør han av hensyn til pasientene.

Andresen ønsker seg et helsevesen som går mer i takt. Helsearbeidere som i større grad er produksjonsarbeidere og forvalter mer standardiserte prosedyrer.

Ikke bare er det forutsigbart for pasienten. Andresen mener det også gir grunnlag for spennende faglige utfordringer fordi man dermed får anledning til å evaluere hvordan hjelpen faktisk virker ved hjelp av et stort materiale.

(http://www.psykol.no/Foreningen/Nyheter-og-aktuelt/Aktuelt/Vil-trygge-tjenestene-med-styring-og-standardisering (language)/nor-NO)

Procrustes seng

”……one-size-fits-all"

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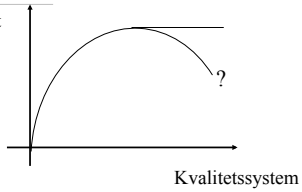
Loven om fallende grensenytte



Kan det gode bli sin egen fiende?

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Overlevingsstrategi….

Når keisaren snur ryggen til…..
Gjer det som er fornuftig

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So,…

Always look at the brigth side…..

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