THE NHS CONFEDERATION

Images of the NHS: an NHS Confederation Salon

Background

It is only right that the NHS should come under scrutiny from a number of different perspectives, after all it is a large organisation consuming large sums of money, dealing in matters of life, quality of life and death, and contributing to the overall economic performance of the UK.

However, although there are many academic fields that could valuably enlarge our understanding of the NHS (including its dynamics, the legitimacy for its decisions, and the impact and manner of its interaction with the wider society) currently those disciplines most frequently used to inform decision making are those of economics and policy analysis. As a result the conversations about and within the NHS often run within predictable tramlines.

The NHS Confederation Salons attempt to bring new perspectives to bear and thus prompt conversations that are unrehearsed[1], bringing together ideas that do not generally meet, and sparking off new trains of thought. At the Salon on 23 May 2007 an invited set of participants gathered to consider input from five different areas of expertise:

- anthropology,
- architecture,
- political philosophy,
- psychoanalysis, and
- psychoanalytically based organizational development.

This note attempts to summarize briefly the key points made by the speakers, highlights a number of distinctions and parallels that were developed during the discussion, and pulls out some themes for further thinking. A list of participants can be found in an appendix.

Speakers contributions : bullet point summaries of key points made

Robert Simpson : Reader in Anthropology, University of Durham

- Anthropology attempts to see the world from the native's point of view, identifying the rules, values, beliefs, aesthetics, routines, language, meaning,

[1] a term used by complexity theorists including for example Patricia Shaw in Changing Conversations in Organisations

symbols etc which make up the lives people lead. This contrasts with the analytical[2] approach of other disciplines and requires the researcher to have a presence in the world they are studying, being alongside rather than outside, and relishing the richness they observe rather than seeing this as getting in the way.

- When an anthropologist looks at the NHS one of the aspects they notice is that the same physical space, e.g. a ward, is 'constructed' in different ways, including as a place of healing, a work place, a place for 'consumers' to have their health care needs met as part of a market for health care etc. The patient too can be 'constructed' in different ways. The list of rules defining the role of the patient on a ward in 1930 contrasts with our understanding of that role today and yet there is still a sense of 'patiency' (as opposed to the agency of HCPs): of what people, when patients, agree to allow others to do to them.
  One suggestion is that the relational underpinnings of agency and patiency – dignity, confidence in the NHS, expectations of autonomy, trust, etc - may be being undermined by an imbalance in the attention given to patients' rights and patients' responsibilities.
- Another observation is that the culture of the NHS, and indeed any organisation, is made up of a fixed element (rules, structures etc) and an improvised fluid component which is the product of human ingenuity. To be able to live in worlds that are predictable and ordered and yet function creatively we need to switch between these.
  This means that there is almost inevitably a discrepancy between what 'people are supposed to do, what they think they do, and what they do do'.
  Ethnographic researchers therefore need to be able to blend narration with interpretation.

Jonathan Wolff, Professor of Political Philosophy, UCL

- In general political philosophers operate at a more abstract level than that of the NHS, and when they do turn their gaze in this direction there is some concern that decisions about the allocation of resources are being informed exclusively by economists and not by people with an understanding of theories of distributive justice.
- An example of this is the reliance on QALYs as the means of measuring the health outcomes associated with particular interventions. Philosophers question the very concept of putting a value on years of life. They are further concerned that QALYs, as currently used, discriminate against older people (with shorter life expectancy) and against people with long term disabilities[3]. The fact that NICE is

[2] analysis: simplifying, the better to understand

[3] whose maximal health rating is described in QALY terms as less than 1 .i.e. a year of life as a disabled person is rated as only a percentage of that of a year of life of a non-disabled individual.

applauded for making 'rational' decisions in a publicly accountable way, and that philosophers do not have any better proposals does not prevent them from seeing grave problems with this as a means of distributing scarce resources.

- If we could think more widely we might be prepared to allow health expenditure to be spent in a way that is economically 'inefficient' if considered narrowly but that yields much wider benefits. E.g. when hookworm was eradicated among white 'trailer trash' in the southern USA the whole community lost its stigma and the social and health benefits were wide and long lasting. Similarly when mental health services were introduced for single Irish men working in London they shed the drunken belligerent stereo type and the health of the whole community benefited.
- When philosophers observe health professionals they are struck by the way they prioritise health as the ultimate good. There is an assumption that, for everyone, health is more important than anything else. And yet we know that at an individual level people make trade offs between health and other aspects of their lives, and if, as individuals, we can make these choices perhaps we need a way of discussing this kind of trade off as a society.

Matthew Lloyd, Matthew Lloyd Architects

Architecture is the art and science of designing buildings. Similar to medicine in its central importance to our lives in that survival depends as much on shelter as on health and we are nearly as dependent on buildings as we are on our bodies. A description of the profession offers a number of parallels and contrasts with the medical profession:

- The professional body is 'an expensive club which represents us badly and costs a fortune'. It values the wrong things when it comes to awards and accolades.
- The profession is market driven, and architects have to hunt for work to survive. Matthew spends about a fifth of his time on this.
- The state of architecture (the market for it and the vibrancy of the profession) is connected to the health of the economy.
- Practices range from individuals working alone to those of several hundred (never more). Between them they work on projects ranging from bathrooms to cities and everything in between. Some earn millions a year, some £20k.
- The profession has been held in different kinds of regard at different periods: *post war* in a time of progress, equity of housing, modernity, architecture was popular. I*n the '80s*, as articulated by Prince Charles it became unpopular and in *the Blair years* it has become part of the celebrity culture.
- Women fare badly in the profession, forming 50% of entrants to the profession but only 15 % by the time they are 40. This is partly because architecture is NEVER sessionally based, always project based.
- In spite of long hours, liability for the performance of buildings, increasing levels of state invented regulation, there are very low levels of depression

and suicide. There are wonderful designers and talented artists and all are involved in something compulsive – making real physical things that are around for a long time.

- Architects are in their prime in their 60s and never in their 30s.
- Buildings can be built without architects. So why do people employ them? Because buildings look better, feel better, perform their function so much better if an architect is involved. It is difficult to measure the quality of architecture, to the trained eye the quality is apparent in one's reaction to a building (Matthew's heart can sing when he enters a well designed building).

Deirdre Moylan, Co director Tavistock Consultancy Service

- Working in the NHS creates anxiety: people are sick and might die, as a HCP you might make a mistake and kill someone, or end up facing the GMC or equivalent, you have to deal with people's grief, and may have to wipe the bottom of someone who reminds you of your Dad.
- When anxiety exceed the level that is tolerable (and this is quite low) our defence mechanisms are stimulated.
  Melanie Klein described, as the main defences for avoiding pain, two processes she called 'projection' and 'splitting'.
  - Projection: putting into (projecting onto) others feelings and attributes that we can't bear or can't own in ourselves.
  - Splitting: instead of acknowledging that we are all a mixture of both good and bad, splitting these so that we label one person or group as good and another as bad. (e.g. patients bad, doctors good. / nurses good, doctors bad. / me good, you bad. etc).
- As technology increases our capacity to do things (both good and bad), so our anxiety increases and the NHS can be a maelstrom of projections and splitting. E.g. managers can be seen as uncaring, only interested in money, lacking humanity etc and doctors as omnipotent, humane, with amazing creativity and so on.
- There is an idealization – denigration twist. Any group that has been unhealthily idealized, through projection and splitting, can be found wanting, and is then likely to be viewed just as negatively as they were previously seen positively.
- One social defence against anxiety is counting. 'When things get really difficult we go and do an inventory'. The fact that there is a lot of counting nowadays reflects the anxiety of people who have little control over what happens – e.g. policy makers are helpless because they are dependent on people they do not and cannot control, clinicians feel helplessly directed rather than allowed full professional rein. Statistics and audit are needed, but should be used as a tool to improve performance and not as a defence.
- Identifying and naming the real anxiety is important and allows it to be contained and not displaced onto something else (like counting).

- In the NHS some of the defences against anxiety that have evolved over time have been unhelpful and expensive but they *have* served to contain those anxieties. If they are removed in pursuit of efficient use of resources these anxieties are no longer contained, there will therefore be great resistance to those changes, and if instituted there will be a huge increase in anxiety which will manifest itself in a number of different ways.
- The way forward is to help develop healthier defences and to move from the 'good – bad' split to a 'third position' where both sides are able to understand the other and acknowledge the good and bad in both.
- Leadership needs to be able to deal with the loss of the old as people move towards the new: giving space for mourning and the human response to a sense of loss – as well as space for a sense of the excitement of the new. When a leader focuses only on the latter this is an assumption on their part of an 'omnipotent position', and so they have to *pull* people along with them, and instead of lots of minds helping design the change there is only one. Any reflection of the loss is seen as an attack.

Erik de Haan, Director Ashridge Consultancy Services
Erik's specialization is coming in with an empty sheet of paper, taking a Michael Moore stance (naïve, not understanding a particular setting,) to facilitate change from within. In the very little time available to him he took us on the journey he had captured on his empty sheet of paper.

In the course of the discussion we had followed the patient on a journey from being a *patient* to a *client*, a *litigant*, a *tourist*, an *anthropologist*, a *god*, to being *ourselves*, and finally to being subject to a 'dark room at the DH with a fountain spewing out anxiety'.

Erik also observed his own feelings during the discussion, his fear of not being heard[4] and the anger that attended this, and suggested that these may reflect a parallel process with the experience of many within the health system, including patients and professionals. 'Is there enough of the resource (time/money/beds) to go round?' 'Will there be enough for me?' 'Do I need to fight for my share of it?'
He also observed those feelings present in the room. These included:

- the expressed wish of those present from within the NHS 'please help us we have big problems';
- the competition among those present to be helpful;
- assumptions that the NHS is good and the private sector isn't;
- the attractiveness of the degree of professionalism allowed to architects;
- a recognition of the levels of anxiety in hospitals.

All this suggested to Erik that an understanding of Karl Weick's work on loosely coupled systems, recognizing that the patient is not the only thing that needs to be addressed would be valuable.

[4] He was the last speaker and had been left very little time

Discussion

The different contributions each prompted debate and those discussions are captured here in two forms: a) a set of themes that warrant further thinking and b) a note of some interesting distinctions and parallels that emerged in the course of the conversations.

Themes that warrant further thinking

1. The tyranny of informed consent

Even high quality ethnographic research is falling foul of research ethics committees, largely because researchers are being required to seek informed consent from patients, whether or not this will invalidate the research. This situation has come about because of insufficient debate (and of insufficient quality) about the ethical underpinnings of health care. Medical ethics has not attracted the best philosophers nor the best clinicians and the four principles[5] defined by Gillon have been allowed to be taught to generations of HCPs and managers without challenge. In the US, some universities are addressing this deficit by recruiting excellent philosophers without a back ground in medical ethics so this situation may change[6]. For further reading in this area see Public Health, Ethics and Equity, edited by Sudhir Anand, Fabienne Peter, and Amartya Sen.

There is scope for medical schools, schools of nursing etc, as well as schools of philosophy to participate in a debate about the guidance given to Research Ethics Committees.

2. Just because we've found an answer doesn't mean we should stop asking the question

There are many limitations of QALYs as a basis for decision making and these include:

- Discrimination against the elderly and physically disabled
- Exclusion of externalities e.g. the wider consequences of macular degeneration
- Lack of research → lack of evidence → lack of ammunition to fit into the QALY formula, **combined with the fact that** allocation of research funding is not equitable, e.g. disability is under funded

The saving grace is that currently the decisions based on QALYs are at the margin and affect relatively few people. However support for the public accountability and 'rationality' of its decisions may lead to more of them using QALYS as a basis and these fundamental problems mean this will lead to increasing unfairness.

The lack of an obvious or even tentative alternative does not mean that the use of QALYs should be supported. A completely different method may need to be found and

[5] respect for autonomy, beneficence, non-maleficence, and justice

[6] For example at Harvard Dan Brock, Normal Daniels and Daniel Wikler

the energy needed to find it may be sapped by their existence. Indeed our desire to be 'nice and definite and rational' may need to be left unfulfilled, ('we can't get rid of death'), and difficult decisions in which reason is only a part should perhaps remain difficult and emotional.

3. Healthcare has lost the authentic, passionate professional voice

Whereas many architects still find architecture compulsive and fulfilling in that it allows them to use all their creative skills and deploy their expertise in pursuit of an end they believe important (real physical things around for a long time), many HCP[7]s are no longer seen, or see themselves, as 'total professionals' in this way but as 'servants of the state', hemmed in by a plethora of guidelines. More, the very things that should be ensuring HCPs perform more safely (and making them and the public less anxious) are making them less so.

Notably architecture is *project* rather than *sessionally* based and perhaps it is worth considering whether this itself contributes to the authenticity and commitment we heard. It might be worth playing with the idea, and thinking through what this could look like in health care. In general practice for example a GP might provide 24/7 care for a 'list' that allowed this to be manageable. A part time GP would offer the same cover but for half as many patients. The managing partner would be responsible for the practice, again 24/7, and would ensure good delegation of duties in his/her absence. Professionals in specialist ('partialist') services would take responsibility for their 'part' of the patient *and* for liaising with the generalist to ensure good ongoing care.

If we think of what these 'project based' alternatives might be these do raise the question of whether part of the mechanism by which HCPs have become servants of the state is through becoming sessional workers.

The education of patients that would be required to make these alternatives work may also perhaps prompt a return to the spirit of community, friendship, solidarity and collectivity that we suggested has been lost in favour of freedom, rights, choice and democracy.

Redefining patients as our project rather than as the myriad other ways we see them (ranging from passive recipients of our care to potential litigants), would also redefine what it means to be a doctor /nurse/administrator, in ways that are more beneficial and less regimented than in the NHS plan.

4. Patiency: the roles of the patient, the way HCPs see patients, is the nature of the relationship affected by demands made on behalf of patients by the government?

Observations made during the discussion:

- When we look at artifacts such as the patients' record we see that although it is all about the patient the patient has no right to write in it.

[7] health care professionals

- When we observe what services 'do do' about e.g. waiting lists (as opposed to what they are supposed to do or think they do) we see them behaving in ways that make sense to them (not counting the period a patient is on holiday) but are not what they would want if they were patients themselves.
- The formal discourse with and about patients focuses on patients rights and doesn't pay as much attention to patients' responsibilities. It also considers patients needs (at least health care needs) rather than their potentials. The informal discourse is different and includes such terms as demanding, difficult, unrealistic expectations, non- compliant.
- 'Because patients are inherently needy, disruptive, difficult and messy we deal with this by giving them rules'.
- HCPs can act as though they believe there is a discrepancy between what patients are supposed to do, what they think they do and what they do do,
- The attitude of the patient may be changing, as IT allows more people to record and share their impressions of , for example, cleanliness, facilities, event the consultation itself, and these will be reflected back to the professionals and their organisations in ways not of their choosing.

All of these observations suggest that if we are to balance the needs of the individual with those of the collective we need to understand more about the beliefs, language, rules, etc that make up the interactions between HCPs and patients. We also need to consider whether these are changing and, if so, the implications of this for a taxation funded system.
We can espouse an ideal, as we did at the Salon, of empowerment, participation and problem solving in partnership, but unless we have this understanding there is a danger that we have empowerment only the on the terms of the providers ('I will work in partnership with you to solve your problems only as long as you behave in these ways').

All of this requires a research method and an academic discipline that can handle the richness of these pictures and not simplify earlier than is appropriate.

5. We could stop trying to be rational in non-rational[8] situations

Almost no aspect of health care can be thought of as wholly rational and yet we pretend otherwise[9]. If we could stop pretending to act wholly rationally we may be able to escape from the image of being all knowing experts intervening in situations where everything can be known and computed.

[8] situations that involve more than reason

[9] e.g. health is only one part of our selves (at least if we drop that silly WHO definition) and different people will place different weights on the benefits and disbenefits of an intervention. Our attitudes to risk, individually and collectively, change, so we are clearly engaging more than our reason when we assess it. Looking after people when ill engages our emotions as well as our reason.

Educating the public (and ourselves) about this would be liberating – not least in reducing enormously the potential for censure from the likes of the Daily Mail. Indeed, as the role of the press is likely to become increasingly dangerous as a publicly funded system attempts to finance more and more technological advances and politicians pander to them to ensure positive headlines, the liberation associated with honesty about the non-rational elements of decisions may be the only way to allow decisions not to be based on the prevailing anxiety of the moment[10] . In other words for decisions to be less (party) political and *more* rational.

6. In groups of people who have a particularly unhealthy mix of health and other aspects of life (social, employment, housing, education) how can resources be used wisely and well?

If it is a requirement that we spend *health* money *efficiently* how can we ensure these wider gains?

If HCPs should focus on using their specific skills and not stray into social care or housing how can they ensure that others with those specialist skills contribute them? This is especially problematic where clients needs in a non health arena do not make them a priority compared with other clients of that service.

This needs a debate in an arena wider than health, but there may be benefits to health (the NHS) prompting this and engaging meaningfully within it.

Or should we worry less about efficiency?

7. We need to understand more about the factors inherent within the clinical task if we are to design health care systems that will 'work'

If we understood more about the nature of the clinical task we may find that there are factors inherent within it that require particular features of the wider health care system that currently such systems do not provide. This insight needs to be multifaceted and we would benefit from using a number of different lenses to reach this understanding:

Anthropological
Sociological
Moral philosophy
Political philosophy
Economic
Psychoanalytical
Psychological

[10] we heard at the Salon of research which indicates that the more newspapers people read the less well informed they are about particular issues

8. A new look at professionalism

The term 'interpretive flexibility' was introduced during the Salon, and we could view health care professionals as masters of this: moving between modes of discovery and delivery[11] in response to circumstances.

It may be however that many of our existing health care professions have reached an era of 'commodificaiton'[12] in which too much of their expertise is becoming codified and available to others ('evidence based health care', guidelines, protocols) for them to retain an appropriate degree of interpretive flexibility. We may need to encourage our practitioners to think creatively about how to use their knowledge and skills to contribute to the health of individuals and populations in new and different ways.

As these new roles are designed (or emerge) we will need to, and have an opportunity to, recognize the anxiety inherent in a role involved with health care and also that associated with moving into new roles in a time when patients and public are no longer projecting onto them an assumption of certainty and expertise.
We will have an opportunity to avoid the particular example of *splitting* that currently occurs, in which the two different tasks of securing the best care for a particular patient and securing the best care for the greatest number, are deemed by different groups (stereotypically doctors and managers) to be good or bad. As we do so we can use one to prompt thinking about the other (*I want this patient to have this kind of care, how can I organise my service so that every patient who needs it can have a similar level of care?* or *I want everyone who needs it to receive good care, how do I have to organise my service to ensure that this equitable care is of a good standard?*).[13]
In other words at a time when professions will be searching for a new role we have an opportunity to design roles (or encourage the emergence of those) that are 'doable'.

Perhaps we need to reflect too on the professions of management and of policy making, on the interpretive flexibility that is legitimate within them, and on the anxiety that will be experienced here also. We need to name those anxieties, recognize them as legitimate and avoid structural re-organisation as a means of displacing them.

One of the ways GPs and other doctors describe their role is that of holding uncertainty, it may be important to consider and acknowledge the uncertainties that managers and

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[11] The terms used by Richard Bohmer, Harvard to describe the activities of 1. observation, assessment, review, concern, wonder, to reach a diagnosis and 2. implementation of guidelines appropriate for that diagnosis

[12] If we think of professions as having as S curve like any other technological product then they have passed the early development stage in which there is great innovation but slow uptake, and the market growth stage in which there is continuing innovation and rapid market growth, to the point at which all 'products' look similar and the market growth slows or diminishes. It has been argued (Gary Hamel 2007) that management too is at this point in the S curve, with all the major advances made in first half of the last century

[13] To do this will require a decrease in projection and splitting, since this is the way that the energy that would otherwise go into service redesign of this sort is displaced towards.

policy makers are holding. As we do so we may be able to re-engender health care management as a profession with full interpretive flexibility and move it away from it being a mere conduit.

Distinctions and parallels

A number of distinctions and parallels were introduced or developed during the meeting.

These included the **distinction** between:

What people are supposed to do	what they think they do	what they do do[14]
People behaving as individual patients	and as collective citizens	
Roles that people would like to play at different stages in their journey through a service: citizen, visitor,	guest , patient	
Health care provided for the benefit of the UK economy	or as a benefit to individuals and their networks	
The 'only'	and the 'best'	
Health as ***a*** good	and health as ***the*** good	
Decisions on cost effectiveness applied across a population	and decisions made when a patient is in front of you	
Allocation of budget *between* votes (health v education v defence etc)	and *within* votes	
Means of allocating resources: • profession (allocation by judgement), • market (allocation by consumer choice and ability to pay), • bureaucracy (allocation by algorithm) • politics (allocation by influence)		

[14] This prompted Malcolm to quote a cabinet secretary as saying that cabinet minutes are not what cabinet members had said, nor what they thought they had said, but what, if they had thought, they would have said!

Combining these two distinctions led to the following observation, that currently the situation is as follows:		
Allocation between votes	Allocation within votes	Individual patients
politics	profession and bureaucracy	profession and bureaucracy

Naming and addressing the underlying cause of anxiety	and engaging in displacement activity
Authentic, passionate professionalism	and professionalism within overly bureaucratic bounds
Patients rights	and patients duties
Patiency	and agency
Unhealthy defences against anxiety	and healthy ones
Language used formally about patients (patients rights, patients needs)	and that used informally (difficult, demanding, non- compliant, patients' duties)
The culture of the initial NHS (community friendship, solidarity)	and the culture today (choice, freedom, rights)

There were also a number of **parallels** that could be seen to emerge:

The anthropological approach of narrative and interpretation v the economists approach of analysis and prescription	The role of general practice v specialist (partialist) branches of medicine??
The cabinet secretary's perception of cabinet ministers	HCPs perception of patients??
The feelings and interventions of those speakers who were later on the 'list'	The feeling of patients 'will there be enough resource left for me?'
The lack of a 'fair' allocation of time for the different speakers	Lack of a fair allocation of health care resources

Valerie Iles
Paper for discussion
29 July 2007

Participants

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