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Humanistic Management: an alternative way of organising

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Guest Editors: Christina Schwabenland and Paul Harrison

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Cover image: A Gaudi mosaic: photo by Christina Schwabenland

A humanistic challenge to systemic organisation failure

William Tate

I think of today's organisations as complex social systems, with the best adopting a humanistic approach to management. This perspective affects how systems are analysed, managed and improved. A modern understanding of organisations in the post-scientific management (post-Newtonian) paradigm is a belief that living human systems behave organically rather than mechanistically. The new mindset challenges the traditional bureaucratic model that imagines the organisation's operation running like clockwork, with every part's movements and relationships predetermined. Old linear cause-effect assumptions are supplanted by complex, non-linear relationships. Less uniformity and greater resource variety are better able to respond to a less predictable and faster-changing world. Leadership and management processes are more systemically aware and operate less hierarchically.

In this article I question how well relevant authorities and business leaders understand this shift in thinking, particularly the implications for holding officials to account in the context of operational shortcomings and collapses. This shift of viewpoint questions the popular but mistaken practice that conflates organisation performance issues with personal mistakes and individuals' assumed deficiencies. Most crucially, a move away from a blame culture is needed, as my case study illustrates.

Keywords:

leaders, leadership, systemic, system, complexity, fishtank, blame, accountability

Context

There is no shortage of organisation failures, many of them scandalous: Grenfell Tower, Gosport War Memorial Hospital, Birmingham Prison, Costa Concordia cruise ship, Manchester Arena, HBOS, Carillion, Windrush, Roman Catholic priesthood, and Baby P/Sharon Shoesmith are a few examples. There are also untold in-company disciplinary cases requiring investigation and justice.

The examples mentioned are inherently socially complex and are talked about as 'systemic failures'. The work in such systems, and also in any subsequent investigation, is successful only when there is sufficient curiosity about the system's relationships, inter-connectedness and consequences. Where there has been a serious failure, it can be resolved honestly and morally only by viewing the case through a systems lens rather than looking for who to blame.

While system features may be spoken of during investigations, they rarely take centre stage. Moreover, the inquiry process itself will contain its own systemic aspects, biases, shortcomings and implications, affecting direction and outcomes. The inquiring parties' ability to grasp the full significance of this is often in doubt. Just think about the need to re-run inquiries such as Hillsborough and Northern Ireland's Bloody Sunday.

I examine the tragic death of six-year-old Jack Adcock in the Children's Assessment Unit, Leicestershire Royal Infirmary. This case brings to the fore both systems and humanistic sciences. Predictably, we saw headlines like 'We need to learn the lessons of the tragedy of Jack Adcock' (Cunningham, 2018). But did we believe the rhetoric? Will those lessons be learned? And what are the lessons (we rarely hear), and who needs to learn them? If the system of governance is our guard against the most egregious instances of organisation failure, who guards the guardians when investigations themselves so often act unfairly and fail to get to grips with the full scale of human issues?

Children's Assessment Unit, Leicestershire Royal Infirmary

Photo from Digital Health

Backstory

First, a summary of the case. On Friday 18th February 2011 Jack Adcock died in the Children's Assessment Unit in Leicester Royal Infirmary. He had acquired group A streptococcal sepsis, a notorious killer, that led to a cardiac arrest. Jack was already a seriously ill boy with Down's Syndrome. He had a known heart condition, was vomiting, had diarrhoea, and had difficulty breathing.

A long-running legal case followed Jack's death, pursued more intensely since 2014, with many twists and turns and many players, only being resolved by the Court of Appeal in August 2018. We don't need to know all the legal technicalities, nor the full detail of medical interventions, but we present here a synopsis before turning to the systemic aspects of the operational failure, where a bungled attempt to allocate blame was contested and humanity fell short.

In December 2014 junior registrar Dr Hadiza Bawa-Garba (left below) and two nurses were charged with manslaughter by gross negligence. The doctor and one of the nurses were convicted. They were denied leave to appeal against their convictions. But, rather surprisingly, in August 2018 Dr Bawa-Garba was effectively exonerated in her professional practice by the Court of Appeal (though her conviction, which was not the subject of her appeal, was not reviewed) and she was then allowed to resume her medical training and employment.

Dr Hadiza Bawa-Garba and Jack Adcock [Photo from ITV News - Twitter feed]

But before we come to the process's denouement, the tortuous facts are these. In June 2017 the case was considered by the Medical Practitioners Tribunal, the adjudication service of the General Medical Council (GMC). The tribunal decided that Dr Bawa-Garba should be suspended for 12 months after which she would be able to continue her training and could practise again in the same hospital trust. (There were precedents for criminal convictions not to lead automatically to loss of employment or licence to practise). Then the GMC's own chief executive (the doctors' regulatory body) surprisingly and controversially appealed its own tribunal's 'lenient outcome' to the High Court.

In January 2018 the High Court agreed with the GMC's appeal, though it expressed the view that a criminal court was not well placed to consider the systemic factors introduced by the accused doctor (Dr Bawa-Garba)

in her defence. Having secured its desired outcome, the GMC then struck her off the register, arguing that her conviction meant that she could not be fit to practise. However, in March 2018 the doctor was given leave to appeal to challenge her erasure from the register.

With much professional support, and following a crowd-funding campaign, the appeal was heard, and in August 2018 the Court of Appeal overturned the High Court's judgment that had supported the GMC and its chief executive. As a result, Dr Bawa-Garba's registration was reinstated, allowing her to practise once more. That led to the Doctors Association UK and the Hospital Consultants & Specialists Association to call for the GMC chief executive to resign.

Some implications and unanswered questions

The Court of Appeal was principally concerned with the question of whether or not it was reasonable for the Medical Practitioners Tribunal to conclude that the doctor was safe to practise. That legal focus left a number of organisational issues of a systemic nature dangling unresolved. This raises a key issue: to what extent is it reasonable to blame and deregister a doctor, given the exceptional systemic hospital working conditions and the particular circumstances at the time, as well as the role played by the doctor's colleagues. Together, such systemic considerations impact on the performance of individuals (Dr Bawa-Garba in this case), taking into account that the system – experienced as real or perceived – affects people's choices, decisions, priorities and their allocation of time and resources.

Important issues that we lack space to critique here include the unsatisfactory and protracted disciplinary and legal system and the medical treatment interventions that Dr Bawa-Garba made. If you choose to read the medical detail and are on the lookout for system shortcomings you will find them popping up from the start of the very day that Jack was admitted and died. Many such failings would be thought of as normal – stuff happens, such as delays in receiving blood tests and X-rays, even though they may have contributed to Jack's weakening condition during the progress of the day.

The account published in the medical Pulse website, ['Bawa-Garba: timeline of a case that has rocked medicine' (2018)] doesn't point out all these failings as system failures, nor lay them at Dr Bawa-Garba's door. It chiefly reports facts and describes the doctor's working conditions and short-staffing. But there is a related system that is our main concern – this is the disciplinary and legal process conducted over a number of years from 2011 to 2018, where there was a potential significant miscarriage of justice that holds implications for the wider medical profession as whole. It is here that we find a system blindspot in the actions of those concerned with assessing Dr Bawa-Garba's actions and with determining her guilt and failings.

System conditions and circumstances in question

So what was happening in Hadiza Bawa-Garba's workplace in February 2011? She was a junior doctor specialising in paediatrics in year six of her postgraduate training, with an 'impeccable' record. The day Jack was admitted to hospital, she was the most senior doctor in the unit.

She had just returned from 14 months of maternity leave. This was her first shift in an acute setting. It was claimed that she had not received the necessary induction that the hospital trust would normally provide in such situations, and she said she had not worked with the supervising consultant before.

On the day that Jack Adcock died, the unit was short-staffed. The consultant who was on call that day was off site for much of the time. Her junior colleagues were new to paediatrics and required close supervision. Dr Bawa-Garba was effectively doing the job of two registrars. She was covering six wards across four floors and was responsible for over 75 critically unwell children. On top of this, the hospital's electronic computer system went down for four hours.

Note that there are several systems at work in cases like this. Some are obvious and major. Some are matters of intention and design, however flawed they may be in practice. Others are darker, shadow systems. For example, in the previously mentioned Windrush scandal politicians deliberately set out to create a hostile environment, which was a major contributing factor in that immigration system's design and its consequential failure.

A deliberate decision to cut hospital staffing levels would be a conscious system design issue. But many system conditions are unplanned and consist of the daily messy reality of organisation bureaucracy and resource issues such as a staff member being sick or taking annual leave. Issues at this less formal level also shape how an organisation and its individuals work and perform on a given day.

Note, too, that there are social systems (how people are relating to others in their work – colleagues, bosses, patients, etc.), and there are non-social systems (how people are relating to structural factors in their work – rules, incentives, objectives, targets, computers, etc.). Both types of system are addressed in this article. Crucially, as we search for the truth as we see it, these structural systems can affect our level of sympathy with the employee who is accused of failing.

"The Dr Bawa-Garba case has shaken the medical profession." Anas Sarwar on Twitter

The authorities' response

It was admitted in court that Jack's care was inadequate due to a perfect storm of human error and system pressures. But by her own admission, Dr Bawa-Garba did not 'think sepsis' initially when she first assessed

Jack. That oversight, coupled with the failed IT system (which might have alerted remedial teams), sealed Jack's fate.

But the Medical Practitioners Tribunal subsequently found the doctor to have reflected on her actions and to have remediated her deficiencies. However, the possibility that such a judgment was too lenient triggered a series of emotional and legal interjections by both sides, with fellow medics becoming anxious about their own employment vulnerability in over-stretched workplaces.

ANALYSIS

Accountability in a system context

In any complex living human system, there is always a question of the extent to which an individual's performance is truly individual, and for which they can therefore reasonably be held solely accountable for their performance, and whether they should be blamed and punished when things go wrong. This was the line taken by doctors working in stressful situations not dissimilar to those experienced by Dr Bawa-Garba and who were supporting and funding her defence.

In systems terms, the language of the 'individual' is a misnomer organisationally, because it implies 'alone or apart'. The word and the concept misrepresent the various contributing sources of people's performance, their inter-related acts and outcomes in an actual organisation context. Privileging the 'individual' leads to HR policies and practices that understate the effect of hierarchies, colleagues, teams and processes such as goal-setting and appraisal. The individualised focus also raises false hopes for the efficacy of training as a solution to organisational dysfunction.

On this question of personal accountability (and therefore openness to blame) there are two schools of thought. On the one hand, if performance is truly systemic (i.e. someone's performance depends on a myriad of relationships, interactions and interdependencies), then no lone individual can fairly be held accountable for outcomes. In that case, for Dr Bawa-Garba to be charged with manslaughter may be unreasonable and show a lack of systemic awareness by those judging performance.

On the other hand, for an institution to ensure that its desired performance is delivered, it seems reasonable for employees to expect to account (along with others where appropriate) for their decisions, actions and achievements. In practice, an appropriate accountability process is rarely undertaken fairly and robustly. Nor is accountability usually informed by an understanding of how organisations work as systems. Institutional leaders rarely seem aware, able or willing to get to grips with the dynamics of systemic dysfunction.

Four questions needing answers

This common oversight raises four troubling issues:

4. In cases of failure, are the relevant authorities and regulatory bodies aware of, curious about, and able to take into account, the most obvious system conditions, as in Dr Bawa-Garba's contextual work life and environment? It hardly needs any specialist training to be able to seek and notice the prevailing conditions and to empathise and give due consideration to them.

5. At a deeper level, what minimal understanding do the relevant authorities need to have concerning how organisations work as systems in a post-Newtonian world of non-linear cause-and-effect, let alone the implications for management?
6. Thirdly, where lessons need to be learned and improvements recommended and carried through, how is a serious theoretical grounding in the discipline of systems thinking and complexity science acquired, located and practically applied?
7. Lastly, what constitutional and legal powers, frameworks, traditions and other constraints affect answers to the above questions?

Some related observations and questions

A dysfunctional system does not automatically lead to individuals performing inadequately. Nor does its existence automatically excuse an individual's neglectful performance.

It is possible to empathise with individuals' systemic conditions that affect their performance while at the same time being open to the possibility that someone's performance may still be grossly neglectful.

A culture of openness, reflection and learning in relation to mistakes should be encouraged and run alongside the possibility of employment-threatening sanctions where serious personal mistakes have been made.

In a non-linear world, tribunals, hearings and courts should avoid the trap of thinking binary 'guilty' or 'not guilty'? More nuanced outcomes should be available.

Does traditional management training and the century-old Newtonian scientific management paradigm incline employers and 'judges' (in hearings, tribunals and courts) towards seeking an individual to be held responsible for organisation failure?

Do hearings, tribunals and courts have the necessary constitutional powers to include 'trying' the system, or at least to enquire into and give due weight to significant factors in the accused person's work environment/system?

If systemic factors are found to have contributed to failure, how available are organisation-based sanctions and remedies instead of, or as well as, individual-based sanctions such as withdrawal of a professional licence?

How can institutions acceptably respond to criticism and calls from the media, public and relatives for greater openness and transparency when all they really want is to find an individual to blame and punish?

Should hearings/tribunals and courts feel deterred from finding fault and imposing sanctions when faced with the argument that the fear of such action will make individuals less reflective of their behaviour and performance, and less likely to admit to mistakes? Reformists and Dr Bawa-Garba's defence counsel claimed that the strictly legal process hinders the development of a learning culture.

The processes that authorities follow in their enquiries, and their own training, often lack a systemic foundation. It is usually 'individuals' who find themselves in the dock, in media comment if not literally. It is individuals who are assumed to be guilty (or not); the system escapes scrutiny and sanction. It is paradoxical that inclinations to discuss systemic factors is itself a systemic issue.

The handover from enquiries and inquests through to implementing recommendations finds a wide gulf in the system of learning and improvement. Taking the Grenfell Tower case from the examples listed earlier, witness the failure to implement the learning from the Lakanal House fire in Camberwell in 2009 that caused six deaths (that fire had spread unexpectedly fast across exterior cladding). The authorities already knew the risks at Grenfell. Similarly, Dr Bawa-Garba's work circumstances were also well known locally, were tolerated, and yet no system improvement action taken.

In these circumstances, what might represent a 'just culture'?

A just culture

> *"What we need instead is a just culture. Rather than attributing blame, we need to ask why something happened. And then the questions should be who is hurt? What do they need? And whose responsibility is it to make that happen?*
>
> *A just culture seeks to address the rawness of families' grief as well as the hurt of staff who are involved when tragedy strikes. A just culture seeks to learn from events and apply this learning to bring about change."*

(Dr Cicely Cunningham)

Learn not Blame is a new campaign from the Doctors Association UK, prompted by the perceived unjust nature of this case.

There can be little doubt that cases not dissimilar to that of Jack Adcock are occurring more frequently than we like to admit, given under-resourced public services, where chaotic organisations are struggling to cope.

> *"We need politicians to understand problems more deeply … complex issues have systemic foundations."*

Matthew Taylor, RSA chief executive, house journal, Issue 1, 2017

From the medical profession's response to the Jack Adcock case it seems reasonable to conclude the following:

Findings in the Jack Adcock /Dr Bawa-Garba case

> That while Dr Bawa-Garba undoubtedly made mistakes, in the stressful circumstances of absent colleagues and computer failure she worked sufficiently diligently and with care, and that withdrawing her licence to practise would have been too harsh an outcome.
>
> That the GMC and its chief executive mismanaged its relationship with its own Medical Practitioners Tribunal.
>
> That the GMC and its chief executive seemed more fixated on the doctor's personal culpability than on the system conditions which she had to navigate on the day.
>
> That an interest in learning from this sad case seemed a secondary consideration, judging from the reporting of the case.
>
> That a more humanistic management approach and outcome would have resulted from a greater systems focus, awareness and management, notwithstanding that the parents of Jack wanted Dr Bawa-Garba to lose her licence.

(Lind, S., 2018)

> *"Internationally, the emphasis of disciplinary sanctions from now on will more emphatically rest on whether a practitioner is likely to place the public at risk, rather than upon public distress after a tragic outcome of deficient medical care. That is both realistic and humane. We are all fallible. While such an approach will not satisfy Jack Adcock's mother, sadly a harsh disciplinary sanction cannot bring Jack back, and the community is better off with Bawa-Garba back in practice. "*

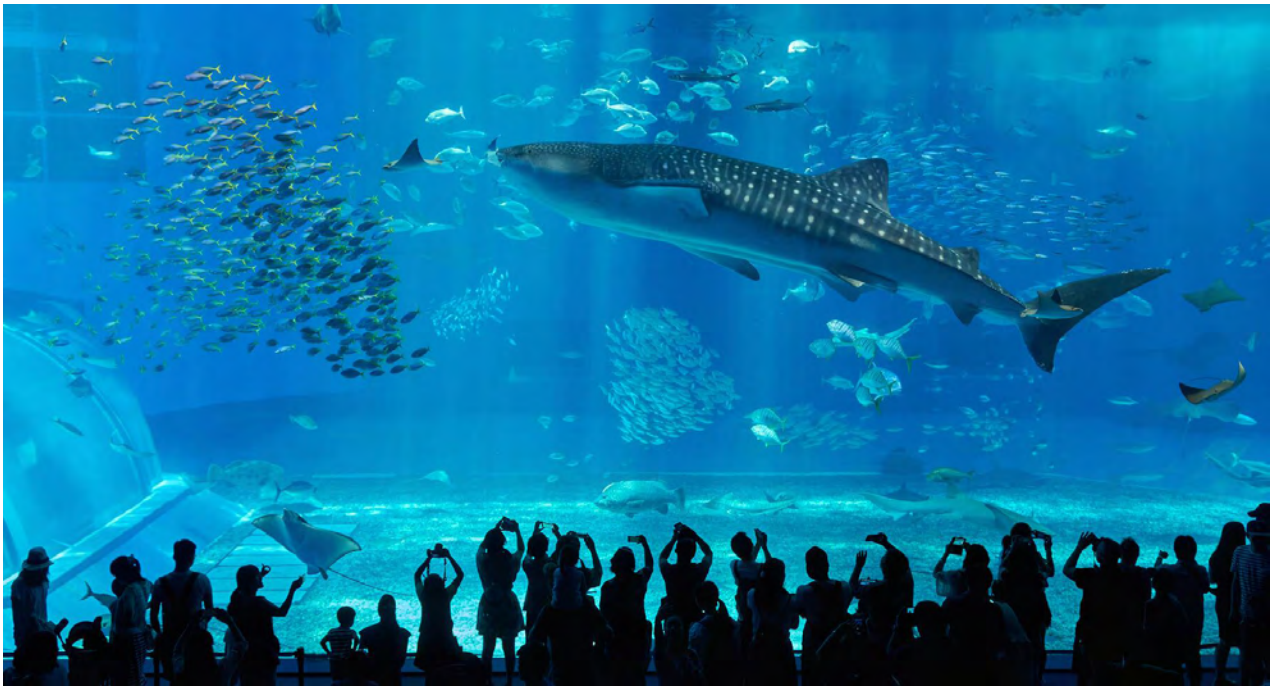
(Extract from 'What happened in the Bawa-Garba case and why was reinstating her the right decision.' The Conversation, Ian Freckelton, 17 August 2018).

Advice on making system improvements

People in positions of authority – including doctors like Hadiza Bawa-Garba – have a responsibility for improving the way the system works, such as reflecting on all the problems she encountered on the day Jack Adcock was admitted and died. Here are seven suggestions to help make this happen (based on Tate, W. 2016):

1. ***Give everyone two jobs***: The first is the job they think they have. The second is the job of improving the first. Appraise the two job roles separately.
2. ***Make tomorrow different***: People should ask themselves "Why am I continuing to do what I am continuing to do the way I am continuing to do it?". Make tomorrow work better than today. This is part of every manager's job. Colluding with the present, or actively sustaining it, is simply managing, not leading.

3. ***Improvement defines leadership***: Bringing about improvement is a true component of leadership. The leadership role needs recognising and managing distinctively as a separate part of an official's performance.
4. ***Think of your organisation being like a fishtank***: In this popular analogy employees are the fish, all at sea (as it were) in a threatening and dirty climate and culture. Instead of taking sluggish ones out of the water, giving them a good talking-to and then plopping them back in the same dirty water, notice the state of the water and focus on your detoxing responsibility.



The Fishtank Metaphor [Image credit leungchopan - stock.adobe.com]

5. ***Manage accountability***: It is generally assumed that an individual has to want to change if change is to happen – that the will has to come from within rather than an outside force being required. But large bureaucratic organisations can weaken people's resolve, with individuals sitting back and waiting for someone else to do something to improve the system.
6. ***Bosses hold crucial cards***: The person to whom an individual (or a team) reports is key. The boss has the organisation's authority to lead a discussion and ask and say what change is needed, then follow through.
7. ***Put things right before waiting for failure***: Routinely invoke a fair and robust accountability lever with the appropriate parties for getting things right, not only when things have gone wrong and people want someone to blame.

Conclusions

Noticing and picturing systemic forces and inter-relationships in organisations is an acquired interest and a vital managerial skill. But caring for people's wellbeing and managing humanistically is a matter of choice and values – for individuals and organisation cultures. The two concepts don't necessarily intersect. An organisation may recognise systems and their interconnecting relationships – for instance, how incentives

work. But the humanity of the situation may be neglected or even abused – again, the misuse of incentives (revealed in Alfie Kohn's Punished by Rewards, 1993). And the converse may be true too, if the organisation is too comfortable and inefficient. I argue that the two concepts should flow naturally together and be mutually supportive: one's eyes are opened to appreciating people's feelings once one sees who is doing what and why, and recognises the damaging consequences. Addressing a bullying climate is a case in point.

Spurred by John Adcock's death and the Hadiza Bawa-Garba case, the General Medical Council (GMC) has launched a programme to train fitness-to-practise investigators to recognise 'human factors' alongside systemic ones (Lind, S., 2018). In the health and welfare sector, David Zigmond's polemic (elsewhere in this edition) challenges regulators of the GP health sector to show greater respect for traditional, small GP practices that get to know and value each patient as a whole person. He makes the case for preserving the subtext in the doctor-patient relationship and providing ease of continuity, rather than closing down such practices – which happened to Zigmond – in favour of more technically focused 'factories', as he describes them.

There are hopeful signs. But taking an example from the 'gig economy' parcel-delivery world, the working conditions, the attitude of owners and the management processes seem to be getting worse. A development that elevates a feelings perspective as an equal consideration alongside a factual analysis is attracting much interest (Nervous States: How Feeling took Over the World, William Davies, 2018). Thinking of the state of the world today, and considering the financial crash ten years ago, Davies concludes that there is a need for a sociological as much as – or even more than – an econometric perspective. As one book reviewer expressed it,

> *"There is a strong sense of Hannah Arendt running through this work. Arendt analysed power and spoke of the west's curious passion for objectivity".*

The reviewer added that:

> *"the present factual bias has produced experts armed with statistics that bear little relationship to lived reality"*
>
> [Moore, S., 'How to feel our way towards the future', Guardian, 28 October 2018].

At this stage in the process of establishing the UK Humanistic Management Chapter there is no finalised methodology in place that can be used to inform and drive analysis and improvement, as in cases like that of Dr Bawa-Garba. What I have attempted to do here is to attune our senses, thoughts and feelings more keenly when encountering systemic failures that have tragic consequences. I make a plea for us to take account of both the systems and the humanity dimensions, and avoid looking for answers through a forensic and analytical lens alone. A change in approach is badly needed when planning and conducting accountability processes. The aim should be to appreciate the spectrum of system and human issues confronting the range of stakeholders. Just think of politicised cases like those of the Bawa-Garba, Hillsborough, Windrush and Grenfell scandals; by not seeing the social dimension and showing too little interest in people's feelings they risked failing in the search for a greater truth.

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About the author

Dr William Tate is a leadership strategist, consultant, writer and mentor. Director of The Institute for Systemic Leadership. Visiting Fellow in Leadership at Cass Business School and London Metropolitan University. His work draws on the new sciences of systems thinking and complexity theory. Leadership is viewed as an organisation property, not simply of individual managers. The aim is to liberate and apply leadership.

William has written over 40 books and articles. He uses the fishtank as a metaphor for the system – everything that is going on around and between people in their organisational context and relationships, impacting on their ability to exercise organisation-serving leadership.

Email: bill.tate@systemicleadershipinstitute.org Phone: 01252 792322

Website: www.systemicleadershipinstitute.org

About the Humanistic Management Network and AMED

The Humanistic Management Network (HMN) is an international group of practitioners and academics who share a concern that organisations exist to benefit society. Humanistic management is based on three principles; 1) respect for the dignity of each person, 2) ethical organizational decisions and processes and 3) on-going dialogue with multiple stakeholders. Humanistic management (HM) can be a driver for sustained business success and can reduce the cost of conflict, high levels ofContents stress-related absence, and the costs of raising capital. But HM principles are not shared by everyone and are increasingly under threat. As the newly-established Humanistic Management Network UK Chapter, we are very open to your suggestions and ideas about how we can develop and grow.

Contact - Christina Schwabenland: christina.schwabenland@beds.ac.uk

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