Article

Caring – An Idea Past its 'Use by' Date?

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Health services in NZ have undergone major changes over the last ten years. This article examines the 'reformed' health service delivery framework and its impact on clinical practice with a particular focus on the concept of 'caring'.

Caring – What is it?

'Healing' and 'health care' are social constructs. By definition they incorporate interrelationships between individuals and their wider communities. Humans have evolved to where long term social relationships with others, in a sustainable environment, are necessary for long term survival. Social relationships which develop do so as a result of historical context, available resources and the prevailing economic systems. In our society, caring or concern for ourselves, each other and our communities generally underpins social relationships. Historically, the need to sustain and maintain communities has underpinned health services – be they those of the shaman, or of the modern day practitioner. Healing and health care are related to helping people achieve lives which are integrated with their social environments. In this context caring relates to helping. Lack of caring for ourselves, each other and our environment, tends to result in a breakdown both in communities and in the environment in which communities live.

The notion of caring has under-pinned clinical practice in a very fundamental way. It is so intrinsic to health services and clinical practice that it is often overlooked.

Caring[1] by the health professions involves more than a well done technical intervention. It involves seeing people in the light of their needs which extend beyond physical diseases and degeneration. Caring involves having positive feelings for clients, being careful in regard to them, listening and being sensitive to another's reactions and performing interventions from a generous motivation or out of concern for the recipient of the action. Caring can be seen as helping the other to grow and involving a number of characteristic virtues including patience, honesty, humility, hope and courage.[2]

The Health Reforms

In 1988, 1991 and May 1997, Government reports were released detailing structural changes to the New Zealand health sector.[3]

All the above reports adopt classical neo-liberal agency theory as the basis for evaluating health services. Agency theory describes public servants (including clinicians) as self-interested, unaccountable, inefficient and open to capture. It goes on to say that the market approach to service delivery ensures neutrality, independence and self-discipline.

This ideology features predominantly in the above reports, which focus on public hospital services being large institutions which are poorly managed, inefficient, inflexible, self-serving, ignore other providers, and discourage innovation. Health professionals are portrayed as lazy, inefficient, inflexible, constrained by their working environment, poor managers and self-serving. Health services are described as being able to be quantified into discrete measurable units, delivered discretely, and, if applied efficiently and effectively leading automatically to improved health (measured in outcomes and outputs). The key words that underpin the proposed solutions are market model, competition and financial responsibility. The reports promote the private sector as more efficient, with the application of the private sector model, built on a profit motive, being the way to deliver more services for the same money.

There is no mention in any of these documents of words essential to patient/clinician relationships; words such as caring, healing, trust, competence, confidence, empathy, respect, equality, partnership, humility, experience and wisdom. Within this framework there is no room for the rituals of caring. Therefore the essence of clinical practice (ie caring) is completely overlooked as a basis for analysis and evaluation. Rather, clinical practice itself is relegated to the black box which somehow occurs within the proposed 'agency' problems and market solutions. This lack of clinical grounding results in reports which describe the attainment of a utopian reality, a clinical nirvana which bears little relationship or relevance to the day to day work of clinicians.

Why Agency Theory?

The interventionist state is seen by liberal economists as the reason for declining profitability.[4] Agency theory has been rigorously applied to New Zealand (including the health sector) to enable the continued growth of the international economy.

So how has the logic of agency theory been applied to the health sector? In line with the language of the market, buyers and sellers were separated. Health services moved from money being allocated to providers and their being asked to use their skills and expertise to make necessary trade-offs and ensure value for money, to discrete, predefined units of services being bought for the State by a 'purchaser'. Detailed contracts define discrete units of service which are specified in very precise terms. In this model there is little room for clinical trade-offs. These have already been made by the State before funding is allocated. Clinical practice has been reduced to individual technical interventions for 'disorders', be they physical or psychological. This 'technological quick-fix' approach appears to be the sole focus for clinical practice. In this environment, caring is now subservient to 'maximisation'.

This application of libertarian theory is not peculiar to the 1980s and '90s. The same rationale was applied in the late 1800s as an answer to increasing poverty, disease and disorder result-

ing from economic changes brought about by the industrial revolution.[5] To protect the industrial economy from its social by-products, politicians prescribed the liberal panaceas of free trade and individual responsibility and self reliance.

The Caring Cycle

Over time medicine has gone through cycles where the emphasis on caring has gained or lost prominence depending on clinical ability to identify and cure afflictions.

Classical medicine taught that working with patients to bring about the right frame of mind, composure, control of the passions, and suitable lifestyle, could surmount sickness or even prevent it in the first place.[6] These links were maintained through medieval times and the Galenic-Arabic tradition of the 1500s. However, it was challenged by the scientific revolution which enabled disease to be established as objective ('ontological'). The development of the hospital, which grouped people with 'like' symptoms together, enabled clinicians to identify patterns of disease. Seventeenth century philosophers such as René Descartes and Thomas Hobbes argued that nature was made up of particles of inert matter and nature was the same as a machine. Health and well-being were compared to the running of a well-tuned, well-oiled machine, and sickness was depicted as a mechanical breakdown. By the nineteenth century doctors directed their gaze not on the individual sick person, but on the disease of which his or her body was the bearer. Disease was seen as having an identity of its own. Caring had come to assume a less prominent focus.

Up to 1935, limited therapeutic accomplishments led to doctors becoming sceptical about the possibilities of scientific treatments in general. This scepticism was called 'therapeutic nihilism' which taught generations of medical students that physicians could do relatively little to cure disease and, by implication, the real function of medicine was to accumulate scientific information about the body, rather than to heal. Organically based medicine was seen as able to do little save yield diagnosis and prognosis. However the demand for help from patients with ill health resulted in the birth of the patient-as-a-person movement, with a focus on the psychological benefits inherent in the consultation.[7] Caring was making a resurgence.

The development of diagnostic imaging, laboratory tests and improvements in the success of surgery resulted in the whole patient-as-a-person movement falling into disrepute after 1950, (although it was retained in general practice to some extent), and being replaced by a new generation of physicians filled with therapeutic self confidence. The 'caring' aspects of the doctor-patient relationship with which patients had identified, became down-played in favour of using technology in the diagnosis and treatment of disease. The caring doctor as a healer was replaced, to a varying extent, by the doctor as a body technician.

These developments have fed the fallacy that clinical practice consists of discrete units of service devoid of any interpersonal relationships.

Turning the Tide

A growing awareness of a number of variables may reverse the decreasing prominence of caring. Firstly, the growing intervention of medicine in all aspects of daily life (for example, reducing the cosmetic impacts of ageing) has led to what Illich has called the 'medicalisation of life'.[8] Illich believes that medicine is allegedly set on course to put all aspects of living into the hands of doctors.

Secondly, since the 1960s medicine has started to be seen as not having all the answers. Cancer and many other major diseases remain embarrassments, and medicine itself is increasingly held responsible for pain and sickness through iatrogenic complaints.

Finally, medicine is not and has never been value free in its accounts of its diseases or their causation. Material reductionism is by no means self-evidently right for comprehending the true character of all kinds of human sickness. An historical review of discarded 'diseases' shows that medicine has categorised strange collections of clinical symptoms, social phenomena, and prejudices into disease envelopes. Further, bacteria do not cause disease in precisely the same way as lightning causes thunder. The apparent 'frailty' of medicine arises from the fact that sickness is not simply the work of pathogens; it is a function of social relations.

The above factors have resulted in patients often feeling alienated from mainstream medicine. In an attempt to be seen as more than malfunctioning biological mechanisms, they are now embracing alternative therapies.[9]

The Technology Focus: Likely Impacts

Clinical practice, by its very nature, has the potential for misdiagnosis and treatment. However, technical processes are not seen as having a margin for error: if the mechanical prescription is followed, the outcome should be right every time. In continuing to promote technology as the essence of clinical practice, there is no room to argue that some margin of error is inherent in the business.

A system which is at odds with an increasing number of its users is likely to invite increasing criticism. The lack of overt acknowledgment of the importance of caring and the clinical process is likely to result in public criticism being focused on visible, quantifiable features of the health system such as lack of money and resources, waiting times for access to technology and poor performance by clinicians. The use of often disparaging terms such as 'soft', 'fuzzy' and 'woolly' to describe the notion of caring may act to further target criticism at quantifiable symptoms rather than the causes. With every publicised error it is likely clinicians will be increasingly be seen as cold, calculating and self-serving.

The technological approach lends little room for the recipients of health services to accept responsibility for their part of the clinical relationship. The onus for success rests solely with clinicians. This approach is at odds with the nature of clinical practice.

The calls for increasing regulation of health services through institutions such as the Health and Disability Commission and disciplinary mechanisms for health professions also suggest the current framework could be at odds with the essence of health service delivery. The ongoing debate on the failures of the mental health system could also be seen as the result of a 'one-off intervention' framework with no regard to the overall picture of community relationships, a framework at odds with the essence of what mental health services are, or should be, about. More money is

unlikely to improve results if the fundamental framework is inappropriate.

The need to reemphasise the inherent nature of caring has not gone unnoticed by the professions. Caring is making a resurgence in clinical teaching. Curricula are giving greater emphasis to communication skills, holism and social contexts for ill health. However, clinicians trying to implement this practice focus in a framework which lacks coherence with their education, could result in disintegration of individuals unable to reconcile practice with the requirements of the current economic framework. The likely outcome could also include disaffection and loss of practitioners from their professions.

The National Waiting Times Project (NWTP) has the potential to redress the balance through the use of social indicators as part of the assessment of patient need. However, there is a danger that it too could be completely technically focused if the Clinical Priority Assessment Criteria (CPACs) are not properly developed.

Conclusion

The current framework for the delivery of health services in New Zealand is based on neo-liberal economic theories. This framework focuses on using a production model for clinical practice, which could be said to lack the support structures required to enable 'caring' and associated clinical processes from gaining prominence. To some extent it could be argued that clinical practice, with its current focus on technology and one-off interventions, has assisted the implementation of a technologically focused framework.

However, caring is fundamental to current clinical practice methodologies, even if practice moves through cycles where it is emphasised or deemphasised. Regardless of emphasis, it is always present. The integration of current clinical practice with its social environment is reliant on a framework which enables caring to be manifested. The irony is that at the time when 'caring' is set to regain prominence, this economic framework could prevent this from occurring.

So does this present us with an ethical dilemma?

Ethics are derived from the interaction between context and behaviour. To identify if a dilemma exists we need to determine if caring is still a valid notion in relation to clinical practice. If it is, we have a duty to evaluate and develop health service frameworks which give caring prominence, and enable it to be reconciled with day to day practice. If however, caring is indeed a concept that is past its use-by date, we should openly acknowledge this and refocus practice accordingly. However, resolving the issues at hand is unlikely if 'caring' is neither acknowledged in a formal way, or is overtly dismissed.

This is the ethical dilemma for clinical practice – whether to continue the pursuit of technical advancement and body maintenance, as identified by government agencies, and tailor clinical education and practice accordingly, or to give caring more prominence and work towards the implementation of health service delivery structures which support interactive caring relationships between clinicians and their communities on the basis of equality. The NWTP has the potential to enhance a caring perspective if properly implemented, and could mark the beginning of a redress which would encourage the recovery of the concept of care. The dilemma is one of either recapturing the essence of health care, or moving away from it entirely and leaving the 'healing' side of the business to others and thus establishing integrity for both clinicians and patients alike.

Notes

1 A detailed discourse on 'caring' is beyond the scope of this article. For a comprehensive discussion see: Van Hooft, Stan. *Caring: An Essay in the Philosophy of Ethics*, USA: University Press of Colorado, 1995.

2 Mayeroff, Milton. *On Caring*, New York: Harper and Row, 1971.

3 Hospital and Related Services Taskforce: Unshackling the Hospitals, Department of Health, Wellington, 1988 *[Gibbs Report] Your Health and the Public Health: a Statement of Government Health Policy.* Hon Simon Upton, Minister of Health, July 1991. *Implementing the Coalition Agreement on Health. The Report of the Steering Group to oversee Health and Disability Changes to the Minister of Health and the Associate Minister of Health.* Ministry of Health, Wellington, May 1997.

4 Chomsky, Noam. *Powers and Prospects: Reflections on Human Nature and the Social Order*, Australia: Allen and Unwin, 1996. Kelsey, Jane. *Rolling Back the State*, NZ: Bridget Williams Books Ltd, 1993.

5 Watts, Geoff. 'Looking to the Future', in *Cambridge Illustrated History of Medicine*, Porter Roy (ed), New York: Cambridge University Press, 1996, pp3l7-19.

6 Nutton, Vivian. 'The Rise of Medicine', in *Cambridge Illustrated History of Medicine*, Porter Roy (ed), New York: Cambridge University Press, 1996, p93.

7 A discussion on this topic can be found in Nutton, Vivian. 'The Rise of Medicine' in *Cambridge Illustrated History of Medicine*, Porter Roy (ed), New York: Cambridge University Press, 1996, p93.

8 Illich, I. *Limits to Medicine: The Expropriation of Health.* London: Penguin, 1977.

9 In 1997, a survey at Harvard University showed that 42 per cent of adults with cancer had tried alternative or complementary medicine at a cost of $US 21 billion. [*Otago Daily Times*, Thursday May 20, 1999, p15].

Summer Seminar

Call for Papers

The Bioethics Centre is happy to announce that we will be holding our biennial Summer Seminar in February 2000, and we are planning an international event. Papers are invited on any topic, however possible main themes of the conference will be medical innovations, narrative ethics, ethics and the impaired doctor, biotechnology and genetics, reproductive law and ethics, and booking systems and prioritisation. Abstracts can initially be sent to: The Editor, *Otago Bioethics Report*, PO Box 913, Dunedin.