

# ***Challenging the ‘view from nowhere’: citizen reflections on specialist expertise in a deliberative process***

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## **Abstract**

This paper presents analysis of citizen encounters with specialists in a deliberative process, called Deliberative Mapping, which explored options for addressing the shortage of organs for transplantation in the UK. There is a rich theoretical literature about the extent to which citizens are competent to question the knowledge claims of specialists in complex decision-making processes, suggesting the trustworthiness of scientific expertise will depend on the qualities of social interaction in face-to-face dialogue, but little empirical analysis of specific encounters. This paper presents evidence of how citizens located specialist expertise in making judgements about the legitimacy and credibility of specialist knowledge claims, in ways that reflect differences in epistemic procedures valued by the panels of men and women in this process.

## **Key words**

Expertise; deliberation; deliberative democracy; gender; organ transplantation; Deliberative Mapping

## Introduction

One striking feature of the strategies for citizen participation in complex scientific and technological decision-making is the rise of deliberative processes bringing citizens, stakeholders and specialists into dialogue. Co-presence is an important component of new processes, such as consensus conferences and citizens juries, and is thought to play a significant role in ensuring more inclusive, transparent and legitimate decision-making. In some important respects, these new deliberative spaces seek to replicate social relations in scientific and literary public spheres of the late 17<sup>th</sup> and early 18<sup>th</sup> centuries in England and France (Habermas, 1961). Drawing on this socio-cultural context, Shapin (1998) explores the validity of claiming scientific knowledge as universal knowledge, 'the view from nowhere'. In analysing how scientific knowledge travels the world so efficiently, Shapin argues that sociologists of science such as Latour (1987), who draw attention to the materials through which science re-engineers the world, have nevertheless missed the importance of the normative or ethical basis of social interaction in particular times and places, which also constitutes the truth claims of scientific practice. In the early modern period, scientists and their audiences had to trust one another:

A trust relationship is central to the very idea of empirical scientific knowledge. That relationship is inscribed in space: those who have not seen these things know them by trusting those who have, or by trusting those who have trusted those who have. (Shapin, 1998, p.6)

In reflecting on the clubs and other locations in which private citizens gathered to exercise their critical reason over scientific, literary and political questions of the day, Shapin (1998) suggests ideas and knowledge were given credence, were regarded as trustworthy and truthful, as a consequence of the supportive social relations, intimacies and code of courtesy which bound these coterie of gentlemen. The interesting question is whether, in equivalent contemporary spaces and processes, deliberative processes provide the 'practical solvents to scepticism'

(Shapin, 1998, p. 8), the crisis of trust and legitimacy dogging science, politics and policy-making?

A rich and diverse set of academic literatures engages with the substantive and normative dimensions of knowledge and trust. But there is little published work that draws on empirical research to analyse the discursive elements of face-to-face dialogue between specialists and citizens in a deliberative process. To begin to address this lacunae, we offer an interpretation of the encounters between four groups of citizens and specialists that took place as part of research on appraising options for closing the 'kidney gap' in the UK: the shortage of donor organs available for transplantation into patients suffering end-stage renal failure. The project developed an innovative decision-process called Deliberative Mapping, which asks citizens and specialists to assess the performance of different options to close the kidney gap against their own sets of criteria (see Davies et al. 2003). In this paper, we concentrate on one aspect of this complex process: how the citizens made sense of their face-to-face encounters with specialists at a one-day workshop. We introduce the range of spatial metaphors used by citizens for placing the different kinds of expertise encountered and explore how in deliberation these serve as rhetorical means through which citizens contest the knowledge claims of different expert views. These discourses perform a complex positioning of the different norms of epistemic co-operation both within different citizen groups and between citizens and specialists. This analysis thus suggests the different ways citizens experienced a sense of inclusion in the goal of achieving a reasonable outcome. In particular, we draw attention to a question of competence and inclusion that has received little attention in the literature thus far. Our empirical study reveals differences in the ways in which panels of women and men respond to the cognitive and normative dimensions of deliberation, which require further consideration.

## **Deliberation, Expertise and Identity**

Deliberative governance strategies, in many areas of public policy, are one response to the uncertainties posed by the introduction of new technologies into complex, plural and unequal societies (Munton, 2003; Joss and Belluci, 2002; Pellizzoni, 2003). The spectrum of deliberative approaches used in relation to health care issues includes national processes involving citizens

in technology appraisal (Einsiedel, 2002), processes involving local residents in setting health care priorities (Abelson et al. 2003a; Pickard 1998), through to shared decision-making in patient encounters in general practice (Gwyn & Elwyn, 1999). Central to all these deliberative processes is the reconstruction of the relationship between epistemic claims and democratic accountability through face-to-face deliberation (Bohman, 1999; 2000; Pellizzoni, 1999; 2001). A strong case is made for the power of communicative rationality as a basis for deliberative democracy in the work of Habermas (1984; 1987), suggesting the over-weening power of instrumental rationality may be confronted from alternative normative and substantive rationalities within deliberative processes.

Following Habermas, Bohman defines deliberation as 'joint social activity, embedded in the social action of dialogue – the give and take of reasons. But more than that, it is a joint co-operative form of social action' (2000, p.32). The theory of communicative rationality (Habermas, 1984, 1987; Bhattachary, 2001) is appropriate to the micro-level, i.e. to the linguistic and non-linguistic interactions that occur between individuals within the small groups and social spaces that are the primary setting for deliberative processes. It focuses on *communicative action*: i.e. what individuals do in illocutionary acts – how they perform their roles in face-to-face dialogue; and *communicative discourse* – the different knowledge and truth claims deployed in argumentation and the competencies required to articulate and test these claims. 'Speakers have no choice but to warrant their validity claims with the unspoken promise of being able to offer convincing argument to anyone who challenges the assertion' (Webler, 1995, p.44). The warrants supporting different epistemological and ethical claims are expected to withstand the test of public reasons: 'reasons that are generally convincing to everyone participating in the process of deliberation' (Bohman, 2000, p.5). This model of free and open debate is recognised as an ideal that ensures decisions are based on persuasion rather than coercion or strategic action, and gain in stability through discussion of all viewpoints. Deliberation, in this ideal sense, enables 'the construction of the most valid understanding and agreement possible given what is knowable at the time' (Webler, 1995, p.59).

Competence is one of the two fundamental principles for effective deliberation; the other is fairness in terms of the inclusion of as wide a range of voices as possible (Webler, 1995). Engagement with both stakeholders and citizens is critical to the democratic legitimacy and

practical efficacy of decisions that are likely to have broad impacts throughout society. Two main dimensions to wider participation are usually identified; a cognitive one, with reference to knowledge; and a normative one, with reference to different kinds of interests and concerns (Pellizzoni, 1999). Citizens and other stakeholders are widely attributed normative competency in their contributions to deliberative processes. They have a right to take part in public matters, and have their experiences and values taken seriously. Stakeholders, but not always citizens, are also attributed cognitive competency in these encounters; that is providing new knowledge on the issues at stake, and contributing to a better understanding of problems and better solutions. The knowledges citizens bring to bear are sometimes understood as socially contextual, of value to understanding local dimensions to public opinion, but accorded a different status to expert knowledge, being of insufficient generality to contribute to advancing epistemic understanding (Collins & Evans, 2002). For others, incorporating insights from both scientific and social rationalities is critical for addressing the range of both political and epistemic problems to which deliberative processes are addressed (Fischer, 1993). All deliberative processes thus raise questions about the distribution of expertise throughout society and its relation to the distribution of power.

In addressing this question, Bowman argues there are necessarily asymmetries of information in complex societies. However, he suggests 'there is no need to trade-off between democratic deliberation and expert effectiveness' (Bohman, 1999, p.592). He claims citizens play a critical role in making public judgements, not only about the content of expert knowledge, but also about their terms of cooperation. As he asserts:

While democracy can withstand an uneven distribution of information, other epistemic asymmetries are unacceptable. Deliberation about the consequences of specific ends or choices (the content of expert knowledge) is different from deliberation about social norms and epistemic procedures (the terms of co-operation with experts). One of the central differences is the type of public judgement that each entails; judgments about the *credibility* of expert authority on the one hand, and judgements about the *legitimacy* of existing norms of co-operation on the other (Bohman, 1999, p.592, original emphasis).

This latter, Bowman suggests is more important, and more difficult. It needs to be addressed by ensuring the cognitive practices of deliberative democracy are 'more egalitarian, cooperative and accountable' (Bohman, 1999, p.606).

Central to progressing this more symmetrical understanding of co-operative practice and epistemic procedure is the work of Brian Wynne on relations between risk, expertise and identity; notably through his work on disputes between government scientists and Cumbrian sheep farmers following Chernobyl. Crucial to understanding the precarious application of expert reasoning in this context is the uneasy interface between the standardised norms of scientific organization, and their potential erosion of local community identities, downplaying risks that were perceived as threats to social identities as well to the environment (Wynne, 1992; 1996). The study brings questions of social identity and inter-subjectivity to the fore in the understanding the co-operative relations between specialists and citizens.

In Wynne's study, citizen identities are bound into social relations of place, as local knowledges about animal husbandry, soil type and institutional contexts to radioactive expertise are ignored by national experts. In deliberative processes, especially those staged to address national health policy issues, communities are necessarily more heterogeneous and spatially dispersed, but there are still important social dimensions to citizen engagement with expertise, as people negotiate identities as care-givers, community representatives, or as citizens. Wynne's reflections on the relations between expertise and identity are relevant to both contexts: 'people informally, but incessantly problematise their own relationship with expertise of all kinds, as part of their negotiation of their own identities' (Wynne, 1996, p.50). Thus, not only do processes of standardisation through material artefacts or stabilisation through trustworthy expert co-operation play a role in the universalisation of science (Latour, 1987; Shapin, 1998), so do their articulation with the values and lifeworld experiences of diverse publics. Empirical accounts of the interface between citizen and specialist knowledges consistently indicate the agency citizens have in contesting the norms of specialist expertise (Clark & Murdoch, 1997; Irwin, 1995). To date, however, little attention has been paid to the inter-subjective encounters within deliberative spaces through which citizens and specialists renegotiate the legitimacy and credibility of expertise, and there is little specification of how processes of deliberation might be able stage dialogues without recreating epistemic asymmetries.

Many questions thus emerge about the forms of dialogue created within deliberative spaces. Both specialists and citizens are brought into a new forum in which to deliberate, which transforms the knowledge claims and identities of each. 'Translation problems go both ways: not only is it difficult to translate scientific knowledge so as to make it publicly accessible, it is also difficult to translate practical questions and public problems back into the framework of expert discourses' (Bohman, 1999, p.598). There are concerns about how to provide unbiased information to citizens within deliberation processes (Abelson et al. 2003b, p 242). There are widespread assumptions of an inevitable deferral to the experts – the so called 'authority effect' (Pellizzoni, 1999, p.109). There is the challenge of getting marginalised communities involved in deliberative processes that tend to privilege linguistic capacities (Webler et al. 1995). Moreover, there are manifold contingencies in relation to the different personalities and events within each process. As deliberative processes seek engagement between differently situated epistemic communities within increasingly plural societies, these challenges proliferate. As Pellizzoni summarises, 'a political trilemma is gaining importance: how to ensure, at the same time, scientific accuracy, policy effectiveness and political legitimacy' (Pellizzoni, 2003, p.205). This paper uses these theoretical debates to explore one deliberative process, recognising that deliberation is not only a normative ideal but also a messy, socially embedded encounter in which a complex series of judgements are constantly negotiated around the knowledges, legitimacy and identities of all individuals involved.

## **Deliberative Mapping: bringing citizens and specialists into joint co-operative activity**

The context for this deliberative encounter was research developing a new method of specialist and citizen technology appraisal called Deliberative Mapping (Davies et al. 2003)<sup>1</sup>. The aims of the DM project were to examine how far scientific, expert-driven risk assessment techniques could be combined with deliberative approaches to public engagement; developing and testing the process through a public engagement exercise on future options for addressing the 'kidney gap'. The DM process constructs a structural symmetry that acknowledges the normative and

cognitive competence of both citizens and specialists. All participants follow the same multi-criteria decision-making process, and at all stages – defining options, deriving criteria and scoring performance - the appraisal process captures different framing rationalities. The outputs of the DM process are both quantitative assessments – measuring the performance of each option against criteria; and qualitative analyses – exploring the public reasonings participants use to justify their judgements within deliberative spaces.

The pilot process centred on evaluation of six core options for addressing the shortfall of organs for transplantation. These included developing high technology options, such as xenotransplantation and stem-cell research; reorganising donor schemes, through opt-out schemes and encouraging living donation; as well as improving existing transplant services and preventative approaches<sup>2</sup>. Seventeen specialist stakeholders took part in the DM process<sup>3</sup>. The specialists worked through the multi-criteria decision-making process based on individual in-depth interviews and quantitative appraisal using multi-criteria appraisal software. Twelve of the specialists also attended the one-day joint workshop, held in June 2002, with the small groups of citizens who took part in the project.

The citizen strand of the DM process involved four citizen panels of 8-10 members, held in the London Borough of Camden between April and July 2002. Thirty-four citizens were recruited by stratified sampling using a questionnaire administered by a specialist recruitment agency. The key principle in constituting the panels was to create a supportive environment for members to undertake the challenging assessment tasks, so the four panels were differentiated by gender and socio-economic class<sup>4</sup>. Table 1 details the final composition of each panel.

**[Table 1 about here]**

The four panels met fortnightly, for six 1.5-hour evening meetings, each group working independently through the component parts of the option appraisal. Through discussions facilitated by the project team, the provision of written information and participation in the one-day joint workshop with specialists, each panel developed shared understandings of the options, and derived and weighted the criteria important in judging between them. At various points in the process, panellists recorded their judgements of how each option performed



against their chosen criteria on posters. Finally, at the end of the process they reflected on the final ranking of options, and on their experiences of the process. All discussions were transcribed and recorded for analysis by the team, allowing exploration of the discursive reasonings underpinning the final patterns of option performance.

The one-day workshop was the only part of the process in which all four citizen-panels and specialist stakeholders came together. The day sought to support different modes of deliberation between specialists and citizens, enable diverse kinds of associations, and offer the potential to challenge established epistemic inequalities. The workshop took place between the citizens' fourth and fifth meeting. Each citizen panel went equipped with their initial assessment of the options and distinct agendas for discussion with the specialists and other panellists. An open forum in the morning, structured around questions from each panel, was facilitated by the project team to allow different specialists to respond to the citizens' issues. An afternoon event had individual specialists positioned at tables around a large meeting room, open for informal and unfacilitated contact with any citizens who wished to talk to them.

Observational evidence from the day immediately revealed different forms of engagement between the specialists and groups of citizens, with a mixture of informal tuition, heated debate, and causal conversation. Later analysis of the quantitative shifts in option performance showed the workshop to have had a critical impact on many citizen judgements. Qualitative analysis of the workshop forum and panel discussions demonstrated the rich set of rhetorical devices used by citizens; firstly, to make judgements about the legitimacy of the expertise they encountered at the workshop; and secondly, to warrant these different kinds of expertise in relation to their panel's prior experiences. In both processes, a striking set of geographical metaphors discursively marginalise or foreground different kinds of specialist knowledge, opening up different spaces for the contribution of citizen competence in the assessment of kidney transplant options. Also evident was a difference in the way this interface between specialist and citizen expertise was negotiated within each panel. Drawing on the theoretical discussion above, and a grounded analysis of the different panel transcripts, these themes are explored below.

## Locating Specialist Expertise

Each citizen panel meeting after the workshop followed a similar pattern. Panel members had different experiences at the workshop, and they were keen to share their conversations with the various specialists. Members of the panel then negotiated their assessment of the credibility and legitimacy of these experts for informing their appraisal of the options. Much of this discussion involved an explicit attempt to locate the specialist expertise they had encountered. This positioning appeared to have two key dimensions. Firstly, assessment of the credibility of specialist knowledge in this context depended on the relationship suggested between expert authority and patient experiences. Secondly, judgement about the legitimacy of different specialists was contingent upon perceptions of their openness to collaboration with other forms of expertise – what Bohman calls their ‘norms of co-operation’. These inter-subjective and co-operative assessments are evident throughout all group discussions, though the implications vary for different kinds of specialist expertise.

All participants afforded most credibility and legitimacy to representatives of the medical profession at the workshop. Collectively described by citizens as the ‘doctors’, this group included a Department of Health officer with a hospital background, a senior member of a London teaching hospital, and a representative from the British Medical Association. The first two of these individuals fit the almost mythical status accorded to the kindly, middle-aged, white, male doctor (Lupton 1997), which certainly contributed to their positive reception. The citizens’ perception confirms other research that suggests medical practitioners as a whole still enjoy high social standing (Hodgetts & Chamberlain, 2003; Lupton, 1997; Lupton & McLean 1998).

However, there are further dimensions to the way citizens discussed the ‘doctors’ that locate their knowledge claims in quite specific ways. These medical specialists were especially valued for their communicative actions with citizens and their competence resulting from engagement with patients. At times, this relationship was expressed in a positive way, as indicative of genuine dialogue between specialist and citizen positions. At other points, it was expressed more as dependency; an active process of seeking a relation of trust, for to lack faith in doctors was to be vulnerable.

*Rea: I quite liked how they explained everything, especially that doctor from the university ...*

*Rosa: Very pleasant ...*

*Rea: I thought he was very good. (C2D panel)*

*Bianca: I do trust doctors and scientists. If I thought, 'my God, doctors and scientists are [not to be trusted]...' frankly, I'd live in fear. (BC1 panel)*

Citizens sought to place these doctors in positions of trust, and this credibility was reinforced at the workshop by the communicative actions of the medical specialists, who were observed listening attentively to the citizens, something especially noted by the women panellists. However, these medical specialists were also valued for the kinds of knowledge they had about improving health service delivery for all patients, a point particularly emphasised by the men's panels. The doctors' knowledge claims were warranted by the citizens through appreciation of their practical experiences at the 'coal face', even if now in administrative positions. This meant their competence to address organisational issues could be trusted. As Adam reflects:

*It was fascinating talking to [the Department of Health Officer] about the whole reorganisation issues. And he was, like, 'I think we've got to do what we do already, a lot better. It's all very well having these grand plans but you can spend money and it goes missing. It's not very productive.' And obviously he's been at the coal face for a long time and is very high up in his field. [...] And the chap from the Ministry or the woman from the BMA, who was obviously very professional, trying to take a global view. (BC1 panel)*

Thus the 'doctors' were felt to be competent in ways that mattered to patients, whilst also being collaborative in ways that could build forms of co-operation likely to be beneficial for improving organ transplantation. These judgements about the credibility of the knowledge of these medical professionals, as well as their legitimacy as spokespersons and decision-makers in the medical sphere, meant the information they provided was accorded high status. At the workshop, they performed this role in a way that met citizen expectations of the identities of

professional medical expertise, and resulted in further citizen support for health service options, such as better preventative approaches and for a greater role for hospital administrators in organ donor schemes.

Citizen views of the high technology options also changed, as these medical specialists were perceived by citizens to be cautious about the relative efficacy and timeliness of options like xenotransplantation and stem cells. Given the trust already invested in these professionals, their views were convincing. As Aimee summarises:

*It's being very crude, but there were the good guys and the bad guys. The good guys were saying something I felt was very similar [to what we have been saying], which is, 'these technologies are too far in the future'. The people we perceive as the caring types are generally the surgeons and the holistic people. And then the bad guys are the ones who are saying, 'no, we don't care what it takes really'. They're split into two camps. That's how I perceived it. (BC1 Panel)*

Whilst representatives of the medical profession were valued for the authority gained at the 'coal-face' or for their co-operation with other professionals, those individuals involved in developing new high technology options were conversely positioned as tunnel-visioned, isolated in different fields or locked away in the laboratory. As Elizabeth reflects:

*I think they all tried fairly sincerely to answer our questions, especially when we were going round. But I just think that whatever your question was, they would drag you into their terms of reference and answer it on their terms, because that's their field. (Panel BC1)*

The expertise of the two specialists representing the commercial development of high technology options was generally trusted in its own terms, they were not perceived to be deliberately disingenuous, but panellists challenged the loss of context such expertise entailed. In a rich set of discussions, the middle-class women's panel questioned the discounting inherent in the way these specialist communities of practice built research agendas and framed solutions to the organ gap. The perceived lack of a social context to their knowledge meant the

commercial biotechnology specialists struggled to address citizens' concerns about the wider acceptability of high technology options and their feasibility as solutions to current patient needs, challenging the credibility of their expertise. The scientific, financial and personal arenas to which these specialists were seen to be directed challenged their legitimacy as spokespersons for the delivering more effective forms of organ transplantation. As Anne elaborates:

*Because we're talking about a huge amount of research. We're talking about so much, so many different aspects. From actually looking at the human immune system; the pig immune system. And there are so many ways that money can be made from this. There are so many ways that people can lock themselves in a lab for 15 years, and try to get the right sort of kidney. [...] I feel it's one of those subjects where it would be so easy for people doing the research to get so wrapped up in the implications and the actual physicality of the research, that they could lose sight of the fact that they've actually got to produce results. (Panel BC1).*

The apparent lack of relational connection between the representatives of high technology options and patient needs led many in this panel to dismiss the high technology options completely. They were felt to be technical risky for patients, whilst also posing wider risks to society. These women considered both extremely serious and were not satisfied with the instrumental rationality used by biotechnology specialists in answering their concerns.

Similar discussions occurred in other panels, with a comparable set of spatial metaphors positioning high technology options as 'far off', 'distant', a 'side track' or even 'science-fiction'. However, in making judgements about these biotechnology specialists, the men's panels accorded relatively more importance to the co-operative, rather than the personal, dimensions to their expertise. In these panels, there was more confidence that regulation could provide the external scrutiny required to ensure accountability.

*Chatwood: Yeah, I spoke to [the pharmaceutical company, transplantation business manager]. He was all right. He was talking about health companies and that. He said some stuff that made me feel a little bit better about them.*

*JB: What was it?*

*Chatwood: He just said that they're regulated and that. I still think it was a little bit – the area's still a bit funny – but he did say some stuff. Maybe I learned a little bit more and I felt a bit better about the whole deal. (C2D Panel)*

Whilst there were mixed responses to the specialist in complementary medicine at the workshop, overall, his expertise was accorded least credibility and legitimacy by all citizens in the DM process. This is interesting, given the attention given to complementary therapy as an exemplar of loss of faith in science and decline in authority of professionals (Giddens, 1991, p. 140-141). Many citizens were sympathetic to a holistic vision of wellbeing and many agreed he was a highly personable individual. However, the credibility of his expertise was judged restricted by its dependence on the interpersonal relations between practitioner and patient, being effective only for those patients who already believed in it.

*Aimee: I actually quite liked the alternative medicine ...*

*Kate: He was a nice chap ...*

*Daniella: Not that I believe in it ...*

*Aimee: I believe in it very strongly. I found myself drawn to him and I could have sat there and listened to everything he'd just told me all over again. I just found him very, very pleasant.*

*Daniella: I didn't dislike him, I just wanted him to persuade me to change my mind and I sort of said that. And I didn't come away feeling any different to what I did ...*

*Kate: Maybe that's good that he's not pushing it on you. With that sort of therapy, if you don't believe in it, it ain't going to happen, because it's all to do with the mind anyway ... (BC1 panel)*

The wider legitimacy of the alternative practitioner was also limited, especially for the men's panels, who were concerned about the lack of regulatory oversight for alternative medicine, as well as this specialist's lack of collaborative engagement.

*Julian: I thought that he would appeal more to my sensibilities and I actually came away thinking, he sounded more like a charlatan. I was quite disappointed, because I've*

*always had an inclination towards the alternative. The thing that put me off him was I found he was a bit dismissive.*

*Clint: I think every specialist that we talked to, seemed to be of the opinion that complementary medicine or alternative medicine would work in tandem with what we regard as conventional medicine, whereas he was totally [dismissive] - 'Conventional medicine? Witchcraft!' There was no middle point; no 'I can work in tandem with these people'. Dismissed all of them and their snake oil preparations!*  
(BC1 panel)

For many citizens, this specialist failed to persuade. He was judged as lacking professional legitimacy due to the absence of regulatory oversight and his failure to engage with other specialist fields. Many citizens were unconvinced by his knowledge claims and refused the warrants proffered as to their efficacy. Yet a minority of citizens were sympathetic to his point of view. They could see their views reflected within his perspective, and they reasoned since they trusted his knowledge it was likely to be personally effective.

There is thus a complex link between knowledge, credibility, legitimacy and identity in all these encounters. The workshop provided more clues to citizens about whom to trust and whose knowledge was important; whilst new information influenced who should be listened to. Two gendered dimensions appear to pattern this complexity. For the men's panels, judgements about the most stable forms of knowledge were often based upon professional norms of co-operation between different kinds of expertise. For the women's panels, the credibility of the different forms of knowledge is weighted more by how they saw expertise relating to their own identities as members of the public and as potential patients or carers. Trust is essential to understanding the dynamics of these relationships, but it is not an independent variable that can be measured, or a simple cognitive process of judging inherent trustworthiness. Rather, it is based on the quality of communication between specialists and citizens, judged according to these two axes of engagement. In this process, citizens attempt to understand their own position in relation to different networks of expertise, and further contribute to building what they assess to be productive relations of knowledge for producing effective solutions to the organ gap. The different ways panellists were prepared to entrust experts – the value placed on personal relations by the women's panels, and the importance of co-operative expertise to

men's panels – has equivalents in their expectations of what dialogue with the specialists was for and the agency of their own knowledge claims in relation to different kinds of expertise.

## **Constructing Citizen Competencies**

Each citizen panel came to the joint workshop with a different group history (Burgess et al. 1988). This includes not only the diverse demographic characteristics of each group and their different backgrounds (see table 1), but also their experience of working together within groups prior to the workshop. Despite going through the same process, the groups functioned in different ways, and there was a divergence in the processes of deliberation and decision-making for each group. In the two men's groups, deliberation seemed to be understood more as an internal process; a process of listening to others' views and individually weighing evidence to come to an assessment of the relative merits of each option. For the two women's groups, the model of deliberation that evolved was different; a group process, with greater emphasis on sharing personal experiences to resolve a set of practical solutions to the organ gap. Cutting across this axis was a more or less deferential relationship to scientific information, with those of lower socio-economic status less able to challenge expertise directly (see also Lupton, 1997), but conversely more concerned about being patronised by experts or excluded from the process. It is important to note these are not proposed as essential differences dependent on gender or class<sup>5</sup>. Rather, in bringing these individuals together into four groups divided by gender and socio-economic status, in the context of making decisions about health issues, these group dynamics emerged. Differently constituted groups may have resulted in different group dynamics. Nevertheless, these dynamics are important, for they appear to have structured citizen's understanding of their own competencies in relation to organ transplantation, and their feelings of agency in relation to the expertise they encountered at the workshop.

Many in the two men's panels found their discussions with specialists similar to their group discussions. To deliberate was to refine personal values and knowledges, testing assumptions and weighing evidence to come up with better judgements through listening to the views of others. As Julian and Peter debate:



*Julian: Essentially everybody knows their own opinion, everyone has an opinion, the thing is whether you're able to have your opinion challenged.*

*Peter: With me it's the same thing. I had an opinion at the beginning; it wasn't a very well-educated opinion. [...] But then with the information to hand, building on my knowledge, and then working with everybody else's views, helped me shape my own opinion on it. I started questioning what I'd learned, and then questioning the group, to help me sharpen up a bit really. (BC1 panel)*

This emphasis on individual reasoning gives particular importance to listening to others and evaluating their viewpoints. Exchanges in both men's groups tended to be relatively formal, with little overlapping dialogue or personal reflection. Through these iterative dialogues, individuals deliberate towards what they see as a better representation of the relative merits of each option. This style of deliberation fitted easily into the format and discussions of the workshop. Both men's panels stressed how much they valued listening to specialists' views, and wanted more time with experts to learn from them. The difference between the two men's groups was the agency they felt in relation to the expertise encountered. When asked what he valued at the workshop, Peter responds he was keen to listen, but also to critically evaluate what he had heard.

*[I valued] listening to the different perspectives on all the various specialist subjects. Trying to remember what I thought of their particular role. Then when they spoke I sort of watered it down a little and opened up my thinking more, so that I could start questioning myself better. I wasn't necessarily agreeing with anything in my mind that they were saying, but it did help me to open up more thought for myself, to give myself more of a level playing field in my head with a bit more information on what I thought. (BC1 panel)*

The men in the C2D panel similarly stress the value of listening to specialists, though they express less agency in relation to questioning specialist views. Rather, they were concerned they had learnt so much that many of their questions were redundant, and they became uncertain about asking questions for fear of looking uninformed. As Chatwood reflects,

*When you're talking to experts, it's good to be comfortable with what you're talking about and you're knowing. We went there and they said certain things and it's like, 'oh dear', that's just wiped out half of my questions! So it would be nice to be more familiar, because then you could chat them a little bit more, be on the friendly side of them sort of thing. (C2D panel)*

Both men's panels found the exchanges at the workshop productive, for they were largely seeking information on the same epistemic terms as the specialists. Their norms of deliberation and forms of engagement with expertise afforded a privileged position to specialist knowledge, so long as it could withstand the scrutiny of an extended peer community, judging the legitimacy of each specialist through their ability to network with other forms of specialist expertise. This lent authority to those specialists who were seen to be collaborative and accountable, with wider public scrutiny helpful in ensuring this accountability. For these men, the formation of stable forms of knowledge about effective organ transplantation depended on promoting productive forms of co-operation between different expert positions to produce an effective mix of policy options.

Many women panellists, however, found the norms of engagement at the workshop very different from the forms of dialogue that had developed within the groups. Their group discussions had been very dynamic, with lively exchanges, visceral asides, and humorous anecdotes. Deliberation was viewed as an exchange between equally valid viewpoints, often derived from personal experiences, acknowledging the essential openness of the problem under discussion. Decisions emerged through sharing ideas, and testing out the practicalities of each option, drawing on the full range of their collective experiences. As Anne and Elizabeth explain, this form of dialogue could at times be emotional and combative. It nevertheless stressed the importance of everyone being listened to.

*Anne: We did have those conflicts when we talked, but they weren't conflicts because we all listened to each other and respected each other. 'Yes I can understand how you feel about that, but this is how I feel about it' [...] We respected what everyone's viewpoint was, because everyone's viewpoint is valid. That's one of the things about this; there are so many ways it can go.*

*Elizabeth: I felt we had the chance to sound off, like if we had a really violent gut reaction to something, we could let it out. But then you also have to think a bit more critically about it. (BC1 panel)*

In dialogue with specialists, many women felt unable to articulate their views in the way they wanted. Discussion following the workshop stressed the lack of genuine dialogue with specialists, rather than the new information gained. The women did acknowledge the difference between specialist and citizen knowledges, and many felt they gained from the specialist perspectives. However, what they sought from the workshop was an exchange of differently situated truths, in which their personal experiences were also given validity. There was frustration following the workshop about the time given to presenting specialist views, and the lack of publicity given to citizen perspectives.

*Shay: Yeah, it wasn't enough time because the professionals were doing a lot of talking initially, you know.*

*Georgia: by the time we got round to speak to them at the tables there were other people were speaking to them. You couldn't just butt in and ask your question, so you had to finish listening to what they were saying, and then it was too late.*

*Shay: We should have been at the front and asking the professionals, telling the professionals what we think and challenging them. (C2D panel)*

*Loretta: I think I found the workshop was the most frustrating part [...] I feel at these evenings there is the spirit of trying to learn new things, genuinely listening to other people. And my feeling still is – I don't think I'm just being cynical – a lot of it was paying lip service. I didn't feel it was as open as the sessions we had here. [...] I think the thing that came out last week is how much do they want to, and how much can they hear what the normal member of the public really thinks? (BC1 panel)*

The importance of being listened to, as opposed to listening to expert views, emerged from the women's feeling that, as citizens, they held cognitive competencies that specialists lacked. Rather than seeking to make judgements on the same epistemic basis as specialists, the women positioned citizen knowledges as central to all potential options for addressing the organ

gap. They placed high value on personal experiences for providing intelligence of the problems new forms of organ transplantation might entail. These were important to communicate to specialists, as specialist training was felt to result in a loss of ability to acknowledge a place for substantive, as well as instrumental rationality, in evaluating these options.

*Anne: It's an interesting point that perhaps professionals can be limited by the scope of their knowledge. This is their job, this is what they have to do, this is what they have to perform. And often there isn't the time or the scope for lateral thinking, and perhaps thinking outside the box and, 'what if we did it this way, what if we tried doing it that way?'*

*Bianca: The thing is when you're an expert in any field, you think so single-mindedly you forget what the real person, thinks about things ...*

*Kate: We're thinking more emotionally ... We're more objective aren't we?*

*Bianca: So if you had all these experts debating this, it wouldn't be good because they'd all be 'do this, do this'. At least we can say 'what about this...?' And they're like 'oh God, we forgot about that'. They're so down the road, they haven't got that fear anymore. But the public have. And they think 'Christ, that's what's gone wrong'.  
(BC1 Panel)*

The women challenged the epistemic authority of the experts, concerned that any specialist assessment of risks would be constructed within narrowly instrumental rationalities. They validated their own assessments of the social uncertainties of options through sharing individual and family experiences, drawing on prior interaction with the medical profession. At the workshop, they valued specialists who validated these personal knowledge claims, who reflected their relational understanding of medical expertise, and dialogue that was enacted through listening as well as speaking. This lent credibility to those medical professional who were empathetic communicators, pre-cautionary about high technology options, and were crucially seen as able to co-operate with a diversity of publics. The role of the wider public in delivering solutions to the organ gap was critical for their assessment of many options – public actions were seen as vital for delivering preventative measures and changing organ transplant systems, or conversely in determining the wider acceptability of the high technology options. For these women the formation of stable forms of knowledge about effective organ

transplantation is thus relational and recursive, dependent upon forms of expertise that can interface with diverse public experiences, knowledges and identities to build wider circles of trust.

## Conclusions

This paper has sought to demonstrate the complex ways in which different identities and rationalities are engaged in processes of deliberation, enact forms of dialogue that make judgements about various forms of expertise and redistribute competency amongst different groups of citizens. In the research outlined above, we suggest the way this occurred was patterned by gender. This is one aspect encountered in empirical practice, which we suggest requires further exploration, given the claims made for deliberative processes in delivering more inclusive, transparent and legitimate decision-making. The other aspect is the way the negotiation between different knowledges and rationalities was performed through an explicit positioning of knowledges that is both metaphoric, but also about the politics of opening up spaces for different kinds of association. The starting point for this paper, and much of this research, was debates about expertise, trust and communicative rationality. In concluding around gender and situated knowledges, we thus want to bring the work of Habermas and Shapin into a more empirical conversation with that of Haraway. We reflect on the implications of deliberative processes in seeking to enact conversations between what Haraway identifies as 'partial, locatable, critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology' (Haraway, 1991, p. 191).

Firstly, it is important to note the contribution of methodology to the statements of public meaning deliberative processes enact. The complex encounters outlined above are, in some ways, outcomes contingent on research process – particularly on the constitution of groups and the personalities of specialists in this process. We need to reflect critically on these contingencies and learn from them. Nevertheless, some contingencies tend repeatedly to result in more enduring inequalities of power, particularly around gender and rationality, in relation to accessing the spaces in which to engage in democratic practice, which processes have to take into account. In this process, most women felt they had benefited from single-gendered groups.

They talked positively about how this enabled them to develop a dialogue and competency around things that were important to them. Their definition of objectivity stresses the emotional, embodied and situational basis of their reasoning, echoing Haraway's reflections that 'objectivity turns out to be about particular and specific embodiment' (Haraway, 1991, p.190). They felt the situated and 'bodily' nature of their exchanges to be disqualified at the workshop, and concluded they would also have been inhibited in mixed groups. The men's panels were keener to take part in mixed-gendered groups. They talked with interest and surprise about the different views they encountered when talking to women at the workshop. Within their understanding the aims of deliberation, not to have the opportunity to hear and judge these views would have meant losing a valuable perspective on the issues.

Reflecting on the positioning of the women's knowledges helps explain why they matter. Current forms of organ transplantation are a fragile achievement, involving the articulation of numerous worlds, in which donors' families, intensive care nurses, hospital doctors, transplant surgeons, psychologists, health trusts, transport systems, tissue matching, and so forth, all play a key role. These associations give rise to numerous knowledges, practices and bodies, in which actors occupy different positions and have different stakes. The development of many new forms of organ transplantation are pursued through scientific practices and social imaginaries that create new kinds of biotechnological knowledge and new forms of hybrid bodies, but at times risk existing associations. The men's panels talked more about the knowledges and entities identified by experts, from hospital infrastructure to stem cell research, and assessed specialists' accounts in relation to one another, providing external public scrutiny. These citizens recognised the overlapping worlds of organ transplantation, and specialists able to achieve trusted positions mediating between these different contexts were most likely to be judged credible. The women's panels, however, spoke more about how new knowledges brought into being new kinds of relations and bodies they might have to inhabit personally. They felt they had expertise in the embodied perspectives that craft the current and future forms of organ transplantation – from negotiating consent with families, or assembling family lifestyles, to providing the bodily work underpinning stem cell research. Their talk is attuned to these relational elements, which literally situates their 'body' of knowledge, opening up uncertainties they felt the specialists failed to address. Evaluating whether new options for addressing the

organ gap might supplement or weaken existing forms of association requires both of these differently positioned dimensions to trust and knowledge.

In our research, these different knowledges appear to be gendered, though other axis may emerge in different cases. Nevertheless, feminist political thinking is valuable for thinking through the implications of this insight, in highlighting the extent to which definitions of objectivity often hide hegemonic relations or, as Habermas argues, instrumental rationality is able to colonise social, emotional and political worlds. Despite the commitment by deliberative process designers to ensuring that social and subjective rationalities have equal voice, and that the give and take of reasons occurs within the same framing, instrumental rationality and internalised deliberation can still be privileged in new deliberative spaces. In these circumstances, as Mouffe (1999, cited in Pellizzoni, 2003, p. 209) argues, a consensual approach to public deliberation should be replaced by an agonistic one – a confrontation between radically different (but reciprocally respectful) social positions and worldviews. There are framing issues here, about processes that pose different questions, appraise alternative options, and open up the processes of technology choice, which Deliberative Mapping tries to address (Stirling, 2004). There are methodological implications for researching processes and creating spaces that are sensitive to different styles of deliberation. There are also theoretical commitments to the reflexivity of knowledge, which demand we take the practices of our knowledge production seriously, through reflecting on the substantive effects of our forms of engagement and representation. In developing deliberative processes that seek to secure accountability and legitimacy in the assessment of new technologies, where and how we situate our own interventions in these fields is critical.

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**Table 1: Constitution of the four Citizens' Panels**

Individuals are identified using agreed pseudonyms; ethnic identity is self-attributed

BC1 women's panel	BC1 men's panel	C2D women's panel	C2D men's panel
<i>Aimee</i> , 34, white, self-employed	<i>Adam</i> , 35, white, civil servant	<i>Andrea</i> , 35, Cypriot, laboratory technician	<i>Chatwood</i> , 25-34, Black Caribbean, driver
<i>Anne</i> , 32, white, library manager	<i>Bob</i> , 35+, white, teacher	<i>Emily</i> , 34, white, full-time mother	<i>Chris</i> , 57, white, self-employed
<i>Bianca</i> , 43, Black Caribbean, salon manager	<i>David</i> , 33, white, sales manager	<i>Georgia</i> , 38, white, play group leader	<i>Clint</i> , 30, Asian, sound engineer
<i>Caron</i> , 46, mixed parentage, office manager	<i>Ethan</i> , 35+, white, interior designer	<i>Katelyn</i> , 21, Greek, full-time mother	<i>Edward</i> , 21, white, school assistant
<i>Daniella</i> , 35+, white, company director	<i>Julian</i> , 44, mixed parentage, photographer	<i>Mary</i> , 34, white, special needs assistant	<i>Fred</i> , 65, white, retired
<i>Elizabeth</i> , 18-24, white, project manager	<i>Leon</i> , 24, Black Caribbean, site manager	<i>Rea</i> , 55+, Black Caribbean, retired	<i>Ian</i> , 27, Israeli, fitness instructor
<i>Kate</i> , 31, white, IT consultant	<i>Peter</i> , 38, white Irish, store manager	<i>Rosa</i> , 43, Israeli, bakery owner	<i>Kamal</i> , 18-24, Arabic-Muslim, shop assistant
<i>Loretta</i> , 42, Middle-Eastern, bookshop manager	<i>Pierre</i> , 30, Black Caribbean, civil servant	<i>Sarah</i> , 21, Asian, shop assistant	<i>Rick</i> , 21, British Asian, trainee plumber
		<i>Shay</i> , 42, white, mother and beautician	
		<i>Susan</i> , 65, white, retired	

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## Footnotes

<sup>1</sup> The Deliberative Mapping (DM) process was developed by a group of researchers from University College London, the University of Sussex, and the Policy Studies Institute, supported by a grant from the Wellcome Trust's innovative methods in public consultation programme. The DM process integrates prior work on multi-criteria decision-making techniques (Stirling 1997; Stirling & Mayer 2000; 2001) and deliberative group approaches to public engagement (Burgess et al. 1998; Collins & Burgess 2000; Burgess, 2000; Bloomfield et al. 2001).

<sup>2</sup> Four 'prompted options' could also be appraised if participants wished: improved kidney machines, adult stem cells, rewarded giving and accepting death or palliative care. Specialist participants were invited to define unlimited further options.

<sup>3</sup> The specialists represented a wide variety of expertise and professional competencies and included the following: a manager for a medical equipment supplier; a professor of biomedical science from Sheffield University; a transplantation business manager for a pharmaceutical company; an ethnic health development manager from the NHS Regional Executive; a senior medical officer from the Department of Health; the director of an institute of complementary medicine; a medical ethicist from the British Medical Association; a professor of clinical sciences from Guy's Medical School; a health economist from NICE; a professor of applied philosophy from Lancaster University; the National Secretary of the Guild of Catholic Doctors; a manager of a xenotransplantation company; a professor of nephrology from University College Medical School; a kidney transplant patient from Middlesex Hospital; the Director of UK Transplant; a research director from Compassion in World Farming and a director of public health from an NHS primary care trust. The twelve men and five women were recruited through a process of stakeholder review and snowballing, overseen by a Project Advisory Committee.

<sup>4</sup> Previous experience of working with in-depth groups indicated the difficulty of incorporating diverse educational experiences in discussions of science and technology issues (Burgess, Harrison, & Filius 1998; Harrison, Burgess, & Filius 1996), so socio-economic status was used as a proxy to divide the groups on this basis. Existing literatures also suggest that single gendered panels may be preferable when dealing with sensitive medical issues (Wellcome Trust 1998). Furthermore, although still a poorly researched issue, there is evidence to suggest

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that gender plays an important role in accounting for differences in risk perception and assessment (Kerr, Cunningham-Burley, & Amos 1998). In recruiting for each panel, further criteria were drawn up to reflect the ethnic diversity within the Borough of Camden, where the proportion of people from non-white ethnic groups is currently 20%, with additional weight given to recruiting a mix of age groups and participants with and without children.

<sup>5</sup> The different ways in which the groups operated was acknowledged by panellists themselves following the workshop, as were the complex factors contributing to these differences.

*Michael: I must say from the forum, the women's groups seemed to be far more emotive than the men's groups. The men's groups did tend to be, I think, cold hard facts and the women's groups were far more, "how does this affect me?" I personally got that impression. The women's groups seemed to be far more involved almost on an intuitive level. 'This will have an effect on me therefore I will react to it'.*

*Simon: There are some guys who will be very rational about things and some women who would be more emotional about their decisions. But obviously there will be people who sit in the centre of that and who can relate, regardless of what circumstance you put them in. (BC1 panel)*