Chapter Five: Defining, offering, managing and evaluating care

In a book considering what is happening to care it feels about time to define and explore what we mean by the word.

We have chosen or developed definitions derived from several sources: David Seedhouse, M Scott Peck, and the Aristotelian concept of flourishing. We have done so because we observe that this is the part of the terms healthcare profession, healthcare organisation, and health care, that is least defined. In this chapter we want to define it, explore it and convey a sense of it, the better to understand what we lose if we focus only on the transactions of care.

In his book the Road Less Travelled Scott Peck defined love[1] as 'the will to extend one's self for the purpose of nurturing one's own or another's [personal[2]] growth'. Furthermore he suggested that 'If an act is not one of work or of courage then it is not an act of love. There are no exceptions'. Now one way of thinking about care is as a 'thinner' and more widely disseminated form of love, and in that case we could use a similar definition for care: care is the will to engage in acts of work and/or courage in order to nurture personal growth.

David Seedhouse, a philosopher who has observed and considered issues of health and health care for many years suggests, in his book Liberating Medicine that 'any genuine theory of health will be concerned to identify one or more human potentials which might develop, but which are presently or likely to be blocked. Health work, however it is defined will seek first to discover and then prevent or remove obstacles to the achievement of human potential.'[3] And this suggests that we could see 'personal growth' and 'health' in the same terms: progress towards the achievement of potentials; and thus that health care is about the overcoming obstacles to the achievement of those potentials.

Combining these definitions we could say that health care involves acts of work and courage undertaken with the intention of enabling the potentials of patients. Using an Aristotelian concept we could also frame this as acts of work and courage that enable or promote *flourishing*. We could, even more generally, talk about acts of work and courage in the service of the other – where our understanding of the word 'service' incorporates all of the thinking described above.

[1] By which he means agape rather than eros

[2] He actually used the word spiritual but in a sense that is conveyed well by 'personal' as long as we think of personal in its widest sense – a flourishing sense!

[3] Seedhouse D Liberating Medicine John Wiley and Sons 1991, page 48.

So: acts of work and courage – what do we mean by that? The work involved in health care includes things like the core tasks, which many HCPs will undertake, of assessment and diagnosis, prescription and delivery of treatment; but it can also be seen to include the years taken to develop the relevant knowledge, skills, insights and intuition that lie behind these. And for care to be effective other kinds of work are also needed. Work such as planning the interactions with others (patients, other HCPs and managers) that are necessary if 'obstacles to the enabling of potentials' are to be identified and addressed.

Courage may be needed when giving bad news, for example, or when discussing treatment options with ungenerous[4] colleagues, or when it is in the best interests of a patient that the HCP acknowledges their own uncertainty. There will also be times when both work *and* courage will be required, for example when we challenge our own perceptions and practice, or the perceptions and practice of others, or when we have made a mistake and need to admit it and learn from it.

The practical use of defining care in this way (as acts of work and courage with the intention of enabling patients to flourish) can be seen when we are planning care, when in the process of caring and when reflecting later on the care that was given. For example reflection can include the questions: Did I care here? Did I care enough? What acts of work and courage did I undertake? Were there acts of work and courage that would have enabled them to flourish that I failed to make? We can undertake these reflections on our own or with others, and use these questions when supervising more junior staff.

To gain a richer sense of what we mean by care let us look at a couple of examples.

Robin Youngson is an anaesthetist from New Zealand who became an advocate of compassionate care after experiences as the father of a patient. His description of his approach to dealing with 'difficult patients' is an example of the kind of care (acts of work and courage) we are talking about.

No more difficult patients

> *"Some years ago I attended a long series of weekly sessions with a life coach. I vividly remember the day she tried to teach me the rule of "non-judgement". I railed against such an absurd idea and 'patiently' explained that the exercise of professional judgement was the very essence of how I added value to my patients. Why else had I trained for fourteen years to become a medical specialist!*

[4] I've defined generosity in Really Managing Health Care as having five elements: choosing to care; choosing to meet hostility, aggression and self congratulation with compassion rather than fear or hostility; choosing to include and value rather than exclude and compare; choosing to expect the best; and choosing not to allow self image to be shaped by the ungenerous. Ungenerosity is of course the converse.

The patience, gentleness and non-judgement of my life coach in her response to my protests were a nice object lesson. Of course I didn't 'get' that she was talking about moral judgement, not technical judgement. My inflated sense of self-importance prevented me from seeing the difference.

Over the years I have reflected on my role as a doctor. I have realised that for much of my career, my identity and self-esteem were wrapped up in being a highly-trained technical expert. Now I try to open my heart and to be a caring human being first, and an expert second. That has enabled me to be much more humble and respectful, to listen patiently, to form more trusting relationships with my patients and to strengthen my compassion.

One day I just decided that I would no longer have 'difficult' patients. I resolved that difficult patients didn't really exist 'out there' but were a consequence of my own attitude or judgements, an internal problem. I owned the problem as my own, rather than projecting it onto the patient. The real problem was a 'difficult doctor' not a difficult patient. If a consultation was feeling difficult it was because I was failing to listen or to respond to an unmet need.

This shift in attitude had a remarkable effect. I felt like Harry Potter waving a magic wand! The difficult patients somehow just melted away. This was definitely an improvement in the quality of my working day! Paradoxically, the only person who changed was me. At last, I had understood the lesson my life coach was trying to teach me.

Judgement comes in many subtle forms. Fixing a patient is a form of judgement (the patient is broken). Even helping a patient is a form of judgement (you are less than me). Serving a patient on their own terms means letting go of judgement. There is no better strategy for renewing the meaning and joy in your practice."

As another evocative example, Iona Heath, currently President of the RCGP, quotes[5] a colleague who describes difficult patients as 'extreme general practice' (as in extreme sports), in other words interactions in which you draw on all your reserves of skill, energy and enthusiasm to meet the challenge.

To link this discussion with that of Chapter Three where we distinguished between transactional care and care that is covenantal we can suggest that it is what is needed to enable the patient to flourish that should determine whether the care offered is the former or the latter.

[5] For example at the workshop How do good people offer bad care in Feb 2010

A patient with a short term condition (a fracture that will mend, an infection amenable to antibiotics, a rash of short duration), good support and abilities to function well in their world needs only transactional care: care given promptly, in accordance with evidence based protocols.

Someone with a condition that changes their expectations of what is possible in life (whether because it may be shortened or because their functioning within it is changed in some way) needs care that is a covenant between them and the care professional (as well as not having their time or good will trespassed upon, so again offering care that is prompt, efficient with their time and that draws on protocols when these are helpful).

And since many patients fall somewhere between these two prototypes care professionals will need to use their judgement about the kind of care that is needed – and to discuss it with the patient.

But it is difficult to care for others unless we are also capable of caring for ourselves - caring for our ability to care for others - so we need to enlarge the definitions we arrived at above to include ourselves in them. Thus care becomes the will to engage in acts of work and courage in order to nurture another's personal growth and our own ability to do so. Health care involves acts of work and courage that enable or promote the flourishing of others and our own ability to flourish in their service.

The balance between these two aspects – care for the other and care for ourselves – is important and needs to be explored, considered and kept under review, because many of the concerns about professional judgement, professional altruism, professional autonomy and professional capture spring from this.

If professionals care exclusively for others they become martyrs to their profession or calling. If professionals (wittingly or instinctively) put their own needs, wishes and comfort above that of the other we have care that requires the patient to be grateful for what they get: I will look after you but I will do it in a way that is convenient for me , whether that is convenient for you or not.

If professionals act on their own view of what is best for the other (the patient) without involving the patient in discussion and decision making then care becomes patronizing or paternalistic.

So throughout our professional lives we need to keep refreshing the debate about what acts of work and courage will further the flourishing of both parties in the care interaction and about ways of encouraging these.

Caring about wider health needs

If we cared only about the patients that were seen by health care professionals we would of course be failing a lot of other people who need our care if they are to flourish. So we need also to engage in acts of work and courage on behalf of the population at large, on behalf of colleagues of all kinds, and of people in other countries (whose trained staff we routinely plunder).

Educating people to care

Now that we focus, as described in Chapter Two, when training our young professionals, on competences and on the tasks people *do*, we have lost our opportunities to help them think about how to *be*. How to *be* in relation to those they are caring for (or about). How to *be* in the moment. How to *be* in themselves. And we need to return to older traditions to help here.

Many of the major world religions have practices of contemplation that, centuries before emotional intelligence was labelled such, enabled the development of compassion, equanimity and sympathetic joy which enlarged people's ability to handle adverse situations and people they found difficult. And many of them, too, encourage acts of kindness and compassion even where feeling is absent.

If we are to take care seriously we will need to look afresh at our competence and knowledge based approach to training our young professionals and think beyond it.

Managing Care

If we want clinicians to care in this way about patients, colleagues, themselves and others then managers too must do so. Definitions of care on the part of managers would include a list not dissimilar to that for care about patients:

'Caring management is manifest in acts of work and courage that enable the flourishing of patients, staff and colleagues, and our own ability to flourish in their service', or in 'acts of work and courage that enable or promote the flourishing of the local community', or in 'acts of work and courage that enable another person's potential to be of service to others'.

Indeed we could suggest that the key role of organisational leaders is to encourage and enable acts of work and courage throughout their organisation. And if we think of it that way we can articulate what it is that feels so wrong about the current style of 'performance management'. Performance management requires acts of work and courage from people in an organisation – but in the wrong direction. Instead of these acts being focused 'downwards and outwards' to patients, public, and colleagues, they are directed upwards. The reports required to be written and meetings attended are directed not to patient care

but to organisational performance (inevitably money and targets). Courage is certainly required – to walk into a meeting with the performance manager, expecting a vitriolic telling off[6]. And the outcome is a reduction in the capability to engage in the acts of work and courage that further flourishing – and hence, ironically, organisational performance.[7]

So how should we be managing care? If performance management has driven out good management what does good management look like? We have said it involves the simple hard rather than the complicated easy, so what do we mean by the simple hard?

At its heart are three 'rules' that, if we care, we use whenever we manage (or indeed rely on) someone else:

1. Agree with them what is expected of them
2. Make sure that both of you are confident they have the skills and resources to achieve it
3. Give them ongoing feedback on whether and how they are achieving it.[8]

There will be many who say this already happens, after all there are job descriptions, person specifications and appraisal systems, but (although important) these are not what I mean. The three rules are implemented day by day, week by week, through ongoing conversations. These conversations (most of which happen opportunistically and informally) bring together three sets of interests: those of the person being managed, those of the 'manager' and those of the organisation. In other words the 'manager' will take a genuine interest in the interests, enthusiasms and ambitions of the HCP they are managing, they will talk about their own ambitions and concerns for the service, and the relevant aspects of the organisational framework they are operating within (for example the realities of the budget, policies, the overall performance of the organisation).

Alongside these conversations the 'manager' will observe and/or find out how well their HCP is doing, and these observations and findings will form an important part of the conversation[9]. As they reflect favourably on acts, behaviours and decisions which have demonstrated competence and care they endorse and encourage these. Where they are concerned about performance they will say so, in ways that leave the other feeling that they need to do something about it, wanting to do so, knowing what to do, and feeling able to do it.

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[6] This is known as 'keeping a boot to her neck' or 'his feet to the fire'.

[7] We will look at this again when we consider a different kind of management in Chapter Seven.

[8] These are described in more detail in Iles V, Really Managing Health Care

[9] Please note that that I am describing here are the ongoing management conversations. Where performance issues have reached the stage of disciplinary proceedings then specialist advice should be sought.

As a result of these conversations both parties will have a good sense of the performance of the individual and how this is contributing to that of the service, and also the performance of the service and how that contributes to overall organisational performance. They will also have a rich understanding of how they can improve all three and help them all to flourish.

In case any reader is thinking that this form of management is indulgent, expensive and unaffordable, or that I am in some way harking back to the days when management was strictly a professional affair (undertaken within professions), let me refute both charges.

It is this kind of management, these robust ongoing conversations shaping behaviours and attitudes, that improves care and reduces costs. Indeed it is the only way to do so. It is only through small everyday changes in everyone's behaviour that we can achieve the massive improvement in NHS performance that the country needs.

And we have never had it – this kind of management. It is not a question of looking back – we won't find it there either. It exists (and has existed) in a few pockets, in a few organisations, but it has never been the norm.

There was a time in the late 1980s when it could have taken off. The Resource Management Initiative was an example of the spirit of that moment, it offered support for those conversations to take place within newly formed Clinical Directorates, and the generation of clinically driven data that is needed as a basis for the conversations. But the moment was not seized, and the spirit was driven out by the introduction of the purchaser/provider split. And, ever since, improvements in performance have been sought by major structural reforms, each successive change diminishing the opportunities for the kind of conversations that *would* improve care and satisfaction and reduce costs. This is a large scale example of the complicated easy being preferred to the simple hard. Developing the ability and willingness of a million people to engage in these conversations is both of those: simple and hard.

Making judgements about care

If we look again at the right hand column in table 3.1 in Chapter Three we can see that many of these characteristics of care are internal processes that result in external actions - but those external actions in themselves do not fully indicate the quality of the internal ones.

Furthermore it will be a feature of the complex situations in which professional judgement is most valuable that the courageous/caring action won't necessarily be clear at the time at which a decision needs to be made and different people will have different views about the wisdom of that choice because the ethical assumptions they make may be drawn from a range of ethical concepts (including deontological, consequence and virtue approaches).

So in this domain there may not be a right and a wrong approach and the means of reaching a judgement that an appropriate level of wisdom has been applied is likely to involve **discussion** rather than reporting.

In other words the process of authenticating the care must involve two things: *observation* of actions, and some *discussion* of those actions and the underlying thought and feeling processes that prompted them. It cannot involve just one of these. It requires a *rich understanding* of professional judgement.

If we combine the need for a rich understanding of professional judgement with the issue that many professionals work one-to-one with patients, managers can feel they have no way of knowing how their team member is performing. Educationalists use simulations, and may film some of those interactions (with consent). Clinical managers might consider these, however the old social work model of supervision is also well worth considering. Here a senior social worker would discuss with their team members, individually and on a regular basis, their whole case load. Discussions of this kind give insight into the approach, attitude, and underlying assumptions of the team member, as well as the actions they have taken. They also allow these to be shaped by the manager, perhaps by a gentle nudge or a more direct challenge, depending on the judgement of the manager. It should go without saying that this will not be effective if enacted in a spirit of blame or the professional involved senses they are expected to fail. Expecting well of them, letting them know that expectation, expressing disappointment if they fail to live up to that, and confidence that they can and will do so – that is how to manage care if we want it to be a covenant.

Managing in this way reduces the impact of many of the 'winds' we discussed in Chapter Two, but managing like this cannot be left only to those we call 'managers' – it must be reclaimed as an essential aspect of clinical roles. We will explore this again in Chapter Seven but let me say it again here. Every HCP should be able to expect this kind of support or guidance, and if that is to happen then far more clinicians than currently do so must take on this vital, fundamental professional role. Helping other clinicians to flourish must be welcomed as an essential part of all clinical roles.

The ongoing conversations, with their regular feedback and focus on the interests of both people involved, offer a means of containing the anxiety of both. They will allow any quantitative results arising from the audit culture to be put into context. They allow all concerned to understand how they fit into a wider picture and how to contribute effectively to decisions that affect them. They are an important part of halting the vicious circle of the five winds and instituting a virtuous one. They may be the only way to do so.