Appendix one: The 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 observed that across the developed world health services were struggling to open up the next stage of their own development. Most systems had made attempts at reform and had delivered some early gains in terms of efficiency, effectiveness and access. However further, transformational, change had not taken place in the way it had in other industries. There was also a concern, on the part of some, that these gains had taken place at the expense of the humanity of care[1].

We suggested that, in response to this perceived lack of progress, and to unease about the lack of humanity, policy makers would 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 also suggested that 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.[2]

In the learning set the starting point for our enquiry was 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 can inform our understanding of health systems to which we have given too little attention.

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?
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, we recognised, 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 we believed may illuminate our understanding of these were:

Moral and political philosophy, anthropology, sociology, psychoanalysis, aspects of political science, psychology, and the history of science.

[1] As described in Seeing the Person in the Patient, a report from the Point of Care Project led by Jocelyn Cornwell at the Kings Fund.

[2] Hence the Learning Set was named the Take it to the Limit Set. Not least because one of the sponsors was a fan of the Eagles.

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The fact that so many people contributed their time and expertise 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 lengthy, rich, emergent discussion, which drew on our prior knowledge, our reading, our experience and our practice, and which we feel enthused to take further in forms that will be equally rich, emergent and diverse. This book is one of them.

Appendix Two: What can individuals do?

If the argument is that we have all contributed to the problem and the propagation of the five winds then we have some responsibility as individuals to take action ourselves. Without waiting for any such major changes to take place we can all make changes to our individual behaviours. The impact may not be great but it could still be significant.

For instance (in no particular order) we could:

- *Challenge anyone using a means as an end when presenting an argument. For example if they advocate choice and competition, accountability, transparency, democracy, freedom, even productivity, we should ask for the link between that and something we can indeed recognise as an aim: better quality of care, more cost effective care, fairer care, greater flourishing...*
- *Challenge when we see status being used inappropriately: when it is being used not in the service of others, or when it is being used even though it is not drawing upon the specialized expertise and intuition that has given rise to it.*
- *Welcome souveillance and challenge anyone trying to control or limit it.*
- *Become aware of the way we (as individual, whole people) respond and interact with the world around us. What do you notice – what are you seeing? hearing? feeling? smelling, touching? What emotions are being invoked in you? How do you feel? What had prompted you to feel that? Where has your mind just taken you? What journey has it taken you on, from thought to thought?*
- *Use data, audit etc as a prompt to conversations rather than a rush to judgement. When observing simply observe, reflect our observations back, to form the basis of a rich and valuable conversation.*
- *Take flourishing seriously – others' and our own. Use every opportunity to work towards our potentials and help others to do the same.*
- *Support and initiate attempts to improve transactional aspects of care (caring for) while also using our practical wisdom to care about others (patients, colleagues, staff...).*
- *See anxiety positively, see it as valuable and use it wisely.*
- *Take an active interest in patients other than our own and contribute to discussions about their care also. In this way contribute to a spirit of stewardship of our organisations.*
- *Challenge any explanation that is not accompanied by real empathy.*
- *When we tell stories, make them rich stories that include emotions, observations of events in their fullness, including how they affect the senses and the feelings of those involved, that convey something like reality. Nothing like the kind of case study that assumes all the players are a rational set of interests and nothing more.*
- *Every now and then wonder how aware we are of the amazing phenomenon of being alive, and explore ways in which we can help others to increase their own awareness of it. Help people not to lose this in their striving for longevity.*
- *Take an active interest in the performance of others and reflect back to them our observations.*
- *Reflect on our own performance*
- *Engage with others in the review of our own services and whether they could meet health needs more ably or more cheaply, allowing more care to be offered from the same resource.*

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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.

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