

Why Reforming the NHS Doesn't Work

The importance of understanding *how* good people offer bad care

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For Eleanor and Nicola

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Introduction: The need to understand *how* good people offer bad care before we can renew and reform the NHS

As this book is being written the UK coalition government is about to reform the NHS in England.

Without questioning the good intentions of the government, who are responding to an expressed frustration and dissatisfaction of health care professionals (HCPs), managers, policy makers and the public, it is worth noting that many previous attempts at reform have not delivered the aims of their of their originators, and predicting with some confidence that this attempt will also fail.

This is because the NHS (in common with society at large) is profoundly influenced by a number of forces of which we are only dimly aware, our responses to which contribute to a vicious circle. Each response enlarges the scope and increases the grip of these forces and speeds the spin of the circle. The latest reforms are one such response and will cause several more spins – every spin resulting in care that is poorer and more expensive.

The aim of this book is to draw attention to these forces so that we can respond in ways that are healthier – for the system and for ourselves - and allow us to renew the NHS from within.

The argument presented here has its origins not in these reforms but in the times of plenty under the last government when, in spite of unprecedented sums of money being spent on health care, technology offering exciting advances, and evidence about what works enabling resources to be targeted wisely, those involved in health care provision still did not feel excited, able and effective, and patients and the public did not appear as satisfied and confident as we might have expected.

Understanding how it is that we have had unhappy staff and less than excellent care at a time of such record investment would be important even if money were still plentiful. In straitened times it is more so. However this conundrum is so familiar to everyone involved that it isn't seen as surprising. Instead it is treated with shrugs of shoulders or lazy platitudes.

The problems of the NHS are, for example, said by politicians to be 'all to do with the doctors and the unions'; by economists to be the result of 'capture by the vested interests of producers'; by staff within the service to be due to the short termism of politicians and their unwillingness to take unpopular decisions; and by clinicians to be due to the different values of clinicians and managers.

There is much talk of demanding patients with higher expectations being ever more ready to sue. At the same time observers talk of it being 'the largest organisation in Europe' and of 'culture change always taking a long time'. At the front line people say 'it feels as though no-one is caring about care, only figures, targets and contracts'.

And then there is the final comforting fable that ‘the care is fine it is only the media who say it isn’t’.

Thoughtful observers however, those who have worked across the system for many years, find that these platitudes do not accord with their experience.

Our experience is that the vast majority of people working with the NHS are good people - not saints, but competent people with good intentions who are behaving rationally within the situations they face. We observe too that no matter who we are working with the problems are apparently caused by decisions being made in the *next* room. Whatever room we arrive in the problem is always, we are told, caused by the people next door, people who, when we meet them, we find to be as ‘good’ as those in the room we have just left.

And as we observe the care received by family, friends and colleagues, and the care offered by organisations we work with, we notice that it is not as good as it could be – *as it could be for the same amount of money*. We call that bad care.

So we have a situation where good people are, collectively, offering bad care. Which is odd. We can all see how someone incompetent, behaving irrationally, or with bad intent can give bad care, but *good* people? What is happening and what can good people trapped in a system that is fostering poor care do to change it?

Three years ago a group of thoughtful and experienced contributors to the NHS came together to form a Learning Set and explore this. We set out explicitly to look beyond the economic and managerial literature to the fields of anthropology, sociology, political philosophy, psychology, moral philosophy, and history, to explore in greater breadth and depth three significant issues: the dynamics of the patient-professional interaction; the allocation of resources in a liberal democracy; and the nature of professionalism.¹

We² did so because we believed that when the economic /managerial paradigm was introduced to the NHS (and to British industry more widely) 30 years ago it was a hugely valuable addition to our ways of thinking, but that since it has swept aside those other ways and become the only game in town, its explanations and remedies are not wrong but impoverished, and are leading to the situation in which we find ourselves.

When we looked at these other schools of thinking we found descriptions that explained the world differently from the prevailing views of economists and policymakers, and also from those of healthcare professionals. Our contribution here is in bringing these together into a coherent argument about how we are where we are and how we could, if we chose, be somewhere different.

As you read it you may find that we have reached conclusions you would not have reached, and that some of our assertions based on our own observations do not accord with your own experience. We are not saying this is the only way of looking at things, but that it is a helpful way and we hope you may be encouraged to explore these fields more widely yourselves and contribute to this debate. Because this is a vitally important debate. Unless we change the way we view the NHS we will be caught perpetually between two incompatible power blocks. What we will see is not reform but rationing. We need to

¹ For more information on the Learning Set please see appendix one

² The terms ‘we’, ‘us’ and ‘our’ encompass different people at different places in this text. Often they refer to the members of this learning set. Sometimes they refer to the two facilitators of that set (the author, VI and Julia Vaughan Smith). On occasions indicated by the sense they include all of us as patients and the wider public, including those of us who are also health care professionals (HCPs). Oh and occasionally they indicate a cowardly streak in the author, hiding behind an unspecified plural.

understand that viewing the NHS as we currently do actively prevents reform, and that if reform is to be possible we must understand it in richer ways that have much greater explanatory power. We need to understand how we are all, collectively, squandering the resources of the NHS, by acting in ways that seem to us rational but are responses to forces which we have not thought sufficiently about. This book aims to increase our awareness of these forces, and enrich and enliven the debate so that we can all contribute to a genuine renewal of the NHS – to the benefit of patients, providers, taxpayers and policy makers alike.

It is a book written in haste and the lack of elegance in the writing style certainly reflects that haste, and there will be those who say that the arguments presented do also. Since the purpose of the Learning Set and of this book is to bring together fields of thinking that do not often sit alongside each other and apply them to the arena of health care, there will probably be many familiar with these fields who feel they have been introduced too superficially. If you become irritated as you read you can help make the book and the argument stronger by suggesting amendments, additions and deletions. It is registered under a creative commons license which means you can use any part of it as long as you give credit to the source, so please use it in any way you like and feed back your reactions.

Contributors to the thinking behind this book

Members of the Learning Set:

Sanjiv Ahluwalia, Celia Davies, Sarah Hanchet, James Harrison, Paul Hodgkin, Valerie Iles, Peter Molyneux, Stephen Morris, Pauline Ong, Jan Walmsley, Tim Van Zwanenberg, Julia Vaughan Smith.

All members developed thoughtful papers in response to reading, experience and our discussions. The papers of Jamie Harrison are a major contribution to Chapter Six, those of Celia Davies to Chapter Four, and those of Pauline Ong and Julia Vaughan Smith to Chapter Seven. This mention though does not do justice to the contribution made by Julia. As co-facilitators of the set we jointly coaxed, nurtured and shaped the thinking of the group and then expanded and articulated it, and she has made detailed and valuable comments on all drafts. Paul Hodgkin kept enthusing us with the wonders of the digital revolution, its opportunities and the inevitability of its impact. He also brought an additional liveliness to the discussions by contributing many of the metaphors.

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Kieran Sweeney. Kieran was a supporter of and contributor to the thinking of this set and an inspiration for it. His commitment to an understanding of complexity has influenced my thinking for many years and his work with us (Julia and me) on the RCGP leadership programme both stimulated and endorsed our progress. His last interview can be seen on http://www.e-lfh.org.uk/projects/lead/patient_journey.html. In it he demonstrates his ever-present integrity, compassion and humour and his concern about the kind of issues we are exploring here. His death has been a huge loss.

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Even with all this help many mistakes and inaccuracies and clumsinesses remain, for which I personally must apologise.

Chapter One: A history of NHS reform in England – through different lenses

For over two decades governments in many countries have been concerned about increasing costs of health care. This chapter starts with a light hearted history of some of the major governmental attempts to contain costs and improve productivity within the NHS in England in that time period. It then suggests that all of these policy initiatives, whatever the colour of government, have been strongly influenced by a particular way of looking at the world and that using alternative paradigms could lead to very different approaches to policy.

In 1983 Roy Griffiths, a business man with considerable experience of a service industry, commented, about the NHS, that 'If Florence Nightingale were to be seen today she would be using her famous lamp to try to find out who is in charge'. He advocated replacing the three person District Management Team (of District Administrator, District Medical Officer and District Nursing Officer) with a single General Manager. He explained this as removing 'management by veto', which was how he described the requirement for consensus among DMT members if decisions were to be taken. In a short while administrators and their profession disappeared and a new one was born. Retired Rear Admirals and Wing Commanders competed with business people and those (soon-to-be-ex) administrators for the new general management roles. Now that the problematic 'veto' was no more and there was a single person in charge, the blocks to imaginative provision of services were removed, with improvements in quality and reductions in costs naturally taking place.

Except that they didn't.

Flirting briefly with the idea of dismantling the NHS, Margaret Thatcher's policy advisors decided the problem was lack of incentive to improve organisational performance, and that this could be generated by the creation of an 'internal market'. The 'purchaser / provider split' in which identification of health needs and purchasing of services to address them was separated from service provision, was followed by provider units becoming Trusts, no longer managed by a District Health Authority but selling their services to them, and to GP fund holders, as 'money followed the patient'. Naturally, now that not only had the veto been removed but managers and their organisations were energised by having to compete in a market, services were very quickly and imaginatively redesigned to increase quality and reduce costs.

Except that they weren't.

When changes took place they were at the margins (faster, more reliable discharge letters, shorter waiting times for a few patients) as a result of specific demands from fund holding GPs. There was considerable change, as there always had been, in clinical practice as a result of new technologies and

also as a result of a newfound emphasis on 'evidence based medicine', but the design of services as a whole remained resolutely familiar.

With GP Fund Holding unacceptable to the incoming Labour government, Primary Care Groups and then Primary Care Trusts were formed, in which GPs and other primary care professionals would influence commissioning decisions (which replaced purchasing decisions) through membership of the Professional Executive Committee which was 'the engine room' of every PCT. At the same time the government invested very considerable additional funding and, to ensure it would not be wasted, imposed access targets for a range of services (that were so far from the practice of the time that most providers found them highly challenging) and a requirement that all parts of the system live within their financial means. A culture of 'personal accountability' was encouraged, in which individual managers were held accountable for the performance of large complex interdependent systems, which was another way of energising managers to focus on organisational performance (this time against the targets). This combination of money and reforms led inevitably to the thoughtful redesign that provided better care, shorter waiting times, and lower costs.

Except that they didn't. Even when expertise in service redesign was fostered in a central Modernisation Agency, which seconded excellent health care professionals from specific specialties to generate best practice service templates, local clinicians often resisted implementing them. Targets were, largely, met through additional expenditure and, as there were other calls on the new money (commitments to additional services, new technologies, pay increases, new buildings and plant...) most organisations found it increasingly difficult to stay within budget.

So, if this wasn't the answer what would be? If removing management by veto, giving managers the power and the energy to implement change, informing commissioning decisions with clinical opinion, and ensuring sufficient redesign expertise within the system, does not lead to change on the scale that is needed, what would? Suppose all hospitals were autonomous Foundation Trusts which entered into binding contracts with powerful, well-informed commissioners and they were allowed to succeed or fail according to their ability to offer services of high quality and low costs. Suppose too that patients chose for themselves the service provider they preferred, and that there were a national tariff for payments so that efficient providers were rewarded and inefficient ones penalised, then it would be in the interests of managers and clinicians alike to redesign their services and cut out waste and focus on quality.³

And of course that worked well.

Well it would have done. All it needed was for:

1. Clinicians to behave like professions in many other industries, recognise a management hierarchy and do as they are told
2. The press to lose their habit of reducing complex situations to simple fights between 'goodie-baddie' caricatures in which they almost inevitably cast doctors as goodies and managers and politicians as baddies
3. MPs not to mind negative coverage in the media

³ This is the system described by Monitor (the organisation monitoring the capability of Foundation Trusts) in English Healthcare 2008-9, An interpretation of the government's reform vision. Monitor. April 2005. The actual words were: *'Providers, purchasers and transactions are the heart of the day to day running of the [health care] system'*.

4. The unremitting emphasis on organisational performance not to impede the thinking across organisational boundaries that was necessary for service redesign to yield highest quality lowest cost care

5. Health care organisations in England to behave in a completely different way from those everywhere else. When similar incentives have been introduced elsewhere (e.g. the US) they typically trigger an initial reduction in costs through greater efficiencies which is then followed by a larger and more sustained increase in costs as hospitals try to gain competitive advantage either by adding 'kit' (e.g. the latest scanner, DVDs in private rooms) and/or by securing a regional monopoly which allows them to increase prices and/or 'game' successfully with funders.

This is uncannily reminiscent of the joke:

A physicist, a chemist, and an economist are shipwrecked on a desert island with only a can of beans to eat and with no tin opener or any other tools. The physicist suggests using a stone and calculates the correct angle, mass, and velocity that would split open the can. The economist vetoes this suggestion on the basis that it will spill the beans. The chemist then offers to use some local plants to make an acidic juice that will corrode the metal and open the can. The economist vetoes this too on the basis that it would contaminate the beans. Finally the other two ask for a suggestions from the economist. 'Oh this is very straightforward' he says, 'first, assume we have a can opener.'

So another change was needed and this time it was agreed that commissioning was the problem, that it needed to be tougher. So PCTs were merged into fewer, larger (hence stronger) units and a major management consultancy advised on how to make NHS commissioning 'world class'. Their detailed lists of competences, descriptors and examples of evidence that commissioners could provide to demonstrate their competence were deemed helpful by the new PCT leaders who invested considerable amounts of time, energy and money in enhancing (and demonstrating) the competence of their organisations. In this they were very ably assisted (if they chose) by the same management consultancy.

So now that tough negotiators from the high status acute care organisations met their match in world class negotiators from the PCTs and both sets were informed by better and better information and were meeting regularly as required within the competences, health care naturally became sensibly planned, with local needs well researched and converted into a credible list of local priorities, and care was delivered in seamless packages across primary, secondary and tertiary care boundaries, with clinical quality and patient experience a focus for all involved.

Well it should have done.

Instead recorded admission rates to hospital rose steadily and inexorably, to the consternation of PCTs and their bosses, the Strategic Health Authorities, and to the financial advantage of hospital trusts.

In the absence of credible studies of the causes, accusations flew. GPs were too lazy and greedy to make appropriate referral decisions. Patients were ever more demanding and were insisting on unnecessary prescriptions and referrals. Hospitals were admitting too readily, indeed were using admission as a means of meeting the 4 hour A and E target. Salaried GPs were over-referring. Out of Hours GPs were over-referring. Doctors in acute trusts were actively encouraged to offer procedures they might have rationed before. There was no increase in admissions only in coding⁴.

⁴ When every GP in Plymouth agreed to make referrals through a single referral centre, enabling accurate data to be collected, it became clear that there was no increase at all in referral rates.

Whatever the cause, the hugely generous growth monies that could have been used to develop 'world class' services across primary, secondary and tertiary care, based on thoughtful, sensitive redesign that incorporated the experience and enthusiasm of all the clinicians involved, made its way to acute trusts, whose managers now had no incentive to rethink ways of working, or indeed to do anything other than congratulate themselves on 'running successful organisations'⁵.

PCTs could do little but grind their teeth and make cuts in the services they directly managed: community services. Indeed these became, once again, the subject of vacancy freezes, skill mix reviews, and general asset stripping and budget reduction, just as they always had done – from the days of the old District Health Authority onwards.

In the midst of this two enquiries into 'excess deaths' at a hospital in Mid Staffordshire reported shocking lack of care on some 'care of the elderly' wards – which seemed to stem from inadequate staffing levels⁶. At the same time the Patients Association published a number of similar case studies from a number of different hospitals. It appeared that at a time of unprecedented financial support, care in at least some parts of the NHS was not just poor but scandalously so.

Is there another way of looking at this?

A different history of the same events

The lens through which the health care system has been viewed in all these initiatives is a managerialist (or perhaps MANAGERIALIST⁷) one, strongly influenced by the economists' view of the world. This is so much part of the zeitgeist that many of us have forgotten there are others. If instead we consulted a historian, or anthropologist, a sociologist, a complexity theorist, a political scientist, a psychologist, or theologian, we would find some very different explanations.

A sociologist, for example, or a political scientist, may not have observed 'management by veto' in the old District Management Team (DMT), but a process that reflected the difficulty of reconciling a number of different interests, where some of the stakeholders hold a status that makes them ill prepared to accept challenge and leads others to find it difficult to make that challenge. In such a situation they would have predicted that any general manager would find it just as hard as the DMT to address any issues other than a few hotel services. They would have predicted too that increasing the organisational incentives (and penalties) by introducing a market would lead to a dash for cash in which acute units sought to develop new facilities and attract more patients, with the higher status centres being more successful in this than others, so that organisational energy would not be vested in redesign of existing services but in adding to them. This would also result, they may have suggested, in tertiary centres either receiving more than their 'fair share' of resources or feeling aggrieved that they hadn't.

⁵ This was the answer given by a Foundation Trust CEO when asked how they accounted to members of their community who were deprived of other services as a result of their capture of this money 'I make no apology for running a successful organisation'.

⁶ Interestingly the original cause for concern and the reason why the first enquiry was conducted was a poor set of Standardised Mortality Ratio figures. These figures may have been triggered by excess deaths but it is also possible that they reflected poor coding. In which case the attention of the investigating bodies was serendipitous and we really do not have any idea just how many hospitals are offering the kind of care described in these reports.

⁷ In *Managing the Myths of Health Care*, Feb 2006, Henry Mintzberg distinguishes between managerialism and MANAGERIALISM. We will explore this further in Chapter Two.

Their forward gaze might also have indicated that the higher status secondary and tertiary care clinicians and their management colleagues would perceive PCTs, and especially their managers, as 'low calibre' – whether they were or not. This would be exacerbated, our crystal ball gazers might have speculated, by the fact that because posts in PCTs would always hold a lower status than those in the acute sector, they would not attract people determined on a fast track to the top, however rapidly salaries in PCTs were escalated. PCTs would struggle, they may have predicted, to make an impact. Would they have gone as far as suggesting that acute and foundation trusts would see PCTs off – persuading the department of Health that they had 'failed'? Perhaps.

They would certainly have foreseen that all but the most self confident of SHAs would continue the age old practice of supporting acute sector managers in any dispute with primary care or community care colleagues. As a result they would have foreseen that while PCT folk would be able to see that financial pressures on their health economies were leading to short term fixes and fudges they would be unable to do anything about it. They may also have foreseen that PCTs, unable to prompt change in the design of services in the acute sector, would try and keep patients in (cheaper) primary care settings, thus using new resources to duplicate facilities already available in acute centres. These combined with the cult of personal accountability and the resulting inability to convey any bad news upwards, would lead, they may have suggested, to serious financial problems once those short term fixes and fudges could deliver no more 'savings' and the additional costs of duplicate provision and of meeting and monitoring targets kicked in.

How might they have viewed the suggestion in 2006 that increasing the 'power' of 'strategic commissioners' was what is needed? Perhaps they would have suggested that any increase in pressure on acute sector managers would mean they now found themselves between a rock ('powerful' and intransigent commissioners) and a hard place (clinicians who see no reason to change), and that the increasing pressure would lead to an ever more rapid turnover of those managers and their teams – or to a strong desire to increase admission figures.

And their view of the 2010 policy of 'liberating the NHS' from the bureaucracy of the PCTs, transferring commissioning responsibilities to clinicians? Probably as yet another attempt to bring high status autonomous professionals 'inside the tent', doomed to fail for the same reasons as all previous ones.

What is it we have been trying to achieve?

Philosopher / development economist Amartya Sen⁸ encourages us to focus on what it is we are trying to achieve rather than on economic processes that are supposed to take us there. So perhaps it is worth being clear just what it is we are trying to achieve.

If the problem is that we have professionals, of sufficiently high status to be able to skew local decisions in their favour, paying insufficient attention to the needs of the tax payer and the population as a whole in their concern to be able to offer ever better services for their own patients, then what we want to achieve is good quality decision making informed by clinical perspectives but not inappropriately influenced by issues of status. The solution is likely to involve high status professionals reflecting proactively on their own practices and the design of services in which they are involved⁹, and taking a

⁸ See Development as Freedom Amartya Sen, Oxford University Press 1999

⁹ Making good use of resources will always involve a consideration of whether savings can be made in some areas to allow investments in others. When savings have to be made there are four major means of doing so: cuts, rationalisation of services, redesign of services, and reflection by practitioners on individual practice. In a healthy

collective responsibility for the stewardship of the organisations of which they are a part¹⁰, and if that is what we are trying to achieve we should give it the explicit attention it deserves.

If we do so, if we think about individuals with sufficiently high status to be able to recruit the media and the public to their cause, we can see they will be able to resist any pressure from managers or politicians to change. We can imagine too that exposing them to a centrally generated specification of best practice will influence some but is likely to antagonise just as many. And we can imagine that increasing either kind of pressure will severely reduce any enthusiasm they may have had for sharing a responsibility for the organisation as a whole.

So, if pressure from managers or from centrally recruited peers will not work what are the influences that will prompt high status individuals to design or accept change? There are several (our sociology or political science observers may suggest) and they all involve allowing¹¹ individuals to see for themselves that change is both necessary and possible.

1. Information

Information about how their practice and their service compares with that of others, or with their own practice/service over time, allows practitioners to reflect on what aspects of their practice and their service they could valuably change. The information needs to be credible (based on robust and relevant data) and presented in a way that is meaningful to those concerned (analysed in terms of activity clusters at the right level of detail/aggregation, for example).¹²

system all four are used, starting with the last – reflection by individual practitioners. In organisations with a connected hierarchy in which the front line broadly accept the authority of their managers, in which there are organisationally sanctioned incentives for individuals and teams to reflect and redesign, this is what happens. However where the hierarchy is disconnected and especially where high status groups can operate with considerable autonomy, there is a tendency instead to focus only on cuts and rationalisation and not on redesign and reflection. *See Chapter Six for more about this.*

¹⁰ There is some evidence in the States of clinicians being actively involved in the stewardship of some of what are regarded as the best hospitals and hospital systems (e.g. Kaiser Permanente, Mayo Clinics, Massachusetts General among others).

¹¹ ‘Encouraging’ may be as useful a word here as allowing, but only if it does not stray into ‘requiring’.

¹² Interestingly, one centrally driven initiative in the late ‘80s did focus on information. Work undertaken at six Resource Management Initiative pilot sites brought clinicians and managers together as they devised means of implementing clinical information systems from which information could be drawn for clinical (delivery and audit) and managerial (resource deployment and organisational performance monitoring) purposes. Unfortunately it was overtaken by the advent of the internal market, and the formal evaluation, using the dominant economic lens again, found it had not improved clinical or financial outcomes, despite the major impact it had had on clinical-managerial relationships. A sociology lens might have indicated that these just hadn’t had time to yield tangible results, but that they were well on the way to doing so.

Now that an interest in information has re-surfaced, this time energised from a patient perspective (what do patients want to know about outcomes) and by the needs of boards of foundation trusts to take responsibility for the fortunes of their organisation, some useful work has been done identifying the kind of information needed for effective decisions about deploying resources and monitoring sub-organisational performance. If this is to yield genuine improvements in efficiency and effectiveness it will need to reinvent or build on the approaches of some of the RMI sites. This will mean taking a totally different approach from the national IT project now called Connecting for health which has chosen to focus entirely on lowest common denominator data for clinical delivery, ignoring the opportunity to help clinicians (and managers) understand and control costs, as well as incur and monitor them.

2. Peer example.

While *pressure* from peers can be resisted, opportunities to discover that the practice of peers and the design of their services is different, and exploring the implications of those differences, can lead to very constructive reflections on both of these. Engaging in this process of discovery is likely, however, to be resisted unless one of the two following features is present:

3. Managers who genuinely care about the care that is being offered and who want to help clinicians improve that care.¹³

When managers care first about care and only then about their organisations (as the best means of offering good care), and demonstrate that commitment by taking an active interest and by responding creatively and quickly to clinical suggestions about service improvements, then their credibility will allow them to draw attention to some of the opportunities described above.

This enthusiasm for care cannot deter them from stating clearly financial and other realities, and they must demonstrate their competence at dealing with managerial processes, but they must be driven first by concern for effective care, and definitely not by a primary concern for balancing books which allows care to suffer in order to achieve it.

4. Thought leaders who are from a high status group who don't impose their own prescriptions for action but who hold high expectations of the performance of others.

Similarly the credibility of these individuals allows them to provide the challenges and support that encourage mature reflection rather than defensive resistance.

5. Organisational stewardship.

Where high status clinicians are allowed and encouraged to form some kind of 'clinical senate' whose brief is to shape the organisation's strategy, to ensure the consultant body understands the internal and external pressures that make it the best way forward, and to challenge behaviours and practices that are not consistent with that direction, then results can be impressive.

6. First hand stories from patients and from other HCPs.

While second or third hand stories and written complaints can be dismissed and the motives of their authors impugned, first hand stories are a different matter. These can reflect the experiences of patients or those of other HCPs. It is often one of the most valuable outcomes of discussions about care pathways – as long as the highest status people are in the room to hear the stories, and often they are not; and as long as the discussions are well facilitated so they consist of personal narratives (this is what I experienced) rather than accusation and blame (this is what you did).

7. And especially when these become embedded into the culture of the organisation.

We can imagine that while one or two of these methods are helpful, if they became embedded in 'the way we do things round here' their impact would be very much greater. So we can suggest, and quite strongly, that it is a shift in the culture of this kind that is what is needed.

Could world class commissioning from foundation trusts have taken us there?

Looking through the economic, or MANAGERIALIST lens 'strategic commissioners' were encouraged to:

- draft legally binding contracts skilfully, using knowledge gained from poachers turned gamekeepers (people with a good knowledge of acute sector provision),

¹³ For a discussion of what we mean by care see Chapter Five

- build in penalty clauses for underperformance on a number of dimensions,
- monitor that performance carefully and exercise their power to enforce the contract provisions

on the basis that organisations would then **'have'** to deliver quality, efficiency, effectiveness ...etc

Using instead a sociology or political science lens we might have said, 'yes, but **how** will the organisations do this?' 'How will tough contracts lead to the kind of behaviours just described?' A historian would have observed that similar pressures have not had this effect in the past. An anthropologist would have noted that when people resist change they do so for a reason: '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.'¹⁴ They would have encouraged us to ask ourselves how 'tough commissioning' overcomes those feelings that realities are being traduced.

If, as we approach clinical commissioning, we keep in mind that what we want is clinicians in all care settings reflecting on their own practice and on the design of the services in which they are involved then, instead of emphasizing the toughness of the contract, we will encourage commissioners to focus explicitly on this dialogue between all those concerned with the provision of care.

To do this though we need to understand much more about the dynamics at play. We need to understand what it is that stops clinicians reflecting on their own practice, and on the design of services in which they are involved, in ways that draw on their creativity and good will. We need to see the health care system as very, very, much more than a set of transactions between purchasers and providers. Just as importantly we need to understand how it is possible that health care has ever been described in that way.

This is vitally important, not only because the NHS does not currently meet the legitimate expectations of its patients, nor because of the country's current financial problems, but also because of the very great impact that sociodemographic shifts (rapidly increasing longevity and equally significant decrease in birth rates) will have on demand for health services and our ability to pay for it. Increasingly policy makers and commentators are making the case for a paradigm shift, a shift in which services are radically reformed and attitudes seismically refashioned.

The shift being pursued at the moment, as described above, is one devised largely by economists who believe that the public services have been captured by the vested interests of producers and whose remedy is choice, competition and regulation leading to innovation and hence increasing efficiency and productivity.

This view of providers as self interested units of production contrasts with others that see professionals as society's way of dealing with uncertainty (its only way in some cases) and the need for professionals not to abandon their concern for society and its members and become self interested, depersonalised units of production. These other views have not been sufficiently heard or understood, and the following chapters in this book explore them and look at what happens to care when they are not.

In other words, even if it is 'true'¹⁵ that public services have been captured by the vested interests of the producers, that is a very high level abstraction, so distant from the level at which real people act and

¹⁴ McDonald. M, Chapter 4, Audit Cultures Ed Strathern M [2000]

¹⁵ By which I mean that this phrase is one way among many of describing in a short hand manner the complex reality which is too big to be described in full and so can only be discussed in ways that do not represent it fully

interact as to be, on its own, useless. The important question that should always accompany it is '**how** have the vested interests of producers captured the public services?' If we understand **that** we can begin to devise means of releasing services from that capture. When we understand that we can find means that allow all those involved (patients, tax payers, professionals and policy makers) to flourish.

So in this book I am not suggesting that the analysis of economists is wrong merely that on its own it is unhelpful and that other fields of knowledge must contribute to our ways of thinking about this. Without these contributions the reforms demanded by economists and policymakers are dangerous.

Chapter Two: The making of a vicious circle – factors that affect the nature of care

When we look beyond the mainstream managerial and economic literature to the fields of anthropology, sociology, psychology, history, moral and political philosophy and more, we find vivid descriptions of factors that strongly influence the behaviours and reasoning of all those of us involved in health care. Our responses to these factors are reasonable, not foolish, but cumulatively, as all of us respond to them in a myriad of actions every day, they render the overall system less and less healthy and our experiences of it less and less satisfactory. This chapter introduces those factors and describes their impact on the nature of health care.

Factor One: The Digital Revolution

Although the term ‘digital revolution’ is in common use, not many of us pause to consider quite how revolutionary our ability to collect, store and mine data has been¹⁶. 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 key points from client/clinician conversations and the treatments prescribed therein has led to an ability to compare and monitor the performance of individual clinicians, of teams, and of organisations as a whole. Performance, that is, against particular observable and measurable criteria; for example, whether blood pressure has been checked, or statins prescribed.

Similarly, when decisions are made about operational issues or about organisational strategy, discussions are recorded and minutes are kept. Looking these up to trace the pathway of the decision and the factors taken into account would, not long ago, have required tenacity, time, physical access to

¹⁶ ‘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]

records, and some understanding of the issues involved. Now these records are available almost instantly to almost anyone who asks.

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.

All of this sounds positive, or at worst neutral in effect. It assumes that observing an individual, or team or organisation simply gives us information about what they are doing and how. But, as anthropologists and others have noted, the very act of observation changes the process we are observing, and the nature of the data collected digitally changes it quite profoundly.

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 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, and it is worth looking at some of the less beneficial features of this culture

Factor Two: A Culture of Audit

Audit has been described as '*a relationship of power, between scrutinizer and observed*'¹⁷ and this is certainly the way that it is experienced by many in health care. We describe some of the feelings of HCPs on page 45 in chapter Three but the impact is felt much wider than this, so let us consider some of its observable effects:

- *Reduction in creativity:* When performance is measured against objectives, these objectives are required to be specified in advance. While this is often a valuable discipline 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 act of specifying them 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 record only the 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.¹⁸ In the area of professional decision making, judgement and 'practical wisdom' are an essential feature and the wisdom drawn upon to inform an act is as important as the act itself but is not (and cannot be) captured. Thus 'hyperactivity and discourse are privileged over wisdom and silence'.¹⁹

¹⁷ Strathern M [2000] Audit Cultures Ch 2

¹⁸ 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.

¹⁹ Ibid

- *We don't measure what is happening, only how we are managing what is happening*²⁰: As a result of the above points there are difficulties in capturing the nature of 'first order activities' (in health care these first order activities are the interactions between professionals and patients) and thus it is not these that are monitored but second order processes. These second order processes are supposed to ensure delivery of the essential, first order, activity and they include a range of governance activities and performance targets. However 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.
- *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. This in turn leads to a preoccupation with risk, the development of risk registers and requirements to 'manage' risk²¹, which all misunderstands the multifaceted *nature* of risk and its different meaning to different people. In fact meaning is something the audit culture ignores.
- *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. This is explored in more detail in chapter four.
- *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. While financial data is of course important, and we fully accept a need for financial responsibility that has often eluded the NHS, it is more valuable informing decisions rather than dominating them, especially decisions that have many impacts, not all of which can be anticipated. Please see box 2.1. for an illustration of what we are concerned about.
- *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. In other words targets can be met as a result of improvements to the system, getting everyone involved to reflect on how things could be done differently and better. Or they can be met by focusing solely on the target at the expense of system.

²⁰ Or what has happened

²¹ This changed attitude to risk is worth emphasizing. Not only does it become the predominant factor in any decision, but risk is now something to be assessed and managed – rather than taken. But as we have noted above, only elements that are codifiable can be recorded. So the elements of risk that are not quantifiable are not given the weighting they deserve. As a result risk has been described as 'the acid bath that corrodes trust'. Beck, B, The Risk Society.

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.

Box 2.1

Participants of a workshop about this work were invited to bring with them examples of good and bad care that they themselves had witnessed. This is one of those brought.

'I was a ward sister on a rehab ward in a district general hospital.

A woman age 50 was admitted who had recently had a heart attack, but she was admitted with weakness in her legs which made it difficult for her to walk. The week she had been admitted she had hoped to return to live in New Zealand and had given up her flat and been staying with friends. It proved very difficult to diagnose what was causing this weakness but gradually she deteriorated and lost the use of her legs and gradually became weaker and weaker until she was no longer able to lift her head.

During these weeks and months, we as a team cared for all her physical needs, and also provided emotional support during a very frightening time. Eventually she was diagnosed with an extremely rare syndrome and had various forms of treatment including radiotherapy and a stem cell transplant. Some of these treatments took place in other hospitals but she always returned to us for rehab.

After being successfully treated she required months of intensive rehabilitation until eventually she was able to fly home to New Zealand.

I look back on the care we gave her as being of a very high standard. However soon after, the rehab ward was closed and one of the reasons given for this was that it was too expensive, patients stayed too long and this patient was cited as an example of what was wrong with the ward²².

I have heard recently that she is now able take steps in the gym and is living independently and that gives me immense satisfaction.

²² Just to be clear about this. We are not for a moment saying that financial considerations are not important, we believe deeply that they are. At a societal level however the costs of these rare cases can be afforded in a way they cannot at a local level, that is why we have a national and not only a local health service. We have to find a way of making the money flow, the alternative of not offering the care is simply inhumane. The ability to count costs more easily than benefits distorts, in an *audit culture*, our decision making priorities towards the inhumane.

Taken together there is a danger that these often unacknowledged downsides of the audit culture are leading to a change in the nature of care. A change in which patients are no longer cared *about* (I care about what happens to you and about how the quality of our interaction can help you and I will make sure you get the best treatment for you, within the resources available) but cared *for* (you have condition X for which the best, evidence based, most cost effective treatment is Y. I will make sure you get Y).

We can see this by considering the impact of the audit culture on the health care practitioner dealing with a patient, where it results in:

- An agenda for the care they offer that is neither theirs nor the patient's but is imposed in response to governmental or organisational 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 and worries).
- 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 'depersonalized unit of economic resource whose productivity and performance must be constantly measured and enhanced'.²³
- What is more, even when HCPs support particular policy intentions when they are declared by policy makers they do not recognise those intentions in the onerous lists of 'must do's that arrive on their desks months later, having passed through many layers of well intentioned policy implementers each adding a level of detail that enables performance to be audited and reported upon.

Now before we are dismissed as Luddites or romantics, we need to make clear that we all acknowledge that it is important to use data and that there are very many positive aspects of an audit orientation. **We cannot and absolutely do not wish to turn the clock back.** However we believe we should take seriously the way professionals describe the negative aspects of the audit culture and the disempowering impact it has on them.

When features of the audit culture are advanced by policy makers and managers, and health care professionals feel the approach is one sided – necessary but not sufficient – they find that when they seek to have a debate about the importance of other factors (not so amenable to being counted) they are misunderstood, judged to be 'off the pace', left out of decision making, disenfranchised.

As a result they stop engaging in constructive dialogue and in so doing one of the foundation stones of professionalism is threatened: the earned right to professional autonomy²⁴. Where there is no opportunity for dialogue and debate, because advocates of audit misjudge those who have reservations, then the audit culture becomes the accepted norm and health care professionals find themselves hostile to it without being able to articulate what it is they find so wrong about this. At the same time they are seen by managers and policy makers to be resisting change and a vicious circle ensues.

²³ Strathern M Ed [2000] Audit Cultures Ch 2 The quote continues 'Thus audit technologies transform professional, collegial and personal identities'.

²⁴ 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 value in a relationship with a health care professional. We will discuss this further in Chapter Four

Factor Three: the Triumph of Reason and Managerialism

While the audit culture was enabled and fuelled by the digital revolution its origins are much older. Arguably it started with double entry book keeping in the fifteenth century but it is unquestionably associated with the flowering of management over the last hundred years, as a distinct set of practices and approaches that can be applied in any field at any time. Taught in the business schools that developed within US universities in the early twentieth century it has become one of the most popular university subject areas.

John Ralston Saul, a Canadian political philosopher who has himself experience of the management and business worlds argues in his book *Voltaire's Bastards* that this management method is one example of *reason* separating itself from, and out distancing, the other 'more or less recognised human characteristics of spirit, appetite, faith and emotion, and also intuition, will and experience'.

When Voltaire advocated the use of reason as a basis for society, Saul argues, it was to oppose the arbitrary use of power by an immoveable elite – the aristocracy. Were Voltaire to return today he would be horrified to see how 'dictatorship of the absolute monarchs has been replaced by that of absolute reason'. 'It has reached an imbalance so extreme that the mythological importance of reason obscures all else and has driven the other elements into the marginal frontiers of doubtful respectability'.

In the discussion that follows we look at the development of a particular management method and how it exemplifies this wider insistence on the value of reason and logic over other ways of knowing. Please note that as we do so we are not doubting that individual managers can add value, nor indeed that there are many highly effective and even inspiring managers. We are not anti managers, merely reflecting on a particular (and increasingly dominant) style of management. One which Henry Mintzberg has termed **MANAGERIALISM** (capital letters are his).

At the heart of teaching at the most prestigious business schools is the case study method in which information about a business or industry is taken away from its rich, complex reality and turned into a 10-20 page description. In this move from reality to story all sorts of things happen. Humans described in them become a set of rational interests, nothing like the people we meet in real life who have emotions and beliefs and experiences all of which influence (even govern) our choices and behaviours as much as does our rational self interest. For better or worse but certainly for richer, we are all much more vivid, complex and interesting than are the ciphers represented in these case studies. The same is true of the settings depicted. As a result the situation is turned from a 'mess' into a 'puzzle',²⁵ something that can be solved using the formidable intellect of the students and the logical decision methods of their teachers.

So management is taught and has developed in ways that allow logic and reason to trump all other ways of knowing what is really going on in a situation²⁶.

²⁵ Russell Ackoff the systems theorist is credited with the distinction between puzzles (a conundrum to which there is an answer, it may take a while to find it or a number of experts to ask, but there is one), a problem (a conundrum to which there is no right answer merely better or worse ways of dealing with it) and a mess (a dynamic interactive system of problems). A similar distinction is explored more fully in Chapter Four.

²⁶ Unfortunately management can be sadly ill informed by other bodies of knowledge and with little examination of its underlying epistemology (how it is thinking and the assumptions that this rests on). Much of its research is incestuous, for example asking current managers for their views about good management, or measuring yardsticks defined as critical by managers rather than anyone else involved, or asking what they think they do rather than observing what they *do* do. And it then often draws on literature searches that encompass only management, leadership and economic literature.

The rise of this management method has accompanied the increasing size of organisations, and perhaps this is inevitable. Once you cannot know the people in your organisation, and the messiness of the situations they are dealing with, then you have to steer by a set of numbers or other abstractions (such as replacing people with a set of rational interests) and not by what is really happening.

And once you have replaced the need to know reality with a set of numbers and ‘facts’ that you can collect, then the size of organisations that can be managed has no limit.

Saul argues that our belief in reason and management is just that, a belief. *‘Today we are in the midst of a theology of pure power. The new priest is the technocrat, the man who understands the organisation, makes use of the technology and controls access to the information –which is a compendium of ‘facts’’. What is more, because the belief is so firmly held it is invisible and hence impossible to argue against: ‘To argue against reason means arguing as an idiot or an entertainer who seeks only to amuse. The structures of argument have been co-opted so completely by those who work the system that when an individual reaches for words and phrases which he senses will express his case he finds they are already in active use in the service of power’.*

Had the application of management methods yielded consistently positive results we might then have to accept the virtue of privileging reason over experience, however they have not. If we look at what happens when reason is detached from experience, values, desires, beliefs and meaning we come across examples such as the following:

- Business Process Reengineering (a process of the 1990s in which whole organisations were completely redesigned around an idea that had no evidence to support it, only logic, and failed utterly)
- The dominance of Evidence Based Medicine in domains where it is inappropriate. While evidence informed decisions are vital, decisions dictated by the kind of evidence privileged in EBM are appropriate in only certain contexts. (Before you reject our argument here please see Chapter Four for a further exploration of this)
- QALYs advocated as the basis for resource allocation decisions. (Again, see later in this chapter)
- The turning of every rich policy idea into a set of well intentioned, rigid descriptions and prescriptive guidelines. (Chapter Three)
- Rich terms and ideas being operationalised in impoverished ways (e.g. ‘patient safety’ is translated merely into targets for cleanliness)
- The dominance of explanation over empathy. HCPs and HCOs²⁷ no longer apologising or empathising with the distress expressed by people about their care – instead explaining why it is how it is²⁸

And in spite of manifest signs of failure we have no means of questioning the underlying method. When there is ‘expression of any unstructured doubt²⁹... it is ‘automatically categorised as naïve or idealistic, or bad for the economy or for jobs’.

²⁷ Healthcare organisations

²⁸ In a similar way that children and adolescents protest their good intentions when their actions cause distress.

²⁹ unstructured doubt is doubt rooted in something other than pure logic e.g. experience, intuition, tacit knowledge and the deep understanding this embodies but which cannot be expressed in ways the person using only reason can understand - or even recognise

We have lost sight of the fact that this is only one way of looking at and understanding organisations. We fail to observe that when we leave out feelings, deeply held values, the meaning people place on and derive from aspects of their work then our logic can so easily lead us to many, many 'reasonable' heartless decisions.

And yet in spite of this there always are people who do resist these reasonable decisions. And many more of us than actively fight against the explanations of those who espouse only logic, do experience an increasing sense of overall distrust. Distrust of spin, and of political and managerial success stories – especially when these are accompanied by a what we perceive to be a failure of common sense and ordinary humanity. As Saul describes, the 'phenomenon of technocrats... versus practical humanists plays itself out in every sector of our society. It is endlessly repeated with the same imbalance and the same results. The more these conflicts are examined the clearer it becomes that certain of our most important instincts- the democratic, the practical the imaginative – are profound enemies of the dominant rational approach'³⁰

So we suggest that the managers who genuinely add value to the teams, services or organisations they manage are those practical humanists rather than the technocrats. People who use data and logic but also draw upon experience, tacit knowledge and intuition. People who are in touch with other aspects of themselves and others than their brains.

But of course if logic is the answer to every problem then only people who can reliably draw on logic are valued and recruited. So these practical humanists are under-represented in senior positions. Indeed we now have a requirement in many job descriptions for 'emotional intelligence', people who will be able to draw on reason and not be diverted by emotional responses. In this way we are turning our bureaucracies inwards so that we engage in 'governance of the soul', and are appointing, to run our organisations (or even join them), only people who can achieve this.

How has this happened? We are now in the hands of a self perpetuating elite. In the West we now have elites in every country who have been trained in the same way – whether this is Harvard, the ENAs in France, or the elite schools of any country. And the elite believes that it is acting in the best interests of all.³¹ A sociologist might describe the phenomenon as 'professional capture'.

As an example of this capture, it is noticeable that in the wider economy as well as in health care, and right across the West, there has been a massive increase in salaries for top managers. NHS top salaries exemplify this. As jobs became bigger and more complex and more important (and therefore needed the 'best' people) so salaries leapt.

This raises the question: are some jobs too big to be done and too important to risk giving to one person?³² But of course part of the professional capture, the rationale for an elite, is the engendered belief in some people having been sprinkled with pixie dust so they are no longer mortals but 'leaders'.

³⁰ Saul. Ibid.

³¹ Ibid 'like all functioning elites they seek to perpetuate themselves for the general good. As always this involves the creation of an education system'.

³² Especially when in reality the same individuals moved around the same strata of the system at ever higher salaries

Before we are deemed to be unremittingly hostile to managers and management may we point out that we are not. Many people complain about the number of managers in the NHS, Saul would probably argue that it is not only the *number* that is the issue but the *method*.

What we are arguing for is management that certainly uses reason and analysis but also values and uses experience, feelings, a belief in others, and an ability to articulate a direction of travel for the organisation that encompasses the enthusiasm and concerns of others. This is so far from the kind of management that is currently valued as to sound old fashioned and out of date. And yet we know that many managers feel they are uncomfortable about the persona they have to wear when at work, the bullying and steam rolling they are required to undertake. And we should be even more worried about those who are not uncomfortable with this.

Factor Four: a Change in the Nature of Politics

Just as the digital revolution has fanned the flames of the audit culture, so it has accompanied and fuelled a change in the nature of politics.

Historically democracy has 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. Indeed the election of a governing body was once the outcome of democracy and not its purpose. So it inevitably involved dispute and the conciliation of conflict and a certain ‘politicalness’. Not any more. Sheldon Wolin observes that ‘Politics has become the rational administration of liberalism, where liberalism is defined as freedom, private industry and un-coerced relations between individuals’ and he suggests that because it has been replaced by management procedures and market mechanisms we need to *rediscover* ‘politicalness’, i.e. ‘the capacity for developing into beings who know and value what it means to participate in and be responsible for the care and improvement of our common and collective life’.

Alasdair McIntyre also notes that ‘The modern state is run by oligarchies disguised as liberal democracies in which what passes for debate is the antithesis of serious intellectual enquiry.’³³ Philip Blond, reflecting on how politicalness can be developed, suggests that serious enquiry has to emerge from *local* reflection and *local* political life, constructing in local communities a sense of the common good and translating that into things we can see and feel: services and buildings.

We will look later at the importance of developing ‘politicalness’ within health care but first let us look at what changes there have been in the nature of politics and see how these have been fuelled by the digital revolution. How it has, for example, influenced profoundly the behaviours of the politicians and the characteristics of the arguments that win elections.

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 (and sometimes 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, as Saul puts it, there is a belief that ‘public policy must emerge mysteriously, fully formed.’ But, as he points out, ‘The proper debating of policy is not smooth, Words are not air. Talk is not a waste of time. Arguing is useful. And speed is irrelevant unless there is a war on.’

³³ After Virtue, a study in moral theory

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.³⁴

Furthermore, to increase their popularity (or decrease the risk of unpopularity) politicians increasingly leave decisions where the just or wise outcome is likely to be unpopular, to 'neutral' bodies such as NICE or the Bank of England. Or of course to the market. However, this lack of real debate, far from reassuring the public leads to a growing distrust between politicians and public.

What does this mean in healthcare? It means the introduction and advocacy of a quasi market. Resolutely dissimilar from a genuine market place in which consumers shape services by virtue of their many individual purchasing decisions from a range of competing suppliers, the quasi market seeks to feature many aspects of the genuine article (such as choice, competition, efficiency, innovation).

What it also means however is that decisions reconciling different interests (between different groups of patients for scarce resources for example) are no longer taken by the people whose profession this is (politicians) but are left to 'the market': the commissioners of care contracting with care providers. But the commissioners are not the consumers, so someone has to turn these impersonal commissioning decisions into lived reality for patients – and that role falls to front line staff.

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 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.

Politics as 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 and be chosen as a model.)

³⁴ As a result, as Saul argues, 'throughout the West we are led by elected and non-elected elites who do not believe in the public. They cooperate with the established systems of democracy but they do not believe in the value of the public's confidence. Nor do they believe in the existence of a public moral code. This means that in dealing with the public they find it easier to appeal to the lowest common denominator in each of us. That this succeeds reinforces their contempt for a public apparently capable of nothing better. They do not take into account that the public, like any of its members, is in fact capable of the highest and the lowest. '

But where does this belief in the efficacy of markets come from? From experience? From history? From convincing evidence? Actually no. Saul, among others³⁵, is persuasive when he argues that globalization (the wider term for the market) is the result of 30 years of applying the thinking from a particular school of economics, and that it was (and is) presented as 'inevitable' when in fact it was an experiment.

How this has happened, Saul argues as follows.

The promise of globalisation was that it would increase wealth and well being because of multiple players competing to exploit the last hundred years of technical and theoretical breakthroughs – by letting commerce lead civilisation and allowing commerce to lead and regulate itself. Interestingly 'no serious thinker on any continent at any time has ever suggested this before'. In other words civilisation has been reformed from the perspective of economic leadership – 'for the first time in history the economic perspective is equated ('sotto voce') with people behaving in their own self interest'. He notes that throughout history societies have tried to find ways of balancing self interest with a concern for others and for society as a whole, and that this is the first time concern for society and others is to be enacted *through* self interest.

So what have been the results of Globalisation? It has indeed delivered very great increases in trade, and also in technology, especially information and communication technologies.

It has also led, according to Saul, to a reduction in public and social capacities, the vaporisation of money through imaginary market activities, lots of binding international agreements about the market and not any about work conditions, taxation, child labour, health, ... etc, the return of oligopolies and monopolies, a significant number of people in developing countries becoming poorer while statistics show them becoming richer (because of the things statistics measure), huge reductions in the amount of tax paid by corporations, a shift of the tax burden in almost every country from the wealthy to those on middle and low incomes (often through stealth taxes such as lotteries), increasing inequality of incomes within countries to the level they were at in the 1880s, steady increases in unemployment with the largest being in long term unemployed, major migrations around the world as richer countries import labour to take up menial roles their populations no longer want to take on, companies constantly moving manufacturing facilities to cheaper sources of labour building in 'boom and bust' cycles every time they enter a new country for this purpose.

How can this be? When there is so much more trade? So many people competing in their own interests to exploit the technology that will allow us to meet needs? Partly because much of the increase in trade is actually movements within multinational companies between countries to avoid tax. But what else? Could it be that the underlying assumptions are flawed? Throughout history, markets have been seen as essential but not of primary importance for the citizen or civilisation, and there has been constant argument about the balance of public and private enterprise. In other words that there is nothing inherently 'inevitable' about globalisation, inevitability has been a convenient tenet of an ideological argument, convenient in that, in the face of inevitability we have no choice but to toughen up. Saul quotes Gerard Baker about the 'sodomonetarism of the ruling school of economists'. He notes that 'in a world of ideologies moderates are always wimps, wets, soft' and that when things get worse rather than better we are always exhorted to 'give it more time, these are big changes'.

No, this was a choice, a set of assumptions made from the '70s onwards, when as Saul observes we had the first generation of the technocratic elite coming to power, whose concept of efficiency took them away from their properly big concerns towards the things for which they were 'accountable' –held to account. For example bankers steered only by inflation statistics and not poverty figures or even the way

³⁵ Saul is far from alone, the reason I quote from him extensively here is that his language is powerful and relates especially well to the issues we are exploring

money flows in an economy. These accountable ‘technocrats’ spanned industry, public sector and politics, and it was only a short step from there to politicians using globalisation as a reason why they could not make national policy decisions over anything that mattered, saying that their hands were tied. So globalisation is not an inevitable force of nature, it is the result of a MANAGERIALIST focus on efficiency and accountability, themselves resting on the false assumption that everything can be measured and counted.

One result of this has been that if politicians are seen as not able to influence anything of importance people don’t see any difference in who they vote for, hence the decrease in voting figures across the West and a further move from politics and politicians to managerial administrations.

The market in health care

With politics now the rational administration of the market, globalization ‘inevitable’ and managerialism (sorry MANAGERIALISM) the method by which organisations can be stewarded into competitive shape, it was inevitable that market principles and practices would be introduced to the public sector.

There has been resistance to this introduction of market principles within public services and much of this resistance has been dismissed as self interested or ill informed, or naive. 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.*’³⁶ To understand why the predominance of market concepts may be seen as negating something many professionals and patients see as vitally important (see their realities being traduced) 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 societies that were or are essentially gift economies³⁷, 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, and 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 made between items of different attributes but similar value. Another way of saying this is that people choose between competing offerings of the same price.

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.

³⁶ McDonald. M, Chapter 4, Audit Cultures Ed Strathern M [2000]

³⁷ See Hyde L, The Gift.

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 market principles in public services, leadership has increasingly shifted to those who do not perceive or understand gift economies³⁸. 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. No longer, and 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 emphasizing: the very way that healthcare leaders conceive of health care has changed. The language may stay the same but it means something different³⁹. Words which have one meaning in a world that has an understanding of and commitment to human, non-market values take on a different meaning when seen through the cynical self interested lens of the economist.

Little wonder then that when the economic managerialist paradigm was introduced to the NHS in the 1980s, although it seemed valuable because it added a dimension that had previously been missing, there was resistance, some clinicians refused to 'play the numbers game' as they 'cared for people and not for statistics'.

As the economic/managerialist paradigm has become dominant, these feelings of frustration on the part of professionals⁴⁰ have not gone away. Some have been targeted at private sector ownership within the NHS but arguably it is not the ownership that matters, it is the loss of the gift economy that does. The loss of the element of gift means that the nature of care changes profoundly⁴¹.

Factor Five: The Role of Anxiety

Anxiety is an emotion that is very valuable. It prompts us to take greater care about (or within) the situation that prompted it. And yet it is uncomfortable. So it is an emotion that, as individuals and as groups, we can go to great lengths to avoid. Psychotherapists describe these lengths as social defence systems. In other words we can respond to anxiety in ways that are healthy in that they use this emotion to achieve positive ends, or unhealthy in that the anxiety is reduced in ways that do not address its original cause.

Healthcare necessarily involves dealing with situations that are difficult, emotional or unpleasant. For example, it can involve 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

³⁸ And when they do notice them they try to fit them into their 2 dimensional framework by reducing rich feelings of gift and belonging and other aspects of non-market economies to the term 'utility'.

³⁹ For example 'personal care' has four distinct meanings:

- 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 and 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.

⁴⁰ as well, admittedly, as those of self interest

⁴¹ 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.

defences against this anxiety.⁴² Many of these defences are subconscious, they are ways in which we 'contain' our anxiety – keep it within bounds we can cope with.

Healthy responses to this professional anxiety involve things like:

- 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.

If we think clearly about these various concerns and interests (our own and those of the other) then we are able to make a free choice about how to respond. That response may be a decision to embark on a course of 'aware altruism', the taking on of a difficult or distasteful task because of our concern for the other and our preparedness to put their needs ahead of our own preferences. Or it may result in a meaningful dialogue with the other, without knowing what the outcome of the conversation will be and tolerating that uncertainty. Or it may involve seeking support from someone more skilled in a particular procedure.⁴³

Unhealthy defences, on the other hand, include blaming others, 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), or 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).

Given the adverse impact of unhealthy responses compared with healthy ones it is surprising that we do not teach people to become aware of their anxiety and how to respond to it constructively. Yet we do not, largely because of the impact of the audit culture on educational processes which we will explore again in Chapters Six and Seven.

Anxiety as patients

If we are anxious as health care providers then so too are we as patients. Naturally we are fearful of our own mortality or the onset of an incapacitating illness, and in a market-driven society where as consumers we are told we can 'have it all' and where family structures are often broken or dispersed and there is a reducing sense of community, we have fewer societal opportunities for containing our anxiety than we would once have done. So, as patients facing these issues, we often turn to health care professionals for solace, guidance and support: a relationship. If we then find the same market-driven transactional culture within health care that prevails in wider society and feel 'held at arm's length' by the professionals in whom we wish to place our trust our anxiety increases. As it does so, we try to exert

⁴² For health care professionals, a 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).

⁴³ We are, of course, much more likely to be able to do this if we are merely anxious and not anxious about (or ashamed of) being anxious! This is an important point, if we do not teach our young professionals to value anxiety they worry about being seen as anxious.

more control, asking for greater accountability, transparency etc, not realising how this will increase anxiety all round (including our own).

Furthermore, anxiety combines naturally with the other factors described in this chapter, contributing to the development of the audit culture, the increasing dominance of technocratic management, and the decrease in politicalness. And we can see these as a vicious circle in which they prompt further anxiety and hence more audit, more MANAGERIALISM and less politicalness, and so on.

Politics and anxiety

When we observe the pervasiveness of anxiety we can see it is certainly no stranger to policy makers and politicians. How could it be otherwise. The number of unintended consequences is always great, inevitably, and the impact on the electorate will depend on 'events' as much as intent or competence.

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.

Anxiety and the gate keeper role

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 HCP who is expected to help balance the books, patients can ask themselves (consciously or sub consciously) "does he or she care about *me*?", 'may I be abandoned by this care giver in whom I'm placing my trust?', 'should I perhaps respond to them with less trust, or abandon them and use the internet or find a complementary therapist as an alternative health care advisor?'. Again a vicious circle is developed- in which a sense of healing and trust is lost.

MANAGERIALISM and anxiety

Another way of conceptualising the difference we explored earlier in this chapter between the manager as technocrat and the manager as practical humanist is to distinguish between the *simple, hard* and the *complicated, easy* of management: the complicated easy requiring only intellect and the simple hard requiring things like courage, integrity, judgement. The target culture of the NHS over the last 10 years has undoubtedly led to the complicated easy squeezing out the simple hard. Or to put it another way: performance management has replaced good management.

What is it that pushes people who are basically good towards the complicated easy from the simple hard? Undoubtedly the attraction of interesting ideas for able minds plays a part. But so do the uncomfortable emotions associated with the simple hard. It is much easier to retreat to writing a strategy document than to listen (really listen) to the concerns being expressed about a situation and then respond in ways that are fresh and humane. It removes a lot of the emotional distress of management and the difficulty of dealing with the distress of others. So MANAGERIALISM too is a response to anxiety.

Using anxiety well

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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. After all these educational processes are themselves subject to the five factors and the audit culture is changing them just as substantially as it is changing health care. So they now tend to focus on what people *do*, not on the kind of people they can *become*. The implications of this are profound and we explore them further in Chapter Seven.

Five winds and a vicious circle

In this chapter we have looked at five factors, five forces which we could usefully compare to five 'winds'. These winds, we suggest, surround us all and influence our actions without our being aware of them. We have chosen the term 'wind' because a wind is part of our immediate environment that is beyond our control - and yet we can find more and less enjoyable and useful ways of coping with it. More than that, our responses could be thought of as breaths that either add to the wind or counter it, so that although individually those breaths have miniscule impact, collectively they are what the wind is made of.

These five winds, our responses to them, and the vicious circles that entwine them together are leading to progressively poorer care, higher costs, and more dissatisfied staff. Our attempts at reform do not tackle the underlying causes of the poor care, higher costs and demotivated staff, which include our unhealthy responses to the winds, instead they merely provide the next step in a vicious circle that encompasses all of these factors.

If there were limitless resources or reducing health needs this might not matter, but our increasing longevity and changes in family structure, combined with advances in technologies of all kinds mean that we urgently need everyone involved in healthcare to respond thoughtfully and healthily to the five winds. Instead of their current naturally unaware unhealthy responses we need them (us) to think carefully and responsibly about how to offer good care for the greatest number of people. In other words, they (we) must think with care for patients, and the wider public and other people involved in providing care, about what we ourselves can do and about how we can act as agents for the results of our thinking.

This requires a completely different approach and not just another cycle of the vicious circle.

How can we do this? How can we free ourselves from this vicious circle? That is what we start to explore in the following chapters.

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 transactions of care. So here we have used the word covenantal to encourage a more robust view of the relationship between care givers and receivers⁴⁴.

⁴⁴ We still like the term relational and welcome you to use it, but encourage you to see its rigour and richness.

<i>Care as a set of auditable transactions in a market economy</i>	<i>Care with elements of a gift economy included</i>
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 <i>and</i> 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.

Table 3.1.

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 courage⁴⁵.

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.

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

⁴⁵ 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.

themselves have an impact on the outcome⁴⁶. 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.

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.

⁴⁶ 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

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 McDonaldization⁴⁷ 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.

⁴⁷ McDonaldization is a short hand term for the audit culture, coined in 1993 by George Ritzer in his book *The McDonaldization of Society*.

Chapter Four: Why Society needs professionals, and the kinds of professional behaviour that allow society to remember that it needs professionals

In this chapter we look at why it is important for all of us that professionals can dance and not always be required to march, and at how professionals should behave if they are to be granted the leeway to do so.

If we are to consider the care that professionals give, and decide on the kind of care we want, we will be wise to stop for a moment and consider the role that professionals fulfil.

The rationale for having professions is that they use their specialist knowledge base in the service of society. More than that, they have a particular role in helping society handle indeterminacy (those situations that are too complex for a clear, correct course of action to be determined in advance).

In this chapter we look at what we mean by this, and then consider the kind of behaviours on the part of our professionals that will allow society to grant them the professional autonomy they need in order to fulfil these roles.

It is helpful to start by distinguishing between four 'domains of knowing',⁴⁸ four types of situation in which we ask people to apply their professional knowledge: the known, the knowable, the complex and the chaotic.

There are situations we understand well. We know that if we do X then Y will happen, and that if we want to achieve A then we have a choice of doing B or C but not D. In other words there are clear cause and effect relationships. We can find out more about these relationships by conducting rigorous, quantitative research of the type described and classified by the Cochrane Centre and disseminated under the heading of Evidence Based Medicine, with Randomised Controlled Trials giving the most robust results.

This is the domain of the known and once we KNOW that G is caused by F and better than it is caused by anything else, then if we want to achieve G we can insist on everyone doing F, and indeed all reasonable people will see for themselves the need to do F.

The number of situations where we can be this certain are few (compared with the number of decisions each of us takes in a day) but when we come across them we can be 'feudal' in our approach to leadership and insist on certain practices.

⁴⁸ This section draws heavily on the arguments presented in Mark A Snowden D 2006 *Researching Practice or practising research: innovating methods in health care – the contribution of Cynefin in Innovations in Health Care*. The Cynefin website is also an excellent resource.

There are other situations where these cause and effect relationships are not as clear. This may be because they are separated from each other by time and/or geography. So doing something here and now has an impact over there (out of my sight) or then (much later when we have forgotten about it). This lack of ready association means the cause and effect relationships have been noticed and investigated by far fewer people, people we call experts, and they can be discovered more appropriately by methods such as experiment, fact finding, and scenario planning. In other words they involve more speculation and guess work and multi faceted detective work. In these settings, rather than turning to a set of defined practices supported by RCT evidence, if we want to know what to do next we turn to a group of experts who understand these relationships better than the rest of us. If we are wise we keep an eye on the experts and ensure that they remain constantly open to re-appraisal of the field and that they keep challenging their assumptions. We can call this the domain of the knowable and the style of leadership 'oligarchic'.

There is a third kind of situation which we can call complex. Here the cause and effect relationships are so numerous and they interact with each other so frequently and unpredictably that it is no longer possible to predict what will happen if we do X.

The research methods that are valuable in the first two settings do not work here and, worse, can be actively misleading. They can suggest causality where there isn't any and if we approach a complex situation expecting it to be known or knowable then there is a very real danger of 'spurious retrospective coherence'. This occurs when we look back at a situation and believe we can discern that action A led to outcome B and, if B is undesirable, blame action A or the person taking it. But the individual who did A may have had no way of knowing it would result in B because it often doesn't – since it leads to X, Y and Z which are affected by E, F, G and H, which are themselves influenced by M, N and O etc. So a person choosing to do A was 'muddling through elegantly' which is just the right approach in settings of this kind. Thus an edict that 'to avoid B no-one must do A' would be misguided.

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 different too: a combination of a firm foundation of effective administrative procedures and safe governance, with enabling behaviours and an ability to adapt to situations as they arise.

We can therefore see the importance (great importance) of distinguishing situations that are complex from those that are known or knowable. 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 an understanding of the situation or to ways forward.⁴⁹

In the fourth domain, settings that are chaotic, there are no perceivable cause and effect relationships. The system is too turbulent, and the 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.

⁴⁹ It can be so frustrating to reflect on a complex situation in which something has gone wrong and not be able to identify someone to blame. Here is one example of that frustration.

<http://archive.constantcontact.com/fs065/1102665899193/archive/1103589810918.html>

Once we can accept that complex situations are fundamentally different from known or knowable ones we can look for the instead for the full range of contributing factors, with the aim of better understanding the complexity rather than trying to pin the blame on one.

The best leadership style here involves the readiness to act quickly and decisively, and a hierarchy where such decisions can be relayed quickly and acted upon without question. The aim is to deploy 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’⁵⁰ of professionals.

This is so important it is worth saying again: in contexts that are known or knowable we can rely on information from the internet, on algorithms and on statistics. In complex situations we need people with something beyond all that – what Aristotle called *phronesis*, or Practical Wisdom, an ability to muddle through elegantly⁵¹, drawing on deeply held knowledge, experience, expertise and intuition.

If we understood that better, patients would cease to distrust doctors who look things up when consulting them (‘she can’t be any good she had to look up the drugs before she prescribed them’), clinicians could welcome information patients bring with them from the internet and we could all focus on the *added value* that professionals bring: practical wisdom, seeing ways forward in situations of uncertainty.

So practical wisdom on the part of professionals (of all kinds) is important to society as a whole and we need to ensure they are able to acquire it. We need to help foster it and nurture it, and it is here that we find the greatest danger of a focus on the transactional at the expense of the covenantal – we prevent our young professionals from developing the professional wisdom on which we all depend.

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’.⁵² 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 covenantal 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 dangers 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*⁵³, or science and logic over mystery and meaning. If we were to accord mystery and meaning more attention we would encourage the development of tolerance and generosity and an ability to accept uncertainty, indeterminacy and risk. We would also value anxiety and teach people how to respond with respectful uncertainty to situations in which the way forward is not clear. To achieve this we could remind ourselves that tolerance and generosity are not innate characteristics that people either have or do not but habits that can be actively cultivated and we might look to the contemplative meditation of many Eastern philosophies, (and also of many earlier traditions of Christianity) as ways of doing so.

⁵⁰ 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.

⁵¹ The phrase used by systems and complexity theorists

⁵² As described by Barry Schwartz and Kenneth Sharpe in 2005 in the *Journal of Happiness Studies*

⁵³ Karen Armstrong, cited in Vernon M, *After Atheism*.

If we saw uncertainty as inevitable and anxiety as valuable 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 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 demanding 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 to be only demanding then again we will prevent professionals from developing and using their practical wisdom.

If we are indeed to encourage the development of practical wisdom then we need to help society understand the inevitability of uncertainty and risk and to understand too that people who work with these will inevitably, on occasions, make decisions that do not have successful outcomes.

Of course we must be mindful of the large literature cautioning us against professional power and privilege and be particularly aware of the concept of professional capture – when a profession claims for itself power over decisions that belong more properly to a wider (or other) group. So we must subject all claims by professions to special expertise (and therefore to additional forms of power) to scrutiny – and the professions themselves must welcome that scrutiny and take thoughtful part in the ensuing debate.

How, then, 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 some of the resistance on the part of professionals to targets and to systematization is a result of an implicit recognition that a focus on good transactional care undervalues the covenant of care: that their concern for the latter leads to their resenting pressure for only the former. But we can also note that in countries where politicians are no longer involved in championing the patient's interest by setting targets and other requirements, the services offered quickly meet the needs of providers more than those of patients. In other words we can observe a large element of self interest (in addition to professional altruism) that needs to be challenged, and challenged effectively.

Professional behaviours

Let us remind ourselves that professions have a specialist expertise of value to society, so that in return for investing the time and energy in developing that expertise in the interests of society, society confers on professionals a status that allows them certain privileges. Thus, for example, health care professionals routinely touch patients in ways that would be considered assault in other circumstances and they earn rather more than people in other roles who have not made this investment of time and energy. Professionals, knowing more about their field than the rest of society, are granted a degree of professional autonomy.

Along with autonomy, rights and income comes a status – status that is conferred by society and enjoyed by the professions, and which differs from profession to profession. Just what determines the status accorded to a profession has been the subject of discussion among sociologists for some decades

and the work of Jamous and Pelouille is probably not the last word on the subject but does seem to have some descriptive and predictive value. They suggest that it depends on what they call the technicality indeterminacy ratio. That if the knowledge base of a profession or specialty is highly technical and definitive and its members can give clear, closed answers to questions (yes /no/ 3.95%) then it is likely to hold higher status than a profession or specialty that gives more contingent answers (it depends, it could be this or that, let's try it and see). However if the knowledge base is too technical then the people using it could be replaced by a computer protocol or an algorithm, so status will be protected only if the knowledge needs to be interpreted differently in each of the cases to which it is applied.

Status is valuable when it is used wisely and well, for example it allows professionals to resist demands for them to practice in ways that do not benefit patients and society, but it can also be used self-interestedly and then it skews decisions against the interest of others and society as a whole. Unfortunately once a high status has been conferred there are very few mechanisms to challenge its misuse, except in the most egregious instances or in cases where other factors such as racial discrimination come into play.

When status is used wisely it draws on the experience, expertise, specialist knowledge base and practical wisdom that is the reason the status has been awarded, and it is used in the service of society or its members. So when a consultant surgeon argues for a particular surgical practice in theatre, having thought clearly and deeply about alternatives, discussed it with others and decided that this is the way the best outcomes will be achieved for patients, then we are wise to listen to them carefully, and often defer to their judgement. When the same surgeon argues for a particular car parking scheme and especially if it is a scheme that makes life easier for him or her at the expense of others, then we should make sure that view is heard no more loudly than the views of everyone else involved⁵⁴.

Being clear about when it is wise to defer and when to insist when dealing with people of high status (and *as* a person of high status) is important. It not only makes for better decisions but happier professionals. Even so the high status of some groups in health care means that health care organisations are not hierarchical in the way that many organisations are, they are what Henry Mintzberg terms 'disconnected hierarchies'. In other words status protects professionals from being managed.

Status is little talked about and yet pervades day to day life in health care settings. Its impact on behaviours, decisions and working practices is constantly apparent to those working within health care. How is it that this is not discussed more openly? Somehow we have allowed a political correctness to dictate that we pretend there are no differences in status between different healthcare professions, nor between specializations within them, nor between professionals and patients. And this political correctness prevents us reflecting on the complex set of actions and reactions between the high status professions and society, and between these professions and government, that are jeopardising our ability to offer good affordable care.

Let us look briefly at some of the ways in which the relationship between the medical profession and society has changed.

The young people going into medicine are some of the best qualified teenagers in the country and the training they embark on is arduous and long. Some feel called to a life in medicine (although vocation as a term is frowned upon) and most believe their chosen career is of great value to others and see their established seniors as figures of standing and moral authority. Once qualified though, although no longer expected to embody the role 24 hours a day, as their professional forebears did, they find they

⁵⁴ And of course many issues in healthcare fall somewhere between these clear examples

are dealing with a public less deferential and more ready to call upon medical services for help at unsocial times of day and night, than they would have done 20 years ago.

They find too that the expanding roles of other professions have encroached on the medical one and at the same time many different groups have reacted against what they have perceived as inappropriate superiority assumed by the medical profession. For example some patient groups have protested at medical paternalism, and altruism and self sacrifice have had a bad press from quarters as diverse as the feminist movement and public choice economists. Simultaneously other health care professionals have resisted doctors assuming leadership roles in multidisciplinary teams.⁵⁵

These behaviours and others like them have felt like 'doctor bashing' to those on the receiving end.

The contexts in which doctors work have also changed. Organisations have become bigger and more complex, and management (as described in Chapter Two) has become a specialist role, divorced from the professions where it previously lay, exercising control over resources previously under the purview of senior professionals. Concern for clinical care and financial accountability have tended to be held separately: professions focusing on clinical matters and managers on finances. The battles that have ensued have left both camps lamenting the power and intransigence of the other.

So the relationship between the medical profession and society has been a complex set of actions, reactions and interactions from which have emerged the current behaviours and attitudes. These include:

- An attitude of entitlement and grievance on the part of doctors that manifests all too often in a refusal to engage with agenda set by politicians and enacted by managers, even where their aims could be said to coincide, e.g. over access, waiting times etc. For example a consultant surgeon is infuriated at requests that patients about to breach a target are given priority over more urgent cases – and yet makes no constructive attempts to improve processes so that no patient has to wait an unacceptable length of time.⁵⁶
- A frustration on the part of policy makers at their inability to influence the behaviours of clinicians and deliver more or better care, that has led them to wield blunt instruments of coercion – the bluntest of all being the quasi market.

So we have a situation where society needs its professionals to be able to develop and use their professional judgement (practical wisdom) if it is to deal with uncertainty. However the professional autonomy it accords to its highest status health professionals, doctors, has led to a set of dynamics which is manifested in a deep seated lack of trust between policy makers and doctors. They then each use their power in ways that increase the lack of trust.

One governmental reaction has been to try and reduce professional autonomy and status by increasing the numbers of doctors (increasing the number of places at medical schools), paying them for piece work (GPs) or for defined periods of time (hospital consultants) rather than a professional salary, systematizing as much as possible of the care process and treating them as impersonal units of production.

⁵⁵ Instead of constructive dialogue to resolve these tensions the situation has all too often been allowed to degenerate into long term dysfunctional team behaviours. Observing this younger doctors, especially in specialties such as psychiatry, have learned the lesson that they should not assume the lead. Since this is again not discussed teams and services are left effectively leaderless.

⁵⁶ The response of management is to pay for an additional surgical list at a weekend, something they would not consider doing when a lower status profession attempts to refuse to play ball.

But, as we have seen, a flourishing set of professions is important to our collective wellbeing so it is in all our interests to try and develop a new set of dynamics.

Sociologist Celia Davies,⁵⁷ a long-time student of the relations between doctors and nurses, argues that the ‘emotions work’ that nurses so often do, can serve to split off the caring role, enabling doctors to develop and maintain a classic professional identity with many of the features described in this chapter.⁵⁸ She has articulated a new sense of professional identity⁵⁹ that may be needed, as summarized in Table 4.1.

Table 4.1

<i>Classic Professional Identity</i>	<i>Towards a new professional identity</i>
A strongly bounded individual -a sense of self apart from others	A strongly connected individual – a sense of self in connection with others
Mastery of knowledge – expertise as hard won personal acquisition	Reflective application of knowledge – blending knowledge and experience in a specific context
Detachment – emotionally controlled and self referential	Engagement – explicit use of self and acknowledgement of emotions
Autonomous practice – a unilateral, personally accountable decision maker	Team practice – welcoming and valuing the contributions of others
Interchangeability – a company of equals with presumed equal competence	Specificity – acknowledging unique expertise/experience of all
A singular identity – professional identity outweighs /transcends all others	Multiple identities – calling on the specificity of team member experience as a resource for clients.
Concern for individual	Concern for individual and society

We might also add:

Working hard for patients despite the organisational context	Helping the organisation to help them succeed, through a good understanding of how organisations work
Concern for and audit of own practice	Continuous reflection on and improvement of service as a whole, using rich data, and their understanding of statistical process control and improvement technologies

⁵⁷ Professor Emerita of Health Care at the Open University

⁵⁸ Gender and the Professional Predicament in Nursing, Open Univ Press 1995

⁵⁹ Celia Davies: Workers, Professions and Identity in Henderson J and Atkinson D eds Managing Care in Context London Routledge 2002.

So if we look back over the thinking presented in this chapter its argument is as follows.

Society needs professionals to develop and use practical wisdom (professional judgement) in situations where it is needed, and to standardise and systematise in situations where it is not. It accords professionals the status and autonomy to be able to exercise this judgement and then because of that status and autonomy finds it difficult to challenge individuals and groups of these professionals when they use them in ways that are not in the best interest of society. Often this involves professionals refusing to recognise when standardisation is appropriate. This is understandable because standardisation feels like a loss of professional status and is bound, almost always, to be resisted. Expecting this resistance and influenced by the attitudes and behaviours that result from the five winds, managers and governments choose to use transactional methods of interacting with (and trying to control) doctors rather than constructive covenantal approaches.

These methods are unhelpful, however professions have a responsibility to ensure their members keep the interests of society foremost, and to help them see that it is by accepting and initiating sensible standardisation that they demonstrate their trustworthiness to retain the autonomy to use professional judgement in cases that require it. However unless this responsibility to society is explicitly taught it becomes confused among the acrimonious relations between a profession and the government, and the professions forget their wider responsibility to society, and forget too that society is so much more than the government. They need to help protect society from the inadequacies of government by rising above their squabbles with it.

In other words professions need to redevelop a rich understanding that Government is only one part of society, as are patients, the population, journalists and very much more. 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. Of course it would help if governments understood this too, but professions can and should rise above their frustrations with governments and find ways of honouring their deal with a wider society. We explore this further in Chapter Seven.

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 love⁶⁰ as ‘the will to extend one’s self for the purpose of nurturing one’s own or another’s [personal⁶¹] 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.’⁶² 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.

⁶⁰ By which he means agape rather than eros

⁶¹ 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!

⁶² 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 ungenerous⁶³ 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!

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.

⁶³ 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.

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, quotes⁶⁴ 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.

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

⁶⁴ For example at the workshop How do good people offer bad care in Feb 2010

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'.

You are welcome to use this book in any way you like as long as you do not charge for it and you credit the author, Valerie Iles, and the website Really Learning – www.reallylearning.com

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 off⁶⁵. 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.⁶⁶

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.⁶⁷

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 conversation⁶⁸. 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.

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

⁶⁵ This is known as 'keeping a boot to her neck' or 'his feet to the fire'.

⁶⁶ We will look at this again when we consider a different kind of management in Chapter Seven.

⁶⁷ These are described in more detail in Iles V, Really Managing Health Care

⁶⁸ 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.

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.

Chapter Six: The importance of monitoring ends and not only means – choice, competition, efficiency, innovation and regulation, in health care

Ever since the principles of general management were introduced into the NHS by Roy Griffiths in the mid 1980s and followed a few years later by the quasi market, health care professionals have protested that health care is so different from other service industries that it should not be subject to the same management practices, nor to the same assumptions about its underlying dynamics. While these claims have been largely dismissed (with a little justice) as self interested, naïve or ignorant, there are indeed real and important differences.

In this chapter we look carefully at how the concepts of efficiency, choice, competition and innovation are described, how they are enacted and at the consequences when they are. We go on to discuss the very great importance of keeping in mind the ends we are trying to achieve and not only the means we have chosen to take us there.

Choice

Choice is a word that sounds wholly benign. It suggests we are offered a range of options and can choose freely between them the one that most meets our needs or tickles our fancy. As a result of our choices some goods and services fare well in the market and are developed further, and others do not and are discontinued. In this way resources move to where they are best used, quality rises and prices fall.

Thus customers offered options feel (and have) a greater sense of control than those who are not, and the efforts made by customers in comparing these offerings are translated into higher quality, lower cost products.

This is the rational background against which choice and competition, combined with regulation, are advocated as the way we increase quality and decrease costs in health care. The extent to which this is being pressed into service may not be fully appreciated by some of those involved. One Medical Director of a PCT was surprised that when he raised concerns about the quality of care in a local hospital surgical service with the Director of Commissioning, the latter's response was that since patients now had a choice and could go elsewhere the quality was no longer a Commissioning concern.

If we think carefully about this instance we might suggest that, for a choice of this sort to be meaningful, patients would need to know enough about the quality of different services to be able to make an initial choice, understand and afford the consequences of that choice (e.g. increased travelling time for themselves and their families) and be able to change their choice midway through their experience if

they find it unsatisfactory. Furthermore that they fully understand all the consequences of that choice – for example that they may be unable to access local physiotherapy services on discharge but have to travel to those attached to the hospital they chose instead. As James Harrison⁶⁹ notes ‘these seem big assumptions, not least for the weakest who need the most protection’.

This is an oddity. A concept that sounds as though it is conferring a benefit on the patient (you don’t have to go here, you have a choice of there and there as well) is instead being used for the benefit of commissioners. They now do not have to engage in that most difficult of tasks: ensuring that clinicians are encouraged to review and improve their service. Instead they can leave it to ‘choice and competition’.⁷⁰ It is surprising how often this happens in the NHS –that a term that seems beneficial for patients turns out in practice to be the opposite. We will look at other examples shortly.

Choice has been considered by some interesting and eminent reviewers, so let us look at what they have concluded.

Amartya Sen argues that instead of being fetishistic about freedom of choice we should ask if it nourishes or deprives us, makes us mobile or hems us in, enhances self respect or diminishes it, enables us to participate in our communities or prevents us. Increasing choice among goods and services may not add to any of these, indeed it may impair our freedom in that it steals the time and energy that we need to put into choices that do contribute to these.

Rowan Williams observes that by making one choice we close off another, and that we are changed by our choices and can’t revert to what or where we were before. This is especially true when those choices involve education or health care. Furthermore the very fact of having these choices changes society. Choice in education is increasing inequality. ‘Wanting what is best for the growing generation’ is not the same, he is surely right to argue, as ‘wanting what is best for my child’, and giving individual choice leads to a loss of corporate responsibility in education: a ‘shared responsibility of inducting children into a social environment with at least some common values and the providing of what is needed to understand and question that environment in terms of its success in embodying those values’.

Furthermore, choice does not always even feel like a good thing: Barry Schwartz writes of the ‘tyranny of choice’, citing research that people are happier with the chocolate they choose when given choice of three chocolates than when confronted with a choice of 20. He argues that while we embrace choice in that it gives us control over our lives that we wouldn’t have without it, ‘just because some choice is good does not mean that more choice is better’.

Indeed when we think about it, can we be sure that the options available to us in health care can be described in terms that are meaningful to the chooser? The indicators available about different care providers do not reflect in any way what *being* there will feel like, and nor they do give clear indications of which option will achieve superior clinical outcomes for the chooser (even if they can for 100 patients allocated the same diagnosis they cannot for an individual). Thus GPs report that patients usually ask which they, the doctor, would choose, and they sometimes see this as childlikeness on the part of patients. It is however an indication that patients do not know *how* to choose, and that they believe the doctor will know more about the options and about how to make that choice than they themselves do. If we think about this more carefully we can see that this kind of choice is either terrifying or meaningless. If it is a choice that is a matter of life or death, better or worse clinical outcomes, then that is surely a

⁶⁹ A member of the learning set whose paper on choice is the basis for this section.

⁷⁰ Making the assumption that hospital managers will see the need to encourage their clinicians to do so – but we have been here before – see Chapter One.

terrifying responsibility for people with no clinical knowledge. If it is a question of whether the bedside phones are provided by operator X or Y then that is of so little consequence as to be meaningless. If we are to be given choice let us have an honest debate about what aspects we want to be able to choose.

It has been said, and often, that the public do not want choice, they want the local hospital or school to be good (and as good as any other). But then we need to ask the question: how do we ensure that every local hospital IS good? If the argument is that the effort that goes into making that kind of choice translates into good services for all then we could ask the question: if the public do have to make some effort if every local hospital is to be good, what kind of efforts are we prepared to make? If we put it that way we could have a good debate about it, consider what other options there are and choose between them.⁷¹

One of the options we might devise could involve finding ways of generating some form of local pressure informed by real experiences and by an understanding of the options and approaches available elsewhere.

How? A committee? (oh no!). No really not. Giving patient representatives the responsibility of making decisions on behalf of all patients is lazy and crazy. What is needed is really credible meaningful information, perhaps serious, in-depth feedback from patients after every encounter with services about what it was like to be a patient and about the kind of details that enhanced or diminished the care they received. Routine follow up from independent researchers could provide rich, multi faceted, useful information in a way that the current patient surveys simply do not.⁷²

Such an exercise would need to be combined with some means of finding out how services had used this information, and perhaps this could take the form of a carefully considered report,⁷³ by an independent body, of what people have said and how the service has responded. The public could then take an interest in this and discuss it (both rationally and emotionally), in a number of different forums.

But this is only one idea. Exactly what could be done to make the most effective use of the time and energy of patients and public could only be devised (and revised and re-envisioned) over time, and there will be many who talk of apathy and the difficulties of involving more people than a few activists. There is considerable electoral evidence however that very many people care deeply about the NHS, so finding a way of tapping into their support must be possible, but only once we decide to re-take responsibility for quality and costs and not leave them to processes like choice and competition. Another way of describing this is to remember our definition of care (acts of work or courage in pursuit of flourishing) and use it to find ways of helping people who care about the NHS to do so. This is so much more exciting and liberating and has so much more potential than the imposition of choice and competition in the belief that it will, magically, result in better and cheaper care.

So choice is important, even essential, but the choice that is important is that about how we ensure that care is of good quality and is affordable, choice is not an end in itself.

⁷¹ After all there is a lack of internal logic if we have no choice about whether we have choice.

⁷² This is done routinely some fortnight after discharge for many Not For Profit hospitals in the US. Discussed with CEOs from NFP hospitals at an ODPN seminar in 2006

⁷³ Many will protest that this (or something like it) is already being done. And indeed there are transactional variants of this aplenty, all devised with good intentions but ensnared in the management method. For this to be real we need a different kind of dialogue

Competition

The value of competition is that it energises, it increases creativity and reflection and leads to better ways of doing things, or cheaper, or ways that are both better and cheaper.

Well sometimes it does this. Or rather: some kinds of competition do this. The kind of competition that yields good results is where I look over my shoulder at any rivals, notice what they are doing, and think ‘oh is that what they are doing, I could do that, in fact I could do better than that, let me see...’ Or ‘oh I hadn’t thought of that’ or ‘oh are they reviewing that aspect of care? What would we find if we did?’

Many kinds of competition do not lead to this. Instead they lead to concentration of power and assets, ‘winner takes all’ market domination, protectionism, risk aversion, increasing bureaucracy about tendering for contracts etc etc and results in an *increase in costs overall*.

In a cash limited service of vital importance increasing overall costs in this way is, clearly, a matter of great concern. It takes money away from *real* things and diverts it into these paper trails, tendering processes, back covering, and other unproductive activities. Worse, it leads to a race to the bottom, in which, for example, NICE guidelines become not a baseline but an upper limit.

So we need to ask the question: in the NHS what would a good level or type of competition look like?

Do we need it at all? Well we need something to ‘keep us honest’, by which I mean steer us away from complacency, arrogance and waste. But we need to be clear what it needs to keep us honest about, and that is *reflecting on our performance, reviewing the quality of the services we offer, challenging ourselves and each other to perform better and to design services that are better and cheaper*. To do that we need to be doing the sort of things we described in Chapter One: supporting, enabling and challenging everyone involved, including high status individuals and groups who are mostly untouched by the pressures of competition.⁷⁴

In other words, it isn’t competition that works it’s this: supporting, enabling and challenging. Competition is only the means of getting to this, it’s not an end in itself. Economists will tell you that competition leads to the four Is: innovation, information, investment and incentive,⁷⁵ and you can tell this is economist speak because it is so depersonalised. If we put people back in then it is about people choosing to innovate, people receiving and acting upon information about the quality of their services compared with others, people choosing to invest in areas that will yield a better return, people receiving rewards for efforts they make. Put that way we could suggest that the kind of quasi market we have in health care does not in fact produce these features and we could usefully design the competition we build into our system so that it does do this, not more and not less. Thus competition that is healthy and productive should look different in different industries and the different settings within them and we

⁷⁴ Are we really going to get rid of a highly specialist consultant it has cost millions to train? When it comes to a standoff? However vituperative the discussions at the time the consultants are much more likely to be working in similar ways with similar patients 1-2 years later than are the managers who berate them to be in their same job.

⁷⁵ See for example Peter Jay’s Road to Riches

should be suspicious of any attempts to introduce a particular kind of competition just because it is perceived to be successful elsewhere.⁷⁶

While we are talking about economic perspectives on competition in health care we should not ignore Michael Porter's analysis that competition in health care (in the US anyway) is not working because it is too broad (the competition is between hospitals and not between, e.g., urology services), too narrow (it involves only part of the pathway) and too local (services should be able to compete for custom over a wider geographic area, leading to centres of real excellence). Our argument about the kind of competition Porter advocates is, again, that there is nothing about it that will lead inevitably to the reflection needed. It could easily lead to major centres in which clinicians are protected from the need to reflect by the size of the budgets available to buy the new kit that will appeal to patients.

But is not only that unhealthy competition does not lead to better care (because it does not lead to the reflection and review that would deliver better care) but, worse still, it will be reflected in bad behaviours at all levels of the system. Complexity theorists with their understanding of fractals⁷⁷ would predict not only competition between organisations but stressful competition between patients, between practitioners, between services, even between health care systems (for example the NHS stealing staff from around the world).

Once again we have a word with benign connotations enacted in a way that delivers unhealthy consequences.

Efficiency

When you are making baked beans efficiency is great. We want beans that are healthy and tasty and cheap, we don't want any resource to be wasted in their production because that would increase the cost. And in health care we also don't want to increase the cost so we also want to avoid any waste.

To ensure this we talk of the importance of doing the right thing at the right time in the right place in the right way. And doing the right thing at the right time in the right way in the right place sounds great, indeed one would be thought disagreeable, if not perverse, to protest. But it makes a major assumption: that we know what 'right' is. And behind that assumption lies another: that there is such a thing as 'right'. But very often there is no single 'right' answer or approach. There might be a best. Or a better and a worse, and it is often more helpful to think in terms of those. More or less compassionate can sometimes be more helpful still.

The 'better' way to care for someone may involve giving them time. Or close attention. And to time and motion experts the first will look inefficient and the second will be invisible. Because these efficiency experts are looking for something that is not health care. What they are interested in are things like: How many people had their dressings changed? How long did it take? Could they have been done quicker or cheaper? How are people being given information? Are there quicker or cheaper ways of doing so?

⁷⁶ E.g. utility industries

⁷⁷ Fractals: the behaviour found at one level of a complex adaptive system replicates behaviours found at every other level. So if we introduce competition at one level (between organisations) we will eventually find it at every other level, including between patients, as well.

But the outcome we care about isn't the speed of the dressing and how many dressings, or that people are given information; it is that a patient (a person) becomes reassured, and on a path to recovery at a time when they may feel vulnerable and unsure. And if that is our outcome then to see how efficiently we are achieving it we will have to find different ways of measuring.

Of course we must not waste money, we must make sure it is used wisely, and we could even call that using it efficiently – but only if we can agree on what our desired outcomes are.⁷⁸ If we could do that then we could indeed think about the most efficient way of getting there. As we did so, we might find that we have to turn some current assumptions on their heads. If we saw our outcomes as including patients' confidence in their treatment and their care giver, then we might find that, for example, rather than reducing skill mix as we have done for years, we should enrich it again.⁷⁹

In other words: if we are to be 'efficient' we need always to keep in mind our ultimate purpose. In health care it is sometimes the case that both the purpose and the processes that will lead us to that purpose are clear. In these cases (in the domain of the known – see Chapter Four) efficiency is a concept that can be helpful.

Often the desired outcomes are multiple and to some extent individual, and are more 'fuzzy' – they can be articulated but not easily measured. In the domain of complexity efficiency is not a concept that is helpful. Nor is 'productivity'. 'Wise use of resources' is language much more likely to prompt the reflection and redesign that will yield results.

What does a focus on efficiency lead to?

- Skill mix reviews where we look at what people DO, not how they are thinking and what knowledge based judgements and practical wisdom they are using that inform what it is they do.
- A transfer of cost from provider to customer. Think, for example, about train companies. Once upon a time you could buy tickets on the train, thus turning up at the station with just enough time to catch your train. To be more efficient the train companies cut back on ticket inspectors on the trains and made it a fineable offence to travel without a ticket. Now you have to arrive at the station with enough time to join the queue at the ticket office or machine to buy your ticket. That is a direct transfer of cost from them to you. This isn't efficiency it is theft.
- A belief that you can take money out of a service without losing anything of value. At dinner a Director of Social Services was heard to boast that he was he was able, through commissioning, year after year to take money out of his services and achieve the same results – apparently completely ignorant of the enormous impact this had on the staff and clients of the voluntary sector organisations he bought them from. The fact that the consequences of this kind of action do not show immediately does not mean there are none, as BP and the water companies and many more

⁷⁸ This is a point well understood by academic economists but to their foot soldiers, local performance managers, it is not so clear.

⁷⁹ Not at greater expense. There is an argument that replacing two health care assistants with one nurse not only leads to better care but costs less. This is of course the converse of the argument often used.

organisations have all found out,⁸⁰ and unless they are taken very seriously the values of the commissioner can be conveniently ignored when contract decisions are made.⁸¹

- A belief that the private sector is better at managing resources than is the public sector.

Since this is a widely held belief (that the private sector is better at managing resources) let us look again at a concept introduced briefly in Chapter One.

Many private sector organisations ensure they harness resources efficiently (maximize productivity) by using four approaches:

1. *cuts* – they make sure they cut out unnecessary expenditure and in some cases cut out customers they cannot serve profitably
2. *rationalisation* – they rationalise production from several facilities into one, *realising* all the synergy that they can. In health care we would call that reconfiguration
3. *redesign* – individuals and teams work together to redesign flows and processes so that they are as efficient and customer focused as possible
4. *reflection* – individuals and teams reflect on their own performance on an ongoing basis to see how they can improve it.

All four of these methods can be (and are) used because staff can be incentivised and required to do all four, in other words they are part of a *connected* hierarchy.

In a hierarchy that is *disconnected* staff cannot be *required* to engage in these and *incentivising* them to do so is difficult (because the things they value are not in the gift of managers, e.g. papers and citations in prestigious peer reviewed journals, the regard of renowned peers). Thus in a disconnected hierarchy efficiency is pursued by means of only the top two options (cuts and rationalisation). This is a pity since these will produce only one-off savings – it is the other two forms that yield ongoing productivity improvements.

So it is not the ownership that matters (public, private or social enterprise⁸²), it is whether the hierarchy is (or can be) connected or whether it is important that it is disconnected. A misunderstanding of this is often what leads to the charge of ‘cherry picking’, when NHS professionals look at the work of independent sector providers. These latter offer good and efficient care in the sort of cases that lend themselves to protocols. Professionals here are operating in the domain of the known (Chapter Four), the leadership can be ‘feudal’, in other words it is clear what is the most appropriate pathway and everyone is happy to agree to this. The hierarchy is effectively connected.

⁸⁰ As described by many observers including for example Anthony Hilton in the London Evening Standard.

⁸¹ Have you checked the terms and conditions of the people actually providing your patient transport now that these services have been contracted out? Minimum wage and no pension is not unheard of. While the Trust manager who negotiated that deal may congratulate him or herself on a great deal it feels like stealing from the most vulnerable.

⁸² The rhetoric abounding in the current enthusiasm for social enterprises insists that since every member of the organisation becomes an equal owner, decision making will be transformed and creativity unleashed. But equal ownership rights do not outweigh the differences in status that are accorded by wider society. Organisations made up of members of different status have only functioned as egalitarian democracies when there has been a benign dictator insisting upon it. Julian Tudor Hart has written of the paradox of this.

In more complex cases where professional judgement and practical wisdom are needed It will be important to allow professions to ‘muddle through elegantly’ amending decisions in light of events as they unfold. Here the hierarchy will be disconnected.

Those making the charge of cherry picking have a valid case, or would do if in their own practice they distinguished between cases that could be efficiently systematised and expedited and those that required their professional judgement. They would then be able to compete for the cases that benefit from stream lined protocols and rapid throughput and retain their ability to offer a different kind of care in cases that require the exercise of their professional judgement.

So it is not the ownership that makes a difference , it is a firm commitment to good outcomes and to wise use of resources and the ability to work constructively with (i.e. support, enable and challenge) high status professions. This can be found (or not) in all three sectors: private, public and voluntary.

Just as an experiment to end this reflection on efficiency compare these two questions: ‘What is the most compassionate use of this money?’ and ‘What is the most efficient use of this money?’

As you do, make sure you think widely enough about compassion: the most compassionate use will yield care that meets the needs of the greatest number of people. Compassion is a response to an understanding of the needs of others. So, to increase compassion and therefore reflection, redesign and innovation towards better and cheaper care, we must help HCPs to understand more about those who need their care, what those needs are, and the impact of the processes of care on their lives. An emphasis on compassion can motivate them to offer services that meet as many needs as possible by using resources as wisely as they can. A focus on efficiency, by contrast, provides no such motivation.

Regulation

We have not yet mentioned the role of the regulator. After all choice and competition are not the whole of the picture, healthcare organisations must satisfy the regulator about the standard of care and in this way organisations can be sure to take care as seriously as financial targets. But as we have seen in Chapter Two regulators are concerned with second order processes and not first order ones – at their distance they can do little else.

If we want good affordable care then what is needed is concerted local action with everyone playing their part. Everyone has to care about care, and they are more likely to do this than to care about second order processes to appease a regulator. Both are clearly necessary but again a focus on one (the second order) decreases commitment to the other, and thus the tougher the regulator gets the less involved will front line clinicians want to be. They will leave it to regulation experts.

There has been a history over the last dozen years of the Modernization Agency and the NHS Institute, both showing people how to improve the quality of care and its affordability. Their reports have had the potential to be very valuable. What has happened in practice? Local staff have been told by their managers to implement the reports (e.g. The Productive Ward) and to hand over the savings that result. This has inevitably led to mixed feelings for the staff charged with implementing them: enthusiasm to improve care (both by offering better care and by liberating resources to spend on other aspects of care), resentment at being told what to do and how, fear at losing more staff resource in their service instead of being able to use the freed up time to spend with patients, and a desire to sabotage these initiatives.

In a different climate these reports could be very useful. Let’s reflect that alongside the complexity of the health care task there is a raft of statutory requirements of all sorts (just as one example think of the

European Working Time Directive), and all the other NHS pressures of increasing longevity, increasing costs of drugs and technology, and government imposed targets. If we see them as separate tasks, puzzles, each with one person accountable for them then we end up with the kind of delivery we have now. If we saw them as contributing instead to a complex ‘mess’⁸³ which necessarily and appropriately has a rich set of multifactorial aims, and we made (or rather saw, or expected) *everyone* responsible for contributing towards them, then we would need a different way of managing. We would manage through conversation not diktat; through truly engaging with what people care about; fostering constructive dialogue between clinicians; giving credible, rich information about patient experience and outcomes, and about staff experience. We would take a real interest in the behavioural dynamics and day to day logistics. We would want to know whether when people turn up to work they are looking forward to the day; whether everything they need to do a good job is ready for them when they need it; or whether they are going to waste hours during the day trekking to other wards, or offices to find basic supplies or the right forms because ‘theirs’ are missing. We would want their views, based on their experiences, about how to improve care and use money wisely so we would find ways for these to be sought and listened to.

Size is relevant here. Current conventional wisdom has it that organisations have to be ‘big enough to be financially viable’. That is a way of saying that organisations have to be big enough to afford all the specialist expertise associated with the contracting and regulatory processes. And in a system in which, as the Monitor report described, *‘Providers, purchasers and transactions are the heart of the day to day running of the [health care] system’* that is the way you can think. But this is topsy-turvy thinking. If we care about good care and good use of money, we might instead say that organisations have to be small enough to allow meaningful clinical stewardship and management of the kind just described⁸⁴, and then we would design our regulatory processes to support this rather than prevent it.

Innovation

One of the reasons given for competitive markets is that it results in increased innovation: innovative new products or the development of new processes. In health care these innovations will, it is said, lead to care that is better or cheaper.

Innovation is an important part of economic growth because people can be persuaded to want novel products much more easily than to replace familiar ones - novelty provokes our interest and desire. In health care, like choice, competition and efficiency, innovation has a positive contribution to make and a negative one : thinking of new ways to tackle old problems can genuinely add value; wanting to do something a new way just because it is new can be wasteful and disruptive, if not dangerous.

Innovation is not in itself either good or bad, its moral worth depends on the use to which it is put. The gas chambers of the concentration camps were an innovative use for that technology, for example. The same is true of a lack of innovation, it may or may not be a good thing and we must be careful to maintain current systems that work better than innovative alternatives. Inventive clinicians will pursue technical novelty and so will market driven suppliers such as drug companies and while this will be important and valuable we also need excellence in areas that aren’t novel and don’t require novelty so much as attention to detail and effective application of what we already know. Attentive care on Care of the Elderly wards, for example.

⁸³ As we have seen before, Russell Ackoff distinguished between puzzles, problems and messes. A puzzle has a right answer. A problem does not but can be approached in a way that is better or worse. A mess is a dynamic system of interacting problems.

⁸⁴ And, more generally, that decisions about organisation or service size should be based on clinical factors

And let us remember that lots of innovation does not improve the quality of our lives one iota. Oh we imagine that it will, when our desire for it has been aroused by media themselves competing for snippets of information to titillate us in their infotainment role. Our homes (attics and recycling bins) can be full of goods we once hankered after but which did not affect the quality of our lives, just provided a passing distraction. In health care we can all too easily be persuaded of new illnesses (such as social shyness) or the virtues of a novel pharmaceutical solution rather than a life style one (diet and exercise).

In other words there are occasions when innovation is valuable and those where it is not. In areas like health care (with its asymmetry of knowledge and understanding) we need a buffer between the consumer and self interested competitive players in a market to help us distinguish between them. Who could that be? This is another important role for professionals – as long as the professionals are themselves encouraged to behave as professionals and not as market traders.

One of the arguments for innovation is that novel ideas use resources in better ways, but sometimes novel ideas free up resources that were used in wasteful ways only because they were available. It is believed, for example, that technological developments were slower to take place in Rome during the Roman Empire than in other centres because of the number of slaves. With this ready supply of labour there was no incentive for labour saving innovations. Another example is that of recent innovations in heart bypass surgery. Quadruple bypasses can now, in some cases, be performed ‘off pump’, keeping the heart going and beating throughout the surgery. Apparently some South American countries have always used a version of off pump procedures since they have never had the resources to do it any other way.

This suggests that ideas don’t form or aren’t supported when there is a complacent, dominant alternate incumbent. It also suggests that novel ideas respond to the amount of resource available: if there is a lot then the innovations will cost a lot and if there is a little they will cost little – whether in the public or private sector, whether there is competition or not.

So, once again, it is not innovation per se that we are seeking, it is the flexible and imaginative thinking that a genuine concern for a compassionate use of resources will foster.

Those considering a sustainable model for prosperity, one that is not based on economic growth (since that is inherently unsustainable) talk of ‘alternative hedonism’, that instead of finding enjoyment in acquiring new ‘stuff’ or new travel people are (and will have to) find it in other ways – meaningful experiences, purpose: perhaps bringing new meaning to *old* belongings or ideas. In other words using our quest for and talent at novelty in other aspects of our lives, and indeed in the way that we see our lives.

How is this relevant to health care? Perhaps it will mean that the era when patients resented time spent on health care because they wanted to get back out into the market place, earning enough to be obedient consumers, buying more stuff for themselves and their families may, in retrospect, be seen as a blip. Tim Jackson, professor of economics and author of *Prosperity Without Growth* describes this phenomenon as ‘spending money we don’t have on things we don’t need to impress people we don’t care about’.

But perhaps it indicates something else too. That we might change the focus of our search for novelty and put more energy into things like the quality of attention given to patients or the quality of relationship between different clinical professionals. Perhaps we will all remember the importance of the day to day conversations with others that make up much of the richness of our lives and start demanding bespoke interactions rather than automated ones. Perhaps we will find the buzz that we currently associate with novelty *goods*, in an increased sense of meaning arising from using our creativity to enhance our own abilities. Perhaps the novelty is a new us!!

What we need is people thinking creatively about all aspects of care, bringing innovation to ensuring a meaningful day for long term care of people with dementia, for example, just as much as to new devices and drugs.

Ends and means

We can see, then, that choice, competition, efficiency and innovation are all too often talked of as ends, when they are not ends at all but means. If we were to specify the ends towards which they are the means then we could have a properly informed debate about alternative means of achieving those ends. Instead we hear of the importance of choice, competition, efficiency and innovation when what is meant by those words is very different from what might reasonably be understood by those hearing them.

And then we hear the argument that because it is the market that delivers choice, competition, efficiency and innovation we should support a form of quasi market that delivers none of them, not really. If not actively deceitful this argument is lazy, illogical and dangerous.

Language and the NHS

One conclusion we might draw from this chapter is that the language used by governments about public services is interestingly paradoxical.⁸⁵ The term freedom is often deployed when those given the freedom feel anything but free.⁸⁶ The title Our Health, Our Care, Our Say is the harbinger of 'us' being told what it is that we are to be denied.⁸⁷

Words like choice which seem to offer a benefit to patients instead make life (at least temporarily) easier for commissioning managers and offer no comfort to patients. Competition, that should make choice meaningful, instead takes on an unhealthy tinge when it leads to anxiety as patients feel they are having to compete with others for care. Innovation seems to benefit multinational companies more than anyone else.

When language is so slippery we need to look at outcomes rather than declared intent.

If money is to follow patients, and the market is to ensure that resources go to where they are best used, then let's have a look at just where the money does go. When it leaves the treasury where does it go? And where does it go from there, and from there, where does it end up? How much of it gets as far as front line care? Let's look too at where it is not going. How many people who might once have been on secure NHS salaries above a living wage, and earning decent NHS pensions are now on wages only just above the minimum wage and with no pension rights, needing tax credits to stay out of poverty?

Is money following patients? Are resources going to where they are best used? Let's stop just saying they are, find out and then try to find ways in which they could be.

⁸⁵ A point made at the Think About Health Conference September 2010 by David Fuller, Emeritus Professor of English, University of Durham

⁸⁶ Universities are now 'free' for instance to raise tuition fees to whatever level they like up to £9000 a year. Their funding has been cut so severely that they have no choice but to raise them.

⁸⁷ Think About Health Conference: Femi Oyeboode, Professor of Psychiatry at the University of Birmingham pointed out the difference: when Marks and Spencer talk of 'your M and S' they mean to offer us good quality and service. When the government talk of 'our NHS' they mean to tell us what we cannot have.

If the tariff is supposed to ensure that hospital trusts up their game because efficient providers are rewarded and inefficient ones are penalised let us look to see if that is what is happening.⁸⁸ If the PFI scheme was introduced because the private sector is more able to deliver projects on time and within budget then let us look at whether the sums paid for these are, overall, greater or lesser than similar builds: either previously in the public sector, or elsewhere in the private. When we do so we may find that some of the contracts negotiated between NHS managers and their private sector counterparts ensure that the NHS not only pays handsomely for lots of aspects that became visible only once contracts had been signed, but bears all of the risk associated with the project.⁸⁹

When we make policy let us not rely on language based assertions, but on a deep understanding of what is actually happening. We have had a recent history of monitoring aspects of the system (such as choice and competition) as though they are ends in themselves when they are not ends but means towards an end. It is perhaps important to remind ourselves from time to time of what is the end: the declared purpose of the NHS, and to remember that Nye Bevan described as ensuring *tranquillity*. Tranquillity that comes from knowing that when care is needed it will be provided, free of charge, for all.

So tranquillity is what we need to measure all these 'means' against.

But we have got out of the habit of considering ends, and perhaps the most frequent confusion of ends with means is that of economic growth. According to the government, the media, economists galore, and business leaders our aim as a country is to restore economic growth.⁹⁰ But economic growth is not the end and should never be represented as such. At most it is one of a number of possible means towards what is surely the real end: a flourishing society in which there are dignified relations between the individuals and groups that together make it up, and in which individuals are making progress towards their potential.

If we keep that in mind then we would never suggest that to increase economic growth we take action that causes relations in society to become more hostile or individuals to have their means of achieving their potential further reduced. As we consider how to make the most of a health budget we may find it helpful and ethical to keep these ends in mind also.⁹¹

⁸⁸ What do we find? That because the tariff bears no relation to real costs the money being 'saved', as care is moved out into primary care, is fictional and instead of efficiency we have duplication. If we encouraged instead an understanding of real costs and how they behave we could find ways of allocating overheads so that care could become flexible and responsive instead of rigid and 'demand managed'.

⁸⁹ Interestingly this scandal is now blamed on the lack of competence of NHS managers at negotiating contracts with the private sector, not on any avariciousness and behavioural duplicity on the part of private sector companies involved. Traditionally there has been social stigma and significant emotional reaction to the discovery of self centred acts to the detriment of others, and these reactions evolved because they work very effectively as sanctions. These were much more effective and a lot cheaper than layers and layers of oversight or the involvement of large teams of lawyers. The loss of this social stigma and the assumption that everyone is operating only in their own self interest is both corrupting and expensive.

⁹⁰ Thus can a spokesman for the rail operators make a case on the Today programme for removing rail cards from young people and the elderly since the focus of those companies should be on enabling economic growth.

⁹¹ For example when actions are suggested that foster resentment towards people who are the victims of a system that is not of their making, actions such as refusal of care to those who are overweight or who smoke - casualties of the ongoing and one sided battle between the food and tobacco industries and consumers

Chapter Seven: Caring about care – responding differently and uncoupling the circle

If you recall, this book opened with everyone unhappy about the nature of care (and much else besides) and blaming everyone else. Well this is a slight exaggeration but there was a lot of unhappiness, there were a lot of candidates for blame, and blame was pervasive.

I hope that in the course of the last six chapters I have convinced you that we have all, unwittingly, contributed to the impoverishment of the care experience and to its increasing expense. All of us: professionals, managers, policy makers, citizens, as a result of our responses to the five winds have contributed to the vicious circle that these responses fuel. The more positive corollary of this argument is that if this is the case then by changing our own responses we can transform the NHS.

This would mean though that groups of people who currently believe they are behaving well, sensibly, professionally, better than others ... must choose to behave differently and in this chapter we consider what this will look like.

But the argument is more than that: without waiting for anyone else to do things differently we can, if we work in health care, make a difference to our own experiences and those of our patients and colleagues by changing our own individual responses.

In this chapter, then, we begin to look at how members of different groups could behave differently and in so doing change for the better the nature of care, and the reach and value of the NHS.

Professions behaving differently

In Chapter Four we suggested that professions change the way they are interacting with society, so that they use the status and autonomy accorded to them in the interests of society. This will then allow governments to stop wielding blunt instruments of coercion that merely enrage and discourage. We can think in more detail about what this involves by considering how the professions could respond differently to each of the five ‘winds’ we described in Chapter Two.

Responding to the audit culture

If they are 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, and while it is straightforward (though not necessarily cheap) to

measure transactional aspects of care it is much more difficult to do so for care that is covenantal. It will be important to find ways of 'accounting' for those aspects of care that cannot be counted.

One important step forward could be for professionals to re-articulate the nature of the care they wish to give and which they perceive us to need, and to articulate it clearly so that it encompassed both aspects of good transactional care and the additional elements that comprise good covenantal care. If they were to do this then we suggest that they would find this valuable, even transformative,⁹² transforming their own sense of professionalism, but, more than that, fostering a trust and understanding that will benefit us all.

But the audit culture is about holding people to account through the use of measures and metrics, so if we are talking about means of accounting then perhaps it is helpful before going any further to explore what is meant by the terms 'account' and 'measure'.

The purpose of a measure is to give an indication of performance – whether this is excellent, satisfactory or not good enough – to the practitioner him or herself, to their organisation and to the people purchasing or receiving services from them. This allows the practitioner to reflect on their performance and on any changes they want to make, and allows their organisation to enable, support and challenge them, so that this reflection can involve others, and can be translated into new processes and systems as well as individual action. It also allows commissioners to energise this activity on the part of provider organisations, and to some extent it helps patients to choose between practitioners or services.

Measures enable individuals, professions and services to persuade society that they are conforming with certain aspects of care that people value. They are means by which services and professions are held to account. But they aren't the only means of accounting and when it comes to the covenant of care they are not at all persuasive. Another way of expressing this is to note that the terms accounting and accountability have brought with them from their financial origins a numeric and a hierarchical connotation and that we need to see them more richly and find other ways in which people can give an account of what they are doing, ways which can encompass the things we feel are important even if these are difficult to measure.

For example, as Ananta Giri describes:⁹³ the term '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 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.'*

So the challenge is to find persuasive means of accounting for the actions and performance of individuals, teams and professions when they are exercising Practical Wisdom – all the aspects of care touched on in the right hand column of figure 3.1 in Chapter Three.

Finding ways for many professions to account to society for this kind of care will not be easy and must involve serious reflection on the part of professions themselves. Here is Giri again: '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 self critical

⁹² As Jamie Harrison, a member of the learning set, puts it: 'Being able to articulate a sense of professional calling, to something and some people outside my own selfish agenda may offer me hope and direction in a world increasingly worried about motives. To offer reassurance of my own good intentions may prove transformative for all concerned.'

⁹³ In an inspirational Chapter 6, of Audit Cultures

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.’

When we think in this way we can see how shallow and unsatisfactory many of our current metrics are. More satisfactory means of accounting are likely to involve methods other than counting, and they are also unlikely to lead to quick and easy verdicts about who is offering ‘better’ care or which institution is ‘safer’.

So we are talking not only about devising new methods of accounting but also developing a more sophisticated understanding of the issues involved on the part of a larger fraction of society, so that the accounting process becomes less a one-sided monitoring and more of a dialogue.

We must not forget that in the search for ways of accounting for covenantal care the transactional aspects are still vital, after all, good covenantal care encompasses good transactional care and the professions will need to recognise that much of care *can* valuably be systematized so that unhelpful or dangerous variation can be eliminated and that here good use of metrics is invaluable. 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. Part of a 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.

Who might professionals account to, in practice?

We have seen that holding high status professionals to account is not easy. We also know that relations between professional colleagues are an important feature of developing and maintaining good practice. Indeed we could suggest that how professionals treat colleagues is an important factor in their performance and wellbeing. So it is worth considering whether these relations between professionals could be a significant way forward. If we imagined that health care organisations contained within them a critical mass of professionals who really cared about care, (i.e. were prepared to engage in acts of work and courage to ensure that the care received by patients itself involves acts of work and courage), then we could further imagine them keeping an eye on each other and on their performance, and acting on their observations by giving constructive feedback to each other. This richer kind of peer review could become an important part of holding professionals to account – in its most beneficial sense.⁹⁴

Initially taking place within one profession, we might imagine further that once trust had been established, members of different professions involved with the same patient group or service might review each other’s care in a similar way. Of course great care would need to be taken that status differences between professional groups did not skew the discussions, and reflections on this process could themselves yield valuable insights.

Responding to the dominance of reason and of MANAGERIALISM

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. People focus on hitting the target at the expense of the system as a whole rather than

⁹⁴ Please note the constructive way this is described here. We are describing something much richer and more rewarding and valuable than the GMC’s insistence on ‘whistle blowing’.

improving the system and as a result hitting the target.⁹⁵ Indeed this is a particular example of the wider issue of technocratic MANAGERIALISM driving out practical humane management.

Professionals can help keep their organisations honest by refusing to play games and, instead, suggesting ways of improving the system so that targets are met without sacrificing other aspects of value. So as well as keeping an observant eye on colleagues within the professions professionals must take a real and knowledgeable interest in the performance of the organisation as a whole and in the decision making of organisational leaders.

As the highest status profession medicine has the greatest responsibility here and it will be important that doctors do not abrogate this by leaving responsibility for the performance of the organisation to managers alone but instead foster a spirit of clinical stewardship across the organisation, in which clinicians of all sorts take an interest in its performance as a whole, provide advice and guidance, and engage in reflection across disciplines about how care can be nurtured and sustained in ways that are affordable.

Re-energising politics

At the heart of the political task is the reconciling of different interests. While it is clear that this must take place at a national level it is also an inevitable feature of life within organisations, departments and even teams. The different interests to be reconciled include those of different patients or client groups and it should be obvious that, for decisions at this level to be properly informed, health care professionals will need to be actively involved. What would this look like in practice? It would involve professionals being prepared to engage in genuine dialogue (that will sometimes be heated and emotional, because it involves much more than logic and reason) about things like the design of a service pathway, 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 kind of dialogue will require abilities to work collaboratively to an extent rarely seen to date, and therefore a new set of assumptions, attitudes and behaviours, developed in a new kind of training.

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. Doctors and others need to be taking an active interest in the nature of our society, how it is governed and the models guiding it; they need to recognise ideology for what it is and not confuse it with inevitability; and to be able to view debates about this through a number of different lenses to develop a rich understanding of a complex reality. They may choose to accept that western liberal democracy founded on capitalism is the best way of organising affairs but they should at least have understood that proposition and considered alternatives and critics. If they (we) do not, how can democracy itself be healthy?

And, we must not forget too, that there are relevant and important ideas that do stem from the economic paradigm. If it is true that the way markets succeed in improving quality and reducing costs is through the 'four Is' (innovation, information, incentives and investment, introduced on page 64) 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.

⁹⁵ It is worth noting that there is an explosion in the number of 'audit experts' wherever and whenever targets and evaluation processes are introduced. While not illegitimate, these experts rarely focus on the underlying systems, paying much more attention to the means of convincing the auditors, helping organisations rehearse their responses and ensure that they score well in the processes used.

Understanding and honouring anxiety

Since anxiety is inherent in the health care task then our HCPs and managers need to be able to respond to it healthily. As so much about health and health care is as yet ill understood, even the most experienced of practitioners will be anxious on occasion. A sense of anxiety is a very valuable reminder of the need to take care and can be seen as an appropriate and healthy to a tricky situation.

Let us remind ourselves of the healthy responses to this:

- noticing an unpleasant feeling of anxiety
- 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.
- bringing together our own concerns with those of the person who has prompted our anxiety
- deciding to embark on a course of 'aware altruism'
- or of meaningful dialogue with the other the outcome of which cannot be anticipated
- seeking support from someone more experienced in a particular procedure or situation.

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 covenantal care we can see that anxiety may well be provoked by the kind of situation in which a patient needs the latter. And when this happens the anxiety can be reduced in three ways: 1. to withdraw both care and compassion and offer bad care, 2. to offer good transactional care, or 3. 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 last will require both courage and work but is the only one that can reduce anxiety levels fundamentally and long term.

We do need to recognise however that choosing (either consciously or subconsciously) one of the first two is a natural human response to anxiety, so when we find people offering care of these kinds it is more valuable to try and find ways of reducing anxiety rather than increasing it further by calling for evermore punitive monitoring and accountability.

Using the opportunities of the digital revolution

The informational world we are moving into in which digital code moves freely (in both senses of the word) in ways that we can only begin to imagine, means that voice will increasingly be exercised by people on their own behalf and not through representative or governance structures, and that we will be able to track real activities in real time and assign reputations to people and organisations based on these, rather than on proxy measures and reputation management exercises.⁹⁶

Surveillances (large numbers of people looking up) will at least accompany and perhaps outperform surveillance (people at the top looking down). In other words 'souvillants masses can replace the

⁹⁶ For example think of Trip Advisor v Michelin or star rating systems by tourist boards.

surveillant cadre', in a 'dance of millions of people and hundreds of thousands of organisations leading to meta level patterns'⁹⁷ which describe real behaviours and actions from real people in real situations.

This is of course very challenging for professionals and their organisations but may allow more of the covenantal aspects of care to come into the picture – since these are an important part of the overall patient and family experience. So professionals can valuably welcome these sort of initiatives rather than trying to protect against them. Indeed they could encourage them.

Developing our professionals

Since the behaviours just described are radically different from those we see today they will require an equally radical new form of development.

Medicine, and the healthcare professions more widely, have in the past been seen as among the most fantastic jobs in the world, a real privilege to have the opportunity to be entrusted with the health and wellbeing of individuals and society. Somehow, sometime, we lost this sense of privilege and we would all benefit from restoring that, along with a sense of honour, enthusiasm, creativity, and fun. At the same time we could usefully lose the sense of entitlement, resentment, and grievance that characterizes many conversations within professions.

For the professions to engage in the kind of open dialogue described above, and for them to be open to the need to earn their autonomy, and to see autonomy as a value to live for (as Giri describes it, see page 74), will require them to have as their foundation a genuine sense of self worth, and ways of engendering this 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 covenantal care requires. 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 as whole people (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. 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 covenantal education.

This is an important point. Since education has been as exposed to the five winds as health care has, the educational process through which our young professionals are developed is now almost wholly transactional in nature. Assessment is driving what is taught and how it is taught. The attention now is almost entirely on competences and on facts. Indeed it is the audit experts' mantra that assessment must drive the curriculum. But this means that essential aspects that are not amenable to objective assessment in the way that meets the needs of auditors cannot now be taught and there are holes in the curriculum that are currently compensated for in the world of practice only by those old enough to have been taught in pre-audit eras⁹⁸.

⁹⁷ Paul Hodgkin, Learning Set paper

⁹⁸ Jane Macnaughton, GP and Professor of Medical Humanities, University of Durham at the Think About Health Conference 2010. She went on to say 'understanding a subject in a coherent way is diminishing because students

So we must find ways to help those educating our young professionals to loosen the grip of auditors and enter into an educational covenant with their students, so that they can pay attention to who these young people *are*, who they can *be* and how they can behave, and not merely what competences they can demonstrate.

There are many ways of describing aspects of how we want our health professions to behave. Carl Rogers' description of the therapeutic triad (of genuineness, non-possessive warmth and accurate empathy) may be a good starting point for this. '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'.

In the management world too Otto Scharmer talks of 'presencing' and of the 'inner space... the source from which we operate, ... the quality of attention and intention we bring to any situation'. In addition concepts such as respectful uncertainty, compassion and 'loving-kindness', deep listening and more, have entered the language from many sources and all of these are surely relevant to the ability to offer covenantal care. So we can picture the kind of outcomes we are trying to achieve in our educational processes and relationships and they all depend on a genuine self confidence on the part of our young professionals.⁹⁹ That means their training processes will need to feel, to them, safe as well as challenging.

If we are to achieve this we may need to turn our training programmes (especially for medicine) upside down. Currently the training we offer tends to include a scramble for places, a constant proving of ability to succeed which often leads to an entirely pragmatic focus on what is being assessed, an intolerance of anything else even if it may help them to be better care professionals, and an arrogance in relations with other professions associated with a history of being able to demonstrate superior intellectual skills. We could try a different approach. What would we offer instead if we aimed to liberate their potential as much as imbuing facts and testing competences?

Suppose we inducted them into an exciting journey, inculcated a sense of privilege, a sense of purpose and of inquisitiveness: 'go where this takes you as long as you are serving society, oh and first of all have a look at how you are understanding society'?¹⁰⁰ Certainly we would need some kind of net to catch those who aren't capable for reasons to do with effort, intellect or personality, but let us offer an ethos very different from today's competitive, exam based, competency driven production line. We could think of it as educating them in the same way as the way we want to work with them (and they with us and others) in their working lives, in health care organisations. An introduction to the world of good practical humane management.

This is an important point: that we must develop our young professionals to be able to function effectively in the organisations in which they will work. Currently they enter these organisations with no idea of how organisations work. With no understanding of the inevitability of organisational politics, no recognition of organisational hierarchies and decision making processes, no recognition of the need to identify networks of people who can help solve problems, these young professionals are severely handicapped. When they then find that the organisation does not always welcome their ideas for

don't want to do more than will be assessed and institutions discourage teachers from teaching it' and 'We arrest people's interest in going beyond competence'. We could see this as yet another example of 'efficiency'!

⁹⁹ Managers too

¹⁰⁰ Really understanding it, in all its richness (not the collection of self interests the economists and managers and policy makers tell us it is).

improvements they blame the organisation rather than consider how they could have helped their ideas to succeed, and a pattern of mutual mistrust ensues. If we want to we can change this.

But it is certainly not only the professionals who need to change. Let us think now about managers.

A different style of management

Since the mid 1980s we have made the assumption that there is a method of management (a set of behaviours, analyses and techniques) that can be applied to beneficial effect in any setting, including the NHS. And indeed some of the insights and approaches have, when used wisely and sensitively, been valuable. However it is worth reminding ourselves of the very real differences between health care and other industries and when we have done so we may consider that these differences in context require a difference in the management method that is used. In other words management will be just as necessary in health care as it is anywhere else but the approach and the characteristics of managers themselves should be designed to suit the purpose and dynamics of health care.

We have suggested in Chapter Six that the economic definitions of choice, competition, efficiency and innovation are problematic in health care. In Chapter Four we explored 'disconnected hierarchies' in which groups with professional autonomy cannot be required to act at the bidding of management. Nor can they be incentivised to do so since nearly all of the incentives (the things professionals care enough about to affect their performance) are not in the gift of managers. In Chapter Four, too, we saw the importance of healthcare organisations fostering and nurturing professional judgement (practical wisdom) for the good of society as a whole, and the importance of enabling and supporting high status professionals in their ability to reflect constructively on their performance while also challenging them to do so if they appear disinclined or unable.

In Chapter Five we considered the role of the manager to include that of enabling their organisations to serve their communities, as well as ensuring their staff and their services are flourishing.¹⁰¹ We saw too that the way they do this is to undertake acts of work and courage and encourage these throughout their organisation. In Chapter Two we looked at the anxiety experienced by all involved in health care and at the defence mechanisms we all employ as a result.

As a result of all these differences in the context¹⁰² the management method taught in schools of business and management is not merely powerless here, it can become actively malign.

Consider, for example, how management has now, all too often, become (as we saw in Chapter Five) 'performance management', with a very mechanistic model of managing performance. It assumes that we can hold an individual to account for the overall performance of a large and complex system, and indeed often results in the bullying of individuals rather than a proper focus on the system as a whole.

We can think of this kind of bullying as management that is neither good transactionally nor covenantally. It happens as people become disempowered or dis-abled by focusing on particular targets;

¹⁰¹ Flourishing in the Aristotelian sense of living to your fullness, of realising potential. And yes flourishing will include a proper concern for financial and other resources –after all we are talking about everything realising its potential – financial and physical assets as well as us, the human assets!

¹⁰² Actually we don't believe the differences between health care and other real contexts are so very great. But the differences between health care and the context assumed by economists and business schools are indeed great.

they both look at the target and not at each other, and they look at each other only insofar as they can help reach the target, they don't see the other as a person.¹⁰³ Thus, it feels to many as though the way performance management has been interpreted in the NHS has destroyed or seriously diminished the intrinsic motivation and passion of all concerned.

If we recognised that what we have are a disconnected hierarchy (Chapter Four) and a complex adaptive system in which interventions cannot have predictable outcomes, then we would know that holding individuals to account for a radical change in the **real** performance of that system - and especially within a short time frame - is absurd. Is it any wonder that individuals given such responsibilities do not seek to improve the system (and thereby achieve the target), that instead they focus on the target at the expense of the system?

When so many of the factors that influence improvements in the system are controlled by people (clinicians) who cannot be required or incentivised by the individual whose job is on the line if the target is not met, these key clinical players can simply watch and wait for the next unfortunate incumbent to replace the current one. That they often describe these managers as incompetent when they themselves have refused to accept any corporate responsibility simply adds to the tension between the two camps and makes the context even more profligate, mean spirited and unmanageable.

In this context a language of 'mistakes' and 'fault' predominates, when, more realistically we could talk about 'trying things out' and 'learning from approaches that haven't yet worked'. Instead individuals are blamed and careers are ruined.

There is one part of the system where the hierarchy *has* been very firmly connected: the management hierarchy running from Department of Health through the chief executives of supposedly autonomous NHS organisations. Here policy is taken from broad statements of purpose and turned, through the various management layers, into detailed guidance. Each layer in the hierarchy adds its own additional detail as the papers cross their desk and they cannot find it in themselves to trust the layer beneath them to enact them wisely. In this way local managers are undermined even further and allowed little room to develop local strategies that make greater sense for their local communities, and opportunities to gain credibility with local clinicians are again reduced.

Another way of describing this cascading of detailed instructions is that it forces local managers to focus on the complicated easy (analyses, reports, ticking boxes, reading the guidance), leaving them little capacity or emotional energy for the simple hard. So they do not spend time on the acts of work and courage that will enable, support, and challenge those around them to be creative and energetic in pursuit of goals important to them as individuals and to the organisation and the people it serves.

¹⁰³ There is interesting evidence from Steven Kelman and John Friedman of Harvard University (An Empirical Examination of Distortionary Impacts of the Emergency Room Wait-Time Target in the English National Health Service) which suggests that:

- Central decision making on priorities is positive, (so choosing cancer, heart disease and suicide was good and drove national benefits)
- Targets change behaviour and deliver results
- Learning doesn't happen; targets are delivered but *no learning on how to run things better and possibly the reverse*
- There is no value infusion. *Nobody* feels good about delivery.

So while you gain results, you lose intrinsic motivation and a sense of meaning. We all become cogs in the wheel/the means of production. There is also some evidence that persons with high levels of power tend to perceive others as a means to satisfying one's own personal goals rather than as individuals in their own right.

Instead of engaging in conversations (genuinely interested robust conversations of value to both parties and to the organisation) and relationships and using observation and intuition to pick up signals about how things are going, they rely on 'balanced scorecards' and stars from the regulators.

Having said that, there is usually little in the guidance that forbids this covenantal approach to management (although the irritation caused by the tick boxes discourages it) and we are perhaps short of managers who are good at both transactional and covenantal aspects.

One reason for this is that Business Schools rarely develop the fluency of their students in a language of emotions. So their graduates are not able to identify what they *feel* as they set about their managerial roles, nor share that with others. Neither do they encourage others to identify and express their emotions, nor do they develop the interest or empathy that would enable them to sense these.

If they understood the nature of anxiety, the role it plays in all our lives and the defence mechanisms we display to avoid it, they may refrain from dismantling these willy nilly (by restructuring, de-layering, redeploying, impoverishing skill mix etc etc) and find ways of achieving the same or similar ends without such damaging impact on motivation and meaning.

With an understanding of universal emotional responses they would not be naïve either about initiatives for working collaboratively. They would look out for the inevitable human emotions of envy, sabotage, and 'them and us', realising that to act as if they do not exist or can somehow be ignored is unrealistic, and that in environments characterised by competition they will grow.

Alongside this lack of attention to emotions, apart from some superficial attention to values, vision and missions, Business Schools do not understand (or pay attention to) the more profound sense of meaning that turns a job into a vocation. This lack has allowed people to be seen as machines, as units of production. The enormity of this loss has been left undiscussed and is perhaps now undiscussable.

Of course a transactional approach to management is exacerbated by (as well as a cause of) the increasingly short tenure in senior management positions. In fact while we can feel angry with those at the top of the managerial heap we need to feel sorry for them too. They've had their spirit quashed, either from outside by a more senior spirit quasher, or from inside by a belief in free market economics and the managerial method.

So we need a new kind of manager. One who understands people as well as numbers and has an understanding of some key insights from psychology, sociology, anthropology and history, moral philosophy and perhaps even theology (not typically the curriculum of an MBA).

Management and the five winds

As managers will be being buffeted by the same five winds as everyone else, we can use these to consider how they could respond in ways that improve and sustain care rather than impoverishing it.

Responding to the audit culture

Just as professions need to earn their autonomy so should organisations and their managers, but instead of earning this organisational autonomy by meeting government targets (as now) organisational leaders would ensure their organisations earn it by placing the organisation at the service of society. We have suggested that professions do this by engaging in creative dialogue with patients, public, and other health and social care organisations and this is also what organisations would need to do. Many would

say they are doing so already but we suggest the current efforts are tokenistic and that we need instead a meaningful dialogue.

Similarly, just as professionals will need to find ways to account for covenantal aspects of care so too will organisations. They will find it just as hard and will, again, need to develop innovative ways of doing so. As part of this they must be prepared to challenge the way commissioning is undertaken if it does not take sufficient account of relational and covenantal elements.

This is a point worth emphasizing. If commissioners chose to see their role as working alongside acute sector colleagues to encourage high status clinicians to work constructively on service redesign in pursuit of improved quality and reduced cost, they could play a helpful, indeed vital role. They hold much of the information that is needed if managers and clinicians are to understand the dynamics of their performance. They can help identify comparable services that are better designed. They can encourage managers to care about care, and so on. If they can see their role as helping rather than as fighting there is a chance this will not be a hugely expensive ‘industry’ of form filling and bean counting, but a genuinely helpful means of energising their acute sector colleagues to address the core issue.

Reducing undue variation in care is an important objective across the system as a whole, and managers will need to work with their HCPs to standardise care where appropriate. They will also need to ensure that this agenda does not interfere with opportunities for good covenantal 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 organisational 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.

At the level of the Board there is a need for reflection on the Board’s (and the organisation’s) attitude to risk. Boards need 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 and encourage.

All in all 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; bringing their values, emotions, and desires to work.

Responses to other aspects of the digital revolution

If professionals are to respond proactively and constructively to digital advances their organisational leaders must encourage and enable this. For example, if *souveillance* (commentary on services by those receiving them using the power of the web) 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.

They could go further than this, they could prompt or support creative thinking across their organisations about how to use the potential of the web to help people flourish.¹⁰⁴

Re-energising politics

We have discussed the need for HCPs to be prepared to get *involved* in decisions about the nature of services and the allocation of resources, and 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 new skills in dialogue and collaboration.

As part of their service to society, organisational leaders involved in this collaborative dialogue must reflect thoughtfully on the appropriate use of organisational status, recognising the differences in status between organisations and not allowing this to dominate the discussion inappropriately – just as we have discussed in Chapter Four in relation to the status of professions. In this way ‘low tech, high touch’ services will receive the same attention and concern as ‘high tech’ specialist care.

Healthy responses to anxiety

If organisational leaders were to support healthy responses to anxiety in all parts of their organisation, recognising anxiety as inherent and not seeing it as weakness, they could help ‘contain’ anxiety through effective leadership, appropriate structures, and clearly defined roles and role-relationships. They could encourage and support appropriate supervision processes and opportunities for individuals and groups to reflect on the emotional impact of their work.

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 those processing those experiences.

Managers who become aware of their own emotional responses to situations, recognise their own anxiety and attempt to respond in healthy ways themselves will not only be more effective and ‘whole’ but will also choose to request help when faced with anxious situations and will certainly find ways of supporting others when they request it.

Reclaiming management from the technocrats

We have suggested that the role of managers is to enable others, enable them to realise their potential to help others (ultimately patients) to realise theirs. So we can see that management behaviours have to model the behaviours managers want to see in those they are managing. Every interaction between manager and managed influences the nature of care offered to patients.

Once we can reclaim the concept of management and see it as guiding and influencing the work of others, as helping others to flourish and in turn enhance the flourishing of patients, colleagues and others, we can see once again that most management in health care is undertaken by people who do not describe themselves as managers but as clinicians. Once we have reclaimed the concept we can

¹⁰⁴ And by this we mean understanding the potential of the web and thinking creatively about means of meeting health needs. Really creatively, not just seeing it as a new medium for old thinking

encourage clinicians to develop their abilities to guide, to influence and enable.¹⁰⁵¹⁰⁶ We need, however, to think about this differently from the way we have approached it over the last twenty years.

One solution to the perceived problem of a disconnected hierarchy has been to encourage clinicians to take on managerial responsibilities. Those who do are then often rejected by their clinical colleagues, seen as having rejected the clinical identity in favour of something else. They can be seen as ‘going over to the dark side’ (!), as dangerous double agents, spies in the camp, to be distrusted. Sometimes this is because people are given jobs they cannot do, either because the jobs are inherently undoable (e.g. persuading their clinical colleagues to do something they don’t want to do), or because these individuals are given no training or guidance, or both. Since this is humiliating, and the individual is often unable to say they are out of their depth or under skilled, they then create a range of defensive systems to hide their incompetence. If we take into consideration, too, the fact that managerial roles carry no additional status we can see there is little incentive and considerable risk for clinicians to take on such responsibilities.

There is now even more impetus towards encouraging doctors in to management under the heady title of clinical leadership (largely because it is believed this will connect the hierarchy, that doctors are more likely to follow others if they are also doctors). So there is a move towards high status joint MD MBA programmes or Darzi fellow schemes. Unfortunately these are not answer – indeed they will exacerbate the problem - because they simply spread the MANAGERIALIST method to the medical domain (where it finds very fertile ground). What is needed instead is for those doctors who are practical humanists to find allies wherever they can and transform the management method and managerial landscape in health care. It isn’t the medical or MANAGERIALIST knowledge that yields results (not on its own anyway) it is practical wisdom, reflection and review of practical experience, by people using all their wisdom and intuition and not merely their logic.¹⁰⁷

So, if we want health care that is excellent (or even good enough) in both transactional and covenantal terms we need to think about the role that managers (including in this term most clinicians) can play in achieving this. How they could feel genuine and deserved pride in their contribution. How they can avoid the charge of ‘meeting the targets and missing the point’.

Some examples of the kind of management needed can be found in table 7.1.

¹⁰⁵ We could, if you preferred, call this clinical leadership, but it would be of a very different nature to the kind of clinical leadership being touted currently – which has more in common with Business School models than the one we are describing here.

¹⁰⁶ As outlined in Chapter Five and in more detail in my book *Really Managing Health Care*

¹⁰⁷ In case we have given a different impression we believe that stewardship by doctors is very important – doctors with an understanding of the humanities not management. We really must start educating our doctors and not merely training them.

Table 7.1: Management as an act of work and courage in service of others potential to be of service

<i>Involves</i>	<i>Does not involve</i>
High transactional and high covenantal working	Just the transactional
A focus on the simple hard	Focus only on the complicated easy
Relationships and conversations, observation and noticing	Only dashboards and balanced scorecards
Feeling pride in the work of the team	Feeling arrogant about one's own success
Modelling care as acts of work and courage and spreading news about examples of it within their organisation	Passing on the hurt down the 'chain of command'
Being self-aware, having an understanding of group relations, able to recognise and discuss emotions	Ignoring emotions – own and others
Learning as much from what doesn't work as from what does	Talking about failure and finding someone to blame
Using language which fosters and rewards intrinsic motivation	Seeing motivation as needing extrinsic sticks and carrots
Building collective courage	Seeing self as the 'only one'
Sense of being in service to the local community (which may be the community of patients in a specialist area)	Driven by a sense of being in service to the DoH/Monitor
Working with the group dynamics of envy, sabotage; understand their inevitability and work to bring containment to them	Working in ways which reinforce envy, negative protections, high anxiety; providing no containment to these inevitable dynamics
Creating jobs of value and worth	Giving no thought to the value or worth of a role, see it just as a skills mix exercise
Supporting, challenging and enabling people taking up roles to be able to be effective and skilful in them	Putting people in jobs and just hoping they make a decent enough job of it; failing to support them then criticising when they don't do it well
Bringing clinicians and non-clinicians together in productive ways that release energy and motivation; be skilful in facilitating co-creation	Talk about 'herding cats' and comparisons with the private sector where 'staff can be told what to do'.
Seeking, and being open to, hearing feedback; being skilful in giving feedback	Refusing to listen to bad news, shooting the messenger, asking for solutions and not problems
Being emotionally literate; be able to use the language of emotions and be in touch with one's own emotions	Feeling a failure if feel anxious, nervous. Valuing a thick skin and the ability to tolerate other people's pain

You are welcome to use this book in any way you like as long as you do not charge for it and you credit the author, Valerie Iles, and the website Really Learning – www.reallylearning.com

Developing organisational leaders

We talked above of the need to find different ways of developing our professionals and, similarly, we must find ways of developing differently our managers. Perhaps more than anything we must reduce the amount of complicated easy in their curricula – this is not the value they add. This can be found elsewhere in the system – in advisory roles – and managers must learn both how to seek advice and not to be bound by it. Making decisions will require of them that they use their Practical Wisdom and draw on their

experience, intuition, and judgement, while also being aware of their own emotional responses and those of others involved. This kind of simple hard requires a very different curriculum and a different approach.

And policy makers? We need a new form of policy making and a new form of civic – ness

Changes such as these among professionals and organisational leaders are essential but they are not enough. They will need to be mirrored by changes in the behaviours of those making policy. Policy makers will find it much easier when professions and managers are behaving differently but there are important changes they must make in their own right.

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.

Separating policy from administration is a good starting point. So that decisions such as the level of resource and the key priorities are decided by policy makers, along with a few critical features of the system. This is the role that policy makers are equipped for and have the democratic legitimacy to fulfil. Implementation is not their expertise and should be delegated to administrators.

How would policy makers reach decisions about resources and priorities? Not by talking with a few ‘experts’, health economists, top doctors, senior managers etc; but by tuning in to the vibrant debates happening at local level: debates about how resources are allocated at community level, at hospital level, at service level.

The purpose of their tuning in in this way would not be to intervene in these for party political advantage (as happens now) but to understand the tensions in the system, to encourage 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.

Were this to happen, that policy makers understood and took an interest in the practical issues that prompt local debates, then contributing to these local debates could become part of professional, managerial, organisational and community life.

As they became more aware of the realities of local systems policy makers and their administrators would be able to stop believing in big top down initiatives and recognise the importance of small changes devised and introduced locally. And they would find it easier to resist the temptation to set

targets just because they *can*. Finally realising that setting targets will inevitably lead to *poorer* services,¹⁰⁸ and that they need to find other ways of energising change.

Perhaps more than any other group policy makers have a responsibility to keep always in mind the aims of a health system: tranquillity, confidence that when care is needed it will be provided in acceptable ways by people who care about patients. It is of course possible to consider reframing these and policymakers have the right to engage in debate about these aims. They do also have a responsibility to engage the public in that debate and in a meaningful way, before they consider changing them.

In general the means of achieving those aims would be the remit of DH administrators but if a major change of approach were instigated by policy makers their role would always be to test the new approach against the aims – and not to become so fixated on any particular means that it becomes an aim in its itself. For example introducing ‘general management’ (back in the 80s) or ‘the market’ is not a policy aim it is a means towards an aim and it must be tested against that aim.

Policy makers also need to recognise the role played by anxiety – others’ and their own – and choose to respond in the healthy ways described previously. These healthy responses would allow them (liberate them?) to behave with an integrity (a virtue popular with voters) that unhealthy responses do not.

It would be helpful, too, if policy makers were to reclaim as political the issues they have farmed out to ‘neutral experts’. Avoiding emotional, difficult unpopular decisions is not a position of integrity and they need to reclaim their difficult, dangerous,¹⁰⁹ 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, their role can include ensuring the health of those local debates (so that they aren’t captured by professionals or managers but genuinely involve views of local people) and taking an interest in the outcomes.

Having separated the making of policy from its implementation we must also consider the role of those administrators charged with the implementation and describe their role as akin to those of the managers we have described above: guiding, influencing, enabling others to realise the potential of their organisations to contribute to the flourishing of their local communities by meeting health needs and seriously addressing health inequalities. So they will need to behave differently too. Fundamentally they will need to understand, really understand, the nature of the system and the impact that policy announcements and changes will have on it, and then leave as much as they can to those closest to the action. To do so they will take an interest in the flourishing of organisational leaders.

Will this require a different set of skills and therefore development process? Almost certainly.

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

¹⁰⁸ Seddon J [2008] Systems Thinking in the Public Sector

¹⁰⁹ 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, they sacrifice careers to caring for children and elderly parents.¹¹⁰ 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 would require us to develop our 'politicalness', our ability to engage creatively in dialogue with people pursuing different ends, or the same ends by different means. We are most likely to develop these abilities at a very local level among local people discussing decisions that matter to us personally: about buildings, services, planning laws and so on.

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 (we) are able to recognise skill in creative dialogue, and identify it in those seeking our votes. We will reward with power those who show their ability to listen, to gain the confidence of others, and develop options which reconcile as many interests as possible.

This feels very different from the society represented to us by economists (and their friends in the media) - consumerist and selfish - and very much more like the kind of communities many of us do live and work in. So it may not require a major initiative to move us in a new direction so much as a series of nudges to remind us of what we care about and how we can become involved.

Different Responses

Different responses to the five winds – that is what we need. Different behaviours, a different sense of contribution (rooted in a different confidence in the self, a genuine concern for the other and a belief in the importance of *being* as well as *doing*), different roles, especially for managers and policy makers, a distinction between policy making and implementation, means by which citizens can legitimately inform debate, and a clear articulation of what we mean by care.

Together these convey a new sense of what it means to **be** a professional, a manager, a policy maker, a citizen.

New Professionals

There have been recent initiatives under the banner of New Professionalism and they form two strands: that developed within the professions and that originating from government. The former focuses on the wish to use professional judgement and could be seen as a plea to offer individualised care without

¹¹⁰ This is now termed the Hidden Wealth of Nations, (see book by David Halpern, Polity Press) although the only people from whom it this wealth and behaviour has been hidden are economists.

sufficient emphasis on the transactional aspects. The latter does the opposite: emphasizing systematizing and standardizing of care and encouraging a move towards a connected hierarchy.

What we are trying to give voice to here is different. We recognise the value of a disconnected hierarchy and do not lament it. We see the need for (and benefit to) the professions of re-establishing a sense of **service** which leads to a genuine concern for good transactional care, much of which can be systematized, *as well* as appropriate use of practical wisdom, with the nature of the care offered being determined by the needs of the patient¹¹¹.

New Managers

The management model we are proposing here is different too. While its purpose looks the same (delivering organisational performance that includes good patient care to meet health needs and address health inequalities, within available resources) the METHOD is profoundly different. It is not strident and bullying, nor soft and fluffy: it is challenging, expectant and supportive. Knowledgeably ambitious for services, keen to hear the enthusiasms and concerns of front line clinicians, aware of financial and other constraints: management like this is a covenant between organisation and professionals, organisation and patients, organisation and community. It delivers transactional aspects of care reliably – while it recognises the importance of care as a covenant: this very recognition allowing front line staff to respond with a concern for the transactional that has often been lacking.

We are not advocating any kind of return to a previous world but delivery of genuinely good transactional *and* covenantal care.

New policy making

In our scenario everyone is doing what they do best, applying *their* ‘practical wisdom’. We liberate policy makers from policy implementation so they can focus on policy. Policy informed by the active involvement of citizens, professionals, managers in local political debate. Economically literate, socially concerned, and so much more.

Forces for change

Can it happen? It has been societal forces that have driven the changes in the nature of professionalism, management and politics over the last fifty years, and it won’t be enough for us simply to declare that we want to change direction, so we need to ask the question: is there sufficient energy in society for a change in direction now? Perhaps:

- The financial crisis has undermined faith in markets and so there is much less belief that politics should be left to markets. At the same time it has shaken the belief that risk can be calculated, controlled and managed away – or avoided by taking decisions which diminish people’s lives.
- New developments in neuroscience seem to prove conclusively that relationships are an essential element of care. As a result we may soon be able to lose our concern about patients becoming ‘dependent’ and recognise that in any genuine relationship there is a loss of some autonomy and that this is beneficial rather than dangerous.
- The depth of dissatisfaction on the part of professionals and the public about the nature of care will have an impact.

¹¹¹ Without an understanding of the previous chapters this last sentence is likely to drive professionals to anger.

- Cuts in the public sector should provide pressure to reduce the amount of resource tied up in unnecessary complicated easy activity.

So although we must not underestimate the attraction of the complicated easy, and the determination of those who use logic to the exclusion of everything else to continue to do so (and both of these are amply demonstrated in the current - May June 2011- debate about the precise nature of the coalition government's NHS reforms) we need not feel too dispirited, for two important reasons.

First, although change will be needed in all four groups of people (professionals, managers, patients and public, and policy makers) if the NHS as a whole is to be renewed, and it may feel as though we have to wait for others before making any changes of our own, many of us fall into several of these categories and we will be able to have an impact in all of them simply by changing our own attitudes and behaviours. And the second follows from that: that this kind of renewal will come about as a result of people seeing things differently, choosing to respond differently and behaving differently – none of these require structural change and can start anywhere.

Chapter Eight: How we look determines what we see: loosening the grip of the economists, reforming the NHS and improving the delivery of care.

Unless we understand and accept the causes of poor performance in the NHS and the dynamics that allow these to remain unchallenged we will never be able to reform it. This book has suggested that the fundamental causes are our responses to the five winds and the vicious circle created as a result and that the more limited diagnoses of economists do not help us either to identify this or address it. In this chapter we will look at how we must expand our ways of diagnosing the NHS, at the special responsibilities of the most powerful professionals and at how the current reforms could be used by these professionals to work in ways that take us closer to its original aims.

In the preceding chapters I hope to have convinced you that we have all, unintentionally and unwittingly, contributed to an impoverishment of the kind of care offered within the NHS. We have done this in our responses to the five ‘winds’ blowing around us. We could not of course have changed the direction of the winds or protected ourselves from them, but we could have responded to them differently.

For example, we haven’t realised that concepts such as *audit* and *transparency* that sound so neutral or beneficial can change so radically the systems we think we are merely observing. (And of course we are never merely observing, we are also labelling, judging, and rewarding or punishing. Perhaps if we could find a way of merely observing we could use these concepts without the insidiously devastating consequences that we have described).

We have run from the simple hard to the complicated easy as our able intellects jump from half understood problems to solutions. Solutions that require only the agreeable engagement of our minds rather than the more challenging use of other senses: our observations, our experience, our intuition, our empathy and our courage.

We have lost our ability (or our preparedness) to include subjective judgement in our decision making, choosing to take the pronouncements of expert advisors of all sorts¹¹² as the decision itself and not merely factors to be taken into account in making the decision.

We have failed to take our places in stewarding our organisations, services or teams: not being prepared to engage others in difficult dialogue about decisions that affect us and our patients, and the outcomes achieved by the organisation as a whole.¹¹³

¹¹² Including those who devise guidance and protocols.

We have implemented diktats imposed from above, knowing as we did so of their negative consequences but failing to protest or suggest alternatives. We have not kept in mind the ends and used those to challenge the means that have been presented to us. When we have objected we have done so on ideological grounds (anti privatisation for example) rather than insisted that the means are tested in real life against the ends they purport to achieve.

We have lost touch with the value of our emotions, blaming ourselves and others for our anxiety and pushing it as far as possible out of sight, where it influences our decisions and behaviours in damaging ways, that in turn increase our overall levels of anxiety in a vicious circle.

Taken together across the NHS as a whole, from front line to policy makers, by behaving in these kinds of ways we have introduced armies of people undertaking complicated easy¹¹⁴ tasks which do not need doing. Collectively, responding to the five ‘winds’, we have squandered the greatest new investment the NHS has ever had.

Not all is lost. We can try to realise the potential of what we have gained (some new buildings, new kit, new insights, experience) but to do that we have to **look at the NHS world with new eyes**. Otherwise we will simply repeat our mistakes. We need to realise that it is not particular solutions or policies that have been wrong, it is the LENS through which decision makers have been looking when they devised those solutions and policies.

At the macro level we have let economics dominate all other kinds of thinking, so that politicians and managers become merely its technicians. Along the way we’ve almost swallowed the economic fiction of the rational, self interested human. The ‘human’ who uses only reason (no emotion) to make well informed consumer decisions, comparing goods of like value.

In moving away from a view of patients as people who should be grateful for whatever health care they get, we have chosen to treat them as demanding consumers when we could instead have treated them as welcome guests. In parallel with this we have treated our professionals as impersonal units of production. And in doing this we have corrupted both our ideas *about* people and us *as* people. We need to remember that we are so much more than economic units operating in an economy, and that to understand us and the dynamics between us we need to consult so many more schools of thinking.

We can describe our nation of 55 million people, including the one million or so working in the NHS, as an economy and consult economists to understand us better. Or as a society and consult the sociologists. Or as people and consult psychologists and anthropologists; people with a history and consult historians, with a sense of fairness (moral philosophers) and power distribution and a need to reconcile different interests (political philosophers and political scientists). And if we really want to understand us then we have to consult all of them and more.

These are all rich subjects with deep knowledge, to which the imperialistic efforts of economists, as they attempt to colonise them under the heading of behavioural economics, cannot possibly do justice. So we need to see economists and their technicians (managers and politicians) as valuable contributors (but only contributors) to a richly multifaceted debate. We somehow have to find ways of loosening their grip.

¹¹³ And although we say, and mean, ‘we’, we suggest that the highest status professions should bear the greatest responsibility here. Without their involvement in this kind of stewardship any decisions that are critical are either avoided or imposed – neither being at all satisfactory and both exacerbating the problem.

¹¹⁴ I.e. distinct from the simple hard

When we do so, one of the profoundly important things we realise is that humans are so much more than our intellects. We know that ALL decisions have an emotional component to them, and that we involve our emotions as much as our reason all through every day. We also know that in decisions we take at times of disease, distress or impending death the emotional element is especially strong.

We therefore have to include in our decision making processes people with heart felt experience of life events – the events that link us to the emotions of human kind: loss, pain, sorrow, grief, hope, joy, contentment, anger, frustration, peace.

We must not have our NHS run by impatient intellects, we must have our health care services designed for people who are in need of them by people who fully and genuinely understand those needs. Otherwise we will continue to have systems that rely on fictions and simply cannot work in the real world.

We must never again say (or even think) that *‘Providers, purchasers and transactions are the heart of the day to day running of the [health care] system.’*



But if those are conclusions for all of us, there are special messages in this work for doctors.

The nature of their expertise gives this group the highest status and thus the power to set the tone for their practice, their services and their organisations. This group could be the key to a human approach to health care. The fact that they so often do not behave this way makes it tempting for policy makers to try and reduce the power they have to block changes to the system. And over the last 20 years they have attempted to do so in a number of ways that we have described in Chapter Four.

However I hope we have shown that it is in part because doctors are not being cared about and encouraged to flourish (in their ability to serve others) that they are not able to do this for others.

This lack of being cared about applies just as much to other healthcare professions and they too are finding it difficult to care about their patients¹¹⁵ and many may be irritated at the focus on doctors. All are important and we do need to find ways of caring about all our staff, but we have to have the courage to address the doctor issue directly or nothing else will ever change.

Unfortunately the professional pride that rightly accompanies the assumption of professional responsibilities (and the weight of those responsibilities) has, in an environment in which professional status is under attack, all too often led to a stronger sense of entitlement and grievance that even those who are friends of the medical profession can support. Indeed the greatest of supporters (and this includes the members of the learning set) see this spirit of resentment towards change, towards anything that challenges practice in any way, as self righteous, self indulgent and complacent. And that it damages the profession and its members as much as it does society.

How could we find a way of helping all the professions to see their professional autonomy as ‘a value to live by’? Suppose we were explicitly, deliberately and purposefully, to choose to value our professions and professionals and, as we do so, *expect* them to behave as professionals using their expertise, their

¹¹⁵ See if you can read the Patients Association report ‘Patients ..not numbers, People ... not statistics’ without a sense of distress

experience, and their judgement with good will towards individual patients, towards the services offered to patients, towards the overall performance of the organisation in which they work, and towards the communities whose health needs they are meeting. Suppose we expected them to want to help society to flourish.

We would need to stop seeing them as units of production, instead expecting them, as part of their role working towards a healthy society, to accept the need for systematisation and standardisation of many aspects of care.

We would move from expecting them to behave badly to expecting them to behave well. And if any failed to do so we would act.¹¹⁶

Of course we must not be naïve and we will need managers (most of whom will be clinicians themselves) who understand emotions and our psychological defences against perceived threats, so that they can help professionals deal with anxiety, with envy and with sabotage, without being disabled by them.

So we should envisage, too, a different task for managers: caring about their professionals, in robust relationships in which they are supportive and challenging, and make their high expectations confidently clear; helping professionals care about patients and about each other, encouraging all to work together to realise the potential of ALL the assets of the organisation in the best interests of society. And these assets are fantastic – some of the most able people in the whole of society, as well as more kit than the health systems of many other countries put together. But at the moment the whole is so much less than the sum of its parts – and the fact that we do not see that as a failure on the part of management suggests that we are conceiving of the management role in a very odd way.

If we conceived of the management task differently who knows what might happen? Perhaps we would find that we do not need a market and that we can afford all the care the country needs.

So where does this leave us, and at a time when a major reform of the English NHS is us? In five years time will clinical commissioning be describable in the terms used in Chapter One? As yet another rationally sound attempt that fails to change any of the dynamics that matter? Or could it transform the system and take us into a new covenant of care?

That will depend on whether these new commissioners adopt the viewpoint and assumptions of their predecessors or look at their task through a different lens.

◊

The two tales that follow are just that, tales, fairy tales written to illustrate the these different lenses.

While the details of structures, systems and policy will undoubtedly not reflect the real world of 2014 and onwards, the attitudes and perceptions of those in positions of influence are the real focus. Critically the tale that most closely prefigures the NHS of the future will depend on whether the highest status health care professions prove the economists right by behaving as self interested units of production or whether they choose to adopt a sense of professionalism that leads them to use their status and their professional judgement to serve the interests of society.

¹¹⁶ Currently we rarely act effectively when they fail to perform to acceptable standards

Conclusion: Life after Liberation – Two tales of Clinical Commissioning

Fairy Tale One¹¹⁷

Choice, competition and the market

The Boards of Hospital Trusts entered the financial year 2013-4 with mixed emotions. Negotiations with PCTs over QIPP had been troublesome from the beginning and ludicrous towards the end. After all everyone knew neither the PCTs nor SHAs had any teeth anymore and the new commissioning consortia had not yet grown any so the overspend that year had been massive and most care economies went into the new arrangements burdened with large debts and even bigger arguments about where these would land.

However their clinicians and managers *did* feel energised. They had ambitious plans for improving services and were optimistic that their good relationships with clinically led commissioners would ensure a more sympathetic hearing for these than they had received from PCTs.

They were prepared for skirmishes with GPs as these attempted to move care from secondary to primary care settings, seeking the commissioning of a number of new multipurpose community care centres offering a range of services ‘closer to home’, although surprised at just how ambitious there expansion plans were.

Using their status and their credibility with the public, and thus their leverage with MPs, the acute trusts made a number of arguments:

- that in times of financial hardship it was ridiculous to spend money on new buildings when existing ones were adequate,
- that the tariff was merely a fictional cost that was distorting decisions, and that when real costs were examined it was clearly more efficient to offer care in one place (the hospital) rather than in many,
- and that GPs had a vested interest in offering services that increased their income,

and were thus able to see off what they saw as predatory action on the part of primary care.

In the years that followed ambitious young clinicians in provider trusts started to take MBAs (and many medical students the increasingly common MD.MBA dual qualification) and moved into positions of influence, first at specialty, then divisional and organisational levels.

The Trusts (and/or parts of them) became Social Enterprises, as did several teams of enterprising health care professionals keen to shake off bureaucratic constraints and develop new services and pathways. In the heady rhetoric of social enterprises, about shared ownership and the way that this was bound to prompt entrepreneurialism and innovation among the ‘owners’, the underlying sociological dynamics were ignored. Behaviours continued to be shaped by them however – just as they had through all the

¹¹⁷ These are just that –fairy tales; nothing within either tale should be taken as referring to real people or organisations

previous reorganisations.¹¹⁸ So, while the formalities changed the behaviours did not and services and service levels changed disappointingly little.¹¹⁹

At the same time a new breed of organisation entered the market in which entrepreneurial doctors partnered bright financiers, sought and accessed city money and built glitzy new facilities. These doctors were each given an explicit business target to reach (bring in £X of new business each year), while over in the acute Trusts clinicians worked with management colleagues to develop enthusiastic plans for increasing trust income by improving and expanding services. In both cases they believed they were doing the best for their patients, although outsiders observed that these plans and ambitions were at least as much in the interests of the clinicians who devised them. This eliding of professional and patient interests had been observed by sociologists for many decades so, as far as they were concerned, this kind of behaviour was not unexpected.

The escalating competition led to provider organisations starting to merge, and services being ‘rationalised’. Many mergers were ‘horizontal’ but more and more involved care along the pathway on the basis that this would allow efficient, effective, seamless care. Historians noted that this was an argument at least 40 years old and constantly found not to be borne out in practice: low tech / hi touch community care always eventually financially bailing out the hi tech specialist care.

With fewer, bigger centres as a result of these mergers a ‘Russell Group’ soon emerged, of ‘centres of excellence’ with new buildings and comprehensive kit. ‘Local’ hospitals (some as far away as 100 miles and in cities as large as Bradford) became feeders, becoming smaller and more generalist (i.e. lower status) in the process. As the NHS was still a major employer these changes in the numbers, skill levels, and attractiveness to the highest status staff, had a direct effect on the economic health of areas, with some centres gaining and others losing, thus exacerbating socio-demographic inequalities.

Soon there were a few giant chains of providers with whom local commissioning consortia negotiated in vain, so the consortia, too, merged. Negotiations now resembled the clash of the Titans, with the services available to millions of people depending on ‘who blinked first’¹²⁰ when provider and commissioner negotiators met. Those small social enterprises, already having difficulty being commissioned (despite developing new services and radically improved pathways, with good evidence bases to support them), now found it impossible. They were first put into administratively tidy but clinically nonsensical ‘provider consortia’ (ragbags of various small providers clumped together to reach a scale that warranted the attention of the commissioners’ contract negotiators), and then ‘merged’ or acquired by bigger providers.

The negotiating teams were of course armed with mountains of data collected by armies of data collectors in every organisation. As commissioning contracts became more sophisticated increasing sums made their way to lawyers and contract compliance teams. The costs of running the system rose inexorably and the percentage of the NHS budget spent on front line care fell from approximately 40% in 2010 to 27% in 2017.

¹¹⁸ See Chapters 1, 3, 4 and 6.

¹¹⁹ It is the preparedness to engage personally and with others in thoughtful reflection and redesign that brings about difference and there is nothing about social enterprise structures that (on its own) makes this inevitable or even likely.

¹²⁰ This preparedness not to blink first was the pre-requisite defined by at least one SHA Chief Executive for chief executives of PCTs – in the days when there were PCTs.

Competition between organisations also led to the emergence of ‘star managers’ whose reputations and salaries hit the stratosphere.¹²¹ Star consultants too realised that they could choose where to work and became self employed, successfully negotiating for admission rights to a number of different hospitals.

Discussion in the media of what was happening was led by those who could stand up to the increasing number of interviewers with simplistic superficial understanding and an aggressively disrespectful manner. So ideologies (‘choice’, ‘competition’, ‘transparency’, ‘accountability’,) were peddled and statistics traded (‘I don’t recognise your figures, what I can tell you is...’). The debate was structured by those with complete faith in markets. No-one mentioned tranquillity.

Care

There was of course¹²² an overall cap on NHS expenditure. Costs however were continuing to rise. There was the cost of increasing longevity, and the ever higher costs of new technology and drugs. In addition the providers of acute care had such a strong incentive to fuel demand for their services that they were unable to resist doing so, and consortia found it impossible to contain demand for admissions. So once the mergers had squeezed all the rationalisation savings (see chapter 6) out of the system (and people were dealing with call centres at the other end of the country to book their care) government ministers were forced to have a ‘grown up conversation’¹²³ with the public, in which it was explained that not all care could be afforded. The prospect of rationing was introduced in a White Paper entitled *Your Health, Your Choice, Your Responsibility*, which was quickly followed by a national decommissioning initiative called *Making the Most of Our Money* (MMM for short). Along the way NICE guidelines became the ceiling for care instead of the floor.

As services decreased and service levels sank further, those who could took out private health insurance.

As competition intensified, as prescribed by the think tanks, organisations innovated, and stripped out cost after cost, becoming ever more efficient. Wherever possible staff were replaced by IT. A visit to the GP or consultant involved touch pad reception, on screen questionnaires with menus allowing patients to say why they were there, and piped music (to reassure and calm those waiting). This allowed the consultation to be as brief and efficient as possible. Every aspect of nursing was covered by a protocol so nurses were largely replaced by Health Care Assistants. In these ways health care was made demonstrably more efficient, a point that was highlighted in the media by managers and ministers.

Other observers noted a large increase in overall health costs and an even larger increase in health inequalities.

Consultation with patients about organisational changes (required by a government that took patients voice seriously) took place through representation on commissioning boards. These single representatives naturally became colonised almost instantly – not least because no-one became a patient representative unless they were reasonable, aware of financial realities, conscious of the need

¹²¹ Systems and game theorists who had researched Napoleon’s wish to appoint lucky generals and found that luck has nothing to do with it (these are just what you would expect from the dynamics of the system), would have predicted this emergence and noted that it was unlikely to have anything to do with ability

¹²² Rightly

¹²³ A grown up conversation always being at the behest of someone in parent mode telling you you are not allowed to have or do something you previously could.

for prioritisation and understood just how hard everyone was trying to make the system work fairly, efficiently and effectively.¹²⁴

The quality of patient experience (again of genuine concern to the government) was measured by patient surveys. This ensured that survey after survey reported over 97% of patients were so enthusiastic about their care they would recommend the service to others.¹²⁵ The fact that the questionnaires never included questions that real people cared about answering seemed to go unnoticed.

It was only the elderly and the mentally ill who did not report such satisfaction and no-one cared about what they thought since it was only the votes of Middle England that mattered and somehow there are few vulnerable people in Middle England. Indeed the *most* vulnerable of these groups, whose care costs were considerably higher than average, found it increasingly difficult to persuade commissioning consortia to include them in their membership, and for the first time in the UK since the inception of the NHS a health underclass developed – of people with no access to health care other than at a few charitable centres.

Staff

Professionals in provider organisations were divided in their response to the changes. Some thrived in the Evidence Based, protocol driven environment, keeping up with all the new evidence, and the guidelines and competences that flowed from it. (For example, when neuroscience demonstrated the beneficial impact of relationships on clinical outcomes they welcomed the Randomised Controlled Trials that elicited the exact width and frequency of smile required to give an 18 % improvement in outcome, the degree of eye contact, the number of relational words to use when, and the resulting competency framework and assessment driven training programmes).

A few were sufficiently expert ('House' – like) to stand above protocols and generated a following of their own.

Others, now fearful for their NHS jobs as resources at the front line were squeezed to pay for the ever more necessary staff who negotiated and monitored the contracts, felt forced to comply with protocols even when their judgement suggested alternative courses of action were better advised.

Individual HCPs looked in vain for havens in which they could offer the kind of care they wished to (and knew was needed), but all the small organisations in which they might have had voice and influenced the approach and culture, had been deemed too small to be financially viable (i.e. too small to deal with all the contracting) and had merged and disappeared. So those HCPs who cared about care and about people rather than only processes, and who wanted to make a mark as an individual relating to other individuals, failed to thrive in the large thrusting organisations left in the market, where they were treated as merely units of production.

GPs segmented. Some became fluent in economic concepts. More acquired, like most of the chattering classes, a smattering of economic language, which they deployed to overcome the anxiety associated with not being able to meet the needs they saw in their patients. Some acquired tough negotiation skills and started to use them as much with their GP colleagues as with secondary and tertiary care

¹²⁴ After all this was exactly the way the people selecting them saw the world.

¹²⁵ Especially when guided to that rating by the friendly nurse giving out the questionnaire, as happens in car service departments and mobile phone shops– you really think health care will be different?

negotiators. So general practice also became increasingly specified and controlled, with money following high status conditions (cancer, coronary heart disease...) and their speedy diagnoses, and away from long term conditions, the elderly and the mentally ill. This led to the increasing specialisation of primary care so the generalist, family doctor role became a thing of the past.

The largest health care profession became that of audit: those setting the framework for different kinds of audit, those mining and manipulating the data, those presenting and putting a spin on the results, those responding to the results with counter arguments and additional data. All of which was necessary, naturally, because money followed patients and patient outcomes and quality indicators.

In their zeal to make the most of their commissioning budgets clinical commissioners (like their social service counterparts before them) were oblivious to how provider organisations met their contract obligations. As a result the terms and conditions of people employed in services they outsourced (patient transport for instance) fell drastically, to the minimum wage, with no pension rights. This group of workers grew steadily in number, soon encompassing, for example, most of the Health Care Assistants on hospital wards. (At the same time the people owning or managing the companies providing these outsourced services paid themselves really rather well, as they did their lawyers and their negotiators).

So the NHS (the government still called it that) was no longer a service in which (as in the late C20) the salaries were broadly level between members offering the same level of expertise within the same profession and where the ratio between the highest and lowest paid seemed fair or at least justifiable to most. It became as ruthless a market for services as any, with particular medical specialties attracting higher pay than others (surgery out paying psychiatry by 3 to 1), with every large hospital including in the people working within their walls some of the highest and lowest paid in society.

As a result members of staff used every spare moment to upgrade their knowledge to the next skill level to increase their salary and their (material) life chances. Thus those at the front line, meeting the most intimate needs of patients, were not only the lowest paid but those paying the greatest attention to working hard to move to the next step on the ladder, where they would earn more and then be too expensive for those front line roles.

This wasn't because they stopped caring about patients, but is what happens inevitably when markets are insisted upon and market failure (at every level) is demanded by some and feared by others.

Observers of language noted that no-one spoke of tranquillity, of wellbeing, of community, of a flourishing society or the civilised relations between individuals and groups that together comprise it, of health as a foundation for achieving potential, of health equity and equalities, of fairness, of justice. Not many talked of patients, not with any concern for them as people, of compassion, of care. (Care was now almost always part of a composite term: care pathway, care package, care process, care professional. It had ceased to be a verb and become a rather meaningless label). If they did the words had been purloined and attached to meanings so different that the concepts they had originally labelled had no means of expression.

Instead the language was of choice, of competition, liberty, freedom to choose, efficiency, productivity, cases and case mix, acuity, length of stay, innovation, and many of these words came to mean something altogether more sinister than when they were originally moved from their factory and financial origins into the world of health care.

People talked about health care at school gates and at dinner parties, they also twittered and tweeted. They talked about it in ways that Europeans had not done for 60 years. Interestingly, those using the internet rarely commented adversely anymore on individual practitioners or even organisations, so fearful were they of reprisals in the form of withdrawal of services. Thus surveillance (Chapter Two) had been a short lived 'noughties' phenomenon.

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All, except the wealthy, talked fearfully of how they would afford the supplements being charged or the insurance premiums they felt they needed. The *choices* they had to make were between the different packages of care they opted for when taking out insurance or cover with their commissioning consortium. The *competition* they experienced was that between people with different clinical conditions as they lobbied NICE for guidelines that affected their lives.

Across the increasingly widening social divides the language was different of course. And the tone. The wealthy still relished the choices they had and the way the large insurers, commissioners and providers competed for their custom. Indeed the combination of innovation and financial self interest with the asymmetry of knowledge that is a feature of professional services allowed the pharmaceutical industry and entrepreneurial clinicians to develop products for all sorts of life style illnesses, for which the wealthy became obedient and grateful consumers. The poor (who now included many of those working in health care) felt ever more acutely the importance of choice (which hospital, which school) but had no means of taking more than the lowest cost option. Social strata further separated and solidified.

In parliament though, and in the media, it could be demonstrated that choice and competition in the NHS had delivered the more efficient care that contributed, if not to wellbeing or flourishing, then to the ease of the money markets, that appeared now to dictate national policy.

Fairy Tale Two

Some clinicians recognised the financial dangers as PCTs and SHAs lost influence and recognising that this would make their commissioning role more difficult shrugged off their habit of sitting back and blaming the government and decided to do something about it themselves. They talked with clinical colleagues across the primary, secondary and tertiary care divides early in the transition years, and fostered a sense of clinical stewardship across the care economy. Not everyone played ball of course, but enough to ensure that overspends were manageable and the culprit departments clearly identified.

What fuelled these relationships? Information. The real time information of the GP referral collaborative was so much more accurate and credible than that produced by the provider trusts that it drove down primary care referrals and literally kept the Trusts honest (up-coding became a thing of the past), and led to sensible discussions about pathways, about the nature of the relationship between GPs and consultants, and about effective liaison services. With the improved clinical relationships length-of-stay came down dramatically, admission and readmission rates rose slightly but were not seen as inappropriate, and indeed readmissions were not seen as failures (unless they really were) but as a sensible taking of risk.

With such effective collaboration, early plans among GPs to move care out of secondary and into primary care, and, on the part of hospitals to develop outreach services, lost their partisan support and instead a web of services was developed, without the label of either primary or secondary.

Since the tariff got in the way of some of these decisions the clinical stewards (as we can call them, i.e. the GP commissioners and their secondary and tertiary colleagues) started thinking instead in terms of real costs. They thought about cost structures and how costs behaved with changes in volume, and negotiated sensible arrangements about which cases would be charged at average cost and which at marginal. Monitor (the regulator of Trusts) huffed and puffed but faced with a hostile media scrutiny of their argument merely issued dire warnings about the lack of any financial bailout.

In all of these discussions the people involved drew directly on their experience and on credible data generated for clinical purposes. There wasn't space for MANAGERIALISM, merely for good management.

Serendipitously something else happened that proved to be transformative. With so many other organisations (including other commissioning consortia) ticking the patient and public participation box by putting a tame patient on the board, the clinicians here exhibited a not unheard of rebelliousness, self righteousness and elitism (as well as a good measure of ethics and common sense!) and decided they would commission some in depth research into patient experiences and expectations. They got the local university interested and put together a steering group which included a sociologist, an anthropologist, a psychologist and a historian. To their surprise they discovered when they read even the preliminary findings that their patients, far from being the hostile, demanding, unsatisfiable consumers they had seen them as, were actually very concerned about the welfare of their local health professionals, wanted arrangements that suited *all* concerned¹²⁶, and called upon the services far less often than they might. Their experiences of the services (across the care spectrum) surprised and sometimes shocked the clinicians reading the research. The anxiety before making first contact with a doctor (about whether this was serious enough to trouble him or her), the difficulty in making an appointment, the time spent trying, the feeling of being passed from pillar to post and never seeing the same person twice, the hours and hours waiting in A& E, or waiting for domiciliary services to arrive, the interminable boredom and wretchedness of being an inpatient, the impact on family, friends and neighbours who were needed to provide babysitting, shopping or other support while all this was going on, on jobs even, this was all a revelation. Not in all cases, but far more often than they had realised.

It was clear that this was a very different level of service from that which people experienced in every other area of their lives. Far from being demanding consumers the public (on the whole) routinely accommodated lousy service and were surprisingly forgiving, and supportive of their professionals and understanding of the pressures they were under.

Too understanding the professionals thought. Not always of course, some patients were naturally demanding, and some had found that the only way to deal with the increasing withdrawal of access and attention by health care professionals was to become more demanding. An unhealthy vicious circle had developed, that the professionals now recognised and sought to reverse. With a different attitude, and insight into the impact of their arrangements, and a genuine desire to live up to the reasonable expectations of their patients, they decided they must co-design processes and pathways that genuinely met their patients' needs.

By publishing the research and their response they prompted a dialogue (with the local media actively involved) between themselves, the public, service users, and all sorts of service providers (existing, new, large, small). A number of new service options emerged from these, and wherever possible the commissioners involved the public in decisions about what to commission. Some decisions they put to a local vote. Others to a citizens jury. They made sure that patient representatives made meaningful contributions to service design, actively encouraged web based patient feedback,¹²⁷ set up means of independent enquirers contacting every patient two weeks after an inpatient visit to ask about their

¹²⁶ See Otto Scharmer's description of work with patients and clinicians to revitalise part of a German health care system: Kaeufer K, Scharmer C.O., Versteegen U [2003] *Breathing Life into a Dying System*

¹²⁷ Valuing the independence of these avenues and resisting pressures from providers (including from other clinicians) to try and control them

experience, and fed the results back to the provider services immediately. It cost money but the information was so valuable it was seen as money well spent.¹²⁸

Health promotion programmes were commissioned for specific groups, targeting their needs, availability, and preferences. The take up was huge, the health impact too.

Enlightened by these results the commissioners expressed an interest in the experiences of staff across the care economy. They asked the same researchers to have a look. Initially warned off by the provider managements who made the case that the role of commissioners is to commission and that it is up to the providers to provide in whatever way they choose as long as the service meets contract specifications, the clinical stewards persisted. It helped of course that some of these stewards were providers.¹²⁹ This information was of interest to all, they said, would be shared and used to inform discussion about the nature of the care represented by those contracts.

The levels of anxiety, stress, emotional distress, even exhaustion, shocked them. The different terms and conditions surprised them too. There was, they realised, all too little support for staff at the front line. Too little induction and clarification of what was expected of them, too many practical obstacles to providing good care (stuff not available when needed: linen, IVs, the right forms...; hostile relations between staff groups or individuals, bullying or harassment...), support systems that didn't work, no stable relationships that could reduce anxiety – because shift patterns meant teams came together for no more than one shift. For the same reason no credible, useful feedback was being given on performance.

And if the frustration and emotional labour and vulnerability of clinical staff shocked them, no less surprising were the experiences of people they classed as managers. Without defined shifts the working hours of many of these were long in the extreme. Long and unboundaried with emails being dealt with at all hours of day and night. Here too stress levels were very high with individuals feeling overwhelmed by their responsibilities, given objectives that required changes across a whole system with no authority over many of the people involved in it. When they tried to obtain advice or guidance from their own managers they were told not to bring problems only solutions. Their macho exteriors, the researchers found, hid doubts, vulnerabilities, fear, shame, relief. Feeling that they had to perform in ways that justified their salaries, while aware of how limited their effectiveness was, they often passed their anxiety and insecurity down the management hierarchy. No wonder they focused on the transactional, they had few means of enacting the covenantal – clinicians wouldn't play their part in the covenant. Daunted by those clinicians who wore their status in the form of high handed behaviours, in their refusal to think about systems and processes, and in their arrogant denigration of approaches from other fields ('this ludicrous *lean* language'), managers chose to delay or avoid consulting senior clinicians about issues they foresaw would provoke anger. Thus clinicians felt (and were) consulted only when things had been all but decided.

And yet these managers often held the information needed if care was to be radically improved. They were often the ones who understood things like Statistical Process Control and how it was 'the voice of the system', how using it would enable clinical teams to assess the reliability of their processes and improve them in ways that few other approaches would.

¹²⁸ And it did mean they could save on many of the tick box exercises like the patient satisfaction survey. There was a ruckus of course but once they showed conclusively that the latter gave results that bore no relation to real experiences it died down and they were left to their own devices.

¹²⁹ They even persuaded the Research and Ethics committee to give the go ahead in three months rather than the usual 12 (well this is a fairly tale after all).

Looking at these results the Commissioners felt for everyone involved. Across the care economy¹³⁰ they insisted on a training programme for first line managers, proper supervision, and a task force to look at shift patterns. To their credit the Trust Boards took this on with a will, they had had no idea. Chastened they responded with less hostility when the clinical stewards asked how they *would* know in future, and drew up and invested in a Trust-wide system of supportive supervision.¹³¹ GPs too responded with shocked concern at the findings in their own sector and started to think seriously and differently about the responsibilities and accountabilities of the partners, and about the support, challenge and infrastructure they needed to be truly effective.

Another outcome of this research was the identification of several more proactive and committed clinicians from other professions – therapists, pharmacists, nurses- who jumped at the opportunity to come on board with the clinical stewards to work on care pathways and processes across the care economy.

These inter-organisational conversations also led to the start of a new relationship with provider managers. These made available robust clinical information from their clinical dashboards and, armed with this and the richness of the patient and staff experiences, the clinical stewards and Trust managers worked together to tackle some of the entrenched unproductive clinical practices that had resisted change for years. They did so gracefully but firmly. With support from psychologists they understood that, where behaviours were a problem, it was their colleagues' anxiety that so often lay behind the mask of the complacent arrogance that had defeated many previous attempts to challenge them. The desire to maintain a private income, or the fear of loss of status, or the uncertainty about new ways of doing things, all of these and more had contributed over the years (all the more because they had been unchallenged over that time) to some of them using their status in their own interests at least as much as their patients'.

Steeled by their knowledge of the impact these out dated practices had on individuals across the system (both patients and other staff) the clinical stewards combined empathy with persistence. Gently, lightly and humorously where possible, they raised contentious issues in the course of face to face conversations about credible data and real patient experiences. They prepared well for these conversations and debriefed afterwards, becoming more skilful, more empathetic and more determined, and at the same time less nervous and more satisfied with the results.

Thus information played a critical role. Not in the form of crude and misleading league tables or bare statistics, but rich information from credible sources. And not used as arbitrary judgements on performance, but as the basis for highly productive conversations in which all parties were able to reach nuanced judgements on a range of relevant factors.

Early on in the transition the clinical stewards realised that the measures of clinical *outcomes* suffered from the same limitations as the process targets they replaced. They measured only the measurable.¹³²

¹³⁰ For these patterns of under- supported, mismanaged staff occurred as much in primary care as in acute settings

¹³¹ See Chapter Four

¹³² And so the outcome targets focused on a few lead indicators (for example the outcome about avoidable deaths translated eventually into a target about specific forms of CHD). So it would, the stewards realised, prove almost irresistible for everyone in the system to concentrate on a few, perhaps at the expense of the many, just as schools had delivered their targets of x % of pupils achieving 5 or more GCSE passes, by putting extra resource into the few who could be pushed from 4 to 5

Instead they developed their own ways of understanding and monitoring the overall impact local health services were having. They developed rich ways of knowing/understanding what was happening,¹³³ ways that in themselves contributed to dignified relations across the community, to confidence and to tranquillity. Out of these they were able (often) to tick the boxes of the check lists required of them, so avoiding the need for separate box tickers.

On the occasions when they saw that the situation on the ground locally was being made more difficult by central policy they did two things. They logged constantly exactly what was happening in reality, and reflected these facts and experiences back, constructively, to policy makers. And they developed alternative ways forward- in the *spirit* of the policy although not necessarily the letter of it – and implemented these, explaining and discussing their actions with the local media, patient representatives, staff and politicians. These were genuinely ‘grown up’ conversations.

Their careful noting of what was actually happening gradually increased in its gaze. They started asking how much of their commissioning budget was spent on front line care. They then looked wider and asked where the commissioning budget came from, and how large a proportion this was of the total NHS spend. They asked a research team to track NHS finances more generally. They looked at just how much of the overall sum leaving the Treasury had a trackable beneficial impact on care and flourishing at the front line and into the community. They looked at how much ended up in the hands of lawyers, or owners and managers of companies providing outsourced services such as agency staff, facilities management, patient transport. ‘Interesting’ they thought when they found out,¹³⁴ and they made the figures publicly available. ‘NHS millionaires’ ran the press headlines.

With their greater understanding of the lives of patients and the local population generally, the clinical commissioners began to see their own salaries in a different light. Finding that a Legal Aid lawyer, working longer hours than theirs on complex cases with life changing impact for clients, earned less than half a GP partner’s income amazed them. Realising just how few local people earned anything like their salary they stopped comparing themselves with bankers and the relatively few high paid public servants in the area and instead thought of the many private sector owner managers working long hours with responsibility for the livelihoods of hundreds, who earned modest sums in comparison.

This realisation liberated them from a victim mentality and a self righteous greediness (neither of which they had recognised while in the grip of them, and which they eventually realised had been a disastrous outcome of the 2004 New Contracts).

It also led to their taking an interest in the salaries of senior managers of organisations offering services within or to the NHS. So when the Boards of these organisations argued that they needed to pay large

¹³³ They were inspired by the notion that in Bhutan the government monitored Gross National Happiness rather than Gross National Production, and that they assessed the level of this by interviewing a sample of people for about half a day each. They commissioned in depth interviews of individuals and groups by people who knew how to conduct these – so not opinion pollsters and statisticians but anthropologists and psychologists.

¹³⁴ Indeed they found this so interesting they turns their attention to risk (what risk was being held where) and power. Although crude at first these enquiries became more sophisticated over time. One thing they highlighted early on was that in almost any deal between public and private sector the risk, although nominally taken by the latter in practical terms fell to the former. Power was interesting too. Frustrated when decisions that made good sense locally fell foul of a ruling elsewhere, they investigated some of these. They speculated in jest that there were half a dozen key clusters of people who, by asking questions of lawyers in ways that gave them the answers they wanted they were able to influence the structure of decisions across the NHS. Not with Machiavllian intent, merely a narrowly Hayekian one. This was more tricky to discern so they left a small research team working on it as and when they could and we await their results with interest.

sums (e.g. 8 times the average wage locally) to attract the best people¹³⁵ since the role was so complex, they countered with a suggestion that four posts at twice the average wage be created instead! They had, of course, no right to insist or intervene but their interest prompted conversations that resulted in much more moderate salaries and much more doable roles. The emperor's clothes of the star managers were at last being questioned.

This had a ripple effect over the whole of the local economy. The public now began to challenge the super salaries of any newly appointed council Chief Executive, Chief Commissioner of Police, or Education supremo. They stopped believing in magic and accepted that people in these roles would be fallible. The local press changed from being hostile to those in power and now they were no longer paid such vast sums took an interest instead in the natural, inevitable, structural obstacles to their success.¹³⁶

One unanticipated but healthy consequence was that the spirit of stewardship enlarged and a cadre of those taking strategic decisions in organisations right across the community (health, education, housing, police, industrialists...) developed a habit of consulting others about their plans, and this led eventually to shared community goals. A sense of community stewardship evolved.

Of course this meant that the market in health care became less of a market, as aims for community flourishing replaced those that were more easy to specify and include in a contract.¹³⁷ Where providers were able to offer responsive care from properly motivated staff¹³⁸ commissioners were happy to commit to cover the majority of fixed costs of provider organisations, allowing care to be offered much more responsively and flexibly because the decisions about care resulted in only marginal changes in costs and hence charges. They kept an eye on all the information about patient experience and kept close to possible other providers to see if commissioning changes would be beneficial and when they were they engaged in constructive discussions about managing any transition. To encourage further a healthy rivalry the stewards instituted local 'Nobel' type prizes for different clinical categories with significant awards for the services that won. In these ways they fostered a healthy competition that could be replicated at every level of the system without damage.

Naturally market fundamentalists were horrified – although these arrangements met at least two of Michael Porter's three criteria for effective competition much better than the wholesale quasi market ever did¹³⁹ - and made persuasive arguments about the importance of allowing market failure, that appeared logical and reasonable. However, rooted in their own experiences, their intuition and their research results the community stewards (by now a pretty large group) were *not* persuaded. They could demonstrate (not speculate) that care was so clearly better, both in quality and quantity. The libertarians huffed and puffed and talked of European competition laws, but they couldn't blow this house down.¹⁴⁰

Indeed it was possible to demonstrate not only good care and clinical outcomes but a genuine commitment to tranquillity, to dignified relations in society and to flourishing. The commissioners

¹³⁵ Naturally to sceptical doctors they never seemed like the 'best' people, just ordinarily good people

¹³⁶ Do remember this is a fairy tale – but just imagine if it were possible

¹³⁷ This could have been dangerous if those involved were MANAGERIALIST technocrats, but constantly challenged by the research findings and the, by now much more informed public, the practical humanists were able to carry the day. See Chapter Two.

¹³⁸ I.e. offering acts of work and courage in the service of others, because their managers engaged in acts of work and courage to keep them motivated to do so

¹³⁹ The competition was between services not organisations and whole pathways not parts of them.

¹⁴⁰ This is a fairy tale remember

counter argument to that of the ‘choice and competition’ brigade observed that the choice agenda had been exposed to serious scrutiny and had been out-competed in local opinion by equity and tranquillity.

Reflections

Although the commissioning role and spirit was now held much more widely, the original GP commissioners¹⁴¹ still met as a group and reflected on their progress. On one such occasion, on their way home from a national conference about ‘prioritisation’, they reflected on the metaphorical journey they had taken. Their observations included the following:

When we started:

- we thought that information would give us answers, that it would tell us what we wanted to know. Now we know that information is only ever the starting point for the conversations that eventually lead us to understand what we want to know.
- we thought that health was all about longevity, now we know it is about flourishing and that flourishing is something we can and should be involved with. Not only us, our colleagues in education and housing and local employer too, but we have an important part to play. We also know that our own flourishing is important – not salary, not hours, although those contribute, but flourishing.
- we thought that patients were demanding and that we were being prevented by government from offering care that was covenantal by their focus on the transactional. Now we know that the care we were offering wasn’t either: not transactionally sound nor a meaningful covenant. Now we can offer both, and our own working lives have become more enjoyable and satisfying as a result. We also know that we can’t commission care that is covenantal unless we commission it in a way that is itself a covenant. In other words our commissioning processes need to be sound transactionally and also embody good robust relationships.
- we were using simply our brains now we actively draw on so much more, we are much more attuned to our emotions and intuitions and how these are translated into sensations in the body, and we take notice of these rather than ignoring them. As a result our decision making has improved in ways we would have thought ridiculous before we started.
- we took an interest in our own patients, now we still care about them but we also take an interest in the needs of the wider population. We foster a shared sense of responsibility.
- we thought being ‘tough’ commissioners meant negotiating hard on contracts –but the contracts don’t give power over the things that really matter. These are affected (and only affected) by a spirit of collective stewardship and real concern for patients and these are badly jeopardised by an adversarial stance. It was important not to be suckers but we’ve succeeded by building relationships, being firm and keeping the door open.

That was when we started, now we also find:

- we don’t get seduced by arguments that focus on means rather than ends. If people can’t show us a convincing link to a flourishing society with dignified relations between the people and groups that make it up and individuals realising their potential, then we don’t buy their argument.
- our relationship with the public has been even more important. We didn’t know just how much credibility we had and how much they trusted us – or wanted to trust us. Knowing that has given us an obligation and a real desire not to squander it. We’ve actively tried to act in their interests at all times and to challenge any behaviours or processes or attitudes that put provider interests first. Knowing that this is recognised and valued is hugely rewarding in itself.

¹⁴¹ Those who had been involved from the beginning

- knowing so much more about our patients, our population, and our colleagues of all kinds, has made us impatient with simplistic management models and management speak. When we discuss processes and pathways we always try to tell the whole story (what the existing service is really like for people, real people) and simply won't listen to any explanations from providers unless they empathise with the people involved. Our discussions involve analysis but always relate back to people.
- our contract with patients, public and colleagues has put us back in touch with what we came into medicine for. We now realise we've been developing our own careers and the expectations of our younger colleagues in ways that diminish their (and our) humanity. We have to find ways of putting them back in touch with their concern to help others and related well with others instead of fostering a strong sense of self interest. Somehow we have to get away from the narrow undergraduate medical training and offer instead a real education.

There was much more, this had been such an exciting and, yes, liberating time. Government policy had played a role in that, but more important was the GPs' different responses to the five 'winds' and their understanding (based on excellent multifaceted research) of the dynamics at play in the system. They were behaving like humane professionals who recognised the obligation conferred on them by the trust of the public to earn their autonomy by working in the service of society. They sustained this by engaging directly with the public, asking for their help when it was needed, and accounting to them in rich and meaningful ways that further informed and educated all concerned. The NHS once again became a secure foundation for health, this time an enterprise in which the whole of society was engaged.

So where are we now?

We have a government that intends to transform public services, making them more responsive to users and better able to meet the rapidly growing needs associated with our increasing longevity and reducing birth rate. Empowered by the current economic crisis to make decisions the public would be wary of at other times it seeks to use choice and competition to rescue services which they see as having been captured by the vested interests of producers and invigorate them by unleashing an entrepreneurial (social entrepreneurial) spirit. For all the reasons explored in this book this will not work.

In other words the government has the best of intentions and is proposing the most limited of methods.

The danger of this is great. Healthcare services have resisted for decades change which makes them more responsive to the changing needs and preferences of their users, largely because of the soft power wielded by the medical establishment.¹⁴² This is not a power that arises through economic forces but sociological ones. So unless we look at health care through multiple lenses and not merely the economic one we will have war between a determined government and an entrenched service, in which the losers will be patients and the public. Instead of a focus on using limited resources excellently we will have poor quality, inefficient services being rationed.

We **have** to **look** at this differently, before we develop policy about what we are going to **do** differently.

And when I say 'we' that is what I mean. The charge of the economists is that the vested interests of producers have captured the public services. But ALL of us are complicit in this. Not just the producers

¹⁴² In what they perceive to be the best interests of patients but often coincides with their own.

but also the people making that charge *and* those believing it - because we are all subject to a number of forces (we have identified five, there will be others) that influence our thinking and behaviours in ways we are not noticing. If we understood those forces we could respond to them differently and participate in a renewal of the NHS fundamentally different from the kind of reform that is being introduced now.

We must resist the temptation to blame the government (or the doctors or the unions or any of the usual suspects). Much more constructively we can help them understand how they have arrived at their diagnosis, how their prescription is not a solution but a further turn of the wheel, and that if they thought deeply and openly (using other fields of knowledge) about how to respond healthily and awarably to the five winds they would propose something different. And to do that all the rest of us must do so too.

To support us in this there is a special responsibility on the part of those teachers and researchers in the humanities to make their insights known to the rest of us. If they were to enthuse us with the value of examining the world using their particular approaches and skills we would see that the methods and assumptions of economists are valid but limited, that their field of vision omits much of what we value and deem important. If they were to make their insights available to the public in accessible, compelling prose we would have other vocabularies with which we could examine and discuss the issues that affect us. If they ran commentaries on decisions made by those in positions of power and influence, then our media would have richer material on which to draw and would be able to move away from simplistic labels of left and right, neoliberal, socially conservative etc. In the process we could develop a more multifaceted understanding of what may be gained and lost in the wake of the decisions of the powerful. This would in itself be valuable, but we may also reawaken some other instincts, our awareness of some deeply human needs and cares that we have lost sight of in our obedient response to the injunction to pursue only our economic interests.

This will not be easy since the country, or rather its governing processes, its media and increasingly its chattering classes, have been captured by the vested interests of economists, to such an extent that they now structure the debate and dictate its language. This results in the people who use different language and concepts appearing naïve and irrelevant. We need to liberate ourselves from the economists' dismal grip and restore belief in a richness and humanity that they have forced underground. To do so we need to invite the active participation in policy making and policy commentary of sociologists, anthropologists, historians, political philosophers, moral philosophers, theologians, and more, and escape from the current intellectual straitjacket. And perhaps we in the NHS could lead the way.

You are welcome to download this book as often as you like from www.reallylearning.com or from www.caringaboutcare.net. Hard copies can be obtained from Amazon or from Lulu.com

If you would like to comment on the arguments included here please email v.iles@reallylearning.com. Your thoughts and reactions may be included in an updated version.

If you are interested in becoming a member of a future Learning Set please contact Valerie Iles, or Julia Vaughan Smith via our websites: www.reallylearning.com and www.anaptys.co.uk. We are currently recruiting members interested in exploring what an ethical, sustainable NHS would look like.

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 care¹⁴³.

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.¹⁴⁴

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.

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,

¹⁴³ 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.

¹⁴⁴ 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.

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 surveillance 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.*

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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