Working in health care could be one of the most satisfying jobs in the world – why doesn't it feel like that?

Paper from the

'Take it to the Limit' Learning Set

February 2009

Contents

Learning Set

In the summer of 2007 a dozen and a half individuals were invited to join a learning set. The aim of the set was to explore how health systems all over the developed world have become 'stuck' in ways of inter-acting that leave patients, professionals and policy makers profoundly dissatisfied.

We hoped that by explicitly looking outside the economic and managerial lenses that dominate current thinking we might understand more fully, more richly, three requisite components of a health system:

- the patient/client – clinician interaction
- decisions about the allocation of resources within a democracy
- the nature of professionalism.

The proposal was to apply the methodology developed by Valerie Iles and Julia Vaughan Smith specifically for this type of learning set. This had previously been used to good effect by the Beyond Partnership Learning Set, the publication from which can be obtained from www.reallylearning.com and www.anaptys.co.uk. The invitation in which this is described more fully can be found at Appendix 2. For more information on this method please contact Valerie or Julia.

The set was funded by a generous sponsorship offer from Stephen Morris and Dr Tim Van Zwanenberg.

In the event, a dozen people accepted the invitation, read a number of texts from a range of different strands of thinking, which they summarised and shared, and attended five day- long discussions:-

Sarah Hanchet	Dr Jamie Harrison	Dr Paul Hodgkin
Valerie Iles	Steven Morris	Peter Molyneux
Professor Pauline Ong	Alison Robertson	Dr Tim Van Zwanenberg
Julia Vaughan Smith	Jan Walmsley	

All of these people have a direct interest in the health system in that they work with it or within it; all also have a significant expertise in a relevant field of study.

The fact that so many people contributed so generously over a sustained period attests to our finding the process not only interesting and stimulating but also genuinely significant. We feel we have had a rich, emergent discussion, which we feel enthused to take further in forms that will be equally rich, emergent and diverse. This paper is one of them.

Without wishing to be trite or sentimental we feel we have made a good start, but only a start, on a journey which we would like to see resulting in a re-energising, re-ethicising, re-professionalising, re-conceptualising (that's all!) of health care.

We believe our contribution has been to bring together arguments that are normally explored in separate schools of thinking, in doing so to provide a convincing narrative that explains how people in the health care system feel and behave the way we do, and then to name what it is we want to be different.

If, when you have read our argument you would like to join us in exploring the further stages of the journey we warmly invite you to contact us.

We actively invite you to:
- let us know your reactions to what you have read here
- come and discuss it with us
- help us refine the arguments presented
- help us devise ways of raising awareness of some of the issues outlined.

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We will forward all correspondence to the members of the Learning Set.
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Section 1: Four Forces that lead to dissatisfaction

Part 1: The Four Forces

Across the NHS and beyond it in health care systems in many parts of the world a deep dissatisfaction and frustration has been noted on the part health care professionals (HCPs) including doctors, managers, organisational leaders and policy makers. At the same time unprecedented sums of money are being spent on health care, technology offers exciting advances, and evidence about what works enables resources to be targeted wisely. So why do HCPs not feel excited, able and effective?

This is so widespread a phenomenon that we believe it is systemic. That it is what happens to the health care system when it is subject to a small number of insistent forces that are prevailing today. We[1] suggest that these forces, if not recognised and examined, lead inevitably to good people (that is competent people of good intent behaving rationally) working together to deliver bad care (care that could be better[2] with no additional resource). What is more we believe that care will become worse and more expensive, and that HCPs will become increasingly unhappy, unless these forces are understood, so that our responses to them can be altered.

In the text below we outline these forces, demonstrate how these will tend to lead to an ever narrowing view of the nature of health care and consider how we could respond to them differently.

The four forces we highlight are:
- the digital revolution
- the audit culture
- the change in the nature of politics
- the anxiety inherent in the health care task.

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[1] This paper is the outcome of a learning set whose purpose, method and membership is described in the appendix.

[2] better as *experienced* by both patient and Health Care Professional.

Force one: The digital revolution leads to the audit culture

In retrospect it is surprising that something that has had such a profound impact on our lives has not been heralded with a greater fanfare or caused more discussion and dissension but the digital revolution has been just that – a revolution[3]. It has radically changed our ways of working, of socialising, of spending our leisure time, of holding people to account, of assessing performance, of evaluating evidence about what works, and much more, and we have found those changes beneficial. However it has also had consequences that we may see as not so positive.

Let us look, for example, in more detail at the way in which the digital revolution has opened up to external scrutiny many aspects of professional decision-making. The use of the computer to record, for example, client/clinician interactions and prescribed treatments has led to an ability to compare and monitor performance - of individuals, of teams, of organisations. Performance, that is, against particular observable and measurable criteria; for example, whether blood pressure has been checked, or whether statins have been given within n minutes of a patient presenting with symptoms of a heart attack.

Our ability to ascertain relative performance in this way, or to trace the path of a decision making process, has led to ever increasing calls for the setting of performance objectives, for targets, for transparency and for information about performance, so that this can inform choice, and also inform decisions about litigation. These calls have resulted in many countries in Freedom of Information Legislation.

In short, it has led to the development of what has been described by anthropologists as an Audit Culture. There are many positive results of this: unacceptable practice is identified and addressed, there has been a standardisation of care in which unacceptable variation in outcomes is much reduced and good practice is much more quickly shared. However not all kinds of information are amenable to being collected or

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[3] 'technical code and the manipulation of code, now *constitutes the ground of being of all major cultural systems* including health care systems' Hodgkin P 2007 [paper for the Learning Set]

codified and the digital revolution has, to date, succeeded in privileging only the data that can. The audit culture that it has spawned thus measures only some of the things we may deem important.

Force two: The establishment of an audit culture

It has been observed that '*audit is a relationship of power, between scrutiniser and observed*'[4] and this is certainly the way that it is experienced by many in health care.

Although this might make Health Care Professionals unhappy, whether it matters to society as a whole depends on the impact the audit culture has on the *activities* of its professionals, so let us consider some of its observable effects:

- *Reduction in creativity*: Performance is measured against objectives, and these objectives are required to be specified in advance. While this is often valuable there are many settings where the precise nature of the endeavour will not be known in advance, and there will be an element of emergent creativity in very many more. Thus even where these objectives are set by the people closest to the activity this very specification prevents any creativity or innovation being included when performance is monitored and published. Creativity and innovation are thus given lower priority than performing in accordance with the predefined agreements.

- *We only record activities than can be codified*: Only activities that *can* be measured *are* measured – so this privileges the use of explicit knowledge over tacit knowledge, and activity at the expense of thinking. It is these measurable 'facts' and activities that are then the basis of 'performance' as made public.[5]

- *We don't measure what is happening, only how we are managing what is happening (has happened)*: As a result of the above points there are difficulties in capturing the

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[4] Strathern M [2000] Audit Cultures Ch 2

[5] Thus, to put this another way: 'To be audited an organisation must actively transform itself into an auditable commodity. Audits do as much to construct definitions of quality and performance as to monitor them' ibid.

nature of first order activities (in health care, the interactions between professionals and patients)and thus it is not these that are monitored but second order processes that are supposed to ensure delivery of the essential activity (these include a range of governance activities and performance targets). The link between these second order activities and the full richness of first order activities is not evident. In other words the underpinning assumption that second order activities lead to first order ones, is not tested or sound. The case of Baby P may be an example of this.

- *Litigation increases and the lowest risk option is privileged*: As greater information becomes available (although not full information as we have seen, only that which is codified and stored) and as the understanding of the processes of professional decision-making and action become distorted (as consequences of the points made above), so litigation increases. This, in turn, changes decision priorities, so that the lowest risk option is often given automatic priority, even where there are sound arguments for others. After all, if it were not and the worst happened those who took the decision would be pilloried and sued.

- *Evidence Based Medicine rules the day – and it's epistemological foundations are unchallenged*: The easy availability of information has allowed the development of Evidence Based Medicine, seen as the answer to undue variation in the care offered to patients. As we have seen it has led to many improvements in care, but it has also led to a perceived hierarchy of evidence in which the RCT [Randomised Control Trial] trumps all others. This makes assumptions about the nature of medical knowledge that are left unsaid and untested. It leaves out of sight questions raised about different epistemologies in which, for example, considerations of complexity may be more valuable.   It has become, in some cases, a strait jacket rather than an aid.

- *Financial aspects become the key factor in clinical decision making*: Information about costs and activity can be linked much more easily than in the past, so the contribution that different parts of an organisation make to its overall 'performance' (i.e. financial performance) can be more readily seen. This then becomes the sole (or at least a major) criterion of organisational support for an activity.

- *Policy makers set targets: local leaders game the system*: It becomes tempting for policy makers to respond to public dissatisfaction with a service by setting targets for particular aspects of it. These targets relate to easily measurable aspects which do not encompass the whole. The ways in which they can be met can be divided into those with integrity and those without - the latter being easier and quicker than the former. So as performance is measured only against these targets and not against the service as a whole it is almost inevitable organisational leaders will 'game' the system and find ways of meeting the targets that do not improve the service.

- *Uncomfortable political decisions are moved sideways:* Accompanying the audit culture and influenced by the confidence it inspires in counting and calculation is the phenomenon that decisions that are essentially political have been 'taken out of the political arena and recast in the neutral language of science.' This is discussed in more detail later.

In health care this has led to a change in the nature of care, so that patients are no longer cared *about* (where the focus is on the quality of the interaction and on the outcomes and what these mean for the patient) but cared *for* (where the focus is on process not outcome, and often a limited concept of process: whether they are prescribed the correct treatment programme).

At the level of the health care practitioner dealing with a patient this results in:
- An agenda for the care they offer that is neither theirs nor the patient's but is imposed in response to governmental targets
- Pressure to deliver only care that is evidence based (i.e. that for which the RCT evidence is available) and to ignore other kinds of evidence (even the patient's own experience).
- The knowledge that taking a risk (even a well considered one) may lead to litigation and that if it does organisational support may not be forthcoming.
- Pressure from government, organisational managers and some patients to focus on particular care processes rather than on the patient.
- An uncomfortable clash between two views of professional identity: the autonomous practitioner making a valuable contribution to society through

interpretive application of their expertise versus a 'depersonalised unit of economic resource whose productivity and performance must be constantly measured and enhanced'[6].

- Even policy intentions that HCPs support become distorted, as they are passed through layers of bureaucracy, into lists of onerous activities that make little or no contribution to the policy aims.

We all acknowledge that it is important to use data and that there are positive aspects of an audit orientation. We cannot and do not wish to turn the clock back to some mythical 'golden age'. However professionals describe the negative aspects of the audit culture having a disempowering impact on them. When the audit culture is advocated and advanced by policy makers and managers, health care professionals can feel the approach is one sided. When they seek to have a debate about the relative importance of other factors that are not so amenable to being counted, they report feeling misunderstood, or judged to be 'off the pace'. As a result they feel not only left out, but actively disenfranchised.

In this situation, health care professionals stop engaging in constructive dialogue. This matters because one of the foundation stones of professionalism is the earned right to professional autonomy. That right is earned by being willing and able to talk about the roles of professionals in a changing society, and by remaining in touch with what patients[7] value in a relationship with a health care professional. Where dialogue and debate is absent, the audit culture becomes an accepted norm and health care professionals find themselves hostile to the now dominant norm without being able to articulate what it is they find so wrong about this. At the same time professionals are seen to be resisting change and a vicious circle ensues.

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[6] Strathern M Ed [2000] Audit Cultures Ch 2 The quote continues '*Thus audit technologies transform professional, collegial and personal identities'.*

[7] We are using the term patient throughout this document to encompass patients, clients and service users

Force three: A change in the nature of politics

Another consequence of the digital revolution has been a change in the nature of politics. This has accompanied (and has arguably been a cause of) the current dominance of liberal democracy - at least in the Western world.

Appealing to voters

As a result of mass communications politicians are elected on the basis of televisually appealing sound bites and on being able to justify their actions via the 'infotainment' industry.

Being able to defend decisions, in an era when details of the conversations that led to them can now be accessed through FOI Act procedures if not by phone video clips on YouTube, now requires that politicians say nothing of any consequence or that they hedge comments around with so many caveats as to be worthless.

Thus the kind of dialogue that could result in good policy is increasingly difficult. Policy is now about intentions, and about delivery, enforced through special delivery units set up to monitor performance against arbitrarily set targets. This performance can then be trumpeted in the media, whether or not it accords with the wishes or experiences of people on the ground.

A reduction in politicalness

The change in the nature of politics has another feature – the lack of a sense of politicalness. Democracy has historically been described as a process of 'becoming', in which people become more able (in terms of competence and character) to reconcile different interests within society. However, the role of reconciling competing interests has been relinquished by politicians (hence we talk about a reduction in politicalness) who now leave that to something termed 'the market'. They now see their role as ensuring the efficient administration of the market.

What does this mean in healthcare? We have seen that this means creating a market place where what is available and under what circumstances can be offered in a way that offers patients and clients more choice. Despite this seemingly benign construction,

it brings a very different orientation to how services are thought about and delivered. For example, markets privilege some at the expense of others and without competing interests being reconciled by politicians then, within health and social care at least, this reconciliation role is being forced upon people ill equipped for it – largely front line professionals. Thus the 'gate keeping' role of GPs has changed from a positive connotation describing an expert generalist guiding through a gate to a path best suited to you as an individual. Now it is one of rationing care to the individual, in the name of benefiting the collective.

This has led to many professionals trying to fulfil more than one role, and roles where the aims and decisions are different, within the same encounter with a patient. The anxiety induced in both professional and patient as a result has led to an expensive and unsatisfactory vicious circle in which (in arbitrary, not causal ,order):

- Professionals feel alienated from the patient in front of them and from patients in general
- Patients worry that the professional is operating as an agent of the state and not considering their welfare, and then express their own needs more forcefully as a result
- Patients feel alienated from professionals, for example feeling that they should not take up their precious appointments or time, and that they cannot get to see professionals when they want or need to.

In this context in which the basic transactions of care (convenience of access, equal access to effective care) were seen not to be working, especially when compared with the level of service offered by other industries, and the professions were not seeking to redress this themselves, there has been a pressure for improvement in those transactional aspects of care.[8]

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[8] In this situation both patients and professionals feel their relationship is with the State (and a rather malign and/or incompetent State) and lose a sense of having relations with a collective – society.

Administration of the market

Now that politics has become the rational administration of the market, so the emphasis, in public sector services as well as private, is on choice and competition. (Interestingly the market itself is not required to compete as a model.)

There has been resistance to the introduction of market principles within public services and much of this resistance has been dismissed as self interested or ill informed. However as has been noted in Strathern [2000] *'For anthropologists resistance to reforms is not to do with complacency, backwardness, laziness, inefficiency etc. Opposition is encapsulated in a whole symbolic complex through which people can feel their realities traduced.'* [9]

To understand why the predominance of market concepts may be seen as negating something many professionals and patients see as vitally important we need to introduce some concepts from the literature on other kinds of economy.

It has been assumed by many in the Western world that the market economy is the only kind, but if we look across history and geography we find others. The gift economy is one that has received much consideration.

Non-market economies

In the societies that were or are essentially gift economies, items surplus to requirements are not traded but given away. Furthermore the gifts move; they are given on to others, and are not treated as exclusively the property of the person to whom they have been given. In a gift economy a person or family acquires status by being able to give away more than others. Reputation is gained by the act of giving. Reputation is lost by acts of meanness and personal enrichment.

There are other differences. In a market economy items have *value* – this value can be compared with the value (often a monetary value) of other items so that a choice can be

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[9] McDonald. M, Chapter 4, Audit Cultures Ed Strathern M [2000]

made between items of different attributes but similar value. Another way of saying this is that people choose between competing offerings.

In a gift economy some things have *worth*. Worth cannot be compared with a dissimilar attribute; it can only be compared with itself. In a health care context we might put life into this category for example. Trying to put a *value* on this is fraught with problems and will always feel uncomfortable, rightly so.

Similarly in the market economy we care about what it is that people do, we call this *work*. In a gift economy for at least part of the time people are engaged in *labour* that requires that they give something of *themselves*, so that the kind of person they are is important as well as what it is they do. Work is clearly easier to track and to measure objectively than is labour.

With the dominance of the market throughout Western democracies the organisation of all public services especially in the Anglo-Saxon world has increasingly become the province of the economist and the manager. This is a new phenomenon. Previously management teams in health care included numbers of historians and philosophers, and others from the liberal arts and humanities, as well as members of the professions themselves. As a result the lens through which health care leaders see the service is now that of the economist working within an audit culture. This is a point worth emphasising: the very way that healthcare leaders conceive of health care has changed. The language may stay the same but it means something different. [10]

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[10] For example 'personal care' has four distinct meanings, of which the first two fall within the transactional and the latter two the relational:
Care that meets the preferences of the patient as far as timings and locations of appointments are concerned.
Care that meets needs diagnosed with accuracy for an individual using genetic and other data.
Care that forms part of an ongoing relationship with the patient and perhaps their family.
Care in which someone gives a hoot about what the experience is and the outcomes are.

When the economic managerialist paradigm was introduced to the NHS in the 1980s it seemed valuable because it added a dimension that had previously been missing. Indeed without it healthcare seemed out of kilter with the rest of the world of work. But there *was* resistance, some clinicians refused to 'play the numbers game' as they 'cared for people and not for statistics'.

And as the economic /managerialist paradigm has become dominant, these feelings of frustration on the part of professionals (as well, admittedly, as those of self interest) have not gone away. Some have been targeted at private sector ownership within the NHS when in reality the ownership matters little. It is the loss of the gift economy that does. The loss of the element of gift means that the nature of care changes profoundly[11].

Force four: The role of anxiety

Anxiety is an emotion we, consciously or subconsciously, try to avoid. It is an important emotion to which we can respond constructively by taking care about (or within) the situation that prompted it. When we bring it into conscious awareness this is what we will often try to do. However, we often respond to it subconsciously, finding ways of avoiding it that may or not be the most constructive available to us.

Healthcare necessarily involves dealing with situations that are difficult, emotional and/or unpleasant. For example, when dealing with death, pain, grief, mess, or decisions about allocating scarce resources. All of these will tend to make health care professionals anxious and they (we) will construct defences against this anxiety.

Healthy responses to this professional anxiety involve bringing it into awareness, reflecting on the source of it, seeking support where we need it, thinking carefully through the needs and wishes of the other, reminding ourselves of our sense of purpose.

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[11] The loss of the gift economy has occurred to as great an extent in public sector as private sector organisations. Many dedicated HCPs leave the NHS to work in the private sector because they want to offer better care than they are able to do within the NHS.

This bringing together of our own concerns with that of the person who has prompted our anxiety is the key. We then have a free choice about how to respond and that response may be a decision to embark on a course of 'aware altruism', or of meaningful dialogue with the other the outcome of which cannot be anticipated, or seeking support from someone more skilled in a particular procedure.

Unhealthy defences include blaming, rushing into action that may not be the most valuable (looking instantly for a suitable protocol for care before really understanding the issues, concerns and expectations of the patient for example), looking for something that needs doing that can take us away from the source of the anxiety (stock takes and other forms of counting such as looking at the patient's chart or returning to our computer screen where we are likely to find deadlines for reports etc, imposed by other people to which we can feel we must respond and which we can then blame).

As patients too we are anxious. At the heart of the anxiety is the fear of our own mortality. And in a market-driven, consumerist 'must /can have it all' society, characterised by broken or dispersed family structures and a reducing sense of community and higher social mobility, we have fewer societal opportunities for containing our anxiety. Patients facing these issues, often turn to health care professionals for solace, guidance, support: a relationship. If patients then run up against the same market-driven transactional culture within health care that prevails in wider society and feel 'held at arms length' by the professionals in whom we wish to place our trust their anxiety increases- it is not 'contained'.

For health care professionals, the core anxiety is the unpredictable nature of health, disease and illness, and so we often erect defences to try and make it predictable (and in the process to keep it at a safe distance).

Where professionals are also 'gate keepers' as GPs are for example, there is another cause of anxiety. All health care professionals are concerned with 'clinical effectiveness' however this has become bound up with 'value for money' – an economic concept -on the grounds that wasted resource leads to less care. By asking healthcare professionals to ensure clinical effectiveness (and thereby ensure money is spent wisely) the market

orientated approach has been reframed as more palatable. However the nature of the gate keeping role can be a cause of greatly enhanced anxiety, for both professional and patient. Knowing that 'my case' is being compared with someone else's by a health care professional who is expected to help balance the books, can mean that patients ask themselves "does he or she care about me?". This can lead patients to feel a deep sense of anxiety that they may be abandoned by the care giver in who they trust, or it might result in them abandoning the care-giver, and responding to them with less trust; turning perhaps to the internet or complementary therapist as an alternative health care advisor. Again a vicious circle is developed- in which a sense of healing and trust is lost.

Policy makers, too, experience anxiety, and again at the core of this is unpredictability connected to the lack of definitive link between resources allocated, policies prescribed and the outcomes achieved; and to the lack of direct link between any of this and electoral success.

One particular result of this is a phenomenon we have observed earlier, that of recasting political decisions in the neutral language of science. Political decisions involve reconciling different interests, often interests that cannot be reconciled to the satisfaction of all. What a relief it is to be able to shed that responsibility and hand it over to an impartial, objective, scientific body such as NICE.

However, as with all short cuts (where we try to reduce time or anxiety) there is no such thing: the fundamental tension does not go away, it simply reappears in a different form. Here the political decisions are moved into the ways that QALYs are derived and the weightings given within the calculations – which, interestingly, NICE is coy about providing.

It is possible to see the development of the audit culture and of the decrease in politicalness as unhealthy responses to anxiety. And as part of another vicious circle in which they themselves then prompt further anxiety which is responded to either healthily or unhealthily.

If anxiety is so pervasive then we would do well to develop within our HCPs and our organisational leaders and policy makers the ability to respond healthily towards it, and yet we do not. The processes of education and training for most HCPs concentrate almost entirely on knowledge and skills and on observable, objectively measurable competences. It tends to focus on what people *do,* not on the kind of people they can *become*.

This competency based approach to training is relatively new (the last 20 years or so) so there are still people within the system who were taught in different ways. When they have retired and the system is staffed entirely by people trained within a framework of only 'objective' competence based assessments and no experience of developing skills in subjective judgement we can expect the nature of care to shift still further in that direction.

Part 2: The Impact of these four forces on the nature of healthcare

The combined and integrated pressure exerted by these four forces is experienced by HCPs, organisational leaders, and policy makers. How they have responded to them has had, and continues to have, profound implications for the nature of the care and how it is commissioned, organised and provided

The main impact has been on the nature of relationships at all levels. The worst impact is the withdrawal of compassion and care in within the healthcare system. This results in stories of patients being abandoned by care staff and in stories of staff being or feeling bullied by their managers. To the patient this can feel like no one taking responsibility, not carrying responsibility for the quality of the care provided.

We had many examples to share about relationships, including:

I've come to see you about two things doctor' explained the patient as she sat down. 'Well there's only time to deal with one today, you can make another appointment to talk about the other, which do you think is the more important?' responded the GP.

Two cancer patients sitting in the chemotherapy centre at their local hospital were chatting to each other and bemoaning the discomfort of the chairs and the length of the wait. 'Oh you are quite wrong' a passing nurse told them. 'Our last survey showed that we offer an excellent service'.

An elderly woman has been in a ward in an acute Trust for 7 days; during that time she has had no rehabilitation after the fall that took her into A & E, she hasn't been moved out of bed and now has a deep and painful pressure sore on her heel. She was catheterised because there was not enough staff on to ensure she could be taken to the toilet.

An elderly man, frightened and anxious by his wife of 48 years being in A & E following a massive stroke standing, panicking in the car park as he can't find the change for the parking meter.

Examples such as these are common place in conversations at coffee breaks or at dinner parties, and people who are not health care professionals respond with irritation, amusement or even fury.

Give them to HCPs, including managers, however and their response is explanation: that GPs have only 10 minute appointments, or that control of infection staff will have insisted on no upholstery on seats in an area with patients who are immunologically compromised or that there are staff shortages or that the hospital needs the income from the car parking.

But we can't pretend that this is good care. It is not the kind of care any of us wants to receive. And we can assume that the vast majority of the people offering it are good people (people with positive intentions, who behave rationally and are competent at what they do).

This lack of ability to offer good care, and of the ability to influence the decisions taken by others that affect the quality of care, is surely a major cause of dissatisfaction among professionals, patients and many health service managers.

We identified two different paradigms for the interactions between players within the healthcare system; that is between professionals and patients, between professionals and managers and between organisations. The transactional is dominated by, and limited to, the economic and managerial. The relational also encompasses all the other schools of thinking sociology, anthropology, moral and political philosophy as well as the economic.

Transactional activity: healthcare in the market economy.

An audit culture encourages emphasis on process not outcome, and on targets rather than on the core interaction between people. The transparency it lauds leads to increased litigation, which in turn privileges the reduction of risk over other factors when decisions are made. It increases the use of evidence based medicine, leading to a practice of 'one best way' thinking, which ignores the nature of evidence and more appropriate ways of using it, and reduces both patient and health care professional to units of production or walkers through an algorithm.

One particular point worth emphasising is the changed attitude to risk. Not only does it become the predominant factor in any decision, risk is now something to be assessed and managed – rather than taken. But all the problems of measurement (see pages 7 – 9) apply here too. So the elements of risk that are not quantifiable are not given the weighting they deserve. A focus on risk results from and exacerbates the impact of all four of the forces. It has been described as 'the acid bath that corrodes trust'[12].

Relational activity: healthcare with elements of the gift economy

The relational approach can be envisaged through the metaphor of dancing; being active, alive, creative, present, and taking some risk. We envisaged this as important at every level in the system – between patient and professional, between professional and their organisation, at organisational level[13] and between organisations and policy makers.

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[12] Beck B The Risk Society

[13] Here it will require a change from their current behaviours to:- the making of decisions about what matters, about what risks to take; and the preparedness to accept they might get it wrong.

So at all levels dancing will involve uncertainty and hence require courage. And because people will get this wrong at times there is a need for some litigation-free space in which people can be themselves, feel whole again, interact as whole people, then go back thoughtfully into the more transactional world again.

In Table 1 (page 22), we have applied these paradigms to the relationship between healthcare professionals and patients. We could equally have defined them in relation to the relationship between healthcare professionals and managers.
 On the left is what we may call transactional care - that promoted within the audit culture, where the interactions that constitute the care are transactions; and transactions within a market. On the right are aspects of care that include an element of gift, that include elements that are not as readily amenable to audit, that require some meaning in the encounter. The right hand column indicates, too, a different role for politicians and organisational leaders than that of merely administering a market.
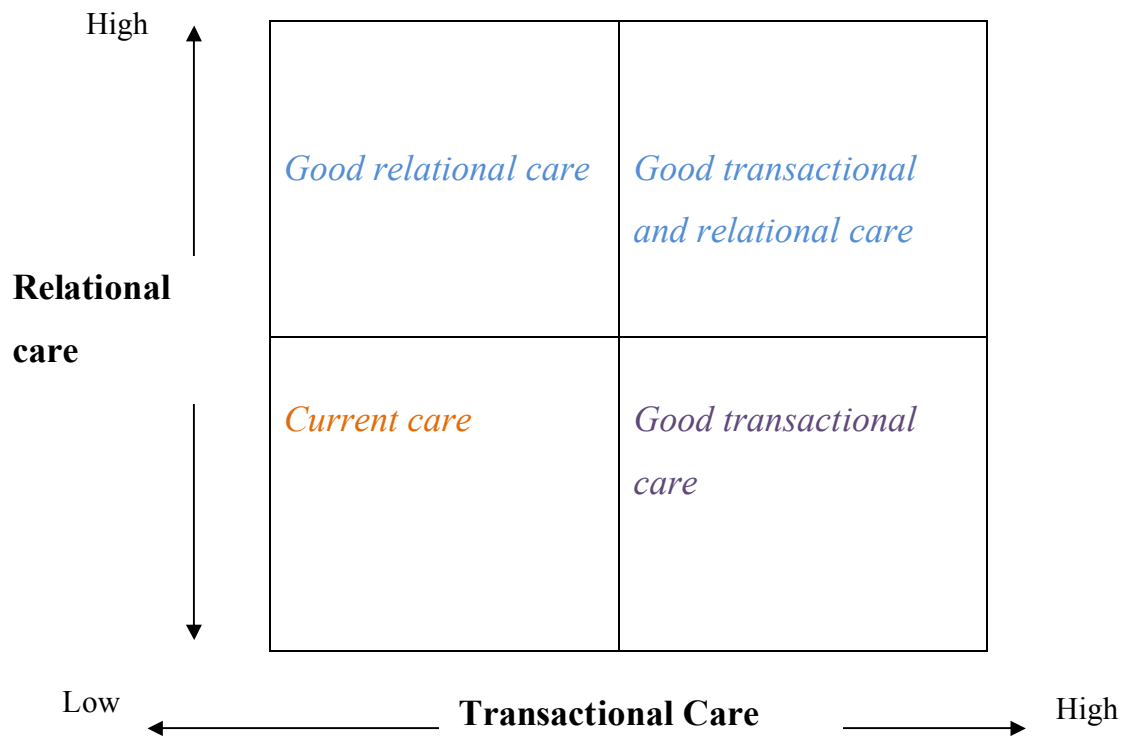
Transactional care	Relational care
Health care in the market economy – patient as consumer, professional as provider	*Health care with elements of the gift economy – patient and professional are in covenantal relationship*
Patient is cared for	Patient is cared about
Professionals are seen as givers (or suppliers) of services	Professionals recognise that in their encounters with patients they give *and* receive
Focus on calculation and counting – this can be seen as objective	Focus on thoughtful, purposeful judgement – this is necessarily subjective
Predetermined protocols	Emergent creativity
Discourse and hyperactivity	Wisdom and silence
Explicit knowledge	Tacit knowledge
Reflection on facts and figures	Reflection on feelings and ethics
Focus on efficiency and effectiveness	Focus on the quality of the moment
Dealing with the presenting problem	Keeping in mind the meaning of the encounter –for both parties
Competence is what is called for on the part of the professional	The essence of the professional is also called upon
Individuals have a relationship with the state and with the market	Individuals have a relationship with the community and with wider society
Good policy ideas MUST degenerate as they are translated at every level of the system into a series of measurable, performance manageable actions and objectives. The focus here is on being able to demonstrate the policy has been implemented.	Policy ideas can stay rich and be added to creatively, so that solutions are responsive, humane, practical, flexible, and adaptable. Here the focus is on solving problems.

Relational care is **not** the opposite of transactional. Many aspects of transactional care are **necessary**, and in some cases will be sufficient as long as it is delivered well. However in many cases the relational is also needed and we must ensure that the drive for improvements in transactional care does not have an adverse impact on the relational. This is especially important as an undue focus on the transactional at the expense of the relational, together with uncontained anxiety, can encourage a partial or total withdrawal of care and compassion, which results in care that is neither of these forms but simply bad care.

To be fair there has never been pressure for a reduction in the relational, and **it is possible to offer both**. However within the audit culture there has been no measurement and rewarding of it, and unfortunately many of the professions have responded sulkily to the pressures for improvement in transactional care when they could instead have articulated a call for the relational. They could have insisted on both/and rather than either/or.

This is such an important point it is worth saying again: it is not that well delivered transactional care is wrong. There are times and circumstances when it is, on its own, completely appropriate. An ailment that is causing only physical distress, which can be treated completely and straightforwardly and in a reasonable time frame, would be a good candidate. Where the patient is working and/or has family responsibilities, wants a ready resolution of the problem and has good support at home, then this may be all that they need. And it will, in all cases be wholly necessary, so we must ensure effective transactional care whether or not we want to offer relational care in addition.

However where the ailment is life threatening, or causes some long-term loss of function, or is causing the patient to worry or is a mental illness, then the relational aspects are vital. They will themselves have a impact on the outcome. They will have an impact too, on both the patient and the professional. It is from this that HCPs have traditionally derived so much satisfaction.

	Good relational care	Good transactional and relational care
	Current care	Good transactional care

Relational care — High / Low (vertical axis)

Transactional Care — Low / High (horizontal axis)

As we have said above the relational approach to care can be envisaged through the metaphor of dancing: being active, alive, creative, present, taking some risk – but not too much – holding the other. It will involve some uncertainty and hence requires a degree of courage.

Contrast this dance with our current focus at all levels on transactions, contracts and price, on VFM [Value for Money] and on professionals and organisations as '*depersonalised units of production whose performance must be constantly measured and enhanced*', and we could ask whether this is marching rather than dancing.

Why does this matter?

It may not. If we consider these observations and decide that this shift towards to the transactional is what we want then we have to take very little action. However at the moment there is little *awareness* that this is the direction we are taking, or what forces are pushing in that direction. This leaves us unable to take that as a conscious decision. We believe that once the decision is brought into awareness there will be a reaction against the current direction of travel, but our role is to encourage that necessary first step: awareness[14].

As we decide whether this matters or not it may be helpful to consider how it is that society handles indeterminacy: situations that are too complex for a clear, correct course of action to be determined.

To be clear what we mean by this let us distinguish between four 'domains of knowing'[15]: the known, knowable, complex and chaotic.

In the *known* there are clear cause and effect relationships and the most useful ways of finding out what to do is research using Randomised Controlled Trials.

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[14] As anthropologist Shore C and Wright S [Chapter 2 Audit Cultures Ed Strathern [2000]] say of the audit culture in higher education:

There are four ways in which anthropologists can usefully respond:

- raise critical awareness of the nature of the audit explosion. Power works most effectively when disguised, when discourses of the governing elites have become so naturalised that they go unchallenged and cease to be recognised as political or ideological
- challenge the language. Re-appropriate key concepts e.g. quality and accountability and professionalism to our meanings and not those of accountants and managers
- scrutinise effectiveness. Who is assessing whether audit procedures are actually helping the sector achieve the aim of high quality mass higher education? Audit systems themselves are rarely subject to the pseudo market forces they require of others.

Understand the cultural logic of audit. As driven by a pervasive belief in the need of the discipline it provides. One way of viewing this is as a response to the uncertainties of the 'risk society' (Beck) a distinctive response to the need to process risk, to provide visions of control and transparency which satisfy the self image of mangers, regulators and politicians.

[15] Mark A Snowden D 2006 Researching Practice or practising research: innovating methods in health care – the contribution of Cynefin in Innovations in Health Care.

In the *knowable* too cause and effect relationships do exist, but they are not as clear, and may only be known to a few people, whom we call experts. Here the ways of knowing what to do are different and involve, experiment, fact-finding, and scenario planning. Leadership tends to be oligarchic, held by the small number of informed individuals who understand the challenges, although their suitability and expertise must constantly be open to re-appraisal and key assumptions must be kept open and discussible.

In *complex* settings, there are discernable patterns, which help us understand problems, and there are cause and effect relationships. But the number of agents, their interaction, and the frequency, richness and unpredictability of their interactions defy categorisation. Most importantly, here patterns can be perceived but not predicted.
The research methods of the knowable and known domains do not work here and can be actively misleading – suggesting causality where there is none, based on a coherence that is spurious or can be apparent only in retrospect.   The methods of research needed here are innovative, unconventional and not yet fully accepted, narrative based research being an example. The most effective leadership style here is emergent: a combination of administrative (in which you provide a firm foundation of effective administrative procedures and safe governance), enabling and adaptive styles. Behaving as though we are in the domain of the known or knowable when we are not simply adds tension and does not contribute to the development of understanding of the situation or ways forward.

In chaotic settings there are no perceivable cause and effect relationships. The system is too turbulent, and the response time to investigate is not available. An example in medicine might be the accident and emergency specialist dealing with a major incident with many people with critical injuries.
The leadership style here involves the readiness to act quickly and decisively, to have a hierarchy where such decision can be relayed quickly and acted upon without question. The aim is to authority to "control" the space, trying to move it into the knowable or known, or in some cases into the complex.

In situations that we can think of as 'known' or 'knowable' then protocols and seeking the advice of experts are good ways of proceeding. However in complex or chaotic settings these cannot work and we rely instead on the experience, knowledge and 'practical wisdom'[16] of professionals.

So practical wisdom on the part of professionals (of all kinds) is important to society as a whole[17]. But if we focus too heavily on the transactional at the expense of the relational we prevent our young professionals from developing this.

Wisdom is the product of experience. One becomes wise by confronting difficult and ambiguous situations, using one's judgement to decide what to do, doing it, and getting feedback. One becomes a wise practitioner by practising being wise.[18] If we teach our young professionals in ways that do not give them the opportunity to practise being wise then we not only lose the aspects of care we have described in the relational column of our chart, but we rob society of its ability to handle situations that are not known or knowable. Situations that are complex or chaotic, indeterminate.

Somehow our approach to risk has reduced our concern about this. The notion that all risks can be quantified seems to give us the illusion that we can get rid of them. We have seen the result of this thinking in one sphere – the financial markets- we now need to become aware of other arenas where we are implicitly making this assumption – and we suggest health care, social care, education, policing and many other arenas are in the frame.

This may be a distinctively post enlightenment western approach: the dominance of mythos over logos[19], or science and logic over mystery and meaning. One effect of this is that instead of training our minds to be tolerant and generous and to accept

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[16] Aristotle argued that we all have need of a master (or executive) virtue that enables us to decide how much of what other virtues, knowledge etc we need to bring to bear in different situations. He called this 'phronesis' or practical wisdom.

[17] Prof A Cribb personal communication

[18] Barry Schwartz and Kenneth Sharpe in 2005 in the Journal of Happiness Studies

[19] Karen Armstrong , cited in Vernon M, After Atheism.

uncertainty and indeterminacy we assume our minds are beyond our control and value instead judgement and discrimination.[20] As we do this we forget to value anxiety and do not teach people how to respond with respectful uncertainty to situations in which the way forward is not clear.

Worse, we review such situations later, find a pathway that looks like cause and effect but is apparent only in retrospect (and may not actually be a causal connection, only look like it)[21], and declare the person who failed to notice that path when in the middle of this messy unclear situation at fault.

How can professionals develop their ability to become wise in these contexts? And how will society deal with complex, indeterminate situations when we have lost this wisdom?

If we saw anxiety as valuable and uncertainty as inevitable we would respond differently. If we allowed more emphasis on 'inner knowing', an Eastern concept borne out by current neuroscience, we would realise that courageous soul-searching for the best response to an unclear situation (which is surely what we want) is dangerously jeopardised by the 'spurious retrospective coherence' of those whose mindset is solely in the domain of the known.

This suggests that when we are patients we need to have two different kinds of mind, one that is appropriately judgemental about the transactions of care when these are not effected well, and one that includes tolerance and acceptance when care options are not straightforward and involve risk and trust. If we encourage patients only to be judgemental then again we will prevent professionals from learning and exercising the wisdom we need of them.

And if we are to encourage this then we need to help society understand the inevitability of uncertainty and risk and understand that people who work with these will inevitably, on occasions, make decisions that do not have successful outcomes.

So when we ask 'does this matter?' the 'this' we are referring to is a large one!

[20] Epstein M, Going to pieces without falling apart

[21] This is known as spurious retrospective coherence

Section 2: How could we respond differently to the four forces?

Part 1: A New Professionalism and a New Managerialism

When we have considered it we may decide that we need to retain a concern about delivering transactional care well, and at that same time that we also need to be able to offer and access care that is relational, and if we do decide this then we will need to respond differently to the forces we have outlined here.

There is no question of going back to previous models of professionalism or policy making. Not only were there problems with those models then, the digital revolution and its impact on so many aspects of society ensures that there is no way they could be supported now.

In other words we will need to have a debate about a new form of professionalism, about a new way of managing health care organisations, and about new ways of reaching political decisions about healthcare. And all of these new ways of behaving need to respond constructively to the four forces: digital revolution, audit culture, change in the nature of politics and anxiety inherent in healthcare.

Our argument is not that there have been some groups of people who have behaved well while others have behaved badly. It is that every group involved in health care has behaved, mostly rationally and with good intent, responding to forces around them, in ways that have not allowed a system to be created within which care can be good. Professions, policy makers, managers and organisational leaders (arguably patients and population too – and certainly their opinion leaders, the media) have all contributed to the increasing impoverishment of the care experience.

So if we are to foster better care (by which we mean care that is more effective, lower cost and experienced as more fulfilling and humane by both patients and professionals) we will need to develop new models of professionalism, of managerialism and organisational leadership, of policy making, of what it means to be a member of society, of consumerism, and of journalism. So we are talking about developing new models that recognise the changes there have been in society, and in technology, and not about a

return to any previous model of care or of professionalism. In short a new compact between healthcare professions and the whole of society including organisational leaders, managers and policy makers.

These new models and this new compact will need to be developed through creative dialogue between these groups and wider society, and the ideas that follow are initial thoughts rather than a prescription.

We suggest that this will be assisted by a refreshment of understanding about what it means to care for health. We liked the following definition: '*Health care involves acts of work and or courage with the aim of enabling the patient (client)'s autonomy and personal growth*[22]'. This is rather different from some of the current implicit assumptions about the nature of care. As we think more clearly about the nature of the care we seek to offer we will be able to look at some resource allocation decisions in a new light.

Currently we tend to equate *care* with tasks, with things that carers *do*, and this allows us, as technology develops, to delegate it to people costing less and less. Expensive technology allows us to delegate many aspects of nursing for example to health care assistants. Receptionists in GP surgeries are being replaced by touch pad entry systems and flashing light notice boards. But care is more than what carers do, it should involve who they are and the judgements they make and the relationship they develop with the people they care for. If we see it in this way we may consider it cheaper overall as well as better to retain the involvement of more expert carers.

A new form of professionalism, a new compact with society

A new look at what it means to be a professional would not be untimely. The professions were largely a development of the early C20 responding to the nature of knowledge and society in the C20. The context of the C21 is different and so that compact needs to be

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[22] Iles V [2005]

reviewed. And so for the compact between professions and society to be reviewed we will need to have a good look at what we mean by society.

Government is only one part of society, as are patients, the population, journalists and very much more. In other words society needs to be seen as something dynamic and changing that involves people, technology, history, different realities, opportunities, risks, single lives, collective relationships, different states of physical and mental health, and the different meanings brought to events by different people. A new compact with society will include and rely on a sophisticated understanding of these.

What else will a new professionalism involve?

The Audit Culture

We have identified four aspects to this:

- Accountability
- Professional autonomy
- Educating about risk and the nature of health and care
- Ensuring organisational integrity

1. Accountability

To be able to practice in the way they wish, professionals will need to find ways of accounting to society for what it is they are doing.

While it is straightforward (though not necessarily cheap) to account for transactional care it is much more difficult to do so for relational care, so new ways will need to be found. These are likely to involve methods other than counting and are unlikely to lead to quick and easy verdicts about who is offering 'better' care or which institution is 'safer'. They will require, and also lead to the development of, a more sophisticated understanding of the issues involved on the part of a larger fraction of society.

How can we persuade society that pleas for professional judgement are not self indulgent and self interested?

We have said before that professionals have not engaged in sensible debate about the current emphasis on transactional care and that many professionals and their negotiating bodies resist pressures from patients for better access and service. So we need to consider ways in which professionals can be persuaded to take these seriously.

We can suppose that it is partly the professionals' implicit recognition that a focus on good transactional care undervalues relational care that causes some resistance. But we can also note that in countries where politicians are no longer involved in championing the patient's interest in the form of targets and centrally imposed requirements, leaving governance instead to independent bodies, the services offered meet the needs of providers more than those of patients. In other words we can observe a large element of self interest that needs to be challenged, and challenged effectively.

So we will have to find ways for professionals to account to society for their performance just as other groups in society do. And while the ways of accounting for the transactional are straightforward, and involve measures of one kind or another, ways of reflecting on the relational have not adequately been developed. If we measure in order to give an account that will persuade, we haven't considered other ways in which we can give an account that will persuade.

Relational care involves caring about the patient, working with the patient, the use of subjective judgement and bringing together the judgements of professional and patient, the application and development of wisdom, and it may take place in silence or in private with little paper trail to illuminate the reasoning going on. It will take account of risk but not privilege it over other aspects of care that may be less easy to reduce to numbers. It will involve the essence of the professional as well as what they do.

So some of these are internal processes that result in external actions but those actions in themselves do not fully indicate the quality of the internal ones. In other words, care is often internal and has to be authenticated externally. It will indeed be manifest externally (in acts of work and courage), and it is arguable that those external acts will lead to an increase of those internal feelings (which is what *cathexis* is after all). One early observation of the external impact of care was that of the Greeks who noticed that the

death rate among early Christians (with their practice of loving their neighbour) was much lower than the norm. [23]

It will be a feature of complexity that the courageous/caring action won't necessarily be clear at the time at which a decision needs to be made and a discussion about the wisdom of that choice may involve drawing on a range of ethical concepts (deontological, consequence and virtue approaches) about which different professionals will have different views.

So in this domain there will not be a right and a wrong approach and the means of persuading society that an appropriate level of wisdom has been applied is likely to involve discussion rather than reporting. The old system of supervision in social work might be a good model to follow.

In other words the process of authenticating care for outside observers must involve some observation of actions and some discussion of those actions and the underlying thought and feeling processes. It cannot involve just one of these. It requires a *rich understanding* of professional judgement. And may involve recognising different ways of knowing including ways other than the intellectual; and even other ways of developing people's wisdom, and insight, including art , dance, constellations work etc.

The terms accounting and accountability have acquired a numeric and a hierarchical connotation. We need to see them more richly. It is worth quoting here the anthropological observation that 'accountability' has multiple meanings. It is not merely a question of procedural validation but is intimately linked to the calling of responsibility. It involves '*not only being accountable for what one is expected to do or perform but to*

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[23] Another example of the link between internal and external: Apparently the difference between the US and UK 'method' of acting is that the Americans start by imagining the feelings of the character involved and those feelings then lead to the adoption of the appropriate posture, whereas in the English method the actors adopt the posture and the feelings follow.

one's responsibility beyond legal minimalism to the growth of oneself and the other and thus contributing to the creation of dignified relationships in society.'[24]

And in the search for ways of accounting for the relational the transactional cannot be ignored. The professions will need to recognise that much of care can valuably be systematised so that unhelpful or dangerous variation can be eliminated. These systems, including reporting and monitoring systems, need to be supported, made as credible and helpful as possible, and used routinely so they consume as little resource (including the emotional energy of professionals) as possible. They could usefully be seen as a background against which relational care is provided. Part of the new professionalism therefore relies on developing professionals who can see many elements of the audit culture as positive and who thus choose to cooperate with it - while recognising and persuading others of its limitations.

2. Professional autonomy

First though, professions must earn the right to any autonomy by demonstrating their concern to meet the needs of society by placing their knowledge at its service. They will need to do this by engaging in a rich and creative dialogue about what those needs are and how they can best be served[25].

Perhaps more than anything else the new professionalism will involve an understanding that ' *[professional] autonomy is a value to live by'* and that it can only be earned and retained by a sincere and competent attempt to service the real needs of society.

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[24] Giri.A Chapter 6 Audit Cultures Ed Strathern M [2000]

[25] Giri. A., Audit Cultures Ch 6 Ed Strathern M [2000] expresses this as follows: In order that a unit may be truly autonomous it has to demonstrate, on its own, its sense of commitment and attitude of servant hood to the wider society.

This does not mean subservience to the illogic of a majority but a dialogical creative engagement with the wider society.

An autonomous unit has to create a self critical space for reflection and interrogation of its basic foundations. Autonomy is not just a pious word to utter but is a value to live for, and as a value it requires creative and critical preparation on the parts of individuals and institutions.

For example, in the past, professions have tended to ignore their own involvement in health inequalities, in racism, in the stigma attached to those with mental health problems and in inefficient service provision. A new openness and humility will be essential.

3. Educating about risk and the nature of health and care
The desire to avoid risk (on the part of public, patients, managers, politicians and professionals) does not sit well with the fact that there *is* risk inherent in healthcare. Some elements of it are avoidable while others are not. So part of this ongoing dialogue will include helping society to understand the nature of health and health care, of the risks inherent within it, the complexity of the health care task and the unpredictability of outcomes.

This will require maturity and confidence since it will always be tempting for society and for the professions to seek expert /definitive 'answers', to treat all health care issues as though they are amenable to 'knowledge' and to 'evidence' when many of them are more complex and unknowable than our current understanding allows. Acknowledging this will have an impact on the self image of professionals and on their status within society, as society becomes disappointed with their lack of definitive answers, so it is likely to be resisted at all levels until the benefits of a greater maturity are perceived.

4. Ensuring organisational integrity
One of the features of the audit culture is that while policy makers do not wish the audit process to become a game to be played by organisational managers, there is ample evidence that this is what happens. Part of the mechanism by which this occurs is the explosion of audit 'experts' who help organisations rehearse their responses and ensure that they score well in the processes used.

Professionals can help keep their organisations honest by refusing to play games like this and, instead, suggesting ways of improving the system so that targets can be met without sacrificing integrity.

Responses to other aspects of the digital revolution

The digital revolution is moving on again and offering new ways of using data. Soon it will be possible for individuals to 'rate' their health care in the same way that many rate their hotels on Trip Advisor. For them to write reviews of their care programme, the way they write reviews of books on Amazon. This offers an alternative to audit from above: instead of surveillance this will, rather, be souveillance. Reputations for services, for organisations, and for individuals will be generated from people on the receiving end of their care. We may find that these reputations reflect different priorities from those people currently setting targets at the top.

Professionals can valuably take an interest in this, support it where it adds understanding, and challenge it where it offers superficiality instead.

More generally professionals could take a greater interest in technological developments that have an impact on things other than the directly clinical, so they are able to support or challenge their use on a wider basis.

Re-energising politics

At the heart of the political task is the reconciling of different interests. Where these interests are those of different patients or client groups then, for decisions at this level to be adequately informed, health care professionals will need to be actively involved. So a part of the new professionalism will be a preparedness to engage in dialogue (sometimes heated and emotional) about how to increase the capacity of a service (perhaps by asking peers to take on different practices), or what services may be funded and which may not. This will require abilities to work collaboratively to an extent rarely seen to date[26].

The design of local services clearly needs good input from HCPs most closely involved, but so too does the design of the wider care system. And, we must not forget too, that there are relevant and important ideas that stem from the economic paradigm. If it is true

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[26] Part of that collaborative expertise will involve reflection on the appropriate use of status during discussions that involve members of professions which have different status.

that the way markets succeed in improving quality and reducing costs is through the 'four Is' (innovation, information, incentives and investment) then professionals could look for ways other than a market in which those 'four Is' can be delivered in health care. If debates such as this are left to non-clinicians we must not be surprised if the results are not roadworthy.

Responses to anxiety

If anxiety is inherent in the health care task then our HCPs and managers need to be able to respond to it healthily. Since so much of health and health care is as yet ill understood, even the most experienced of practitioners will be anxious on occasion. Anxiety, then, can be seen as an appropriate response and an affirmation of competence rather than the opposite. Healthy responses to this (page 15-16 and 35) and the new professionals we are describing here will act in these ways themselves - and respond well to others who seek their help when they themselves are anxious.

If we think back to the distinction between transactional and relational care we can see that anxiety may well be provoked by the kind of situation in which a patient *needs* relational care. And when this happens the anxiety can be reduced in four ways: to withdraw both care and compassion and offer bad care, to offer good transactional care – finding a protocol to follow, finding all sorts of measurements to take - to offer compassion but little else, or to offer good transactional care and also to engage in the relational aspects of care. The former two will reduce anxiety levels more quickly but for a shorter period of time. The latter two will require courage and work and only the last can reduce anxiety levels fundamentally and long term.

The development of the new professionals

We can see from the kind of behaviours described above that there are implications for the processes for developing and sustaining members of the professions. A debate about this too would be timely.

While curricula have expanded hugely to accommodate new knowledge this has accompanied a focus on what it is that professionals *do*. The kind of *people* they *are* or

can *become* has diminished in importance. This is itself a part of the audit culture, a manifestation of transactional rather than relational education.

For the professions to engage in the kind of open dialogue described above, for them to be open to the need to earn their autonomy, and to see autonomy as a value to live by, will require them to have as their foundation a genuine sense of self worth. Ways of assessing for and engendering this will need to be discussed and developed. A genuine self confidence (that is the very opposite of the arrogance of which some professionals are accused) will be necessary if they are to demonstrate the openness and empathy and responsiveness that relational care require. That same sense of self worth will also be necessary for them to have the courage to engage in the politicalness described above.

If we are to allow and encourage professionals to bring themselves and not just their skills into the care task then we will need to pay more attention in their education and training to developing their understanding of themselves. We will need to help them pay attention to who people are and can be, and not merely what they can do[27].

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[27] In the course of this we may need to help professionals give serious consideration to their 'inner space…… the source from which they operate, ……… the quality of attention and intention they bring to any situation' Scharmer. O [2007].
Carl Rogers' description of the therapeutic triad of genuineness, non-possessive warmth and accurate empathy, may be a good starting point for this. If 'the therapeutic alliance includes hope, trust, common understanding, and bonding, and is found where there is a supportive, warm, positive attitude on the part of the therapist, who speaks a language the client understands, and is encountered and trusted by that client' then this can all be developed within the new professionalism.

A new managerialism

Many aspects of the new professionalism have parallels in the kind of new managerialism that will be needed to complement it. We liked the following definition of the management role: *the role of managers is to enable the potential of professionals*[28].

We suggest that, in practice, this will involve managers caring for and about professionals, that is, undertaking acts of work and/or courage with the aim of enhancing their professional and personal growth.

Responding to the audit culture

Instead of earning organisational autonomy by meeting government targets organisational leaders would ensure their organisations earn it by placing the organisation at the service of society. As before, this will require creative dialogue with patients, public, and other health and social care organisations about what needs it is best placed to meet and how it can best do so.

Just as professionals will need to find ways to account for relational aspects of care so too will organisations. They will find it just as hard and will need to develop innovative ways of doing so. They must be prepared to challenge the basis and practice of world class commissioning if it does not take sufficient account of relational elements.

To ensure that the benefits of reducing undue variation in care are achieved managers will need to work with their HCPs to standardise care where appropriate, and also ensure that this does not interfere with opportunities for relational care. Managers can help HCPs to respond positively to these aspects of the audit culture, by ensuring they are not given disproportionate prominence.

When it comes to meeting targets or undergoing audits, managers too need to insist that there are genuine improvements to the system that result in achieving a satisfactory 'score', rather than a focus on the targets that distorts priorities and impoverishes care. This requires integrity rather than gaming.

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[28] Mid Cheshire PCT definition

At the level of the Board there is a need for reflection on the Board's (and the organisation's) attitude to risk. In particular the Board needs to understand the difference between reducing risk and avoiding it, encouraging the former and discouraging the latter.

But more than anything else the Board needs to accept that risk is inherent in health care, and that it should be one factor in any decision, *but not the only one*. Organisational leaders must learn to frame questions to, for example, lawyers or control of infection teams in ways that leave the *decisions* to people who are juggling a number of different priorities rather than focusing only on one.

Where there is risk there is litigation and organisations and their leaders must find ways of supporting both the professionals whose actions have had unfortunate consequences and their patients. Some form of litigation-free space where people can be themselves, feel whole again, interact as whole people, then go back into the outside world, could be one way of doing this and something organisational leaders could enable.

The role of the leaders of organisations will be to help the whole organisation to dance: to be active, alive, creative, present, taking some risk – but not too much – holding the other. This, again, will involve uncertainty and, again, will require courage. We will need organisational leaders, as well as HCPs, who bring *themselves* to work, rather than leaving their values, emotions, and desires at home as they become merely a conduit for policy diktats from above.

Responses to other aspects of the digital revolution

If professionals are to respond proactively and constructively to digital advances their organisational leaders mush encourage and enable this. For example, if surveillance is going to be productive organisational leaders will have to take an interest and encourage their professionals to respond constructively to comments on blogs and other web enabled exchanges.

Re-energising politics

Just as HCPs must be prepared to get *involved* in decisions about the nature of services and the allocation of resources so too must health care organisations. Organisational leaders must take an active part in decisions about the kind of services to be provided locally, drawing on the rich information they will have and which is needed to inform the debate, and being prepared for these discussions to become heated and emotional. This is very different from the kind of inter-organisational relationships that currently characterise the NHS and will require skills in dialogue and collaboration currently not seen.

As part of their service to society, organisational leaders involved in this collaborative dialogue will reflect thoughtfully on the appropriate use of organisational status, recognising the differences in status between organisations and not allowing this to dominate the discussion.

Healthy responses to anxiety

Organisational leaders need to support healthy responses to anxiety in all parts of their organisation, recognising anxiety as inherent and not seeing it as weakness. Anxiety can be contained by effective leadership and appropriate structures, including clearly defined roles and role-relationships. It can be supported through appropriate supervision and group reflective practices. It needs to be 'okay' to talk about feelings and experiences that disturb us; and we need to develop the capacity to listen and give space to processing those experiences. Managers will need to become aware of their own emotional responses to situations, recognise their own anxiety and attempt to respond in healthy ways themselves. They may choose to request help when faced with anxious situations and will certainly find ways of supporting others when they request it. Mostly managers need to become better listeners and give more space to the processing of troubling experience.

Developing organisational leaders

Just as we will need to find new ways of developing our health care professionals we must change radically our conception of development processes for managers and for

all organisational leaders. It is worth repeating the section on the development of professionals, substituting the term manager:

We can see from the kind of behaviours described above that there are implications for the processes for developing and sustaining managers. A debate about this too would be timely.

While curricula have expanded hugely to accommodate new knowledge this has accompanied a focus on what it is that managers do. The kind of people they are or can become has diminished in importance. This is itself a part of the audit culture, a manifestation of transactional rather than relational education.

For managers to engage in the kind of open dialogue described above, for them to be open to the need to earn their autonomy, and to see autonomy as a value to live by, will require them to have as their foundation a genuine sense of self worth. Ways of assessing for and engendering this will need to be discussed and developed. A genuine self confidence (that is the very opposite of the arrogance of which some managers are accused) will be necessary if they are to demonstrate the open-ness and empathy and responsiveness that relational care require. That same sense of self worth will also be necessary for them to have the courage to engage in the politicalness described above.

If we are to allow and encourage managers to bring themselves and not just their skills into the care task then we will need to pay more attention in their education and training to developing their understanding of themselves. We will need to help them pay attention to who people are and can be, and not merely what they can do.

Part 2: A New Form of Policy Making and New Form of Civic-ness

A new form of policy making

Changes such as these among professionals and organisational leaders will need to be mirrored by changes in the behaviours of those making policy. This needs further thought and the ideas below are sketchy. It would benefit from some serious thinking about the distinctive value that politicians and policy makers can genuinely add to the system of care provision. It is not enough to talk of democratic legitimacy (although of course that is crucial) there needs to be dialogue about the value adding nature of the processes of policy making.

Policymakers need to work with the professions and organisational leaders as well as communities and media to find meaningful ways to describe and account to society for aspects of care that are not easily *counted*. They have a crucial role to play here and it will require them to behave with integrity rather than party political point scoring. since both professions and managers will also need to demonstrate integrity and there will be great temptation to play self serving games instead there probably needs to be greater discussion about ways in which all of these groups can help keep each other honest.

For example this will require that policy makers resist the temptation to set targets just because they *can*. In particular it will require them to understand that setting targets will inevitably lead to poorer services[29] and that they need to find other ways of energising change.

They could see technological developments primarily as a means for services *being offered better*, rather than as a means for policy makers to *know* whether the services are better.

Policy makers should reclaim as political the issues they have farmed out to 'neutral experts'. Avoiding emotional, difficult decisions is not a position of integrity and they

[29] Seddon J [2008]

need to reclaim their difficult, dangerous[30], role as reconciler of different interests. As much of this will be happening elsewhere in the system as a result of the greater politicalness being developed there, they should choose to step into debates at more local levels only with great care.

They need to think carefully about the interests that need to be reconciled and then about the best ways of doing so. **The market will be the best way for many situations but not for all.**

For healthy responses to anxiety, some of the following thoughts may be usefully pinned on the notice board of the Secretary of State for Health:

- Don't rush into action. Take pride in a reputation for doing things right rather than quickly.
- Don't be bounced by the Daily Mail. Use bad copy as an opportunity for education of the public, of professionals,
- Keep focused on the needs of others (patients, professionals, organisational leaders) before thinking of your own. You will meet yours much more effectively this way.
- When you feel anxious say so. Recognise and help others to do so as well, that people who don't feel anxious make worse (more inhumane) decisions than those who do.

A new civic-ness

As a result of the developments described above we might begin to see a new form of consumerism. Indeed the boundaries between consumer and provider may become less rigid. There is a tendency to promote the assumption that today's society is made up of self interested individuals who perceive their self interest as composed entirely of pursuing their own ends and who will fight for these at the expense of others. Indeed much of the economic paradigm is founded on this belief. And yet this is not the

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[30] dangerous in that it may require them to court some unpopularity and it will therefore require courage

experience of many. People give to charity, they give blood, and they give time to friends and neighbours in need.

There is a danger that we are teaching people that they *should* only look out for themselves rather than reflecting the reality which is that we want both.
We want to meet our own ends *and* to have good relations with others and help them meet their needs. We will also be fairly sophisticated in our ability to marry the two and we will do so in ways that suit our individual motivations and will not be predicted by economists.

A new civic-ness would perhaps start with this debate: does our self interest encompass merely goods and services for ourselves and our immediate family or does it also include a sense of the collective and what does/ could this look like.

Perhaps too we could rediscover our sense of democracy. Democracy can be seen as a process of 'becoming' – as individuals and as communities – in that it achieves the reconciling of different interests, not by the decision of a governing elite but by the active participation of citizens.

This though requires the development of 'politicalness', which we can describe as an ability to engage creatively in dialogue with people pursuing different ends, or the same ends by different means. This is most realistically developed at a local level by local people discussing decisions that matter to them personally: about buildings, services, planning laws etc.

This ability, once acquired, can then be applied at a national level. The very fact that local people have developed their political awareness will mean they are able to recognise skill in creative dialogue, and make judgements about the ability of those who seek their votes at engaging in this. They will reward with power those who show their ability to listen, to gain the confidence of others, to develop options which reconcile as many interests as possible.

Would you like to be involved in taking this thinking further?

If you are intrigued or persuaded by some or all of the argument presented here please help us to develop it further and use it to challenge the hidden assumptions that lead to bad care.

Please:

- let us know your reactions to what you have read here
- come and discuss it with some or all of us
- help us refine the argument presented
- look at some of the other documents or outcomes of the learning set
- help us devise other ways of raising awareness of some of the issues outlined
- take this thinking out into your own world and keep in touch with us to let us know how you modify it as you do so.

Appendix One
Unhelpful responses based in unfounded assumptions

Our experience to date is that most people in the NHS recognise this state of affairs and are keen to think about ways of offering an alternative. However we have come across some common assumptions that have the effect of excusing people from making the effort to connect with it. If you are about to make points based on the following assumptions we strongly invite you to think further.

1. *The NHS must ration services if it is not to be overwhelmed by demand*. The NHS is so much more than a provider of services to demanding patients: it encompasses professionals, patients, potential patients, citizens, technology, ideas, people who care about it. If we can see it in this richer way and seek ways of bringing all these together in ways that respond to needs we may find ways of offering care to meet all needs.

2. *The advent of technology will only make services more unaffordable*. The digital revolution will transform the ways in which we can offer care in ways that are very cheap. There are transitional phases to be sure but we must not be misled by these into pessimism and rationing.

3. *Choice is **the** way to increase quality of services*. The quality of services undoubtedly needs to improve and choice can be an effective method of ensuring that transactional elements improve. Where relational care is also required choice can have perverse effects. Individuals making the choice may feel less certain of the wisdom of their choice, especially when there has been a wide range of options; and they may find that subsequent choices are constrained by an initial choice in ways they had not understood at that time. Let us find ways to improve services that do not have a negative impact on care or confidence.

4. *Professions are bound to act in self-interested ways*. While many professions (or their negotiating bodies) have behaved in ways that suggest this, this could be seen as a response to the assumption that care is entirely transactional. When this assumption is made then negotiation about fees for transactions becomes a rational response. If we

can think of responses as arising from a 'rich symbolic complex' and we try to understand this then we can avoid trampling all over it and 'traducing [their] realities'.

5. *Professions are bound to act altruistically*. They'll behave as altruistically as anyone else.

6. *Managers are bound to care only about money*. Somebody *has* to and if professionals won't then managers will have to. Where professionals engage in dialogue about how to make the latest diktats from policy makers work then managers can devote time and energy to supporting initiatives for better care.

7. *Politicians only care about headlines in the Daily Mail.* While we sit back and allow the opinions of patients and the public to be swayed by the kind of copy that sells newspapers this is bound to have an impact. The new forms of professionalism and managerialism will need to include a commitment to finding multiple ways of informing and educating the public – as well as listening and acting upon their concerns.

8. *Individual members of the public care only about having their own needs met.* We know that people ration their time with the doctor to their own detriment, and that they care about the care that others receive. While this is not conclusive we have no more evidence to support the view that people are purely selfish than to support the counter view. We also know that people respond to what is expected of them. So once we start to expect people to behave as a community and we provide ways of allowing this to happen we might surprise ourselves!

9. *The middle class will always push for more than their fair share.* Again there is little evidence of their intent to do so, it is more a question of their ability to use their social capital. If we assist less advantaged groups to use their social capital too (and this could be part of the remit of front line primary care professionals) we will be able to reduce inequalities in access to care.

Take it to the Limit - A learning set

The invitation to join the learning set

This described the issue to be explored as follows:-

Across the developed world health services are struggling to open up the next stage of their own development. Most systems have made attempts at reform and have delivered early gains in terms of efficiency, effectiveness and access. However further, transformational, change has not taken place in the way it has in other industries. There is also a concern, on the part of some, that these gains have taken place at the expense of the humanity of care[31].

In response to this perceived lack of progress, and to unease about the lack of humanity, policy makers understandably reach for radical structural solutions. (For example they may consider changing the means of funding the system or shifting the financial power balance within it). However we may have to consider that NO structure can deliver the changes sought, because there are factors fundamental to the clinical task that make health care inherently difficult to organise into a system.

If this is the case then further gains will require an understanding of these factors so that individuals and organisations within the system can use this awareness to 'take to the limit' whatever system they find themselves working within - to their and their patients' advantage.

In this learning set the starting point for our enquiry is the proposition that there are three factors common to ALL health care systems, about which we know too little and that there are fields of study which would inform our understanding of health systems to which we have given too little attention.

The three candidate factors are:

1. The core of any health care system is the interaction between client and carer, are there dynamics inherent in this that have implications for performance at a more macro level?

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[31] As described in the Point of Care Project led by Jocelyn Cornwell at the Kings Fund.

2. All democratic societies need to allocate finite health resources wisely, justly and defensibly, is this intractably difficult?

3. High status professionals, trusted by the public, are key players in all health care systems. What is the nature of professionalism in health, how does it affect decision making at different levels within health systems, and where does the legitimacy of this model of professionalism derive from?

All of these have been explored by policy makers over the last 20 years, but using primarily economist and managerialist frames of reference.

The fields of study that may illuminate our understanding of these are:
Moral and political philosophy, anthropology, sociology, psychoanalysis, aspects of political science, of psychology, of management science, of economics and game theory, systems type thinking and the history of science.

Over a six-month period, including five one day meetings and intervening reading and exploration, participants will consider these fields of study in such a way that contrasting lenses will be used to view the three questions, and to frame others.

This set is for people who like *learning with a purpose*, through discussion and exploration, reading and reflection, so that they combine theory and practical experience.   It will be a rich learning/investigatory experience that is intended to lead to greater insight into the dynamics of health care systems. A final paper will summarise the most interesting and illuminating learning points in an attempt to inform and refocus those shaping the agenda for those both trying to shape the system and those trying to 'take it to the limit[32]'.

Participation is by invitation, to ensure an interesting and high calibre mix. Participants will need to be committed to being a full part of the group, facilitating each other's insight and interest, and arranging busy diaries so they are able to come to each of the Learning Set meetings.

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[32] You may need to remember the Eagles to warm to this phrase!

Appendix three

Reading undertaken in the course of the learning set.

It would be incorrect to suggest that the views of the set were influenced only by the following texts since members placed their own specialist knowledge base at the service of the group, however these texts were all considered by all members and influenced the nature of the discussions.

Beck U, [1992] Risk Society. Towards a New Modernity, Sage Publications Ltd

Boyett J & Boyett J,[2003] THE GURU GUIDE TO MARKETING: A CONCISE GUIDE TO THE BEST IDEA FROM TODAY'S TOP MARKETERS Wiley

Bury.M. and Taylor.D. [2008] *Towards a theory of care transition: from medical dominance to managed consumerism*, Social Theory and Health, 6, 201-219

Chisholm.A, Cairncross.L. and Askham. [2006] SETTING STANDARDS. THE VIEWS OF MEMBERS OF THE PUBLIC AND DOCTORS ON THE STANDARDS OF CARE AND PRACTICE THEY EXPECT FROM DOCTORS. London. Picker Institute.

Coid D.R., Davies H [2008] *Structural change in health care:why so much?* Journal of the Royal Society of Medicine {article under review}

Cooper Z., Le Grand J [] *Choice, competition and the political left* Eurohealth Vol 13 No.4

Degeling P, Maxwell S, Kennedy J and Coyle B [2003] *Medicine, management and the continuing 'danse macabre'.* Br Med J 326:649-52

DoH Report on Kent and Canterbury NHS Trust C Difficile Outbreak

Dowton SB [2004] *Leadership in medicine: where are the leaders*? Med J Australia 181:652-4

Duffy S et al [2006] ECONOMICS OF SELF-DIRECTED SUPPORT In Control

Edwards N, Kornacki MJ and Silversin J [2006] *Unhappy doctors; what are the causes and what can be done?* Br Med J 324:835-8

Epstein M [1999] Going to pieces without falling apart. A Buddhist perspective on wholeness. Bantam Doubleday

Fotaki M [2006] *Choice is yours: A psychodynamic exploration of health policymaking and its consequences for the English National Health Service* Human Relations Vol59(12):1711 – 1744 Tavistock Institute Sage Publications London

Giddens A [1986] THE CONSTITUTION OF SOCIETY Polity Press.

Graham I. W [2006] *Consultant Nurse – Consultant Physician: A New Partnership for Patient Centred Care?* Journal of Clinical Nursing

Ham C [2008] *Competition and integration in the English National Health Service*. Br Med J 336:805-807

Harrison J, Innes R and van Zwanenberg T [2003] REBUILDING TRUST IN HEALTHCARE. Radcliffe Publishing, Oxford

Harrison J and Innes R [1997] MEDICAL VOCATION AND GENERATION X. Grove Books, Cambridge.

Hinshelwood R.D., Skogstad W [2002] OBSERVING ORGANISATIONS: ANXIETY, DEFENCE AND CULTURE IN HEALTHCARE Karnac London

Hirschhorn L [1999] THE WORKPLACE WITHIN: PSYCHODYNAMICS OF
ORGANISATIONAL LIFE Karnac London

HM Government CORPORATE MANSLAUGHTER AND CORPORATE HOMICIDE ACT
2007

Hodgkin P, Munro J [2008] USING THE EMERGING ECONOMY OF ALTURISM TO
UNLOCK THE TALENT OF COMMUNITIES Patient Opinion
Horvath J [2005] *The future of health care and the role for medical leaders*. Presentation
to Australian Medical Students Association (AMSA) Leadership Development Seminar
on 7th September 2005

Hyman P, [2005] 1 OUT 10: FROM DOWNING STREET VISION TO CLASSROOM
REALITY*,* Vintage,

Iles V [2004] REALLY MANAGING HEALTHCARE Open University Press

Levenson.R, Dewar.S. and Shepherd.S. [2008] UNDERSTANDING DOCTORS.
HARNESSING PROFESSIONALISM. London. King's Fund and Royal College of
Physicians.

James O [2007] AFFLUENZA. HOW TO BE SUCCESSFUL AND STAY SANE.
Vermilion, London.

Jay P [2001] THE ROAD TO RICHES Phoenix

Kaeufer K, Scharmer C.O., Versteegen U [2003*] Breathing Life into a Dying System* SoL
Journal of Knowledge, Learning and Change Pub Society for Organisational Learning

Kay J [2004] THE TRUTH ABOUT MARKETS Penguin

Klein R [2008] *Does the NHS really need a constitution?* Br Med J 336:804

May.C.[2007] *The clinical encounter and the problem of context*, Sociology, 41, 1, 29-45.

New B & Le Grand J [1996], RATIONING IN THE NHS: PRINCIPLES & PRAGMATISM, King's Fund

NHS Confederation [2008] COMPASSION IN HEALTHCARE. THE MISSING DIMENSION OF HEALTHCARE REFORM? London, Futures debate. Paper 2.

Pilgrim D., Rogers A., Bentall R [] *The Centrality of Personal Relationships in the Creation and Amelioration of Mental Health Problems: The Current Interdisciplinary Case* Health:An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine.

Porter M., Tiesberg E.O., [2006] REDEFINING HEALTH CARE Harvard Business School Press

Porter M., Kramer M [2006] STRATEGY AND SOCIETY – THE LINK BETWEEN COMPETITIVE ADVANTAGE AND CORPORATE SOCIAL RESPONSIBILITY Harvard Business School Press

Runciman D [2006] THE POLITICS OF GOOD INTENTIONS; HISTORY OF FEAR & HYPOCRISY IN THE NEW WORLD ORDER Princeton University Press

Sanders.C. and Rogers.A. [2008] *Theorising inequalities in the experience and management of chronic illness: bringing social networks and social capital back in (critically),*Research in the Sociology of Health Care, 25, 15-42.

Scharmer, O [2007] THEORY U: ADDRESSING THE BLIND SPOT OF OUR TIME www.theoryu.com

Schroeder, S.A. [2007] *We can do better – Improving the Health of the American People* (Shattuck Lecture). New England Journal of Medicine 357:1221-8

Schwartz, B [2004] THE PARADOX OF CHOICE. WHY MORE IS LESS. HarperCollins, New York.

Schwartz B and Sharpe K, [2005] Practical Wisdom: Aristotle meets Positive Psychology. Journal of Happiness Studies.

Seddon, J [2003] FREEDOM FROM COMMAND AND CONTROL: A BETTER WAY TO MAKE THE WORK WORK Vangard

Seddon J [2008] SYSTEMS THINKING IN THE PUBLIC SECTOR: THE FAILURE OF THE REFORM REGIME.. AND A MANIFESTO FOR A BETTER WAY. Vangard

Shaller, D [2007] *Patient Centred Care: What Does it Take*? Revised report for joint publication by Picker Institute and Commonwealth Fund

Strathern, M. Ed [2000] AUDIT CULTURES: ANTHROPOLOGICAL STUDIES IN ACCOUNTABILITY, ETHICS AND ACADEMY Routledge

Strathern,M. [2000] *The tyranny of transparency*, British Educational Research Journal, 6, 3, 309-321.

Strachey, L [1918] FLORENCE NIGHTINGALE (IN EMINENT VICTORIANS). Penguin edition, London.

Suchman, A. L [2005] *A New Theoretical Foundation For Relationship-centred Care: A complex responsive process of relating* {prepublication article]

Sztompka, P [1999] Trust. A Sociological Theory. Cambridge University Press, Cambridge.

Thistlethwaite. J and Spencer. J [2008] PROFESSIONALISM IN MEDICINE. Radcliffe Publishing, Oxford.

Twigg, B [2008] *Matron, measles and medicine – 60 years of the NHS.* The Times 27/6/08, London.

Vernon, M [2007] After Atheism: Science, Religion and the Meaning of Life. Palgrave Macmillan

Williams, R [2003] LOST ICONS. REFLECTIONS ON CULTURAL BEREAVEMENT. Continuum, London.

Williams, G. [2007] *Incapacity,* Plenary address to the Annual BSA Medical Sociology Conference, Liverpool, 6th September.

Wolin., S [unknown] PRESENCE OF THE PAST: ESSAYS ON THE STATE AND THE CONSTITUTION [unknown]
[1] Prof A Cribb personal communication
[1] Barry Schwartz and Kenneth Sharpe in 2005 in the Journal of Happiness Studies
[1] Karen Armstrong , cited in Vernon M, After Atheism.
[1] Epstein M, Going to pieces without falling apart