Rational Judgement Revisited: Practices of Deliberation in Healthcare Funding Decisions[1]

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Abstract

In this paper, we aim at exploring how rationality may become a practical accomplishment. We maintain that it is not known or adequately understood how organisational actors may actually produce 'rational judgement' in practice. We thus examined a context where actors seek to be purposefully rational when making healthcare funding decisions. Building on a focused ethnography of decision making in the English National Health Service (NHS), we provide an account of how rational judgement is dynamically pursued and accomplished in practice. We show that, for rational judgement to be constructed in this context, organisational actors perform three kinds of interrelated activities: *performing procedural requirements, making sense of decision cases and deliberating the merits of cases on the basis of public reasons*. Our paper makes an important contribution to our understanding of organisational knowledge and learning by unpacking how rationality is sought and performed in actual organisational situations, and by altering our existing image of rationality. Instead of treating rationality as a 'grand concept' or metaphysical logic, our paper elucidates how a specific form of rationality – grounded in common (political) convictions of fairness and the common good(s) – is produced in organisations through practices of deliberation.

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1. INTRODUCTION

Rationality and rational judgement has been at the centre of organisation theory since Weber's analysis of the ascendancy of bureaucratic rationality (Townley, 2002) and Simon's seminal insights into the 'bounded rationality' of human behaviour and decision making (Simon, 1955, Simon, 1978). Rationality represents one of the most widely debated forms of knowledge, and the concept of 'learning to be rational' has attracted the attention of a great number of scholars. Overall, existing organisational perspectives have been intellectually organised around an abstract 'maxim of rationality': that decision making and judgement is (should be) model-based and explicitly reasonable (Shenhav, 2005), principally involves logical analysis, relies on systematic evaluation of the consequence of choices (March, 2006), and precedes action. Most studies discuss rationality in virtue of developing an argument in favour of, or against, this grand rationalistic maxim (Townley, 2008). The field has been flooded with typologies of alternative notions of rationality (or even irrationality), which have been developed as ideological responses to that maxim. This politicisation of the discourse on rationality has resulted in the creation of oppositions, dichotomies, and widespread cacophony in the field, as Townley observed (2008):

> "Organization studies seem content to relegate rationality to economics and the colonizing tendencies of rational choice theory, preferring to present positions 'in opposition to'. The dominance of a means–end concept of rationality is so prevalent that it has become taken for granted. This does not, and cannot, exhaust our understanding." (p. 2)

At the root of this theorising regression lies the scarcity of empirical investigations of rationality as a practical accomplishment (Cabantous et al., 2010). Organisation studies have largely failed to clarify the empirical propagation of rationality in organisations and have rather focused on theoretical arguments or critiques of a specific type of rational judgement.

Our understanding as to how rational judgement is actually pursued and arrived at is very limited, since rationality in existing organisation theory is effectively 'black-boxed' (Cabantous and Gond, 2010). This is manifested in the theorising efforts of both proponents and opponents. On the one hand, proponents assume and suggest that actors (should) rely on various technologies to pursue rationality and thus reify a normative framework of rational choice theory or 'logic of consequentiality'(March and Olsen, 1998). On the other hand, opponents suggest alternative typologies, such as political, institutional, action rationalities, etc. in order to either reject the possibility of rationality (as described by rational choice theory); or to complement it, i.e. suggesting that there are *other* kinds of rationality, which are based on alternative logics e.g. of appropriateness or institutions. This polarised development of organisation theory has created great confusion, since rationality is ascribed both to scholars and actors (Townley, 2008). There has been ambiguity as regards the phenomena, to which rationality refers. Is rational judgement an empirical phenomenon or a topic for theoretical debate? For example, some suggest that rational decision making is not possible in organisations because e.g. complex decisions require iterations, bargaining with various stakeholders, dealing with interdependencies with other decisions, etc. (Langley et al, 1995). That is, the focus is not on rational judgement per se as an object of empirical enquiry, i.e. investigating where it might happen and how, but whether it is (un)justifiable to use rationality as a general normative principle to explain various (empirical and theoretical) phenomena, such as decision making (Shenhav, 2005; Townley, 2008). In short, the analytical focus of existing studies has been quite narrow

and has encouraged the conflated examination of qualitatively different theoretical and empirical phenomena.

In essence, we maintain that it is not known or adequately understood how organisational actors may actually produce 'rational judgement' in practice, and whether they draw upon rational choice theory or other rational models in any potential efforts to rationalise, since accounts of rationality are preoccupied with a single foundational hypothesis (H0 hereafter): rational judgement is (should be) based on the principles of instrumental rationality, i.e. efficient generalisable rules that promulgate causal linkages between organisational means and ends/goals (Shenhav, 2005). Most scholars in the past have thus attempted to test H0, while very few have explored empirically whether and in what sense other kinds of rational models, which possibly belong to a different ontological sphere i.e. exist as distinct normative frameworks of rational judgement, have an impact on practice. A number of important questions haven't been investigated: What may organisational actors seek to achieve through their rational stance and what resources do they rely on to perform their roles as rational decision makers? Do ideal types of rationality manifest in practice? If they do, how do they do so? Do actors latch on the normative ideal of RCT *only* to ground rational judgement in practice? If not, what other models of rational judgement may organisational actors draw upon in practice, and under what circumstances? How do these models resemble/differ from documented 'technologies of rationality' (March, 2006)?

In this paper, we aim at exploring empirically the above questions in a context where organisational actors seek to be purposefully rational when making healthcare funding decisions. Building on a focused ethnography of decision making in the English National Health Service (NHS), we provide an account of how rational judgement is dynamically pursued and accomplished in practice. Our study examined how three NHS healthcare purchasing (commissioning) organisations consider individual funding requests (IFRs) for exceptional cases. IFRs are routinely discussed by an independent diverse group of experts, whose formal remit is to make rational decisions. We show how rational judgement is accomplished in the context of IFR consideration through, what we describe as, *practices of principle-based deliberation*. Contrary to current perspectives, which put H0 at the heart of their argumentations, conclusions and/or criticisms, our findings suggest that organisational actors' quest for rationality relies on distinct normative ideals – universal principles – for safeguarding the *common good*, and produces 'rational judgement' that is widely receivable and publicly defensible. Deliberation practices are characterised by a careful and systematic search for *fairness*, which is achieved through the medium of reasoning and explicit argumentation for the common goods at stake (the NHS principles). Deliberation practices involve discussions that aim to be rational (albeit not in the sense proposed by H0) by analysing and 'calculating' the consequences of a resultant IFR decision (approval or decline) in terms of fairness and public justifiability; not merely for efficiency (e.g. funding a drug that 'works' and is cost-effective). We show that, for such rational discussions to be constructed in situ, organisational actors perform three kinds of interrelated activities: *performing procedural requirements, making sense of IFR cases and deliberating the funding merits of requests on the basis of public reasons*. In what follows, we illuminate the actual process of deliberating and the outcomes of that process – justifications that are publicly defendable.

This paper makes an important contribution to our understanding of organisational knowledge and learning by unpacking how rationality is sought and performed in actual

organisational situations, and by altering our existing image of rationality. Instead of treating rationality as a 'grand concept' or metaphysical logic, our paper elucidates how a specific form of rationality – grounded in common (political) convictions of fairness and the common good(s) – is produced in organisations. We shed light on the complex dimensions of pursuing a distinct kind of rational judgement through deliberation practices, which have so far been largely unexamined.

The paper is structured as follows. We begin with a review of existing literature on rationality and explicate its key limitations: an insular focus on explaining or critiquing a single form of reified (instrumental) rationality, which has led to ideological polarisation in the field; and giving prominence to theoretical issues, which are treated in isolation from practice, and thus failing to shed light on how rationality may actually be accomplished in organisations. We proceed by outlining our research design, methods, and setting. We then provide rich examples of how rational judgement is sought and accomplished in the context of IFR consideration. These examples are accompanied by an analytical account of the deliberation practices performed by organisational actors as they go about making rational judgement. We conclude our paper by sharing our thoughts regarding the key contributions of our research.

2. LITERATURE REVIEW

The structure of organisation studies of rational judgement appears to be anchored on a 'grand' and abstract notion of instrumental rationality – as in Weber's account of the ascendancy of rationality and bureaucracy (Shenhav, 2005) as well as in rational choice theory (March, 2006). In particular, the field has been divided into two major camps: (a) those who believe that instrumental rationality is possible and represents a normative ideal worth pursuing, and (b) those who assert that rational judgement through the application of instrumental rationalistic models is unrealistic because such models largely ignore important aspects of organisational decision making, action and organisational life in general. It appears that perspectives aligned with intellectual camp (a) such as the "synoptic," or "comprehensive" model of strategic decision making (Eisenhardt and Zbaracki, 1992, Elbanna and Child, 2007b, Elbanna and Child, 2007a) as well as decision analysts (Cabantous et al, 2010) have accepted enthusiastically instrumental rationality as a universal normative scientific ideal. The notion of rationality rarely becomes the object of investigation insofar as instrumental rationality is the very principle that renders their perspective on organisations worthy of attention, consideration and intellectual investment.

Contrary to proponents of the rationalistic maxim, a number of perspectives (intellectual camp b) have developed persuasive alternatives and fierce critiques. They have criticised the rationalistic model from a multitude of perspectives, which focus on different levels of analysis. Predominantly, decision making, neo-institutionalist and sensemaking perspectives have been positioned as persuasive and fruitful antitheses to the RCT model and rational judgement.

In particular, decision making scholars point out that rationality represents a reified ideology, which is based on a misleading assumption that organisational decisions are easily identifiable moments in time. It has been shown empirically, for example, that a lot of what organisations achieve is through routines not decision making (Feldman, 2000); through iterations, interactions and non-decision based work (Mintzberg and Westley, 2001). It is also pointed out that the rational choice model ignores profoundly

the emotionality and sociality of human beings as well as their embeddedness in organisations and institutions (Langley et al., 1995, Laroche, 1995). For most decision making scholars instrumental rational judgement has its limits and should, more usefully, be considered a very problematic pursuit in organisational life (March, 1978, March, 2006); for others, such pursuit is almost impossible due to the inherent irrationality of human action (Brunsson, 1982).

In addition, neo-institutionalists develop a different kind of critique. They posit that instrumental rationality should be more fruitfully seen as symbolic and pertaining to conformity expectations that emanate form the wider institutional and cultural environment dominated by the "myth of rationality" (Meyer and Rowan, 1977). They argue that there are many types of rationality insofar as there are different sources of it – institutional logics (Thornton & Occasion, 2008). For neo-institutionalists, the important theoretical issue is not whether motivation and action is (should be) rational or irrational. Rather, what is crucial is to explore rationalisation processes, e.g. the adoption of rationalistic models, etc. from the premise that institutional forces and logics profoundly influence such processes. Neo-institutionalists effectively maintain that institutional rationality is based on a superior premise or 'logic of appropriateness' (March and Olsen, 1998). This logic, which is contrasted with instrumental rationality's 'logic of consequentiality', places more emphasis on rule-following behaviour, socially constructed identities, institutional meanings and expectations and institutional norms of appropriateness. It is not uncommon for neo-institutionalists to highlight competing forms of rationalities e.g. in processes of organizational change or structuring (Townley et al., 2003), since there is a diversity of institutional influences in organizational arenas. In essence, for neo-institutionalists, rationality is a category of knowledge, that is supplied by various institutional logics, i.e. the "the socially constructed, historical patterns of material practices, assumptions, values, beliefs, and rules by which individuals produce and reproduce their material subsistence, organize time and space, and provide meaning to their social reality"(Thornton and Ocasio, 1999). As a result, the rejection of rationalistic maxim is "given" (Thornton and Occasio, 2008, p. 120) from a neo-institutionalist perspective insofar as it is institutions (rather than instrumental rationality) that provide the substrates for meaningful and successful social action.

In the sense making literature, the idea of rational decision making, as described by the rational choice model, is also rejected because it ignores important social psychological processes. In particular, RCT undermines the interpretation that is necessary for organisational actors to act in the world. Key elements of interpretation or sense making processes include language mediation, identity, plausibility of meaning, embodied mental structures, coordination, and enactment in situations, which are 'talked about' rather than analysed rationally (Weick et al., 2005). From a sense making perspective, story making and telling become more important than logical analysis (Brown, 2000). Narratives become the basis for any meaningful action. Rationalising is not a property of logic but an enacted process of reaffirming one's identity and responsibility as a member of a group or collectivity (Weick and Roberts, 1993); a process of accountability, which is manifested in the assembling of accounts or stories that 'make sense' to and for a group. Rationalisation (albeit of a different kind) is about the enacted narrativisation of 'what is going on', i.e. the development of a plausible story, in a situation (Weick et al., 2005); and part of a quest for coordinated action with others in a group or organisation (Weick and Roberts, 1993).

2.1 Limitations of existing perspectives

Although extant literature on rationality is very rich and insightful in some respects, it is characterised by some important weaknesses. First of all, rationality has become one of the field's organising and dichotomising principles, rather than the object of systematic empirical investigation (Cabantous and Gond, 2010; March, 2006; Shenhav 2005). The debate has centred on the merits, shortcomings or even catastrophic (for our understanding of organisations) ramifications of *a single* rationalistic maxim (Langley et al, 1995). Effectively, rationality has been defined very narrowly:

> "Human action is, or should be, rational in the sense of being derived from a model-based anticipation of consequences evaluated by prior preferences... The technologies of rationality involve three components: first, *abstractions*, models of situations that identify sets of variables, their causal structures, and sets of action alternatives; second, collections of *data* capturing histories of the organization and the world in which it acts; third, *decision rules* that consider alternatives in terms of their expected consequences and select the alternative that has the best expected consequences from the point of view of the organization's values, desires, and time perspectives. The technologies are embedded in an ideology that holds that action should be a product of mind and choice, not tradition, rule, routine, or revelation; that choice should be derived from carefully considered expectations of future consequences, not from the dictates of habit, custom, identity, intuition, or emotion; that insight into the dynamics of histories can be obtained from abstract models of them; and that levels of intelligence superior to those produced by other procedures can be achieved through model-based rationality." (March, 2006, p.202 – 203, emphasis original)

Proponents and critics alike use this notion of rationality to either ground claims for the worth of a theoretical perspective (e.g. the rationalistic decision making model or sensemaking theory) and/or propose competing, alternative, more realistic and sophisticated lenses for studying organisations. For example, criticism has been fuelled over the unfeasibility of coherence required by instrumental rationality (March, 2006). Overemphasis has been put on the disconfirmation of the RCT rationalistic model and on the value of using competing theoretical perspectives that embrace a different logic of and for action (March and Olsen, 1998; Goldmann, 2005). As a consequence, rationality as an empirical phenomenon, i.e. whether and how organisational actors actually pursue rational judgement in practice has hardly attracted sufficient research attention. Actors' reasons and actions for pursuing rationality have hardly been the object of investigation, since the field has latched on a single notion of rationality for ideological purposes (Townley, 2008). Hence, the worth of studying rational judgement and of interrogating the propagation of other rationalistic models empirically has diminished unjustifiably.

Furthermore, the 'ideologicalisation' of the field has led to the emergence of numerous kinds of competing typologies of rationalities, which, their respective proponents would assert, best explain organisational phenomena. Garfinkel referred to 14 rationalities (Cabantous et al, 2010), Weber to 16 (Townley, 2002) while a handbook of organisation studies (Tsoukas and Knudsen, 2005) includes at least 22 versions (Thomas and Cheney, 2005)! Overall, the field is flooded with different ideal-types of rationalities: bureaucratic, managerialist, instrumental, consequentialist, economic, scientific, bounded, limited, decision rationality, action rationality, political and efficiency rationality – to name a few. When confronted with these abstract typologies, one faces a major challenge: should such typologies be used as a yardstick to explain empirical phenomena or as theories, which actors themselves actually use? Existing perspectives tend to conflate the two uses. As a result, notions of, for example, impartiality, efficiency, and enlightenment are usually dubbed as the false and fabricated promises of scientific and economic rationality (rationality critics would suggest); rather than as

notions and ideas that may be meaningful and matter to organisational actors (Shenhav, 2005; Townley, 2008). They are treated as normative ideals for explanation and scholarly criticism, not as performative ideals, which may become entangled in everyday practical accomplishments in organisations (Feldman, 2000). The existence of competing rationalities makes it almost impossible to acknowledge that organisational actors may pursue rational judgement in practice. This is because a competing framework/typology could be used to elucidate the fallacy or impossibility of that pursuit by foregrounding arguments such as e.g. identity matters, institutions matter, narratives matter, etc.; hence rational judgement cannot matter. Due to the availability of numerous rationalities in abstracto, i.e. for analytical and explanatory purposes, examining the emergence of rational judgement in practice becomes trivial since one of the myriad types of rationality could be used to explain action. In essence, it appears that organisational practice has become the setting, not the source of theorising about rationality.

Finally, the concept of rationality itself has acquired metaphysical traits, which have not been grounded in what organisational actors do. This is manifested in the transcendent use of rationality for explaining very diverse phenomena (and/or for proving the impossibility of rational judgement): from formal structuring, decision making, learning, intelligence, breakdowns, etc. Existing perspectives study qualitatively different things and serve purposes other than creating empirically based boundaries for new theories. For example, sensemaking perspectives focus on 'pre-decisional' and meaning making socio-cognitive processes that underpin any action. Yet, sensemaking research has been conducted so far in settings where 'acting' is more salient than 'thinking', such as breakdowns in high-reliability organisations (for an exception see (Brown, 2004)). We thus do not know whether and how sensemaking may be implicated in organisational attempts to make rational decisions. Sensemaking perspectives fail to take cognisance of the possibility that there may be real organisational life situations where thinking logically before acting occurs; deciding after evaluation of alternative options takes place; rational debate unfolds; and incentives to act and think rationally do exist. In other words, existing perspectives do not differentiate among conditions, empirical performances and outcomes of rationality and rational judgement, since the focus is on rationality as a transcendental concept (which most would normally dub as flawed). There has been little effort to create theoretically bounded perspectives on rationality.

In light of the aforementioned important limitations of the extant literature, we argue that we need to explore empirically whether and how rationality and rational judgement may emerge in specific organisational situations. Instead of sustaining unfruitful dichotomies, we need to put practice at the epicentre of our theorising efforts. We may need to view practice not simply as the context container of observable action, but as the site of knowing (Nicolini, 2011); we may well benefit from ascribing ontological status to practice and to what people actually to do to accomplish rational judgement (Orlikowski, 2002). We need to examine how rationality emerges in practice as a practical matter through a repertoire of socio-material performances (Cabantous & Gond, 2010). This research motivation guided our effort to conduct the study described below.

3. RESEARCH METHODS AND SETTING

Our study examined how three English National Health Service (NHS) healthcare purchasing (commissioning) organisations consider individual funding requests (IFRs) for exceptional cases, where requests are made for medicines or other treatments that are not routinely purchased. We selected this context because we were interested in studying empirically the pursuit of rational judgement in practice. The handling of IFRs represents an almost ideal context for studying rational decision making. IFRs are routinely discussed by an independent diverse group of experts. The official remit of the group is to make rational decisions on IFRs after the careful consideration of IFR information and on the basis of specific criteria. Furthermore, IFRs have attracted public and media attention– most commonly, when a commissioning organisation refuses treatment to a patient. For example, the BBC programme 'Panorama' (18th August 2008) popularised criticism regarding IFRs by showing real examples of people who have been 'victims' of this process (e.g. Cancer Patients not being able to receive life-saving drugs, etc.). This dimension complicates the work of IFRs, which is essentially accomplished under conditions of imminent publicity. We maintain that by examining a context where the construction of rationality is explicit and conscious, much can be learned about the quest for, and production of, rational judgement in organisations.

Three of the authors attended individually, as non-participant observers, fifteen IFR panel meetings lasting between 2 and 3 hours. These meetings were the only place where discussions and collective decision making occurred. We observed the unfolding of discussions of 118 IFR cases, which generally involved thorough evaluation of the available evidence and supporting documentation as well as the ways IFR panel members arrived collectively at an acclaimed rational judgement. Each observer took detailed notes of discussions and of collective attempts to make sense of IFR cases and to conclude with a decision, which was the focus of all discussions. After each observation episode, hand-written notes were typed up and converted into an electronic document for each meeting.

In addition to real-time observations, we had access to and studied the voluminous documentation that accompanied each case for every meeting. Before each meeting, a 'pack' of papers was circulated to all IFR panel members and to the non-participant observers. The pack provided detailed information about each case – IFR requests as well as records of all correspondence between the IFR panel and the requestor prior to each meeting. For most meetings, we had access to the meeting minutes, in which the outcome of the decision making process was officially reported. We also conducted semi-structured interviews with the chairs of the 3 panels as well as with other members of the three NHS organisations, who interacted with the panel (lasting from 1 to 2 hours) and had a stake in the IFR process. Furthermore, we reviewed documentation in relation to the IFR process. For example, the policies that inform some of the decisions, the policy framework and terms of reference, the national policy framework (the NHS constitution) as well as other published materials, such as evaluations of IFR processes by various interest groups.

At the end of the data collection cycle, each of the authors/observers produced analytical reports for each of the meeting. We then met several times to compare field notes, analytical reports, and engage in open coding. Open coding/interpretation focused on the mode of accomplishing the socio-material practices performed by IFR panel members; their doings and their sayings (Nicolini, 2011, 2009). We were gradually

sensitised by the interactional patterns we had documented among panel members and the discursive patterns that emerged. Throughout data analysis we were recursively going back and forth between interpretation and field notes. After identifying recurrent themes, each of us went back to the original data to verify the plausibility of, and, if needed to refine, emergent interpretations. The process continued throughout a writing process that was very much a collaborative effort. When our interpretation reached a level of maturity, we shared our findings with our participants, i.e. those who actually do the IFR decision making, who provided invaluable feedback. We modified our interpretations in order to reflect such feedback.

4. RESEARCH FINDINGS

4.1. The context and national policy background

The three NHS commissioning organisations we studied (the so-called 'Primary Care Trusts') are statutory bodies in England responsible for purchasing NHS services from various healthcare providers in a defined geographical area. Although they set their own local priorities and strategies, they work within national policy frameworks, which underpin all NHS organisations (NHSconfederation, 2010). Their most important responsibilities and statutory duties are: to 'break even' at the end of each financial year, i.e. spend, but not exceed, their entire allocated (by central government) budget; and to ensure "free healthcare provision on the basis of need, and not ability to pay" and in accordance with national standards (NHS confederation, 2010). The three organisations we studied, PCT X, PCT Y, and PCT Z (pseudonyms) are located in different regions across England. Whilst these organisations differ in size, profile, financial stability and performance, they all have a very similar formalised process, which handles Individual Funding Requests (IFRs). The sources of these requests are usually multiple, and mostly relate to the following: a particular intervention is not routinely commissioned; the need for commissioning has not been identified; a new drug has been developed for a particular condition, yet hasn't been accredited and qualified for its suitability in the NHS (NHSconfederation, 2009).Whilst the total annual cost of approved IFRs is relatively low for each PCT, these organisations are officially required to deal with IFRs very seriously.

Furthermore, the IFR process has recently attracted significant policy attention. A formal letter of the former NHS chief executive, David Nicholson, to all NHS commissioning organisations, alluded to the need to *"address perceptions that variations in the availability of important treatments can sometimes occur at random, rather than as the result of a clear and conscious commissioning process".* The letter also highlighted the newly-established *"right in the NHS Constitution*[3] *to expect rational decisions"* about IFRs (Nicholson, 2009). According to Section 2a of the NHS Constitution:

> "You [any NHS patient] have the right to expect local decisions on funding of other drugs and treatments to be made *rationally* following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you." (Department et al., 2010), emphasis added)

[3] The NHS constitution is a recently developed official policy document that sets out specific rights NHS patients have, such as access to health services, the quality standards of care, the treatments and programmes available, etc. It should not be confused with the term constitution as in the body of fundamental principles or established precedents according to which a state is governed.

This right has been the basis for the issue of statutory directions by the Department of Health (Department et al., 2009).Throughout England, all 152 (at the time of writing) PCT commissioning organisations have responded to these directions and have established an IFR process. In addition, all PCTs have published IFR policies, which explain their acclaimed rational approach and procedures for dealing with IFRs. Common elements in these policies are the following: (i) the establishment of decision-making groups, with a clearly designated focus of accountability, which include a locally-defined mix of members with the appropriate range of skills, (ii) robust decision-making procedures, (iii) clearly defined standard criteria for decision making, such as considering best available evidence, following ethical frameworks and complying with other statutory requirements, (iv) a formalised process for documenting thoroughly the application of decision-making procedures and the rationale for each decision, and (v) an appeals process for decisions made on individual funding requests, which patients/their doctors can have recourse to, if they feel their request has not been treated fairly. Members of these groups – which in all three PCTs were called 'IFR panels' – include senior commissioning managers (associate director level), a public health physician/consultant, an IFR officer, a general practitioner or other doctor, and a non-executive director; in one PCT they also include finance managers, pharmaceutical advisors, nurses, commissioning experts. IFR panels have the delegated authority to make decisions in respect of funding individual cases and assume no other role.

The three PCTs we studied – PCT X, Y, Z – have published their IFR policies on their websites. These policies outline in a more or less detailed way the principles underpinning the PCT IFR process. All PCTs embrace remarkably common principles (please see appendix 1). Although it lies outside the scope of this paper to thoroughly examine this, the commonality of principles and normative approaches to handle IFRs seems to reflect the widespread concern across NHS organisations to safeguard its universal principles: comprehensiveness, equity (access to all), standards of (clinical) excellence, best value for money and effective use of finite financial resources (Department of Health, 2010). Funded by all taxpayers working and living in England, NHS organisations are officially (and through their statutory duties) expected to demonstrably strive for these principles. The IFR process represents for PCTs a 'well-engineered' decision making setting for demonstrating their commitment to, and discharging their responsibilities as custodians of, the NHS principles. In light of these very stringent policies for handling IFRs and on the basis of the fundamental and universal NHS principles, in what ways do IFR panels pursue the sort of rationality, which is acclaimed in their policies? What form does such pursuit take and how does it unfold?

4.2 Performing Rational Judgement regarding IFRs in practice

In total, we observed in real time how PCT X, PCT Y, and PCT Z arrived at (what they asserted to have been) rational decisions regarding 118 requests/IFR cases; 57, 23 and 38 cases respectively. Despite some interesting differences across panels (e.g. time to discuss a case, composition of panel, number of cases discussed per meeting), we observed an equal concern and mindfulness by all to perform a number of activities that would, from their perspective, guarantee the attainment of rationality in their particular decision making situations. We analytically distinguish among three kinds of socio-material activities, which IFR panel members in all PCTs enacted in remarkably similar ways in order to accomplish rational judgement: (i) *performing procedural requirements, (ii) making sense of IFR cases, (iii) deliberating the funding merits of a*

request and devising a publicly defendable justification for the concluded rational judgement/decision (table 1). These interrelated activities, we suggest, enact a distinct pursuit of rational judgement in practice by way of enabling (activities i and ii) and practising deliberation (activities iii) around the common goods at stake – the NHS principles. In what follows, we provide an account of these activities with rich illustrations from the field.

Table 1. The Pursuit and Performance of Rational Judgement in the Context of IFR

	Pursuing and Performing Rational Judgement (Practices of Deliberation*)*		
	Performing Procedural Requirements	**Making sense of IFR Cases**	**Deliberating Funding merits**
Activities	- *Documenting* every aspect of communications - *Certifying* that a request is IFR - Compiling and *circulating* IFR case evidence *well in advance* of the meeting - *Formally reporting* decisions and reasons for a decision	- *Categorising* a request on the basis of conventional codes - *Authenticating* a request, i.e. establishing its genuineness - *Narrativising* requests, i.e. creating and redrafting a story about it	- *Mobilising* the universal *NHS principles* and re-interpreting a request in light of these principles - Articulating, sharing and debating *arguments* regarding the funding merits of a request on the basis of NHS principles - Formulating consensually a *rational decision*, which is justified on grounds of fairness and public reasons, i.e. reasons which allude to the common goods at stake

4.2.1. Performing Procedural Requirements

From the moment a request was received, the IFR chairs and officers were vigilant to ensure that: every communication with the requestor (e.g. emails and letters to and from the panel) and all other relevant information (e.g. the completed IFR form as well as other diagnostic test results, and reports) was documented and thus de facto constituted case evidence; they certified that the request was indeed 'IFR' and thus fell within the remit of the panel (e.g. in some cases the requested treatment was already available or the request could easily be accepted/declined if the patient clearly met/did not meet eligibility criteria outlined in clinical commissioning policies); documentation for each IFR was printed and forwarded to all panel members at least a week before the panel met, so that everyone had the opportunity to examine the information – case evidence. In some cases, they conducted a literature search for published research (or other) evidence relating to the requested intervention; any relevant research papers were attached to the voluminous pack of documents (not infrequently of the size of 200 pages) that were circulated to panel members prior to a meeting. Finally, at the end of each IFR meeting we've observed, panel members always focused their discussions on creating a formal report and/or a letter, which would explain the reasons for their decision. The following dialogue, which took place at the end of a meeting at PCT Y headquarters, illustrates the effort of IFR panel members to address their concerns about how to record a decision:

> *Panel Chair: How should we put it (in the minutes)? [The panel had reached consensus about approving a case]*
> *Finance Manager: We can use an old expression: '(Approving the request) represents good use of NHS resources'.*

Panel Chair: Yeah, I like that!
[The IFR officer writes down what has been agreed]

The rationale for the decision was later documented in the formal 'minutes' and letter to the requestor:

> *"The panel considered that this patient's condition, complications and unsuitability for alternative treatment may offer an exceptional ability to benefit from this treatment. On balance, the panel felt that this treatment would be more cost effective than the likely alternative treatment and thus represents good use of NHS resources" (Excerpt from formal minutes)*

Whilst in most meetings we observed, panel members performed vigilantly the required procedural requirements, occasionally, they were faced with procedural 'glitches'. For example at one meeting in PCT Z, the public health consultant wondered: "I don't understand why this case is in this panel. This shouldn't be IFR!" Also, a few times, case evidence was scant for a rational decision to be reached. Strikingly, the response of panels to various procedural glitches was to *postpone a decision*, rather than make a decision that was not 'procedurally sound'. When, in rare cases, the procedures were not followed, panel members would condemn that:

> *Caroline, a public health physician, says that in the past she made a quick decision to give a patient a life-saving treatment (an expensive drug). She refers to the circumstances under which the decision was made. She says that the patient's doctor called her and told her: "basically the patient is dying! That drug is the only available treatment"... So, I said 'yes' (approved the treatment)". Caroline says that the patient was saved. The chair says: "So, it was a good decision". Caroline replies uncomfortably: "[It was] a badly made decision!" (Caroline felt guilty, as the procedures e.g. considering case evidence prior to a decision hadn't been followed…)*

Procedural soundness was a precondition for pursuing rational judgement. Unless procedures were religiously followed, the search for rationality could be jeopardised, e.g. not reading the case evidence well in advance, failing to create a record of a decision or evaluating a case that was not IFR. Whilst following procedures was an important part of IFR panels' endeavours to make rational decisions, it represented a 'background' preparatory performance necessary for rendering the pursuit of rationality possible.

4.2.2 Making sense of IFR cases

In addition to procedural mindfulness, the rational consideration of IFR cases presupposed and pre-required the performance of particular sensemaking activities. After a request arrived at the desk of the IFR officer, IFR panel members recurrently enacted a series of sensemaking activities, which enabled them further in their pursuit for a rational judgement. More specifically, IFR panels performed the following more or less heedfully: *'categorisation', 'authentication' and 'narrativisation'* of each of the 118 requests, with which they had to deal. Categorising, which preceded all other sensemaking processes, involved the giving of a name to a request (e.g. IVF, bariatric surgery, acupuncture). Panel members used pre-existing categories (diagnostic clinical codes) to bracket the request and make it a 'type of case'. The IFR form, which requestors used, played a key role, because it guided applicants and receivers of the request to provide and interpret information about the patient's condition and requested treatment/intervention.

Furthermore, authentication referred to understanding whether an IFR was genuine, i.e. the requestor's motives were honest, and/or camouflaged illegitimate interests. Although in most cases the genuineness of an IFR was implicitly assumed and not questioned, in a number of cases IFR panels across settings would wonder why the

requestor actually applied for individual funding, as the following excerpt from a discussion illustrates:

> *Pat from PCT Y (pharmaceutical advisor): [Talking about a case requesting funding for low back pain treatment] Clearly, in this case the patient went to the GP and asked the GP: "could the NHS pay for this?" Patients can always pay by themselves! We will not pick up the cost for treatments that should be funded privately…*
>
> *Claire from PCT X (GP): There is very little information in the letter. It is very difficult to envisage what is asked for. But, why is the GP (acting as requestor on behalf of the patient) so vague? Is it deliberate? We need to know more about the history of the patient and the first procedure that was undertaken.*

With respect to narrativising each IFR case, IFR panel members were striving for constructing a story about who applied, why, under what circumstances, what exactly is requested and how the request becomes addressable, i.e. how the requested treatment becomes suitable. Narrativising was performed in a similar fashion across PCTs and also took a particular form: prior to the commencement of a discussion, the IFR officer narrated the case, while in many cases the story of a case was summarised in one page attached to the voluminous IFR documentation. Quite frequently, narrativisation was problematic, because crucial information was missing. Bart, Public Health Consultant at PCT Z, noted at a meeting:

> *Bart: The big question for me is: what are they asking for?... (Also) The evidence base is really a series of references, rather than evidence. I was unable to quantify benefits. There is a learning for us… how to request evidence.*
> *Adam (GP): I am (also) not sure… When did they stop the previous treatment? We also need more information on the proposed treatment plan.*
> *Gary (IFR chair): it sounds like we can't make a decision.*
> *Bart: I am happy to talk to the consultant to understand more about the patient's condition. I will send you an email by Wednesday…*

Narrativising requests was crucial because it afforded IFR panel members to imagine the immediate consequences of their decisions; e.g. is it going to work? How much would it cost? Will the patient benefit? Are there already available alternative treatments? Dealing with an IFR case effectively entailed the collective redrafting of an emerging story, as a case was gradually being talked about among panel members. Such redrafting enabled a story to become more comprehensible. A lot of the times, however, panel members used their own personal experiences to 'fill in gaps' in a case story. For example, regarding the length of the requested treatment, the cost, etc. In the absence of interaction with the requestor, opportunities for clarification were very few in order to enrich the case story and make it more complete; gaps tended to be filled in on the basis of prior social experience. Presumptions, stereotypes, intuitions and previous social experience occasionally intruded the space and efforts for narrativising IFRs. In short, the story making and telling of a request was essential for dealing with a case and was a necessary precondition for deciding rationally upon the funding merits of an IFR.

Although performing procedural requirements and making sense of an IFR (categorising, authenticating, and narrativising) formed an important part of the activities that unfolded throughout IFR decision making, what actually dominated IFR meetings was a particular form of discussion. We label that discussion for analytical purposes as *deliberation,* which aimed at safeguarding, through reasoning and rational debate, the NHS principles and the common goods represented by such principles.

4.2.3. Deliberating the IFR Funding Merits

During the actual decision making discussion, IFR panel members, equipped with meaning developed through sensemaking, focused their attention on calculating, debating and reaching (what they thought was) rational consensus about the funding merits of a request. Deliberation was performed through: the situated mobilisation of universal principles and the interpretation of a request (in fact all requests) in light of these principles (though not necessarily all principles); the articulation, sharing and debating of arguments by IFR panel members, who made the validity claims of their points explicit and on the basis of public reasons; the incorporation of material tools and resources that enable interpretation and rational calculation of the fairness of a decision; the formulation of a single argument – verdict agreed by all, which valorised reasons of fairness for a resultant decision and thus constituted a publicly defendable justification.

The mobilisation of the universal NHS principles outlined in IFR policies and ethical frameworks included, as a minimum, an effort to identify a case as *more or less exceptional*. The following excerpt from field notes taken at an IFR meeting in PCT Z illustrates this process:

> *Kathryn (IFR officer) summarises the second case... When she finishes, Adam (GP) says: "it's definitely service development [the development of a new service which is in principle available to all]. It is not exceptional!" Bart agrees and says that, "even though the number of other individuals who could also benefit is small, it's predictable. A large proportion is anticipated, so the case is not exceptional. I think it is service development. The patient is not exceptional". Gary (IFR chair) is reading the letter from the GP, who argued for his patient's 'unique clinical circumstances'. Gary adds: "This is not the same as exceptional, there is no evidence of exceptionality..."*

For the IFR panel members of PCT Z, the lack of 'evidence of exceptionality' highlighted equity issues. Approving a non-exceptional case meant that they de facto *treated unfairly* all other people, to whom the requested treatment could/should also be available. The identification of a cohort of similar patients implied that the IFR panel, if they were to be rational, had to conclude on grounds of equity and social fairness, that the request be declined. Had the patient been 'exceptional', the panel would be in a position to acclaim the worth of the request and dissociate the case from the general population. Issues of equity and fairness were also manifested when panel members across PCTs experienced the need to be consistent across time and space in their handling of IFR cases. The notion of *consistency* itself was sufficient to ground an argument for a decision. For instance, if they had approved a procedure for a similar patient in the past, i.e. there was a precedent, this constituted grounds for accepting the IFR.

Quite often the mobilisation of principles in a particular context was problematic. For example, IFR panel members would not always agree on their understanding and application of the principles. This often led to debating and clarifying the meaning of a definition, as the following excerpt from notes taken at a meeting in PCT Y suggests:

> *The case under consideration does not fall within any existing commissioning policy, panel members agree. Caroline, public health consultant, says that, "this case is exceptional!" Pat, pharmaceutical advisor, disagrees and argues that, "it is a service development, it is about a new drug!" Caroline then replies that, "it all depends on your definition of exceptionality". "So, what is your definition of exceptionality?" Pat immediately questions. Caroline hesitantly says, "I don't remember, that the patient has an exceptional ability to benefit." While disagreements remain unresolved, Sue, another public health physician, consults the Oxford Handbook for Clinical Medicine. She is trying to find evidence regarding the prevalence of the patient's condition. She finds out what she was looking for: "the prevalence is 5 in every 100,000". John*

(IFR Chair) suggests that: "Then, there is evidence of exceptional clinical circumstances". The disagreement between Caroline and Pat seems to be resolved... People in the room concur with this view…

Reaching consensus over the definition of 'exceptionality' looked like a 'theoretical' or scholarly issue. Yet, in the IFR context, it was a pragmatic issue insofar as defining a case as 'exceptional' provided strong evidence for making a rational decision to approve a request. 'Exceptionality' was one of the most publicly acceptable reasons for grounding a rational judgment. Problematic or not, the clarification of principles was thus crucial for appraising the funding merits of a request. Building confidence in the application of principles afforded IFR panel members to formulate a more coherent argument, i.e. an argument that was based on solid, principle-based and public reasons. The rationality pursued by decision makers pertained precisely to the crafting of justifications, which demonstrably safeguarded the common goods at stake (in the above case that of equity).

Effectively, for an argument to become as rational as possible, IFR panel members tended to engage extensively in debating and consensus reaching activities. Although such deliberation was always salient, it tended to be more explicit when a case was recognised as more complex, i.e. when the devising of a coherent public justification was less straightforward. This is exemplified in the following excerpt taken from observations of the PCT Y IFR panel, when they continued discussing the aforementioned complicated case.

They all finally seem to agree that this IFR case (a complicated cancer patient) is exceptional and that there is no issue of equity, since the evidence from the Oxford Handbook was clear. Caroline, public health consultant, says, however, that, "I am against (approving the request)… on different grounds. I am not sure about the evidence of (clinical) effectiveness"... Gavin (Non-executive director) says that affordability is not an issue in this case… John (IFR chair) is worried that they are likely to miss something. They are looking at the abstracts of 6-7 papers sourced from an extensive literature search (attached to the IFR documentation). Bill (Finance manager) says that, "there is some evidence of clinical effectiveness". Caroline disagrees. Pat (pharmaceutical advisor) is concerned that they should be focusing on the most important kind of evidence (according to the widely acceptable 'hierarchy of evidence'): papers reporting on results of randomised controlled trials (RCTs)…. Caroline says that there is a big problem with the RCT paper… "From that (RCT paper's) point of view the treatment is experimental…". Pat concludes then that there is, "no evidence of clinical effectiveness. It's a no!". Caroline corrects him and says that, "there is ***limited*** *evidence… The way I am reading it (the paper)… The clinical evidence is insufficient... I wish I had a better evidence base!" As for cost effectiveness, Pat says, "if you don't have evidence of clinical effectiveness, then you can't have evidence of cost effectiveness…. In the literature there is no evidence". John (IFR chair) is concerned about how they document the decision and suggests: "Shall we then say in the report that there is no evidence?". Bill counter argues and says, "that's right, but not for the right population (i.e. for the population under which the patient falls)"… Caroline becomes even more confused about the abstract of the RCT paper published in the prestigious Journal of Clinical Oncology. Pat agrees: "It doesn't make sense! The article contradicts itself!". He suggests that they delay the decision, since they can't draw conclusions from the evidence. Caroline and Pat want to look at the full paper (not available at that time) more carefully. John asks: "What do we do for the minutes?" Pat suggests that they need to read the article and if it doesn't make sense they have to contact the authors of the paper (in order to validate their understanding of the reported evidence). John is worrying about the wording. Bill suggests the following wording: "The panel is not mindful of approving it, but we need to scrutinise the evidence base further". The panel decides to postpone the decision until they will look at the article...*

In the above rich example, the IFR panel members debated the merits of the request on several grounds. After 'heated' deliberation, they established that on the basis of *equity*, the request was worthy of approval since the case was exceptional. Reaching this verdict required referencing an external object, which was seen (not accidentally)

authoritative; an object which provided strong grounds – public reasons – for establishing the worth of the request in terms of equity (Oxford Handbook of Clinical Medicine). A*ffordability* was also regarded as 'not an issue' apparently (i.e. the cost was relatively low), and thus the panel didn't feel the need to debate this aspect of the request. What became more salient and, indeed, problematic was the effort to ascertain the worth of the request in terms of evidence of effectiveness. That was important because, without such evidence, the case could be deemed 'experimental' (according to Caroline) and could become unworthy of funding. Deliberating through the simple debating of discursive arguments for and against the merits of the request was also inadequate. Reaching collectively an acclaimed rational decision, i.e. on the basis of public reasons, was not a matter of creating eloquent statements. For rational judgement to be achieved, it was recognised as essential that they were able to evaluate the merits of their decision by drawing upon an external object of evidence (Boltanski and Thévenot, 2006). The debate, which unfolded at the IFR meeting, concerned reasons that could be made public, and were not idiosyncratic, e.g. a clinician's personal judgement. Such reasons had to be based on authoritative evidence as defined by the widely acceptable in the NHS (and beyond) 'hierarchy of evidence'. The evidence under consideration (the 6-7 research papers) pertained to the clinical effectiveness of a treatment for a general type of condition, to which the patient was ascribed. The panel members were seeking strong evidence (RCT paper), which would enable them to craft a coherent and publicly defendable justification. Caroline's wish for a "better evidence base" reflects her anxiety to demonstrate effectively that a resultant decision was rational in that it guaranteed 'objectively', i.e. on the basis of an external object, the safeguarding of the principle of clinical effectiveness. She and her colleagues were in agreement that, in pursuit of rationality, they should aim for definite and conclusive results from the 'test' of clinical effectiveness. Evidence was needed in order to provide the coherence and solidity needed for creating a *publicly defendable* justification. This was because the test of clinical effectiveness, if ever needed, could be re-constructed by *anyone* who might cast doubt over and criticise the decision (including the patient, the doctor, the scientific community, other NHS actors, the taxpayers, citizens, etc.). Evidence guaranteed that in the scenario of potential criticism (which is immanent in IFR contexts), the IFR panel members could successfully defend the rational and thus fair basis of their decision. In essence, deliberating the merits of a request among the panel was grounded in the explicit articulation and debating of publicly reasoned arguments, which had to be supported by objects of evidence. According to standards of clinical excellence, to which the IFR panel members alluded, consensus over rational judgement should be based on strong, authoritative, superior and peer-reviewed evidence; rather than on personal or group convictions and viewpoints.

5. DISCUSSION AND CONCLUSIONS

Our investigation of IFR decision making in the English NHS suggests that the understanding of rationality may be significantly improved if we address and examine the pursuit and performance of rational judgement as a situated empirical phenomenon rather than as a normative ideal. The results of our focused ethnography vividly demonstrate in fact that deciding rationally and appearing to do so are practical, rather than ideological matters. The pursuit of rationality becomes significant in the organisational life of IFR panel members not simply because it provides the contours for appropriate action or best decision outcomes, but mainly because it affords them to solve a very practical problem, i.e. reaching a rational judgement that is publicly defendable. What counts as rational cannot be thus disjointed from the activity at hand,

in our case the activity of public deliberation on healthcare matters. Accordingly, we suggest that rationality needs to be studied empirically as a situated accomplishment. Models and ideologies become discursive resources used in the process and should not be taken as a description of the process itself. The locally bounded practices of deliberation described in this paper constitute then an exemplar of a wider empirically multifaceted phenomenon – that is, the accomplishment of rational judgement in practice. In what follows, we draw some important implications that out approach bears for the study of rationality from three existing approaches to decision making: the traditional rational paradigm, neo-institutionalism and sensemaking perspectives.

Decision making

In this paper, we attempted to show how rational decision making is achieved in practice. Our study suggests that much can be learned if we view rationality and decision making *as* practice; as mutually constituted aspects of practical accomplishments (Nicolini, 2011; Cabantous et al, 2010). From such a perspective, rational judgement is approached as complex practical activity, rather than as an ideal, which can never be achieved in virtue of various inherent constraints, e.g. politics, cultural boundaries, irrationality of action. We do not refute such constraints. Indeed, in IFR decision situations, the pursuit of rationality was embedded in a group-decision making context, where the influences of groupthink, power asymmetries within the group, hasty arrival at a decision, narrative misnomers and non-consideration of important evidence were salient. Yet, we maintain that these constraints do not provide the basis for rejecting that a particular kind of rationality was important for all IFR panel members, who collectively and actively performed a series of activities – deliberation practices – in order to address a particular and crucial practical issue: the development of a demonstrably rational decision of approving or declining a request. Questioning the *actual* coherence of such decision, as suggested by opponents of rationality as an ideal, is qualitatively different from studying whether, why and how such coherence matters to actors themselves. It should be made clear that we do not dovetail with pure rationalists, who assert the possibility of instrumental rationality, albeit boundaries (e.g. bounded rationality), but we do suggest that rationality, as an ideal, which is *performed*, is a worthwhile subject of organisational scientific enquiry. In short, although the IFR situations are unique in some sense, it can be expected that other situations where rational decision making is pursued do exist in practice and deserve the attention of students of organisations.

We thus concur with Cabantous et al (2010), who argue that rationality should be explored as a 'performative praxis', and we would add that it is not enough to examine the 'degree of performativity' (p. 1555), i.e. the degree to which the ideal of rational choice theory has an actual effect in and through practice. It is rather important that we relax our assumption that instrumental rationality is the main normative ideal for grounding rational judgement; and that the effortful production of rationality in organisations is effectively mediated predominantly by practices of contextualisation, quantification and calculation as Cabantous et al imply (2010). Our study rather suggests that, for those pursuing rational decision making, other ideal models or 'technologies of rationality' (March, 2006) may be relevant (e.g. principles or 'polity models' underpinning rationality for the common good, see Boltanski and Thévenot, 2006). The 'performativity' of a different ideal model of rationality may well entail a different kind of practical accomplishment, e.g. in the context of IFR, the enactment of

deliberation practices, which have little in common with the practices of contextualisation, quantification and calculation identified in Cabantous et al (2010).

Neo-Institutionalists

Our account of the pursuit of rationality in the context of IFRs also suggests that we may need to rethink neo-institutionalist perspectives on rationality. In particular, we showed that it is not merely institutions, i.e. collective, normatively and cognitively constrained modes of acting and thinking, conditioning rational judgement. The kind of rationality enacted through deliberation practices in the context of IFRs assumes a 'logic of abstract publicity', which puts citizenship (safeguarding the NHS principles) at the centre of action. This logic cannot be captured if we view rationality as being permanently institutionally bounded because (Bohman, 1999):

> "Citizenship requires adopting a particular role and point of view, which abstracts from all contingent features of oneself, such as social and institutional roles, self-regarding interests, and particular religious and ethnic identities…. When speaking from this abstract identity and impartial point of view, one participates in the 'public sphere of private persons' in a social space that thereby establishes conditions of equality… The social space so created is a space inhabited by abstract persons, who attempt to remove the culturally 'thick' features of their social identities in order to achieve equal standing... Expressing one's opinion under these conditions establishes a logic for making and criticising claims publicly… The sort of reasons that can be introduced are subject to normative constraints, so that 'non-public' reasons ought to be excluded from democratic deliberation and debate." (Bohman, 1999, p. 178)

As our findings demonstrate, IFR panel members were alluding to this 'logic of abstract publicity' in their efforts to reach a rational decision. Thus, the distinction between 'logic of appropriateness and consequences' (Thornton & Ocasio, 2008; March & Olsen, 1998) is less relevant in this context, since institutional identities were less salient and only formed a background condition for enabling deliberation, that is, "… a particular sort of discussion that involves the careful and serious weighing of reasons for and against some proposition" (Fearon, 1998, p.63 cited in (Abelson et al., 2003). At this point we should issue a warning against polarising (again) the debate. We do not propose yet another 'logic' (of abstract publicity). We simply suggest that, when studying rational judgement from the point of view of organisational actors (Townley, 2008), we may need to refrain from taking the effect of institutional rationalities for granted. Rather, we may need to attend to the pragmatics of arriving at rational judgement and elucidate the work of actors (human and non-human), who may allude to logics and models that go beyond the realm of institutions (Boltanski and Thévenot, 2006, Boltanski and Thévenot, 2000).

Sensemaking

Finally, our study has important implications for enriching a sensemaking perspective on rationality. More specifically, we have shown that sensemaking may provide a fruitful lens not for rejecting, but for studying rationality in practice more systematically. Our rich empirical insights suggest that sensemaking is actually a precondition for the making of rational decision making. The narrativisation of experience *mediates* and does not 'destroy' the pursuit and production of rational judgement. How well IFR members constructed a story from case evidence always affected deliberation; sometimes more or less explicitly. In conclusion, our study suggests that sensemaking researchers have much to gain from focusing on, rather than circumventing, situations where 'thinking' precedes 'acting', decision choices are consciously evaluated, and arguments complement narratives.

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APPENDIX 1: IFR Policies

"The IFR Panel considers requests for [individual] funding in light of local policy, national guidance (where available) and all the information that has been submitted to support the request. If the Panel decides that the clinical circumstances of your case are not exceptional, funding will not be approved…. We operate in the context of an Ethical Framework, which stresses the need for decisions to be fair, consistent and equitable… The purpose of the ethical framework is to: provide a coherent structure for discussion, ensuring all important aspects of each issue are considered; promote fairness and consistency in decision; provide a means of expressing the reasons behind the decisions made…. The Ethical Framework is especially concerned with 1) Evidence of Clinical and Cost Effectiveness, 2) Cost of Treatment, 3) Individual Need for healthcare, 4) needs of the community, and 5) national standards." (PCT X IFR policy)

"The IFR process will ensure that each request for individual funding is considered in a fair and transparent way, with decisions based on the best available evidence and in accordance with the PCT commissioning principles… A principle based decision making process supports the strategic planning and the effective use of resources within the PCT. The Principles that the PCT seeks to support are:

- *clear evidence of clinical effectiveness*
- *clear evidence of cost effectiveness*
- *the cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.*
- *the extent to which the individual or patient group will gain a benefit from the treatment*
- *balance the needs of each individual against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.*

… This policy requires requests to be considered against the tests of clinical effectiveness, cost effectiveness and affordability provided the patient is able to demonstrate that they represent an Individual Patient (or)…. that they have exceptional clinical circumstances. If the patient is able to demonstrate exceptional clinical circumstances (as defined in this policy) the request will be considered against the tests of clinical effectiveness, cost effectiveness and affordability." (PCT Y IFR policy)

"The following [commissioning] principles underpin how financial resources will be deployed to support improvement in the health of the PCT's area:

- *Be clinically effective*
- *Be Cost effective*
- *Promote equitable access for all populations*
- *Be responsive to individual and population needs*
- *Be affordable within a finite budget.*

… In line with the Commissioning Principles, the Individual Case process cannot make a decision to fund a patient where by so doing a precedent would be set that establishes new policy (because the patient is not, in fact, exceptional but representative of a definable group of patients)…. In order for funding to be agreed there must be some unusual or unique clinical factor about the patient that suggests that they are:

- *Significantly different to the general population of patients with the condition in question*
- *Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition." (PCT Z IFR policy)*