The Many Meanings of ‘Quality’ in Healthcare
Interdisciplinary Perspectives
A Cumberland Lodge Colloquium, 4 June 2013
Report of the Cumberland Lodge Colloquium
The Many Meanings of ‘Quality’ in Healthcare: Interdisciplinary Perspectives
written by the Organising Committee

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Executive Summary

This conference brought together academic scholars, healthcare professionals and lay representatives to reflect on the notion of ‘quality’ in healthcare. Delegates represented a wide range of disciplines including: medicine, nursing, social sciences, philosophy and ethics, sociolinguistics, health and social policy; anthropology; media and arts; medical education.

In the opening keynote lecture, Dr Iona Heath reflected on the tendency of quality initiatives to address the human being as an object, thus marginalising the subjective experience of illness and care-giving, with unwelcome consequences. Three parallel streams of oral presentations followed, organised by conference themes:

- Professionals and patients: collaboration and communication in delivering quality healthcare.
- Improving quality of care: management, governance, standards and accountability.
- Professional values and their relationship to quality in healthcare.

The second keynote speaker, Dr Jocelyn Cornwell, discussed patients’ experience and human factors in healthcare delivery and policy. Offering insights into why failures of care might arise, she suggested approaches which may ensure that both the relational and transactional elements of patients’ experiences are addressed in complex healthcare environments. A series of interactive workshops followed, including one focusing on patients’ experiences of care and the meaning of ‘recovery’ in the context of chronic disease and addiction. Another considered the challenges of practice from a creative perspective. Throughout the day, delegates viewed research posters and exhibits of reflective writing and artworks. The event ended with philosopher Dr Havi Carel speaking about epistemic injustice and epistemic virtue in healthcare.

Delegates reflected critically on whether, how and to what extent current efforts to achieve quality of care are successful. A number of key interrelated themes emerged. Many presentations highlighted a range of important tensions as relevant to the meaning of ‘quality’. Delivering healthcare involves oscillating between a range of different (and apparently contradictory) notions of ‘quality’ — a delicate balancing act. An important aspect of professional practice is that of working creatively with these tensions, exercising judgements in particular situations of care. Supporting such professional practice requires robust organisations which are stable enough to foster relationships of professional trust, but flexible enough to allow for this responsive, creative work.

A second theme to emerge was a call for more description and less measurement. Attempts to measure quality of care were regarded as unreliable, and many delegates expressed concern that current quality initiatives focus too readily on those aspects of care which are measurable, risking the marginalisation of ‘humanity’ in healthcare. The importance of description and narrative to engaging affectively with patients’ experience was seen as important not only to patient care, but also to research and education. There was concern that the time and space necessary for innovative, creative approaches to delivering excellence in care were being ‘squeezed out’ and replaced by a range of ‘quality’ initiatives which sit uncomfortably alongside professional conceptions of excellence. Learning to think critically, reflect on practice and act morally was identified as the key to delivering quality care. It was suggested that greater value be given to educational activities which encourage an examination of practices with these in mind. Finally, the word ‘trust’ sat alongside ‘quality’ in many colloquium discussions. A fragile phenomenon, it was identified as centrally important to both professional—patient relationships and professional team-working.
The Many Meanings of ‘Quality’ in Healthcare
Interdisciplinary Perspectives

Introduction

“The Many Meanings of ‘Quality’ in Healthcare: Interdisciplinary Perspectives” was a one day conference held as part of the Cumberland Colloquia programme. This programme offers early career researchers the opportunity to organise an interdisciplinary, inter-institutional conference which addresses an issue of contemporary ethical relevance, with an aspiration of enabling conversations to happen that might not otherwise happen.

This report is a summary of the proceedings of the colloquium, the discussions and some of the themes which emerged from the day’s events. The conference was organised by: Deborah Swinglehurst (Queen Mary, University of London), Nathan Emmerich (Queen’s University, Belfast); Jo Maybin (King’s Fund); Sophie Park (UCL), and Sally Quilligan (University of Cambridge) with the support of Cumberland Lodge staff. It was held in association with the Royal Society of Medicine Open Section and was supported financially by the Wellcome Trust.

The main aim of the colloquium was to bring together academic scholars, healthcare professionals and lay representatives to ‘unpack’ the notion of quality in healthcare and to reflect critically on whether, how and to what extent current efforts to achieve quality of care are successful. We hoped that by bringing together an eclectic mix of perspectives we may make some progress towards identifying key themes which might inform efforts to deliver and evaluate quality of care in practice.

The 67 delegates came from a wide range of disciplinary backgrounds and professions including: medicine, nursing, social sciences, philosophy and ethics, sociolinguistics, health and social policy; anthropology; media and arts; medical education. They included eight students, five of whom received competitive bursaries to present their work.

The programme included: two keynote lectures followed by open plenary discussion; three parallel streams of oral presentations, each chaired by an invited discussant; three parallel interactive workshops; presentations of research posters, art, artefacts and reflective writing; reflective activities and opportunities for both formal and informal discussion, including a lively discussion on Twitter. The colloquium culminated with a public lecture given by Dr Havi Carel (Bristol) on epistemic injustice and epistemic virtue in healthcare.

Background

Healthcare professionals, policymakers, patients and carers want a health service which delivers high quality care, staffed by professionals striving for excellence. But what do we understand by the term ‘quality of care’ and what does it mean to these different stakeholders? ‘Quality’ is a curiously amorphous word and one which is difficult to define, and yet it is one which has become a major policy driver and has considerable rhetorical leverage, and one which undoubtedly deserves our attention.
Recent policy initiatives intended to improve the quality of care include incentivising doctors to meet defined quality standards and an increasing emphasis on accountability and regulation of individual professionals and healthcare organisations. Informing this drive towards standards and standardisation is a particular notion of ‘quality’ in care – and how to assess it – which may or may not resonate with the professional aspirations of clinicians or the needs of patients. For example, most guidelines and care pathways assume a ‘single disease’ model – problematic not only in being disease-centric (rather than person-focused) but also because multimorbidity is becoming ever more prevalent, as is the experience of health problems alongside complex social challenges in a society marked by ever widening inequalities. Standardised protocols fit poorly with the complexity of patients’ lives and the inherently ‘messy’ and uncertain nature of care giving.

In contemporary healthcare settings, the asiduous pursuit of quality, its documentation and assessment may leave little room to reflect on what lies at the core of high quality care. Concern for the quality of care often becomes translated into a concern with particular facets of care – primarily those which can be quantified, measured, monitored and expressed in the setting of targets. Amidst all the effort which is invested in the pursuit of quality care, how confident are we that there is a close match between our metrics and the properties which we seek to measure, and enhance? How and to what extent can we measure quality of care in its complexity, and are such measurements desirable? What are the ethical implications of introducing financial incentives as a means to achieving ‘quality’ in healthcare and how is this shaping care practices? What are the trade-offs in privileging one account of quality over another and what are the moral implications of this? What are the professional and lay values which underpin quality of care in its most holistic sense? How can we involve patients in quality initiatives? How do we educate students and professionals for ‘quality’? How do we reconcile different ideological perspectives on quality whilst being able to reassure the general public that acceptable professional standards of care are being upheld?

This colloquium provided an opportunity to address and debate complex questions such as these, and to examine the contribution that different professional, academic and lay perspectives can bring. Three conference themes were identified, and oral presentations were broadly organised into these three themes. However an explicit focus of the event was to encourage participants to consider how these themes interact and ‘speak’ to each other, identifying the tensions and synergies across and between themes. Several presentations actively explored these tensions and synergies, and presentations included those that took a theoretical, philosophical or ethical stance as well as those based on empirical research, or application of research findings in practice. The conference themes were:

A. Professionals and patients: collaboration and communication in delivering quality health care. In this theme delegates explored the role of communication between healthcare professionals and patients, as well as inter-professional communication, teamwork and peer support in the delivery of a quality health service. Attention was also given to patients’ involvement in efforts to improve healthcare quality.

B. Improving quality of care: management, governance, standards and accountability. In this theme presentations explicitly addressed issues such as the management of healthcare and its governance, professional accountability and the role of regulatory bodies and procedures in healthcare delivery. A number of papers brought a critical perspective to the dominant emphasis on standardisation, formalisation and ‘measurement’ of quality, or sought to reconcile the tension between important – perhaps un-measurable – aspects of care quality and the need to ensure that acceptable professional standards are indeed being met.

C. Professional values and their relationship to quality in healthcare. The focus of this theme was the role of ‘professionalism’ and professional values in healthcare practice and how these relate to quality of care. It included work which focused on the education of students and healthcare professionals for ‘quality’, and included initiatives to support professionals with ongoing reflection activities both as individuals and within the multidisciplinary team.
Keynote Presentations and Public Lecture

Our speakers were invited to present their perspectives on the meaning(s) of ‘quality’ in healthcare, speaking broadly to our conference themes and also to how the themes interact with each other – the tensions and synergies. They were selected to represent a range of disciplines (including medicine, philosophy, and social sciences). Collectively their expertise spans: primary and secondary care contexts; professional practice; research; health policy; education; patient experience; service development, and more besides.

Arm in arm with righteousness

Dr Iona Heath

In the early twentieth century, Joseph Conrad (1913), whose words provided the title for the opening lecture, considered ‘thrift’ to be the catchword of the time. Today, Dr Iona Heath (RCGP, London) says it is ‘quality’ – a word which has become so taken-for-granted that we rarely stop to examine what it means, and too often it becomes a slogan for the exercise of power.

Dr Heath’s opening lecture built upon her observation that a human being is both a subject and an object. Within the consultation, doctors and patients oscillate between perceiving the body as subject (focussing on what is unique and particular: life context, story, meaning) and object (seeing only what the patient has in common with other patients). When it comes to ‘quality’ initiatives in healthcare, she suggested that although it may well be easier to address the latter than the former, in doing so we lose sight of what is actually going on in healthcare, and marginalise the human subject – both patient and doctor, with unwelcome consequences.

Heath suggested that the use of computers is driving an obsession with measurement, and that this is being used in a normative and coercive way, defining and demonising ‘deviant’ behaviour (be it patient or professional), whilst at the same time re-framing disease definitions in terms of biometric measurement rather than patients’ subjective experience of symptoms.

Critical of the shift towards redefining biological variation as deviant biometric statistics – and the limitless opportunity this provides to the pharmaceutical markets – she cautioned that society’s unwillingness to leave anything to chance (and doctors’ collusion in this) poses a real threat to the provision of universal healthcare.

She described the Quality and Outcomes Framework (QOF) – in which doctors are incentivised against particular indices of ‘quality’ care – as a marker of the growing ascendancy of the body as object over the body as subject in UK general practice, and cautioned against the use of measures which are held to be universally applicable whatever the particular circumstances of an individual’s life. The systematic extrapolation of the evidence upon which many of the QOF indicators are based beyond its original range is, Heath argued, a ‘serious cause for concern’. Such systems also allow the ‘ossification’ of evidence, even as more robust, conflicting evidence is forthcoming, allowing for perverse effects such as the financial reward of practices now known to be harmful. Sharing with us the story of a particular patient with complex, multiple, interacting health and social problems, she challenged us to consider the appropriateness of targets such as ‘blood pressure control’ as a reflection of the quality of care such a patient might experience.

Describing the essence of good care as – to all intents and purposes – unmeasurable, Dr Heath quoted Mol (2006) “Even if good care strives after good results, the quality of care cannot be deduced from its results. Instead what characterises good care is a calm, persistent but forgiving effort to improve the situation of a patient or to keep this from deteriorating”. It is time, according to Heath, for: more description and less measurement; patients and doctors to be treated as ends and not just the means to some other purpose; a richer appreciation of the role of judgement and the importance of human relationships in healthcare; valuing the role of reflection and learning in practice.

The lecture concluded with a solemn warning. We currently waste time, effort and money collecting data and pursuing targets. In doing so we not only risk losing sight of the suffering human subject, but in our assiduous attempts to measure quality, instead we destroy it.
Dr Jocelyn Cornwell

Dr Jocelyn Cornwell (King’s Fund; Point of Care Foundation) began her presentation by describing some shocking examples of clear failures of care delivery in three different NHS hospitals, spanning forty years, and arising in both long stay institutions and (more recently) in the acute sector. Against this backdrop, she offered insights into why such failures may arise and suggested approaches which may reinvigorate the ‘care’ in healthcare.

As the title of her presentation implies, Cornwell suggested that failures—including harmful abuse of patients—may arise in part because of deeply embedded normative social structures within organisations, coupled with the inevitable vulnerability of patients who are ill and lack social power. The institutional ‘denial’ of such failures (“both knowing and not knowing”) is, she explained, impossible to understand in rational terms, but may arise out of individual and collective attempts to manage compelling and yet conflicting emotions in an environment where ‘illness’ (paradoxically) is very rarely explicitly discussed. Poor practice, dysfunctional teams, and unkindness can become a fact of the workplace, and the tension inherent in witnessing this situation is often most challenging for those who are poorly paid and poorly supported e.g. healthcare assistants.

Drawing on Menzies Lyth’s seminal study of a hospital nursing service, Social Systems as a Defense against Anxiety (1960) Cornwell described a range of institutional structures (structural defences) which may emerge out of attempts to protect staff from anxiety, but which can ultimately lead to dysfunctional organisations and poor care e.g. splitting of the caregiver-patient relationship and avoidance of continuity through organising work by task not person; depersonalisation and categorisation (‘bed blockers’, ‘breaches’); purposeful failure to define fully who is responsible for a patient’s care; upward delegation of tasks; disallowing the exercise of discretion.

Presenting King’s Fund research conducted in four acute hospital trusts, Cornwell explained that there is no shared language for talking about the quality of the care experience across different groups of healthcare professionals and managers. The research showed that terms such as ‘basic care’, ‘patient-centred care’, ‘personalised care’, ‘customer’ held very different meanings within different groups. However, words that privilege human values and behaviours (e.g. dignity, empathy, listening, welcoming) over corporate concerns were universally preferred.

Cornwell identified the ‘patient experience’ as comprised of both transactional elements (e.g. access, physical comfort) and relational elements (e.g. communication, emotional support, respect for values) but pointed out that performing well at both of these simultaneously has proved difficult to achieve. She was critical of attempts to apply techniques used in manufacturing and the industrial sector (e.g. “lean manufacturing”), arguing that the pure application of process engineering without reference to the human being is particularly problematic in a context as complex as healthcare (“What’s the difference between a hospital and a bottling factory?”). She was also critical of the tendency to delegate patient and public involvement (PPI) activities to small teams of people with low status in organisations, a strategy which often proves ineffective. Instead, she argued persuasively for approaches such as experience based co-design, in which the focus is on things which really matter to patients, complete with a warning that genuine patient-centred care may be “the most disruptive innovation in healthcare” as it upsets existing structural defence systems in ways that people are afraid of. She also introduced Schwartz® Center Rounds as a valuable way of restoring the human dimension to care, providing support to staff from all disciplines to discuss difficult emotional and social issues arising from patient care. Dr Cornwell concluded with a provocative call to action: “We can be reassured when we see that more GPs and Trusts are chronically anxious about patients’ well-being.”
Public Lecture

“It’s got nothing to do with your lungs”: epistemic injustice and epistemic virtue in healthcare

Dr Havi Carel

Drawing on phenomenology and illustrating her lecture with personal stories of her own healthcare experience, Dr Carel introduced us to the notion of epistemic injustice (Fricker 2007) – wrong done to someone specifically in their capacity as knower. She suggested that there are structural norms in our healthcare system which may sustain and reinforce epistemic injustice, and highlighted the importance of paying close and genuine attention to patient testimonies and to the notion of illness as embodied. This orientation, she argued, might go some way towards closing the gap between patients and healthcare professionals in terms of hermeneutic resources, contributing significantly to quality of care. Although not exclusive to healthcare, epistemic injustice is a phenomenon which is particularly important in this context and may arise when patients go unheard, are misheard, or are heard and ignored. Carel described four types of epistemic injustice:

Testimonial injustice arises when a listener gives a deflated level of credibility to the speaker’s word. For example, ill people may be subjected to negative stereotyping and assumptions may be made which result in testimonies being dismissed as emotionally compromised (“too upset to think straight”) confused, or existentially unstable (“we caught him on a good day”).

Hermeneutic injustice describes a gap in collective interpretative resources which puts some person or group at a disadvantage when it comes to making sense of their experience, as interpretations of phenomena are insufficiently informed by the subject group (e.g. healthcare decisions made by the healthy).

Participatory prejudice arises when a person is assumed to lack the necessary capacities to judge what is relevant to an issue in order to participate fully (we were invited to reflect on the participation of patients in the act of diagnosis, for example). Related to this, informational prejudice refers to a refusal to take seriously the ability of the agent to provide information that is relevant to the specific context.

Carel encouraged us to consider the extent to which healthcare professionals are seen as epistemically privileged, by virtue of their expertise and training and how this in turn shapes healthcare policy and practice. This privilege, or asymmetry in epistemic authority, confers on professionals the power to decide which testimonies to act upon.

Carel introduced a ‘patient toolkit’ – grounded in a phenomenological approach to illness – aimed at helping patients to think about and articulate their illness experience, including its impact on life as a whole. She encouraged professionals to actively seek out, recognise, and take seriously the testimonies of patients, whilst acknowledging that structural constraints, such as resource pressures can make this exceedingly difficult. Carel concluded by challenging us to hold onto our humanity, open our eyes to suffering and ensure we do not hide behind the institutional structures that obscure these forms of epistemic injustice; even small acts of kindness really matter.
Oral Presentations

Theme A - Professionals and Patients: Collaboration and Communication in Delivering Quality Healthcare

The first speaker in this panel was Simon Cohn (Cambridge) who introduced the concept of ‘trust practices’, illustrated with data extracts from his research in diabetes. Although the role of trust in healthcare is widely acknowledged and ‘erosion of trust’ is seen as a matter for concern, ‘trust’ remains an under-researched area.

Identifying all aspects of healthcare as ‘intrinsically relational’, Dr Cohn suggested that trust is not a ‘thing’ or a ‘resource’ but is rather a practice, a way of making and remaking meaning, enacted through social encounters and inherently dynamic and distributed in nature. Although trust is widely acknowledged to lie at the heart of doctor–patient relationships, Dr Cohn extended the notion – for example, trust (and distrust) in the health service, the caring professional, the body, the medication. He identified trust as emergent and negotiated, and although highly contextual it is not limited to discrete occasions, nor is the trust relationship necessarily a symmetrical one (“I need to trust my doctor, but my doctor should also trust me to make the right decisions, interpret information reliably and look after myself as best as I can”). Trust may not be explicitly talked about, but might be inferred through particular practices. For example, the use by patients of the word “confess” in the context of a consultation may symbolise a protective and safe environment which enables patients to speak honestly and enter into a dialogue about how they are getting on.

In cautioning against the reification of trust, Dr Cohn also cautioned against any temptation to seek to measure trust, identifying trust as one of a range of significant and important aspects of healthcare, but one that is not amenable to measurement, nor directly observable.

Our second speaker, Charlotte Lundgren (Linköping) is a linguist who works within a cancer care team in Sweden as part of a project aimed at optimising patient care. For two years she attended weekly multidisciplinary team meetings as a researcher, conducting ethnographic and applied interactional research (e.g. discourse analysis and conversation analysis) but through this activity she has now successfully (and perhaps unusually) established herself as an integral team member, beyond her research funding period.

In team meetings Dr Lundgren brings her expertise as an applied linguist, facilitating discussion about what she observes in the interaction between different team members, and bringing theoretical perspectives which are novel and lie beyond those traditionally understood by the multidisciplinary team. Examples include Goodwin’s notion of ‘professional vision’ (1994) and Wenger’s notion of ‘communities of practice’ (1998). Lundgren explained how particular interactional strategies she had observed could be seen not only to improve the quality of clinical decision making, but also to contribute to the development of the team. She told the story of the team’s changing dynamics; working through differences; new ways of working together; new identifications of ‘what matters’; and the gradual breaking down of established norms arising from notions of ‘them’ and ‘us’.

Lundgren suggested that in evaluations of the success of multidisciplinary teams it is important to consider not only patient outcomes but also the collaborative efforts of the team itself, since these are crucial to healthcare professionals’ ongoing sense of doing a meaningful job. She concluded by advocating much closer working between applied linguists and healthcare professionals arguing for its potential to unearth important aspects of healthcare practices and teamwork that might be otherwise overlooked.

The final speaker was Sally Hull (Queen Mary University of London), a GP and primary care researcher who is working on a community arts project with a sewing group for Bangladeshi women in East London as they co-create embroidered health messages for display within the Centre for Primary Care and Public Health (QMUL). Illustrating her talk with an example of the group’s embroidery (see Figure 1), Dr Hull explained...
how the sewing project is an opportunity to explore with participants – over many weeks – their understandings of key health areas such as: preventing diabetes; exercise; the importance of vitamin D.

Bridging the gap between the inside of medical buildings and communities outside, and between public health and society, the project is successful in reaching a group who might be otherwise difficult to access and who may find communication in the hurried encounters of the health service problematic. It offers a creative space which facilitates more detailed, context-specific and locally relevant discussion of important health topics than might be achieved in the doctor’s surgery, emptied of the traditional power relationships which this entails. It thus offers scope for deepening understandings, and contributes in a novel way to their quality of healthcare experience.

Amongst the key outcomes of the project are its promotion of in-depth discussion about health issues which are of particular relevance to the Bangladeshi community; the development of language skills and social capital; sharing of recipes and tips on reducing dietary fat intake; the development of a peer support group… and of course the enduring embroidered artworks, which we were all able to enjoy. In addition, as

Dr Jonathan Silverman, who chaired this session, remarked on the different conceptions of collaboration in the context of delivering quality in healthcare, and how an apparently disparate set of oral presentations had succeeded in bringing to the foreground the importance of practical trusting relationships to this endeavour. He thanked the speakers for encouraging us to consider what it is that engenders trust and how this plays out in practice, and for reminding us that in working together we may achieve more than is possible as individuals.

**Theme B - Improving Quality of Care: Management, Governance, Standards and Accountability**

Dane Pflueger (LSE) opened this session by reflecting that quality improvement efforts in NHS organisations often have perverse effects. For example, performance management systems which decouple ‘quality improvement’ from activities believed to constitute caring can lead to dysfunctional behaviours by staff and new risks. The typical management and policy response to such problems is to classify them as ‘implementation issues’, which can be solved through tweaks or additions to existing ‘measure and manage’ instruments. Pflueger offered an alternative response. Drawing on pragmatist philosopher John Dewey’s Theory of Valuation (1938), he described how the ‘value’ of an activity may be understood both in terms of existing wider values or ideals (such as what is right or wrong), as is often assumed by quality improvement efforts and the sensation of value as experienced by those who are participating in the local activity (which may lead to a focus on staff and patient experiences of care). Pflueger suggests that by taking seriously both of these theories of valuation in quality improvement efforts, an alternative set of design principles for quality improvement could be developed. For example, standardisation drives would be balanced with an attention to local experiences, and conflicting information about care
quality could be understood as a source of insight into alternative conceptions of quality, rather than necessarily resulting from error.

Alicia Renedo (LSHTM) reported on a study conducted with Cicely Marston into the organisational factors which facilitate public and patient involvement (PPI) in quality improvement programmes. Through an ethnographic study of PPI in programmes led by the North West London CLAHRC (Collaboration for Leadership in Applied Health Research and Care), Dr Renedo illustrated the importance of cultural resources in enabling patients and the public to participate meaningfully in quality improvement efforts. Her research found that the discourses surrounding quality improvement programmes and the PPI agenda were used by PPI participants as symbolic resources through which they could make sense of their involvement in improvement programmes, and also reconfigure their individual patient roles in the context of their own healthcare. Renedo and Marston drew on the work of socio-cultural psychologist Tania Zittoun and sociologist Pierre Bourdieu to explain how moving to new ‘fields’ or spheres of experience can create ruptures in individuals’ knowledge and identities as patients (‘habitus’) and also to elucidate the ways in which such symbolic resources can help facilitate these transitions resulting in patients’ active and legitimate participation in both the activities of the CLAHRC and in their own care.

Ross Millar (Birmingham) discussed the challenges faced by NHS hospital boards who have fiduciary responsibility for their organisation’s safety of care, citing evidence of failures at Mid Staffordshire NHS Foundation Trust to support the need for improvement by boards in this regard. Dr Millar highlighted that research and thinking on clinical governance suggests that policy directives which promote external accountability through regulation, performance management and targets can have unintended consequences, crowding out the altruistic motivation of healthcare professionals and fostering a (potentially) false assurance by hospital boards that systems and processes are working as they should be (Francis 2010). Critical of the limitations inherent in hospital board oversight becoming narrowly focused on building ‘confidence’ in the performance of systems, Dr Millar called for a need to re-engage with governance perspectives that emphasise the development of trust based relationships. Drawing on the work of Carole Smith (2005), he argued that effective boards are those able to effectively combine ‘trust’ – characterised by ethical forms of leadership attentive to staff and patient needs and concerns – with ‘confidence’ built on intelligence gathered from national and locally generated information sources. He concluded by setting out the case for re-evaluating hospital board oversight in light of these different perspectives, identifying interventions which support a re-balancing towards a trust based approach.

In summing up the session, Kath Checkland (Manchester) drew attention to the commonalities in the pairings used in the papers by Millar and Pflueger, and in Iona Heath’s keynote speech: in discussing quality in healthcare, tensions emerge between the objective and subjective; between local experience and abstract or nationally-determined values; between the measurable and the unknowable; and between confidence and trust. Such tensions are not only problematic; they also engender creativity. Dr Checkland also reflected on the importance of ethnographic methods to the insights produced by the papers, pointing out how improvement science holds in high esteem traditional hierarchies of evidence, which undervalue this form of knowing. She drew attention to the importance of creating space for reflection in organisations; and to the rhetorical power of managers and policymakers employing the word ‘quality’, making it difficult for professionals to question or challenge management interventions which they feel may actually be counter-productive. Dr Checkland suggested that offering space for individuals to share their stories of what ‘quality’ is, combined with professional courage to challenge normative policy assumptions, it may be possible to foster ‘virtuous circles’ and harness creative ways of achieving quality healthcare.
Theme C - Professional Values and their Relationship to Quality in Healthcare

This session was chaired by Dr Michelle Farr (Bath) and brought together delegates interested in how an understanding of professional values might inform our understandings of quality in the healthcare context.

Suzanne Shale (Oxford, King’s College London) opened the session, presenting work which she has carried out with Murray Anderson-Wallace. She challenged us to consider ‘What is ‘quality’ in the aftermath of healthcare harm?’ Acknowledging that no healthcare system will ever be completely ‘harm free’ Dr Shale suggested that commitments to ethical principles such as ‘first, do no harm’ and to ‘zero harm’ environments of care mean that what constitutes quality of care in the aftermath of harm is rarely considered directly. The presentation included a short video called ‘Alexandra’s Story’ (from www.patientstories.org.uk) which had featured on The Guardian website one week prior to the conference. Building on this, Shale explored the interconnected nature of the three conference themes and presented some possible ‘quality criteria’ for the management of care harms, as a starting point for opening up a conversation about what such criteria might look like. She referred to recent work by Lord Darzi in this area, and argued that in the aftermath of healthcare harm professionals and patients need appropriate support. She felt that whilst an objective and neutral examination of what had happened was important, this version of the truth should not be used to obviate the need to consider the experiences and perspectives of the individuals concerned. Patients and their families need to feel that their concerns have been heard, rather than dismissed as a ‘freak occurrence.’

Chris McLean (Southampton) presented a paper based on his ethnographic research of critical care nurses working in intensive care units. Healthcare policy suggests that quality of healthcare depends on practitioners thinking about patients as ‘whole persons’ – an orientation which is argued to be particularly characteristic of nursing practice. Dr McLean’s analysis revealed that nurses working in this context think about patients in seven distinct ways, as: ‘social beings’; ‘valued individuals’; ‘routine work’; ‘set of needs’; a ‘body’, (un)stable; a ‘medical case’.

None of these equate simply to the notion of caring for the patient as ‘whole person’.

Nevertheless, in constructing their own professional identities, nurses were committed to the concept of the patient as ‘whole person’ and worked hard to reconcile this with alternative constructions of patients, in a care context predominated by technical and biomedical activity, and where early signs of recovery result in a patient’s transfer out of the ward. McLean argued that in practice, the ‘holistic’ conception of the patient was problematic and that it was necessary for professionals to oscillate between different constructions of the patient, in order to accomplish the tasks of care. He questioned whether a set of defined ‘core values’ is necessarily applicable across all healthcare disciplines and suggested that more should be done to ‘rethink’ how nursing work (and indeed medical work) is actually done in practice and what this means for notions of ‘quality’ in the caring professions.

Dr Julie Wintrup (Southampton) was our final speaker in this session, and she called for a radical rethink of ethics education in healthcare, identifying a ‘mismatch’ between conceptions of ethics as found in formal moral philosophy and the real world practices of healthcare professionals. The latter, she argued, demand a refocusing on creating the conditions for acting morally as well as thinking critically. Applied ethics can seem abstract, formal and divorced from real-life experiences, disconnected from the embodied and highly inter-subjective dimensions professional practice, especially in the context of healthcare. For example, the healthcare professional has to balance potentially contradictory aspects of their role which simultaneously requires them to be both ‘objective’ as well as ‘affectively engaged’ – a process which involves moral work. Wintrup suggested that more needs to done to move beyond the dichotomy of formal training (in applied ethics) and informal moral socialisation, concluding that the education of
healthcare professionals should involve the reflexive examination of the social, cultural and political context in such a way as to foster appreciation of these as integral to the moral landscape of care. In this way the critical function of applied ethical thinking may be more fully situated in practice.

A lively discussion followed the presentations, in which healthcare was acknowledged as a professional site of both help and harm, and one in which clinical wisdom involved due acceptance of responsibility for self as an agent of potential harm. Delegates discussed what the appropriate professional response to this might be. In particular, the parallels between the experience of patients and professionals in the context of both healthcare ‘quality’ and healthcare ‘harm’ were noted to be profound, the implication being that both groups need to be able to voice their concerns, ideally within a framework of morally equal dialogue.

**Workshops**

Workshops were designed to enable conference participants to reflect critically on the notion of ‘quality’ in healthcare practice by:

- exploring the narratives and experience of patients (workshop A)
- sharing the experience and understanding of professionals from different disciplinary backgrounds (workshops B and C)
- engaging with creative media (workshops A and B)

**Workshop A: Re-viewing Recovery: Personal Realities of Quality of Healthcare**

This session encouraged participants, who included clinicians, medical students, researchers and policy-makers, to reflect on their own personal experiences of illness and recovery in dialogue with three ‘experts through experience’ of illness and addiction. Anya de Jongh, a young woman who has recently been to medical school and now lives with several long-term health conditions, described how recovery for her requires changes to attitudes, values, feelings, goals, skills and roles. In biological terms she cannot ‘recover’ from her condition (though insights from biology enable her to continue to live); the focus for her must be on the quality of the life she lives in the context of her condition. Anya described this as giving up on “waiting for the storm to pass” and instead refocusing on “learning to dance in the rain”. Recovery for Anya is about learning to juggle what is good for her personally, mentally and physically. She said if she could invite anyone to a final dinner party, she would invite her counsellor, GP, consultant, physiotherapist and specialist nurse, since it would make them all see the multiplicity of challenges she has to deal with. Anya also described recovery in terms of a journey rather than a destination; she will always be in the process of recovering, and learning to live within the limitations of her illness. This requires self-management, not as an alternative to care from the health service or peer support, but in combination with – and made possible by – that ongoing support and facilitation.
On first appearances, the personal experiences of recovery from alcohol and heroin addiction described by Cindy Reay and Toby Peters had little in common with Anya’s story. And yet parallels between the three quickly emerged. Cindy and Toby, who are both now support workers at FLACK (a Cambridge-based listings magazine written and produced by members of the city’s homeless community), described in candid terms the personal, social and psychological turmoil involved in their experiences of both addiction and recovery. Cindy pointed out how addiction is not a choice an individual takes one day, but rather a drawn-out process; and how ‘recovery’ is not a permanent state to be reached, but how as a recovering addict, each day involves battles and choices. Toby emphasised the impact of losing family, friends and lovers through addiction, and how peer-support and love had proved critical to his recovery. His experience had been that doctors had told him how he would die, but had not shown him positive ways in which to live. Seeing and supporting other individuals to recover through his work was an important part of Toby’s ongoing wellbeing. Kirsten Lavers, creative director of FLACK, described how her experience of watching and supporting friends and colleagues in recovery from addiction had led her to see the process as having similarities to her own experiences of bereavement. Recovery (and not just addiction) involved loneliness and heartbreak. A series of short films produced by people at FLACK demonstrated the emotional intensity of these processes.

Dr Sally Quilligan (Cambridge) who facilitated the workshop, drew together closing comments from participants about the issues these stories raised in relation to the conference theme. Participants reflected on the importance of warmth, love and care for supporting recovery as an on-going process, and questioned what could realistically be provided by the NHS, and what ought to be on offer from alternative providers. The importance of listening to patients in clinical encounters was brought to the fore, and recognised as a critical aspect of the quality of care, but one which may be difficult to measure. The different life experiences of the contributors and the nature of their illnesses drew attention to the need for clinicians to recognise that people start in different places and have different desired endpoints; and that services should be both stable and flexible if they are to properly serve individuals with chaotic lives, who may be in the greatest need.

Workshop B: Creative ‘Quality’? The Challenges of Practice

This workshop, facilitated by Dr Jean Carabine (Open University), was an opportunity to explore ‘quality’ from what was, for most, an unfamiliar disciplinary perspective. Carabine began by describing her own journey as an artist, including her transition from working with a familiar to an unknown medium (oils) as she sought to negotiate a process of ‘letting go’. She used images of her art to illustrate her narrative, highlighting the importance of ‘negative capability’ (Keats 1817) – ‘when man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason’ – the artist’s receptiveness to transcend what is thought possible and go beyond current contexts and constraints. She described the mental and emotional anxieties associated with ‘letting go’ in the production of authentic, high quality work – for example: being able to stay with feelings of failure or uncertainty; tolerating the strain of ‘not knowing’; risk-taking; high levels of excitability; creating spaces for nothing or ‘no-thing’ (Bion 1962); exploring what emerges during the creative process. In the discussion that followed, participants reflected on the production of quality in a context where the ‘finished product’ is not yet known, and on the nature of judgements about quality.

Audiences will respond differently – and at different times – to a piece of art, bringing a range of possible lenses incorporating both the technical and the evoked affective response. An artwork may be technically perfect and yet at the same time fail to evoke the observer’s affective response as an example of high quality art. The context is therefore always one of at least two participants and two (or more) perspectives – a dialogical relationship between artist and audience. The meaning(s) of the painting emerges at the junction, and inherent in this is the potential for tension. There are parallels in medicine. A surgeon might conduct a technically ‘perfect’ operation, but the patient dies. More subtly, in the clinical consultation, meanings are not simply those that are intended by the doctor (or patient) but those that emerge at the interface through human interaction.

Participants then considered the spaces of ‘known’ and ‘unknown’ between professional and patient, or artist and painting. Carabine highlighted the
importance for an artist of ‘trusting the process’ and ‘trusting one’s practice’, creating the best quality that is possible at that particular time, with the tools available. The group discussed the process of transition from novice to expert as a healthcare practitioner, the changing conceptions of quality that this may incorporate, the shifts in orientation towards uncertainty, and the potential to become more creative and flexible as the ability to trust one’s own practices and ‘hunches’ evolves with experience. Although the stakes are different for artist and healthcare professional, there are many potential areas of exchange possible. A contrast was drawn between a doctor–patient and the artist–artwork relationship – one between two people, but requiring constant adjustments of performance in the moment and across consultations; the other creating a tangible artwork open to the judgement of multiple, unknown audiences. The ‘performance’ of the latter is perhaps harder to anticipate or control at the time of its producing, despite an aspiration and commitment to ‘quality’. Who has the authority to define ‘quality’? And how does the process of judging quality differ when its object is tangible (e.g. artwork), or intangible (e.g. the consultation)?

Dr Carabine invited the group to experiment with their own painting, providing brightly coloured paints and shapes to print onto black card. Participants created their own small piece of work and observed their own anxieties implicit within this unfamiliar process. Painting was then done in pairs, with participants responding to the paint strokes produced by a colleague. Participants then experimented with bringing pictures together, identifying continuities and discontinuities between the pieces. A cardboard picture frame was used to view sections of the paintings, encouraging participants to consider the quality of different features or elements, and the relationship between ‘parts’ and ‘whole’, and how this might inform decisions about improving quality in future, whilst also signalling some of the difficulties of maintaining quality when working across different teams and professionals to produce a collaborative outcome (see Figure 2).

The group discussed the implications of using creative spaces for teaching and learning, and explored the appropriateness and possibilities of ‘letting go’ in the context of a healthcare professional. Are there aspects of ourselves that we need to ‘let go’ of as individuals in order to improve the quality of our practice and to foster greater authenticity in our relationships with patients? Some felt that novices required a foundation of concrete and known certainty before being exposed to more creative notions of practice. Others felt that learning should acknowledge and engage with more creative challenges early in the educational process so that students familiarise themselves with the ‘struggle with the self’, the ‘need to be able to fail’ and the state of ‘not knowing’ at an early stage in their career. Many felt that medical education was increasingly constrained by the boundaries of ‘safe practice’ suggesting this minimises opportunities to explore innovative and creative ways of addressing unanticipated and unknown challenges.

The workshop highlighted, in novel ways, some of the principles involved in the construction of notions of quality in education and practice. It also challenged participants to consider the potential value of exploring creative spaces within professional practice, offering a glimpse into the possibilities this may hold for improving quality of care.
Workshop C: Round Table Discussion

Alongside the more structured workshops a small and informal round table discussion was convened by Dr Nathan Emmerich. It involved twelve of the conference delegates and was organised according to the Canberra Rules. Accordingly, participants raised their hand if they wished to make a point and raised a finger if they wished to respond or elaborate on the current point being made. This approach was successful in encouraging interaction between participants whilst also ensuring that individuals could respond to major points before the discussion moved on.

The initial discussion was prompted by a video-cast prepared by Professor Mary Dixon-Woods (Leicester), which was made available to all the conference delegates prior to the event. This focused on how we can know if care is safe. Her presentation noted the statistical fact of ‘adverse events’ whilst noting the methodological challenges raised by attempting to measure such events. Professor Dixon-Woods noted the potential mismatch between the concerns of patients, families, and (at least ideally) healthcare professionals and those things which can be measured. Drawing on a paper by celebrated medical sociologist Prof. Charles Bosk her talk concluded with the suggestion that monitoring the safety of care is not just a technical exercise. We need to attend to how care is negotiated socially as a matter of ‘occupational morality’.

The presentations that the roundtable participants had attended in the morning session were also used as a stimulus to debate and this was a useful way of encouraging discussion within and across the conference themes. Issues of contemporary relevance to the conference theme as a whole, such as the Francis Report into the care provided by the mid-Staffordshire NHS Foundation Trust (2010, 2013) were naturally drawn into the discussions.

Whilst discussion centred on the notion of ‘quality’ in healthcare other terms were frequently drawn into the debate in such a way as to suggest that they are of comparable concern, for example: patient safety; value(s), including professional values; and risk.

Some delegates expressed particular concern for the measurement (quantification) of quality and of care. This led to a reflexive interest in the quality of management in healthcare institutions and more widely in the NHS as a whole. Managers, measurement and audit are all facts of modern healthcare, and as such should be included in the ideas concerning quality of care both in the sense that these aspects of healthcare should be high quality and they should be considered in terms of the contribution they make to quality of care, and its assurance, across the NHS. The question is whether, to what extent and how to make use of instruments and measures in such a way that real quality of care is the norm across the NHS and how to ensure attention is not merely focused on the standardized appearance of quality or on a range of proxy measures of quality. Some participants suggested that it was time to relieve healthcare professionals and NHS managers of the political pressure to prioritise structural demands and standardised measures over the needs of patients, families, professional colleagues and co-workers.
Alongside keynote lectures, oral presentations and workshops there were twelve further presentations, including research posters, pieces of reflective writing and exhibits of art and artefacts. Freya Yoward, a medical student from Bristol, presented research which elicited the views of medical students on what constitutes ‘quality of care’ arguing that the student voice is rarely sought in debates around healthcare provision despite the fact that students are key stakeholders in future service delivery. We were delighted to be able to showcase an initiative that has been running for four years at Manchester Medical School where students can pursue a study module on ‘Narrative Medicine and Creative Writing’. Simon Doyle, one of the students of this course presented a poster (Every Picture Tells a Story) which described the initiative, presented extracts of the students’ writings and brought together some of the very positive student feedback.

Students create a character with a life-changing disorder and write their assignments in character, an experience which students report improves their skills of observation, gives them new insights into the experience of being a patient, and helps them to develop as empathic listeners. Katy Ashton and Rachel Barratt, also students of this course, presented their own reflective writings. Ashton presented a moving poem written from the perspective of a prison inmate (Do I Count?) based on an interview she had conducted with a prisoner and on observations of clinical consultations in the prison context. Barratt presented her characterisation of a patient with frontal lobe damage, and highlighted that her experience of the narrative course had helped her to see the consultation as a joint enterprise or collaborative effort between patient and health professional. This collaborative effort is being explored in detail by Josabeth Hultberg (Linköping) whose close interactional analysis of doctors and patients engaged in decision making about drug prescribing shows just how important is the nature of language to this collaborative effort. In a poster subtitled “The Many Meanings of ‘We’” she presented evidence that in prescribing decisions it is not simply the case that patients and doctors negotiate on treatment, they also negotiate the meaning of ‘we’ and it is this negotiated ‘we’ that is the responsible agent of treatment decisions. Hultberg suggests that any assessment of ‘quality’ in doctor–patient communication should incorporate the interactional analytical perspective.

In another initiative which embraces the work of professional and patient as one of ‘co-production’, Naureen Bhatti (London Deanery) presented some work on the role of the deanery Professional Support Unit, including a range of educational opportunities which focus on what can be learned from patients, especially in the area of clinical communication. The approach encourages reflection on practice within an environment of collaborative peer support. Dorrie Imeson, another Manchester student, presented a poster on the potential of social networking platforms as a place for expression of patient narratives and patient–patient support, suggesting that the sharing of narratives in this way may be of therapeutic benefit to patients, and extending the concept of collaborative work in healthcare to explore the possibilities that new media may offer.

Kristina Bennert (Oxford) presented some qualitative work which investigated the extent to which universal principles or ‘core components’ of good quality care are indeed universally held. A series of focus groups with ‘seldom heard’ health service users (e.g. Irish travellers, homeless people) suggested that while there is considerable agreement that core components are important, there is also considerable variation about priorities within and between different groups of patients, and there needs to be a more sophisticated understanding of ‘what matters’ to patients.

Two of the poster presenters looked at the impact of health policy reforms on ‘quality’ in practice. Based on almost ten years of ethnographic research exploring commissioning in the NHS, Kath Checkland (Manchester) expressed reservations about efforts to define what ‘quality’ in commissioning might look or how it might be measured. By drawing together evidence from a number of projects she raised questions about what commissioning can and cannot achieve, identifying a number of problematic assumptions that underpin the commissioning process, and
challenging us to consider whether we should think of some other way to manage health services. Another presenter, Jonathon Tomlinson (The Lawson Practice NHS), presented his reflections on NHS reforms and suggested that policies which support rising managerialism and result in financial conflicts of interest present serious challenges to enacting ethical standards such as those outlined in the General Medical Council’s Good Medical Practice. Entitled “How to be a doctor and ‘be good’” he suggested that there needs to be a more critical examination of the conditions under which such ethical standards are more (or less) likely to thrive, arguing that the exercise of compassion is the over-riding moral duty of the good doctor and that professional freedom to act in patients’ best interest is vital to this. He put forward a case for exercising professional scepticism, scientific integrity, patient advocacy and critical self-awareness as important facets of ‘good’ doctoring.

There were three presentations of art/artefacts at the colloquium. Sally Hull (p. 9) presented a poster and an example of the embroidery from her project. Designer Alison Thomson (QMUL, London) presented a poster, film and a selection of ‘food models’ (see Figure 3) to illustrate a public engagement project called Digesting Science which seeks to increase the awareness and understanding of research on multiple sclerosis amongst patients with the condition and their families. In this project, clinicians and scientists illustrate aspects of their research through use of food models (e.g. showing how the eye is affected by multiple sclerosis) and patients are invited to ‘dine’ with them, in events which facilitate dialogue about their disease and ongoing research. Alec Logan presented an exhibit entitled “Red Roses” – a small collection of vignettes arising from real encounters with patients in general practice. Written by GPs, the texts invited reflection on a range of complex questions arising in apparently ‘ordinary’ consultations. Beautifully mounted and framed the texts were illustrated by artist Helen Wilson with a series of linocuts. As an authentic illustration of what goes on between doctor and patient, Dr Logan suggested that it is when this collaboration is at its best that the essential ‘quality’ of general practice is realised, each interaction holding the potential to be extraordinary, if only we take the time to appreciate it as such.
Other Activities

Twitter
Participants were encouraged to share their insights and reflections on the day via Twitter, using the hash tag #QualityCL. Overall more than 400 tweets were sent using the tag. The organisers used Twitter to advertise the event (a number of participants later reported that this was how they had learnt about the colloquium), and in the run-up to the day, participants used the hash tag to share the latest information about the programme, and make new connections with other attendees. On the day of the colloquium, participants tweeted key points from presentations to share with their Twitter followers not in attendance (‘Powerful argument that obsession w/measurement constructs patients as disease-bearing objects rather than human subjects’). They also used the medium to raise questions about what they were hearing (‘Is patients dying at home a useful marker of GP quality?’); and to sign-post fellow participants and the wider Twitter audience to related internet resources and research articles and books (for example ‘Dewey = the theory of valuation— and the crackling story http://t.co/jgFgluhFjW’). In the final discussion session of the day the organisers drew on the day’s tweets to identify common themes emerging from sessions. Participants followed up on face-to-face meetings with new colleagues through tweets and shared their feedback on the day.

Reflective exercises
The final session of the day provided a space for participants to reflect as a group upon the day’s themes and its meanings for each participant. Each individual was asked to consider something they had learnt during the day, then something they would like to embed in their future practice. These thoughts were captured on a postcard and sent to each participant eight weeks after the Colloquium event. The discussants from the morning’s oral presentations were invited to summarise the main themes emerging from the sessions, the Twitter contributions were summarised and debated, and we began to reflect as a group on how the day’s discussions might be taken forward together. Like the earlier plenary discussions in the colloquium, this was an occasion for lively conversation, challenging questions and critical reflection. The conversations certainly continued over dinner and, we hope, beyond.

Further Resources

Some presenters have kindly provided resources, including presentations and posters, which are available at www.cumberlandlodge.ac.uk/quality
Key Emergent Themes

It is difficult to capture in a formal report the extraordinary enthusiasm which was brought to this colloquium by delegates. The event was heavily oversubscribed, the long waiting list testament to the timeliness of the colloquium and the importance of the topic. Discussion was at all times lively, thought-provoking, and challenging and the conference theme clearly encouraged very positive engagement from a wide range of delegates. In the feedback we received, participants were particularly positive about the interdisciplinary dimension and the extent to which this contributed to the richness of their learning experience. Amongst some of the outcomes identified by delegates were ideas for research and teaching, new contacts, appreciation of different ways of understanding the ‘quality’ conundrum and − for some − affirmation that their particular area of expertise was of genuine value to the issues in question. We will not attempt to identify all of the themes that emerged through the day’s events, but there were certain key areas of discussion that recurred across many of the different conference activities.

Importantly, these key areas are interrelated. Taken together they suggest the existence of deep professional concern about some aspects of health policy aimed at improving quality in healthcare. We will summarise these here.

Delivering high quality care is a delicate balancing act

Many of the presentations highlighted a range of important tensions as relevant to the meaning of ‘quality’ in care, with a recognition that the experience of care (from both the perspective of the patient and the professional) is one of navigating through (or oscillating between) a range of different and apparently contradictory notions of quality. The implication is that the highest quality of care emerges from a ‘care’-ful act of holding different perspectives in the balance and making wise judgements about the proper course of action, responding to the complexities of the local context and the particular circumstances.

Some of the tensions we explored included: the person as object − the person as subject; biometric measurement − affective engagement; measurement − description; rationality − irrationality; evidence − imagination; treating the person as an ‘end’ − treating the person as ‘means’; knowing − the unknowable; universal generalisation − local particularities; monologic − dialogic; trust in practice − confidence in ‘the system’. The value in rendering some of these tensions explicit is not to suggest that one (or other) of the apparently dichotomous descriptors is better or more useful than the other, but to highlight the importance to professional practice of working creatively and flexibly with these tensions, such that the practice of healthcare is − for each episode of care − one of unique tailoring rather than ‘off the shelf’ one-size-fits-all prescription. It is this responsiveness to the complexities of the situation that marks out the highest quality of care from mediocre care (or worse still, poor care).

Healthcare professionals need to work within robust organisations and services which offer both the stability required to foster relationships of professional trust and support, and the flexibility for this responsive creative work.

A call for more description and less measurement

An extension of the first theme, there was a concern expressed by many delegates that quality initiatives have focused too readily on those aspects of care which are easy to measure, but which (in Dr Heath’s words) “mark the growing ascendancy of the of the body as object over the body as subject” and which risk marginalising the ‘humanity’ from healthcare. Attempts to measure quality of care are unreliable, and policies which focus on external accountability through regulation, performance management, targets can have unintended and harmful consequences, as well as generating a vast amount of (new) work, often in environments in which staff are already overstretched. The quantification of quality, or ‘management by numbers’ by adoption of a range of proxy measures may offer a standardised appearance of quality, falsely reassuring healthcare managers and the public that all is well, whilst at the same time crowding out professionals’ intrinsic motivation to altruistic care which may remain ‘unrewarded’. The de-coupling of QI (quality improvement) initiatives from caring, and the
increasingly complex array of approaches to measuring what is – to all intents and purposes – unmeasurable was widely held by conference delegates to be an unwelcome development in contemporary healthcare. In short, high quality care is immeasurably important…and unmeasurable.

The call for more description and less measurement was articulated by researchers, educationalists, patient representatives and healthcare professionals alike. Several of the research papers presented at the conference used ethnographic methods and narrative modes of enquiry, with a focus on detailed exploration of care practices and management practices. The interest here is on what can be learnt that may be of wider relevance and importance through a detailed study, description and analysis of actual working practice. Some delegates expressed a sense of frustration that such studies are often undervalued in the current healthcare research context in which randomised controlled trials are perceived as the ‘gold standard’. Our patient ‘experts through experience’ highlighted the importance of being heard, and of opportunities to tell their stories and personal testimonies about living with chronic illness. Not reducible to measurement, these stories hold the key to engaging affectively with the patient experience, ensuring that the subjective experience of illness is given prominence over objective measures. We were encouraged to actively seek out these testimonies and to ensure that the focus of professional concern is indeed the patient-as-person, and not the patient-as-dataset. It was acknowledged that this is demanding work, especially in contemporary clinical environments that are becoming increasingly subject to external regulatory control and bureaucratisation.

Valuing time and space for reflective activities

Delivering high quality care is demanding, complex, challenging work, and it is difficult to sustain in practice. Concerns were expressed that much time and energy was being invested in implementing a range of ‘quality’ initiatives which sit uncomfortably alongside professional conceptions of excellent care in practice, and which rarely acknowledge the complexity experienced in delivering care in its social context. The mismatch between the concerns of patients, carers, healthcare professionals and institutional definitions of ‘quality’ may itself be a source of tension. Some delegates expressed concern that the space for innovative, creative approaches to delivering excellence in care was becoming ever ‘squeezed’ by externally mandated constraints. Others were concerned about what they perceived as a failure to appreciate fully the importance of professional judgement in matters of quality.

Linking with the previous theme was the observation that it is not only patients but practitioners who need opportunities to have their concerns heard. Collaborative efforts within teams need to be valued, and time made available for practitioners to meet together to reflect on and share their experiences with peers. Learning to think critically, reflect on practice and act morally were identified as key to delivering high quality care and it was suggested that greater prominence should be given to educational activities which encourage an examination of practices with these in mind. Initiatives such as Schwartz® Center rounds and courses which explore narrative and reflective writing were discussed at the colloquium as examples of this approach.

Trust and trusting relationships

The word ‘trust’ was prominent in colloquium discussions. The nature of ‘trust’ was the explicit focus of one of the papers presented (Cohn), but trust was often identified as centrally important to both professional-patient relationships and also to the successful working of professional teams. Trust was identified as a fragile phenomenon, potentially difficult to build, but very easy to destroy. It was also identified as emerging from practice, and not a thing. On several occasions the importance to the quality of care of doctors trusting their patients was emphasised, acknowledging that it is then the doctor’s role to manage any inherent uncertainties that this may involve. This trusting of patients was identified as important not only to therapeutic relationships (where it is a matter of epistemic virtue) but also to quality improvement initiatives such as experience based co-design in which patients are called upon to identify those things that really matter to them in their care within a service development framework.
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About Cumberland Colloquia

Through the Cumberland Colloquium scheme, Cumberland Lodge offers its expertise and beautiful venue to facilitate interdisciplinary and inter-institutional conferences, run by and for postgraduates and early career researchers. Fully mentored by Cumberland Lodge, organisers will have the opportunity to deliver a well-crafted one-day conference and gain valuable experience in the processes of funding applications, administration, recruitment, networking, publicity, report-writing and press releases. Find out more at:

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About Cumberland Lodge

Cumberland Lodge is a house for ideas. It is a former royal residence that has been an independent educational charity since 1947, promoting ethical debate and cross-sector cooperation on a range of matters affecting the development of society. Cumberland Lodge fulfils its mission by designing and facilitating a series of events which enable participants to discuss ethical, moral and spiritual issues.