Culture, Kinship and Intelligent Kindness

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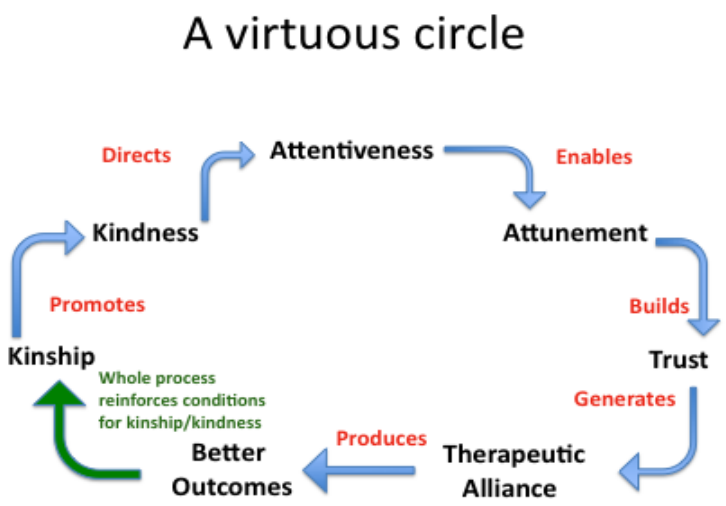
Kindness is an interesting word. It has its roots in the Old English word *cynd* - meaning nature, family, lineage – kin. Kindness implies the recognition of being of the same nature as others - being *of a kind* - in kinship. It implies that people are motivated by that recognition to cooperate, to treat others as members of the family, to be generous and thoughtful. At the time of the Enlightenment, kindness was a core moral concept, fundamental to the political battles of the time. More recently, it has been sentimentalised and somewhat denigrated. There is much to be said for rediscovering its subversive edge and using the concept to think creatively about modern culture – particularly the pressing problem of providing humane healthcare

First, we need to consider what kind, compassionate care looks like. Barry Schwarz, the Canadian Psychologist, tells a simple story taken from some research about janitors in hospitals (TED 2009). He describes one who stopped mopping the floor because a patient, who had been bed-bound for a number of months, was anxiously taking his first steps; another who ignored her supervisor's admonition and didn't vacuum the visitors' lounge because there were some family members who were there all day, who at this moment every day were taking a nap; and a third cleaner who washed the floor of a patient's room twice because the patient was a young man in a severe coma whose father was anxious and hadn't seen him doing it the first time. Whether the focus is on staff like janitors or brain surgeons, these simple stories suggest several core priorities for those seeking to nurture intelligent kindness. The behaviour involved in these stories is not in any job description or specification – indeed, in at least one example it risks getting the person into trouble - but it does capture the essence of kind practice and suggests the following challenges for anyone wishing to promote such compassionate activity:

- How to promote and sustain compassionate *bearing of the patient/other in mind*
- How to generate imaginative *understanding of the contribution a person's tasks* can make to others' wellbeing
- How to instil in people and support a confident *belief in their own value and freedom to act*
- How to ensure that they have the knowledge and repertoire *skilfully and compassionately to act* to fit the circumstances

How is such behaviour nurtured in the wider system and, just as important, what are the forces that make this difficult?

A virtuous circle is envisaged, where there is not only a compassionate connection between the clinician and the patient, but the potential for something to happen in the wider system.



This system will flourish if individuals and the system as a whole are driven by a sense of kinship. This sense of kinship will promote the feeling and expression of kindness which then directs attention and so on. Each stage in this cycle can be seen as a mutually reinforcing cycle in itself: for example, kindness breeds attentiveness which in turn reinforces kindness, attentiveness and attunement feed each other, a stronger therapeutic alliance does not just produce better outcomes but fosters trust which in turn strengthens the alliance. Imagining the system in this way, could be useful in our quest following the Francis Enquiry to transform the culture of healthcare.

The concept of intelligent kindness can also be thought about at a political level. Important to me is the idea that the founding of the NHS was an embodiment of kinship. After World War Two, there was a strong sense that if Britain had been worth fighting for, the civilized and generous values of the NHS were both an appreciation of such commitment, and a demonstration of why it was worthwhile. The NHS is an especially crucial aspect of British 'social capital' in the context of growing inequality and fragmentation as a nation. Despite all the threats and challenges to its founding principles, the ethic of kinship lives on in the loyalty it inspires and in its rhetoric - for example, this passage from the NHS Constitution:

The NHS belongs to the people. It is there to improve our health and well-being, supporting us to keep mentally and physically well, to get better when we are ill, and, when we cannot fully recover, to stay as we can to the end of our lives… It touches our lives at times of basic human need, when care and compassion are what matters most… The NHS is founded on a common set of principles and values that bind together the community and the people it serves – patients and public – and the staff who work for it. (DH 2009 p2)

But all is not well with the NHS. It is not so easy to sustain the virtuous circle described. Patients complain of inhumane treatment and neglect and recent scandals such as that in Mid-Staffordshire have shocked the nation. Meanwhile relentless attempts at regulatory and structural 'reforms' have left many NHS staff feeling demoralized and alienated.

Why then is kindness, sustaining a sense of kinship, so difficult?

Ethology gives us some hints. Michael Chance, a researcher into non-human primates, describes two main forms of culture. Primates such as Savannah Baboons appear to be concerned with self-security, with warding off potential threats and with maintaining status within a hierarchy. Individuals are dominant or subservient, preoccupied with inhibiting aggression. Levels of tension are high. Chance calls this the *agonic mode*. Groups of chimpanzees or gorillas, on the other hand, are mainly preoccupied with nurturing social relations – play, tenderness, stroking and kissing, all soothing, reassuring activities which keep tension levels low. Typically, their attention is released from self-protection, and their culture – what Chance calls *hedonic* – appears to promote self-confidence, empathic cooperation, curiosity and reality-based intelligence. Chance observed a transient third state – the *agonistic* – that is characterized by individuals simply fighting things out for themselves, the violence consuming all important group resources. This agonistic mode did not promote overall group survival, and represented a collapse of culture.

Extrapolating from groups of primates, Chance hypothesized that human groups may become stuck in the agonic or hedonic mode or unconsciously move back and forth between them. Each mode predisposes individuals and groups to deploy their attention in distinct ways, so that they are either prevented from, or enabled, to employ their intelligence.

Chance looked at what happened in Gombe, Tanzania, in the early 60s when Jane Goodall's researchers tried to engage a happily hedonic group of chimps with plentiful (but not unlimited) supplies of bananas, so that they could be closely observed. He observed that they were tipped over into a murderous, competitive agonistic mode. It appeared that competition for bananas had provoked this change: it had distracted their attention, squeezing out the expression of reciprocity and mutual reward so essential to keeping tension down. Members of the community had moved from *awareness to reactivity* in the context of the competitive situation.

It appears that hedonic cultures are the most vulnerable to collapse. Agonic cultures – all hierarchy, subservience and knowing your place – are more protected against such dangers by their rigidity, hyper-vigilance to threat and their being used to managing high levels of tension. They are not, though, gentle, attentive or creative. The problem is that the gentle chimps who habitually focused their energy on nurturing kinship relationships were easily tipped into becoming envious, hateful and violently murderous as their kin became recast as enemy – just like humans really, all humans – from ward to Board to our political masters.

Back to healthcare, ambivalence about who belongs in the family and who doesn't – anxieties, animosity and denial, at the 'edges of kinship' - affect the system from policy through to individual practice. These problems affect our recognition of kinship with, and our tailoring of our care systems to work with many groups, including the dying, the old, people with mental health or learning disabilities, asylum seekers, smokers and addicts. With these 'groups' we are confronted with ambivalent reactions as we consider whether they are like us, whether they belong, deserve or merit care, whether they are understandable, whether we can manage to meet their needs. We face the threat of high vulnerability, dependency and difference. A widespread reaction is splitting – between hatred and love, over-estimation and under-estimation, neglect and over-protection, abuse and idealisation, fear and concern. Frequently an uncomfortable question seems to arise: do these people fit in with our ways of organising and delivering care, or are they just too needy, slow, unpredictable,

unresponsive? We have of course just listed the majority of NHS patients, so these tensions need urgent attention. They can be seen at work everywhere in policy and practice.

In her famous study on 1950s nursing care, Isobel Menzies-Lyth (1959) showed that hospitals were organised in unconscious defence against the profound anxieties inherent in the healthcare task. Put simply, kindness towards patients is undermined because the work puts us in touch with deep-seated, largely unconscious fears of helplessness, decay and death. If these anxieties are not recognized, understood and managed appropriately, they will impact detrimentally on a number of processes in a way that undermines any rational attempt to improve the healthcare culture. This idea is an important one, that the organization of a hospital is defensive, with the unconscious purpose of stopping those who work in it – particularly those in charge – from feeling the emotional pain and anxiety associated with the work. I would argue that these dynamics work at every level of the NHS including the political.

Menzies Lyth noted the resistance to change in the NHS of the 1950s and saw it as part of the social defence system of the time. But half a century on, it looks as if the pendulum has swung, and the uncritical acceptance and promotion of constant change in the NHS has taken its place. There is certainly evidence that major structural change keeps senior managers and board members detached from the frontline of healthcare. Moreover, the simplistic, unthought-through tone of many re-organisations conveys a strong sense that change has a compulsive quality and is driven by unconscious anxiety. There is usually little or no attempt to evaluate the *goodness of fit* between the new structure and the emotional task of caring for ill patients. Risk assessments working out the impact on the whole system are almost non-existent. Negative consequences are numerous because there is little attempt to foresee or pre-empt them. This evangelical approach could be interpreted as a manic defence that seeks to deny the complexity of providing healthcare to people who may suffer and die. There is a lack of understanding, a lack of thoughtful connection – a lack of kindness in the way the organization as a whole is treated.

There are then profound and powerful processes working against intelligent kindness. These are deeply rooted in public and institutional life, and unmanaged, if not significantly restrained, they present a dangerous pull away from kindness. These societal processes and cultural preoccupations may be to some extent unavoidable, but their power to pervert organisational culture cannot be underestimated. Many of the defensive and destructive dynamics in the system have been explicit theses long available for public discourse: yet, as a society, we appear unable to learn from past experience, let alone bring this understanding effectively to bear on present behaviour.

There is little doubt that the communalism and spirit of co-operation that provided the value base for implementing the NHS in the aftermath of the Second World War has been steadily encroached upon by individualism and consumerism in the intervening years. In her book, *The Perverse Organisation and Its Deadly Sins,* Susan Long describes a move in society from a culture of *narcissism* to a culture of *perversion* (Long 2008). Perversion flourishes where *instrumental* relations have dominance – in other words, where people are used as a means to an end, as tools and commodities rather than respected citizens. It is these relations that Long sees predominating increasingly in modern organisations. Her book researches large private corporations rather than the public sector but the corporatisation of

the public sector means much of the thinking in her book is relevant to the modern Health Service.

Perversion is about seeking individual gain and pleasure at the expense of the common good, often to the extent of not recognising the existence of others or their rights. Perverse individuals do not see themselves as such and many of them appear to others as 'kind' – Harold Shipman being the most extreme example.

It is important to realise that Long's emphasis is on perversity displayed by institutions, rather than by their leaders or members. There is no suggestion that individual NHS workers, as people, are any more perverse than workers in any other organisation. Nevertheless, in reality, an organisation and its members are entwined: the decisions and action of individuals are influenced by organisational culture, and, in turn, reinforce it, for good or ill. Perversion may seem a strong word to associate with the health service but it does shed light on frankly exploitative behaviour and helps explain how many people in positions of trust end up abusing those positions and how people may be collectively perverse despite individual attempts to be otherwise.

A core aspect of perversion is the capacity of the individual or the organization to 'turn a blind eye', to know and not know at the same time. Such blindness – at least unconsciously wilful – is horribly evident in the stories of neglect and abuse from the Francis Report.

What happened in Mid-Staffordshire well illustrates the forces at work in today's NHS which can pull in the opposite direction from kindness. Two major intertwined processes at work are *industrialization* and the introduction of the *market economy*. Their combined effect can have unintended consequences that reinforce the pull towards perversion. Over the last 50 years, the huge increases in complexity, therapeutic interventions and diagnostic technologies have gone along with the need to manage limited resources, to shift the focus from caring for individuals and their families to that of organising care to meet the needs of the many. Clearly, such 'scaling up' of the focus is inevitable as part of the NHS's commitment to provide healthcare for the whole population. However, the potentially dangerous effects of the manufacturing model need recognition. Industrialisation has the potential to undermine healthcare as work undertaken by skilled individuals in relationship with patients, and to turn it into the mechanical delivery of processes and systems.

A powerful driver towards destructive industrialization, with its roots in much wider social processes, is that of *commodification.* Driven by consumerism and market thinking, healthcare can become the business of planning and delivering fragmented, costed and manualized *inputs*, of time, skill and intervention by production line operatives, to deliver equally fragmented *outcomes, outputs or 'results'.* The need to be able to organize, ration, cost or plan care slips insidiously into colonizing the thinking and attitudes of people with the danger that their capacity to engage intelligently and skilfully with people and their ill-being is overwhelmed. There is a danger of reinforcing the role of patients as consumers and healthcare staff and their organisations as competing commodity manufacturers; a danger that the competitive market introduces more instability and sets different parts of the system against each other; and a danger that anxiety in individual staff members and in the system as a whole crowds out altruism and pulls attention further away from the patient.

Neither industrialization nor the market in themselves are necessarily perverse. To an extent, they are natural in a mass culture. It is the lack of debate and ill-considered way in which their discourses infect the healthcare environment and its culture that can instrumentalise and dehumanize the relationships involved. As Michael Sandel has famously said *we are in danger of drifting from having a market economy to becoming a market society* (2009). There is widespread failure on the part of politicians, policy makers, regulators and managers to differentiate the market from the task, and to protect the healthcare relationship from such degradation.

The pressures that pull people away from kindness are unlikely to go away but we all have a responsibility to work to counter their dangerous effects in daily life. In general, the NHS gives little thought to group dynamics and how to get the best out of its teams. Too often, structure and culture impede rather than enable good team working. Healthcare staff all have emotional needs that will be stirred by their work. One way to facilitate the emotional work of teams is to set up supportive groups for staff but even in the mental health world, these are few and far between, despite considerable evidence that they are helpful. Crucially, the importance of 'emotional work' needs to be recognized at every level of the health service with better understanding of the emotional task involved and how this impacts on the culture.

The French philosopher Paul Ricoeur talks about the loss of *ethical intention* in public life and the threat to kindness, care and generosity as the market culture becomes more dominant. There is a strong argument that there are worrying perverse incentives operating within today's NHS that undermine its ethical intention. These are known about on many levels but a blind eye is deliberately turned. Professionals need to face-up squarely to what is happening and organize more effectively to challenge such threats. My hope is that articulating a clear picture of intelligent kindness illustrated by the virtuous circle described in this paper could provide a touchstone*,* strengthening relationships with colleagues and patients and counteracting the pressure to adopt instrumental attitudes to the work. The possibility emerges of a kinder culture developing as all aspects of the NHS are scrutinized in terms of how they support this virtuous circle.

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