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Risk, rationality and learning for compassionate care; The link between management practices and the 'lifeworld' of nursing

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SUMMARY

The nursing care experiences of older people in the United Kingdom, has been much reported in the national and international press. Reasons for that poor quality of care in hospitals often focus on the 'culture' of organisations, as well as focusing on individual failings. However, discussions about culture change are partial explanations without a deeper analysis of how cultures and leadership operates in socio-political contexts which characterise nurses' 'habitus' and 'lifeworlds'. Therefore the solutions may not address wider determinants of care such as risk governance, managerialism, instrumental rationality and of course staffing and skill mix. Instead, organisations may be exhorted to change their cultures, without addressing these wider determinants and thus poor care practices may continue to occur. If targets are abolished, this may still leave a layer of managerialist thinking. This impacts on education because students, who are 'working and learning', experience occupational socialisation through immersion in the lifeworlds of their clinical colleagues. What is required is much less managerialism in the care of older people. Instead, there is a need for clinical leadership, based on critical reflective understanding of the occupational socialisation of nurses operating in a context of risk and rationality and organisational objectives; collegiate political and moral action by health professionals and society on behalf of the older person, and support for front line staff who require more autonomy and control over care practices.

Introduction

This paper will discuss older patients experiencing indignities and poor care in hospitals in the United Kingdom as partly a result of the increasing use of a particular approach to risk management, operating within a longer term managerialist context (Enteman, 1993; Fitzsimons, 1999; Preston, 2001a, b; Hood, 1991; Hoopes, 2003) that characterise many healthcare and other public sector organisations. A result of managerialism is constraint on the autonomy of nursing decision making and a lack of trust in professional nursing staff (Traynor, 1999; Gilbert, 2005; Traynor et al., 2010), both of which, it can be suggested, erode the proper context for the delivery of compassionate care.

Managerialism and risk governance also operate in organisational contexts of poor staff to patient ratios, poor skill mix and too often an over reliance on poorly trained, poorly supervised care assistants to care for frail older patients with multiple nursing care needs (Robb et al., 2011). This understanding of context should move us beyond the position of blaming failing individuals, beyond just emphasising their accountability, and beyond simplistic solutions. These solutions have included addressing the selection and recruitment for compassion in nurse education through measures such as giving prospective care experience as health care assistants. There should instead be a focus on the complexity of organisational and social contexts that impact on the quality of care through the construction of normalised practices in a nursing 'habitus' (Bourdieu, 1984) and 'lifeworld' (Husserl, 1936).

Striking people off registers may be the correct process for those whose nursing 'habitus' lacks compassion, but it may do little to address wider structural issues that might construct that habitus in the first place. There is a need to understand human agency operating within certain social structures and how that agency might operate resulting in poor care. Graham Scambler, in wishing to establish a theory of agency in sociology (2013) argues: "Humans…are simultaneously the products of biological, psychological and social mechanisms while retaining their agency…socially structured without being structurally determined" (p147). This idea needs discussing at length elsewhere, but it underpins this analysis of how compassionate habitus might be structured, for example by rationality in management, but not ***determined***.

For the purposes of this paper, the focus will be on the structural issues of risk governance and instrumental rationality as a form of managerialism, to critique these processes. From this it may be suggested that there is a need to reduce bureaucratic load, remove tiers of centralised external inspection, support the front line to allow professionalism rather than managerialism to flourish and ensure care staff receive the resources they need (Salvage, 2012; Dixon-Woods et al., 2013), so that their agency operates within a 'habitus' of compassionate

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care. This habitus requires feedback from peers and other professional staff (Van der Gaag, 2013), and from patients, on how individuals are performing. In short *clinical* leadership not managerial leadership (Edmonstone, 2009), in the context of collegiate political and moral action by professionals and wider society on behalf of and in partnership with older people.

Managerialism and Risk

Manageralism has been understood as both a process and an ideology (Enteman, 1993; Preston, 2001a,b). Its nature and growing influence in both the private and public sector has been described elsewhere (Hood, 1991; Enteman, 1993; Drucker, 1994; Hoopes, 2003; Lees et al., 2013) and more recently in the context of the corporate university (Rolfe, 2013). A defining characteristic being the application of **scientific and rational** means to the achievement of certain organisational goals. Hood (1991) referred to 'New Public Management' which since the 1980's was aimed at reforming the public sector through the application of market mechanisms and a focus on outcomes and efficiency. Preston (2001b) argues it is a belief in a strategic approach…making objective and deterministic claims about the nature of the 'life world', a concept that will be returned to below. Fitzsimons (1999) wrote that manageralism is a form of 'instrumental reasoning' in which efficiency is a defining goal, *regardless of the value* of the activity itself (my emphasis). In the current context of the NHS, a focus on patient safety, efficiency and effectiveness by management might be characteristic of this frame of mind.

Rationality

To get from public issues of social, and organisational, structures to the personal troubles of indignity there is a need to apply a little sociological imagination (Wright Mills, 1959). The suggestion is that modern capitalist society is characterised by a *rational* approach (Weber, 1992) to issues including the management of risk and it is this *instrumental rationality* (zweckrational) that has unintended consequences for the care experience. Weber's theory of 'rationalisation' thus suggests that modern societies become increasingly rational and bureaucratic whereby social life becomes more and more prone to scientific analysis, measurement, bureaucratic control and the application of 'instrumental rationality' to social problems and issues. **Instrumental rationality** is a mode of thought and action that identifies problems and works directly towards their solution, often focusing on the most efficient and cost effective methods of achieving certain ends. It may not stop to ask what those ends should be, or what effect the efficiency has on human relationships. A falls risk assessment could be seen as an efficient and cost effective measure to reduce the number of falls and it is part of the overall instrumental rational approach to risk management. Actually constraining a patient's mobility to prevent a fall may be *rational* but it may not be *human*.

Instrumental rationality in a neoliberal era of economic policies (Plehwe et al., 2006; Crouch, 2011), results in the domination of the market in all spheres of human life (Sandel, 2012) and the prioritization of the bottom line and financial efficiencies. Adverse events, such as falls, not only cause human suffering but perhaps more importantly for those charged with running hospitals and care homes, also costs money and therefore must be avoided.

The health service over the past few decades has increasingly sought to eradicate uncertainties in care, and to control its costs, by the application of practices of regulation and surveillance — protocols, monitoring, targets, audits, evidence based practice and performance measures. This sets up a dichotomy for care staff in that they deal with 'the human' in direct contact, but at the same time are expected to complete myriad managerial diktats many of which are about controlling risk. These tools, on their own, do not automatically result in indignity. However they are part of a wider organisational and social mindset that can reduce patients into categories and numbers and a 'data set'.

This *social* rationality may then become a nurse's practice through the 'colonisation of the lifeworld' (Habermas, 1981).

Lifeworld

Nurses and their patients inhabit a 'lifeworld' (Lebenswelt) of intersubjective perceptions and meanings (Husserl, 1936). It is experienced as that which is 'self evident' 'taken for granted' and for its inhabitants, e.g. nurses, the lifeworld has some 'objective' truth, is always 'there' and a shared foundation for human experience. These will include the rules, goals, values and meaning of social actions. This 'taken for granted' human intersubjective 'objective' space of the lifeworld of nursing is open to 'colonisation' by rationality (Habermas, 1981), i.e. that rationality becomes a taken for granted aspect of human experience and goals. Social integration, and the intersubjective construction of the lifeworld, is based upon the actions of its members *and also* the requirements of wider social structures of economy, hierarchy and, what Habermas considered, 'oppressive' systems. These later requirements, e.g. manageralism manifest in the need to control, record and risk assess everything, can overwhelm and penetrate nurses' lifeworld – to colonise it – so that nurses then take on this rationality '*as a given*', this might result in cognitive dissonance as they struggle to reconcile humanistic care with technico-rationality, feelings of disempowerment, rendering them unable to criticise or posit an alternative. For Habermas, the colonisation of the lifeworld by the instrumental rationality of bureaucracies and of market forces is a key aspect for the analysis of modern societies. When nurses uncritically take on board the tenets of bureaucratic rationality, their humanistic lifeworlds are thus 'colonised'. This is another aspect of the theory practice gap, in that students may learn to construct a praxis based on humanistic values but then, via the resolution of any cognitive dissonance they might feel when confronted by the *reality* of clinical practice (Curtis, 2013), may come to practice *instrumentally*.

Rationality, Habitus and Distorting Care Practices

Hillman et al.'s (2013) research illustrates how managerialist practices can shape the care experience of older people in part through this colonisation of the life world, by the application of instrumental reason and a focus on risk management. Their argument is that indignity results from a structural problem of society as well as of hospitals and cannot be laid only at the feet of uncaring individuals. The focus on risk governance, as an aspect of managerialism, not only reduces the patient–carer experience down from an ethical and moral practice but can even turn patients into 'the enemy', seemingly posing a potential threat to those who care for them.

This may happen through fear over personal accountability, litigation and complaints, resulting in a culture of self-protection. Staff become more attentive to ensuring the litigation and documentary needs of the organisation are met and are seen as important, if not more important, than actually delivering compassionate care. Blame culture accentuates this process resulting in defensiveness especially among health care assistants. Defensiveness creates and sustains a disconnection between staff and patients, patients are set up in opposition and a context of 'them and us' can arise. Hillman et al. (2013) illustrated this with a quote from a carer called Jim: "its turned into a big game of them and us". Jim's use of this phrase was used to explain how some patients, in his view, engaged in behaviour that may not be what it seems. He referred to a patient who claimed to have fallen but who Jim considered did not have a genuine reason for falling, or indeed had exaggerated the fall, in order to gain some attention.

The application of rational judgement as justification for practices can become, for nurses, a 'habitus' (Bourdieu, 1984; Wacquant, 2004a,b, 2011). This is a continuing social practice which constructs a 'history' – our life stories, including working life stories – which then infuses into our memory. It is a 'structure of the mind' based on acquired 'schemata', dispositions and even tastes. In this manner certain behaviours and