Acknowledging the task, acknowledging dependency:
integration, workforce issues and human nature

Tim Dartington

It should not be necessary to argue for the importance of relationships in health care. The argument is already well made, everywhere from current research in neuroscience to ancient texts, the arts, humanities and all the major religions. Why then does health and social policy often take such an ill-informed stance in relation to what we know about human nature?

The integration of different tasks

Every enterprise or institution has many tasks, not all of which are equally acknowledged. When thinking about the ‘task’ of health policy and strategy we may distinguish between what we ought to do (the normative), what we think we are doing (the existential) and what is actually going on (the phenomenal) (Lawrence, 1997). These distinctions help to explain how we have grey areas, indeterminate areas of need that seem elusively not to fit within the task of any systems of health care. These grey areas lie between the normative and existential boundaries of these different systems. So we think we have to cope with meeting needs although we should not really have to. It is then very difficult to sort out what we are doing.

In the integration of communicable and non-communicable disease control, there is a lot of careful work to be done, giving (and requiring) space for thought at all levels in organisations, in funds and budgets, in the integration of services and in new forms of integrated organisations. If mishandled, reconfigurations often seem to drive stakeholder groups into competition with each other, forcing them into an intimacy for which they are not yet ready rather than developing the cooperation that is necessary for survival and to keep the whole picture in mind in providing services. Lacking time to build the necessary trust, individuals and agencies look to their own needs and cannot easily function together (Cooper and Dartington, 2004).

Without the systemic containment of an overall organisational framework that is consistent in its understanding of the needs of vulnerable people, we see professionals – themselves competent and concerned individuals – acting as if they are suffering short-term loss of memory. Like the poorest of the poor they live for the day, overwhelmed by the complexity of what is being asked of them. Those working to sustain and develop services for the vulnerable can be excused for thinking themselves counter-cultural in neoliberal society.

There are increasingly problems of relevance in using such much handled and well-worn concepts as ‘health systems’ and ‘communities’. An important distinction as applied to health services might be that between exclusive services that take the patients out of their existing social networks – for example, often when they go to hospital – and inclusive services that support patients in their social networks.

A clinical setting may be described as an open system receiving inputs from its environment, processing them in some way and then exporting the results. Organisation is a means of carrying out this task. For example, a clinic treats patients; it provides employment for a variety of staff; it may train doctors and nurses; it may conduct or provide facilities for research; and it is one of the institutions in our society that has the task of helping to deal with the chronic problems of debility and disability, dying and being bereaved.

But though clinics are regulated, professionalised and relatively expensive, they are not the bounded institutions that they sometimes look. They consistently inter-relate with other local social systems (another way of talking of community) that include other health systems. The resulting networks of care are thus going to touch at several points within a continuum of more or less exclusive and inclusive resources. With the closing down of much institutional care in more developed countries such as the UK, ‘community’ became for a time quasi-sacred: we were expected to abase ourselves before it and not ask what it is (Bell and Newby, 1972). There are parallels here with critiques of participatory ‘community development’ that it may reinforce inequalities – for example, between women and men – rather than reduce them (Gurjit and Kaul Shah, 1998).

The challenge for management is that it is not enough to integrate people in multi-disciplinary teams, for example, if you do not also integrate the systems in which they are expected to work. The challenge for governments and donors is that integrating the systems is not enough if the national or international economy is pushing the other way, rapidly displacing communities or rapidly introducing new patterns of production and consumption (including the impact of war economies) that carry unpredictable CD and NCD burdens. The more a social problem seems to be intractable, the more the specialised agencies mobilise to counter its effects on their preferred ways of working. The problem is fragmented and its intractabilities split off and projected from one agency to another like a game of pass the parcel. It is necessary then to understand how the different agencies determine what they are there to cope with, what they are not there to cope with, and how they tell the difference. For the definition of task seems to be a defence against the twin pressures of omnipotence and guilt.
Health care management: a boundary function

We should acknowledge that it is difficult to manage the boundary between formal and informal systems of care. Management is essentially a boundary function: at the point of funding and of evaluation, of recruiting and promoting, of social marketing, with individual patients at the time of assessment, treatment and discharge. There are, furthermore, two very different perceptions of management that alternate in a moment and without notice. The first perception is that it is out of touch, arbitrary and deeply problematic – perhaps like a parent suffering dementia, unaware of what you are having to struggle with. This management has to be mollified or ignored, reluctantly loved and actively hated.

The second perception is of management as a caring parent, doing her best in impossible circumstances, understanding our difficulties and someone we do not want to put pressure on but on whom we sometimes need to take out our frustration. This management is seen as exhausted, itself needing but not having recourse to respite care. And sometimes that is accurate. Depending on the country context, denial of our own needs as health-care practitioners or managers may stem from budgetary pressures, orientations to poverty and inequality, professional ambition, masculinity and femininity or intellectual, political and/or religious commitments. Denial may involve some confusion or inhibition about self-interest versus altruism and public interest – and the clashes between market-, faith- and rights-based accounts of that tension.

Defining down of the task (see Box 1) is a symptom of those stresses. We believe conscientiously that we should only be doing so much for such and such a group but look how much more we are being asked to take on. Even when we realise this is happening, criteria of responsibility are not adjusted to take account of the new reality. We do not fully reject the new, nor do we really admit it as legitimate. This same ambiguity serves again as a defence against the quite unrealistic expectations that we have of ourselves. And with defining down may come ‘dumbing down’ – a simplified range of ideas and vocabulary inadequate to the task.

The ‘post-dependent’ society

Can dumbing down also apply to the normative? I believe that in post-industrial countries we are living with a distorted view of what is called ‘therapeutic’ in a culture of supposed emotional tolerance, where it is ‘allowed’ to have feelings. This derives from a deep ambivalence about the importance of psychological understanding of everyday life, either appreciated as emotional intelligence (making for ‘employability’ and ‘success in getting more out of life’) or derided as ‘touchy-feely’ and suspect in the real world of socioeconomic relations. Sensitivity, with a respect for the emotional impact of change and loss, has to hold its space alongside a contrary model of human relations, instrumental and rational in its survival tactics. This is even more of a challenge when attempting to transfer therapeutic expertise from one culture to another (where either practitioner or patient has migrated), and calls for a workforce with diversity and what we may call cultural competences.

Both developed and developing countries have adopted to some extent the language of empowerment versus ‘passive recipients’; in fact, empowerment is a hallmark of human rights-based development practice. But in its neoliberal manifestations, empowerment can at times react strongly against the idea that dependency outside the family has any positive characteristics. While we may pay lip service to our essential interdependency with others, we are continually invited to act according to an independent agenda of personal and economic growth. We may

Box 1

Research findings on the health workforce

In one hospital patients who survived their initial stay in the admission ward of the geriatric hospital were transferred to the rehabilitation ward. Over time it was noticed that the patients on the rehabilitation ward were becoming more physically dependent. The doctors tended to blame the nurses and declining quality of nursing care. In turn, the rehabilitation ward nurses blamed the admission ward for having done an inadequate job. Our observation was that patients were being shifted from the admission ward because these beds were needed for other patients and not because they were ready for rehabilitation. But both medical and nursing staff showed great reluctance in acknowledging this.

No explicit policy decision was made to lower the criteria for transferring patients for rehabilitation. The rehabilitation ward nursing staff made no direct protest to the medical staff about the de facto change in criteria. Of the 20 consecutive admissions to the hospital, at least 4 were clearly transferred from rehabilitation for reasons of expediency. However, each was treated as a temporary exception to the regular rule, thus perpetuating a particular pattern of conflict.

The effect of thus deliberately maintaining ambiguity about the appropriate boundary management between the admission and the rehabilitation wards offered an alibi that related to the patients who were the failures of that care system, the patients who would neither die nor recover. Where there is ambivalence about aims and uncertainty about outcome, nevertheless those working in the different sub-systems were able to be surprisingly specific about definitions of task. According to those definitions of task they were doing more than they should. But the explicit task seemed to contract down to describe only part of the work experience. 

Source: Dartington, 2010.

Box 2

Distorted incentives

A woman had been visiting her mother in an independent living scheme. She complained that her mother was being forced to do things to demonstrate her progress in being independent, for example, doing the washing up with two care workers standing over her, and she saw this as insulting, more a punishment than a support. When she complained to the manager, she was told that they had to demonstrate that they were achieving outcomes such as client independence to justify their funding.

Source: Dartington, 2010.
call this the ‘post-dependent’ society (Khaleelee and Miller, 1985). In it, authority is displaced from traditional forms and located in the individual self rather than inter-generational knowledge. Crudely understood, ‘rights and responsibilities’ thinking can displace our deeper insights and lead us into a litigious climate.

As such, post-dependency is in tension with the more credible ‘good governance’ agendas that emphasise legitimacy and social learning. And if post-dependency is a deliberate policy of the state, where the citizen is required not only to behave but also to know and to feel in certain ways that minimise health costs, there is scope for serious departures from professional ethics – basic human rights included.

The current emphasis on lifestyle factors in both CDs (sexual behaviour) and NCDs (diet, smoking/ alcohol/ other drugs, exercise, ‘life skills’) means that governments are now interested in a wider scope of citizen behaviour. In attempting to change behaviour it should indeed act on what citizens know (education), but in using social marketing to make them feel differently about their consumption choices we are on more uncertain ethical and political ground. Paradoxically, we may also at times be undermining independence of one sort – independence of mind.

Conclusion

The denial and neglect of relationships is in part an attack on dependency. The problem with acknowledging dependency is that it adds weight to our responsibility for others without any corresponding gain of rights. A dependent workforce, one that has to be looked after, provided with security of employment and compensatory benefits in the event of sickness or injury, makes a company less competitive – depending on the regulatory framework. The same can be said of health workforces and of national economies. Governance and management of health intervention that indulges the fantasy of post-dependence, without the need for committed relationships, provides a very defensive environment, psychologically speaking. Clearly, regulation does not sit very easily with relationship. What is spontaneous, idiosyncratic, uncertain or unmeasurable in its outcome does not fit with an agenda of donor or national standards.

I am reminded of a story that my children liked when they were young in which the farmer’s wife, being a clean and tidy person, cleaned up the farmyard and the pig (who she loved) ran away, deprived of the mud and squelch of its familiar environment. I think of this now as a parable for organisational life in a culture of
measuring. Let’s use the integration of CD and NCD services and capacity as an opportunity to rebuild relationships and strengthen our resolve to treat the whole person. And in the process, retain our professional values – not drive them out.

References


Dr Tim Dartington, PhD, is a social scientist and organisational consultant. He is an Associate of the Tavistock Institute and the Tavistock & Portman NHS (UK National Health Service) Foundation Trust. A member of the International Society for the Psychoanalytic Study of Organizations, he has studied public and non-profit health and social care for over 35 years. The ideas in this article are drawn from his 2010 book (see refs.), an article in the journal Soundings (The killing fields of inequality, Issue 42, 2009) and Politics and the triumph of the therapeutic, in Hoggett P. and Thompson S. (eds.) (2012). Politics and the emotions: the affective turn in contemporary political studies. London and New York: Continuum.