Chapter Three: A diminished concept of care: transactions and covenants

As a result of the five winds and our responses to them (Chapter Two) the kind of care that the NHS is explicitly aiming to offer is that of a set of efficient, auditable transactions between consumers and providers.

Implicitly many yearn to offer or receive something more than this: care as a relationship, a covenant between care giver and care receiver, a covenant that recognises that neither is an impersonal unit in a care transaction (in which each could be interchanged with any other such unit) but a whole, richly multifaceted person whose physical responses are strongly bound to emotional ones.

*The appropriateness, reliability and efficiency of the transactions of care are essential and we must find ways of ensuring these, however there is clear evidence from recent developments in neuroscience that the **way** in which care is transacted directly affects physical outcomes, and so we must be concerned about the nature of care as well as its content. If we focus only on the latter we are in danger of losing something very important.*

The 'winds' described in the last chapter swirl around us, often influencing our actions and thoughts without us being aware of just how much they do. As they do so and we respond to them, we collectively contribute to the diminishing of the kind of care that the NHS offers. Of course there are areas where care is still rich and its richness has been protected by its care givers but we suggest that these winds tend to push us all in the direction of a particular kind of care.

In chapter seven we will look at what we can do to mitigate these effects, but first let us look at what is happening.

Table 3.1 gives an indication of what we miss if we focus on care as only a set of transactions. In the left hand column care is just that: a set of efficient, auditable transactions. In the right hand column care is a covenant between care giver and care receiver, encompassing the transactions of care but not limited to them. The left hand column can therefore be seen as absolutely necessary but (often) not sufficient.

In an earlier paper we labelled the care of the right hand column 'relational' and in many ways that is more evocative than the clumsy word 'covenantal'. However we observed that many readers, responding warmly to the idea, appeared to equate it simply with being nice to patients, and often seemed to suggest that being nice to patients could excuse poor

Table 3.1

Transactional care *Health care as a set of auditable transactions in a market economy – patient as consumer, professional as provider*	**Covenantal care** *Health care with elements of the gift economy – patient and professional are in covenantal relationship*
Patient is cared for	Patient is cared about as well as for
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 but incorporates objective measures and evidence
Predetermined protocols	Emergent creativity which can include the use of protocols
Discourse and hyperactivity	Wisdom and silence in addition to discourse and action
Explicit knowledge	Tacit knowledge as well as explicit knowledge
Reflection on facts and figures	Reflection on feelings and ethics as well
Focus on efficiency and effectiveness	Focus on the quality of the moment as well
Dealing with the presenting problem	Keeping in mind the meaning of the encounter – for both parties - while addressing the presenting problem
Competence is what is called for on the part of the professional	The humanity 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 implementing the spirit and intent of the policy.

transactions of care. So here we have used the word covenantal to encourage a more robust view of the relationship between care givers and receivers. We still like the term relational and welcome you to use it, but encourage you to see its rigour and richness.

Often when professionals look at this table they seize upon the right hand column as the kind of care they wish to give and protest that they are prevented from doing so by managerial emphasis on the left hand column instead. So it is worth emphasising that the learning set had little patience with this view, observing instead that currently the NHS is not offering either of these. It is not ensuring effective and efficient transactions, nor care as a covenant. However we understand how professionals feel like this.

One way of thinking about this is to imagine that the features listed in the left hand column are cherries and those in the right hand column are a cherry cake. In other words sometimes the left hand column will be enough, and when the right hand column is needed it always encompasses the left. Our point is that unless we change our responses to the five winds the left hand column is all that the system will offer. And in many cases it will not offer even that.

The covenantal approach of the right hand column can be envisaged through the metaphor of dancing: of being active, alive, creative, present, and taking some risk – but not too much – and holding the other, involving some uncertainty and requiring a degree of courage[1].

Transactional care is an important part of the covenant and could be seen as steps in the dance. However because of the five winds, our responses to them and the vicious circles created as a result, the heavy emphasis on certain transactions of care makes them feel more like a march than dance steps.

The 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. Altogether this does feel like a march in which all are required to be in step, in time and facing the same direction.

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[1] If we think about it for a moment we can see that covenantal care is important at every level in the system – between patient and professional, between professional and their organisation, at organisational level and between organisations and policy makers -and at all levels this dancing will involve uncertainty and courage. 'Inevitably people will get this wrong at times and thus 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.' Paul Hodgkin, a member of the Learning Set.

To be fair to those insisting on improvements in transactional aspects there has never been pressure for a reduction in the covenant, and it is possible to offer both. However within the audit culture there has been no measurement and rewarding of the RH column, and unfortunately many of the professions have responded sulkily to the pressures for improvement in transactional care. They could instead have articulated a call for the covenantal. They could have insisted on both/and rather than either/or, but such a response is understandable in the circumstances and we will discuss it further in Chapter Four.

What is wanted and needed is a service that routinely offers excellent transactional care and also has the flexibility to offer a covenant of care when needed. This is such an important point it is worth saying again: it is not that well delivered transactional care is wrong, *it would be a huge improvement on the care that is currently provided.* There are times and circumstances when it would, on its own, be 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 enter a covenant of care.

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. Vital. They will themselves have an impact on the outcome[2]. So we can see them as an important part of the treatment. They will have an impact too, on both the patient and the professional and it is from this that HCPs have traditionally derived so much satisfaction.

So what *is* happening to care?

Pressure to improve the transactional aspects of care, combined with natural levels of anxiety, is leading to a withdrawing of care as a covenant between care giver and care receiver. This feels so uncomfortable to health care professionals that they respond badly to the exhortations to improve transactional aspects and care gets stuck – poor both transactionally and covenantally. This happens at all levels in the system and results in stories of patients feeling (and being) emotionally abandoned by care staff; in stories of staff feeling (and being) bullied by their managers; and in stories of Boards feeling (and being) bullied by the NHS management hierarchy.

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[2] See for example Matt Grist's [2010] *Changing the Subject: How new ways of thinking about human behaviour might change politics, policy and practice* RSA London

To the patient this can feel as though no one is taking responsibility, not carrying responsibility for the quality of the care provided, and in the learning set we heard many examples that illustrate this.

See how you respond to the following vignettes:

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 has been catheterized because there were 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 not uncommon in conversations in the non-health care world, 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 and 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 does not feel caring to those receiving it and it is not the care, either, that professionals want to offer. Giving and receiving care like this is miserable for everyone. But this is the way care is going, and it is worth remembering that it will not stay at the level of care we see today, because of the vicious circles described in the last chapter we can expect care to become more impoverished and unsatisfying even as it becomes more expensive.

Does this matter? Without thinking further into this future, focusing only on today, as a learning set we were struck by just how many people from completely different walks of life have recognised the picture we painted in our report: vicars, teachers, leaders of sheltered

workplaces for people with learning difficulties, all kinds of clinicians, academics. While some were familiar with the concept of McDonaldization[3] many were not and seemed relieved to have their experiences affirmed. Indeed more than merely recognising this picture, all too often they have expressed a depth of feeling – almost akin to a bereavement. Some have left jobs or changed direction entirely, others hate the limits and constraints and either rant and rebel or switch off emotionally.

Even if we are a nation of complainers this feels far beyond complaint. The impact on the psychological well being of well intentioned energetic middle income professionals seems profound. And that's without considering the reactions of those on the receiving end.

Of course we can dismiss these reactions as emotional. And when professionals make (emotional) pleas for alternative solutions we can then dismiss them as naïve. But as we do so let's remind ourselves of this description from John Ralston Saul: '*the expression of any unstructured doubt* is *automatically categorized as naïve or idealistic.*

So let us, at least, discuss the direction we are taking. Let's bring it into awareness and think about it (and about the wider forces to which we are responding). Then we can reach a considered decision about where we are going, about whether we see our professionals as implementers of protocols or whether we also need them to exercise professional judgement.

It is to the role, value and dangers of professional judgement that we turn next.

[3]McDonaldization is a short hand term for the audit culture, coined in 1993 by George Ritzer in his book The McDonaldization of Society.