Self-managing the System of Healthcare

Learning and quality of learning at multiple levels

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Abstract

This paper documents the dialogue of a workshop entitled *Self-managing the System of Healthcare* at the *Relating Systems and Design* Symposium in Toronto in October 2016: the second in a series of workshops that explore the issues of self-management of long term conditions by individuals and communities operating in the system of healthcare.

The workshop topic sits within the realm of systemic design in healthcare services: exploring an occluded area of opportunity to build resilience and balance demand. The issue of 'self-management' is a key factor in managing demand, preventing ill health, and building resilience. As such, it is a priority focus for health services globally.

This workshop sought to investigate the interrelational dynamics between and among systems relating to healthcare and self-management, suggesting that an opportunity area for addressing the problem of avoidable Long Term Conditions exists in the collective responsibility between healthcare services, people, patients, and communities. It hypothesises that exploring the way in which people engage with healthcare may yield insight into transformational outcomes, made possible through deep learning.

Introduction

In asking the question ‘what would self-management in healthcare look like?’ we are looking at multiple levels of recursion, from the individual, to the communities that surround individuals, to the health systems that provide healthcare services, and the payers that commission services.

We are also seeking further understanding of ‘what constitutes the system of healthcare’. Specifically, our investigation explores the societal design challenges posed by interrelational dynamics between and among the systems that relate to healthcare and self-management.

This work fits within a wider action research dialogue. We held a related session in September 2016, in London, England, which was jointly facilitated with Nora Bateson.

The leaders of this workshop have diverse backgrounds relevant to the research topic, in terms of sector experience, methods, and approaches. Our work is based primarily in the UK and benefits from international collaboration and the experience of conference participants representing multiple health systems. This creates opportunity to look across contexts to address globally pressing problems of health and care.

Our aim is to explore emergent possibilities, combining models of systems and design with the collective wisdom and insight of systemic design practitioners applying their collective knowledge and experience of, and to, healthcare.

Workshop Structure

The workshop was structured as 'double diamonds' (Design Council, 2005) – we actually used a series of diamonds – in which the discussion was encouraged to start from a position of convergence, from which to diverge, and converge again, in a series of cycles. Throughout this process, participants, working in small groups, shared their thoughts in response to the thematic question.

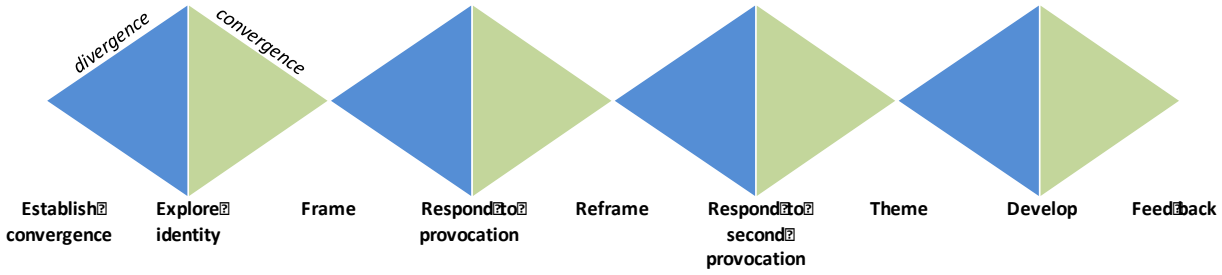

Figure 1 – workshop structure

The outline format followed was:

- An initial provocation, outlining a different way of thinking about self-management
- After each round, the introduction of a key idea or focus from either systems theory or design, which would serve as a catalyst for the subsequent discussion
- A synthesis conversation to draw out the key learning generated by the workshop

During the rounds of group work, the facilitators circulated in order to observe the dialogue in each group, and to intervene as necessary to maintain focus on the purpose. The facilitators also participated freely in the dialogue – no suggestion was made that the facilitators were separate or objective to the content of the discussion.

Three themes were introduced to cover a representational view of the healthcare 'system'. Participants were split across three groups, averaging 4-5 per theme. To achieve sufficient variety of perspectives within each group, groups were not subdivided further into e.g. provider and commissioning functions.

These themes were:

Individual

The person interacting with the system. Traditional healthcare views the individual as a 'patient', seeking care from a 'doctor' (or other clinician), which introduces an implied relationship that can inhibit learning and preclude self-management.

Service Providers

Defined as the accumulation of organisations, services and people employed to facilitate the delivery of healthcare services. For this category, no distinction was made between commissioning and provider functions. Such a subdivision may only have surfaced the differences between the political geographies represented by the participants.

Community

The people who may influence healthcare but are neither the individual nor the service provider. The family unit (immediate and extended) is a special type of community. It was acknowledged that primary care providers, for example GPs, often provide a first point of contact and may be indistinguishable from the communities of which they are a part.

Provocation

Our initial provocation outlined the following elements, in order to prime participants for engaging in a usefully different discussion about self-management and health care:

- We observed a pathology in the lack of healing, or positive learning enabled by the current configuration of services.
- We suggested that opportunities exist in the collective responsibility between healthcare services, people, patients and communities.
- We hypothesised that exploring the way in which people engage with healthcare will yield insight into transformational outcomes, made possible through deep learning.
- We proposed that world consists of both designed and emergent elements; and ask 'how might we address the problem of avoidable long-term conditions in such an environment'?
- We asked 'what elements could we put in place so that the situation starts to improve 'of its own accord'?

Discussions on Identity

We began by exploring the multiple identities that we each hold and represent in each interaction. For example, one of the workshop participants introduced himself as a medical practitioner, but also as a patient, a father, and an academic.

These identities are fluid over time and often context-specific. Participants acknowledged that it is difficult (perhaps impossible) to act consistently and coherently from the perspective of one's several identities simultaneously.

We asked the participants to introduce themselves to one another and then, in their groups, to introduce themselves again, but from the perspective of a different identity. They found this exercise challenging, perhaps because they were participating in the conference, variously as students, professionals, and academics. This is an example of a context-specific identity dominating.

Discussions on Learning

We introduced the concept of 'symmathesy' (Bateson, N, 2016) to reflect the mutual learning that occurs within and between systems. The participants acknowledged that the health system is engaged in mutual learning across the three themes.

For example, an individual seeking treatment will learn whether it is easier to interact with the formal healthcare service providers or to obtain information and treatment through less formal channels. In turn, the service provider may learn (perhaps incorrectly) that a particular offering is not needed, when perhaps it is simply not being used because of other factors.

Further provocation

During the final round of thematic discussion, various printed items were introduced with the intention that they would provoke fresh thinking and more nuanced discussion as each group summarised their findings. The content of the printed items is summarised later in this paper.

Output

During the workshop we captured two primary outputs, in addition to our own notes. Each of the three thematic groups captured its work on a flipchart page, in an unconstrained format. During the final feedback and group synthesis discussion, we captured a sketchnote in response to two questions:

- What does it mean to learn in healthcare?
- How might we gauge the quality of learning?

Learning as an Individual

Participants described the individual as existing in multiple states and dimensions. Identity was described as multiple layers, each of which may exhibit associated behaviours. The relationship between multiple layers of identity was also questioned. Time was also described as contingent – the individual may exist in the present, but also in the past and the future, complexifying the idea of identity. Relationships with authority figures and wider opinion were described as feedback loops.

The group discussed the relationships between identity, which comes with a set of observable behaviours that give some insight into the fluidity of the multiple identities that we hold, the structural coupling of our identities to other groups, and the transitions between the multiple identities that we each hold.

Our identities drive the perspective that we hold in each moment on a particular issue, which is then the source of our opinions (whether privately held or expressed) on an issue. Our identities are our links into the relationships that we hold within our communities and wider society, and often those relationships and roles are the source of authority and respect. Only considering our identities in the context of those relationships leads to conscious learning, and expanding comfort with the inherent complexity of a world, in which every individual holds multiple identities.

This group also discussed positive and negative learning. If it is possible to identify positive and negative, then it may be possible to amplify the quality of learning.

The possibility was ventured that an individual may grow to broaden their ‘comfort zone’ or extent of their self.

Learning as a Community

There are limits to what an individual can hold and learn on their own account, for all that they are closest to the realities of their situation. If it “takes a village to raise a child”, then perhaps it takes a community to be sensitive to the health of its members. The larger group is more able to remember history and to recognise recurring patterns.

Communities also perpetuate patterns in the form of norms and traditions. These interrelated expectations re-inforce the closeness of communities and enable novel funding mechanisms to emerge and be sustained (Collins et al. 2009).

"If I could tell you what it meant, there would be no point in dancing it" (Duncan, I, cited in Bateson 1972)

The group looking at the role of Community emphasised the importance of difference between experience and expression, and the limits of language in conveying experience. Community was seen as playing a vital role in translating between the variety of rich contextual experience and a system of healthcare.

The size of a community was seen as important – of sufficient size to absorb the possible variety of states experienced by an individual, but not so large as to lose intimacy, connectedness, and closeness. For many purposes, the limits of effective community size may be Dunbar's number (Dunbar 1992). As groups grow and industrialise their approach to providing health care, their issues become the issues of service providers.

Learning as Service Providers

The Service Providers group chose to look at what a Service Provider could or should learn, to enable the healthcare system to learn. The definition of the team may need to change to include people within provider organisations and outside of provider organisations. Seeing the community as part of the team was seen as a necessary step to creating a context for shared learning. Hard structural factors such as defined roles may be a barrier to learning, forcing interactions to assume the same dynamics and potential dysfunctionality of existing relationships.

In our previous workshop, one of the clinicians stated that she saw her role as a doctor in recognising patterns and offering an expert opinion, leaving the patient and their family to make decisions within the subtlties of their context. Another clinician observed that, given potential consequences, that he was often in a 'double bind' (Bateson, G, 1956) in which the options of enforcing treatment and of leaving the patient to decide, each led to irreconcilable damage at some level.

This group focussed on two areas in their discussion: changes (desired, necessary, worrisome), and barriers (both as inherent friction, and as barriers to change).

They suggested that behavioural adaptation involves:

- interactions between people
- gathering information
- allocating resources
- finding systemic efficiencies
- dispensing of treatment

Their top barrier to learning by service providers was identified as a fear of losing control and/or revenue. This plays out at several levels, both within individual service providers, in associations of service providers and professionals, and the regulatory environment. There may be a lack of emphasis of empathy and the human context, and gaps in the education of participants within service providers.

Despite the focus of the workshop on the self-management of conditions, this group also discussed how service providers could expand their circle of influence and start deliberately exercising power outside of the medical sphere.

At the same time, there was discussion about making use of service provider spaces to serve multiple purposes, driven by the individuals and the community. We heard one example of mixed use, where senior citizens coming to a medical centre can also socialise and arrange their financial affairs in the same building.

Provocations

In the final round of group discussions, we introduced several items intended to enhance the quality of the output by provoking them to revisit their discussion from a new perspective. The provocations were centered around these concepts:

- Autopoeisis (Maturana & Varela, 1973)
- Biology of wonder (Weber, 2016)
- Campbell's law (Campbell, 1976)
- Darkness principle (Ashby, 1956)
- Double bind (Bateson, G, 1956)
- Economy of habit formation (Bateson, G, 1972)
- Enterprise Design (Guenther, 2012)
- Healthcare as a complex system (Lipsitz, 2012)
- Holling adaptive cycle (Holling, 1986)
- No point in dancing (Duncan, I, cited in Bateson, G, 1972)
- Possible creatures (Wagner, 2014)
- Requisite inefficiency (Velitchkov, 2014)
- Requisite variety (Ashby, 1956)
- Robustness and evolvability (Wagner, 2007)
- Structural violence (Graeber, 2012)
- Symmathesy (Bateson, N, 2016)

Conclusion

To conclude this paper, let us summarised the primary questions posed and the three themes from which they were examined: individuals, community, and service providers.

- What does it mean to learn in healthcare?
- How might we gauge the quality of learning?

Starting from the individual, whose health is of keen interest and by definition is the subject of self-management, one of the chief insights is that individuals are complex and, well, individual. We each exist in multiple states and dimensions, and each of our multiple layers has associated behaviours. From a learning perspective, as individuals we exist and act in the present but co-exist with our histories (past selves) and our desired states (future selves).

More persistent than the individual is the community, for the community is the enforcer of norms, the memory of collective history, and a potential recognizer of patterns. This suggests an opportunity for learning to be sustained within the community and transmitted between communities.

The groups identified two clear types of limit on communities; the size of the community and the limits of language. Size, both as a lower bound to enabling certain types of action and as an upper bound to remaining a coherent community. Language, as an inadequate mechanism for transmitting the richness of experience and learning.

This last point is telling, because as groups grow and industrialise their approaches to providing health care, they tend to rely on increasingly formal language-based mechanisms to transfer knowledge, such as standard operating procedures. These mechanisms may inhibit certain types of learning as much as they enable benefits through efficiency and standardisation.

It may not be possible to adequately gauge the quality of learning in the sense of positive and negative learning. But the notion that an individual can grow and broaden their 'comfort zone' or extent of their self may equally apply to communities and service providers, thereby creating space for self-management and other positive emergent outcomes. It may be easier to gauge the change in 'extent' than to assign qualitative measures of 'goodness'.

Authors

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Russell is a passionate about creating better public services, and connecting public services with the development of communities and sustainable economic forms. He has broad consulting and leadership experience with specialism in service design, facilitation, systems thinking and managing complexity. His current projects include integrated care design with National Health Service organisations in London, the UK, and the Isle of Man.

Philip Hellyer, Philip & Finch

Philip's expertise is in optimising the value of investments in change. He specialises in pragmatic approaches to enterprise architecture that improve systemic structure and reduce unintended consequences. With a background in accountancy and computing science, he works on both 'sides' of the strategy fence. His influence is grounded in his structural understanding of information, technology, and their relation to business models and strategies. Philip edited the Enterprise Design book,

Intersection (Guenther 2012). Formerly the Enterprise Architecture Group Lead at Carphone Warehouse Group, Philip is the managing consultant at Philip & Finch, helping leaders deal with the implications of how the ever-changing elements of their worlds are connected.

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Appendix:

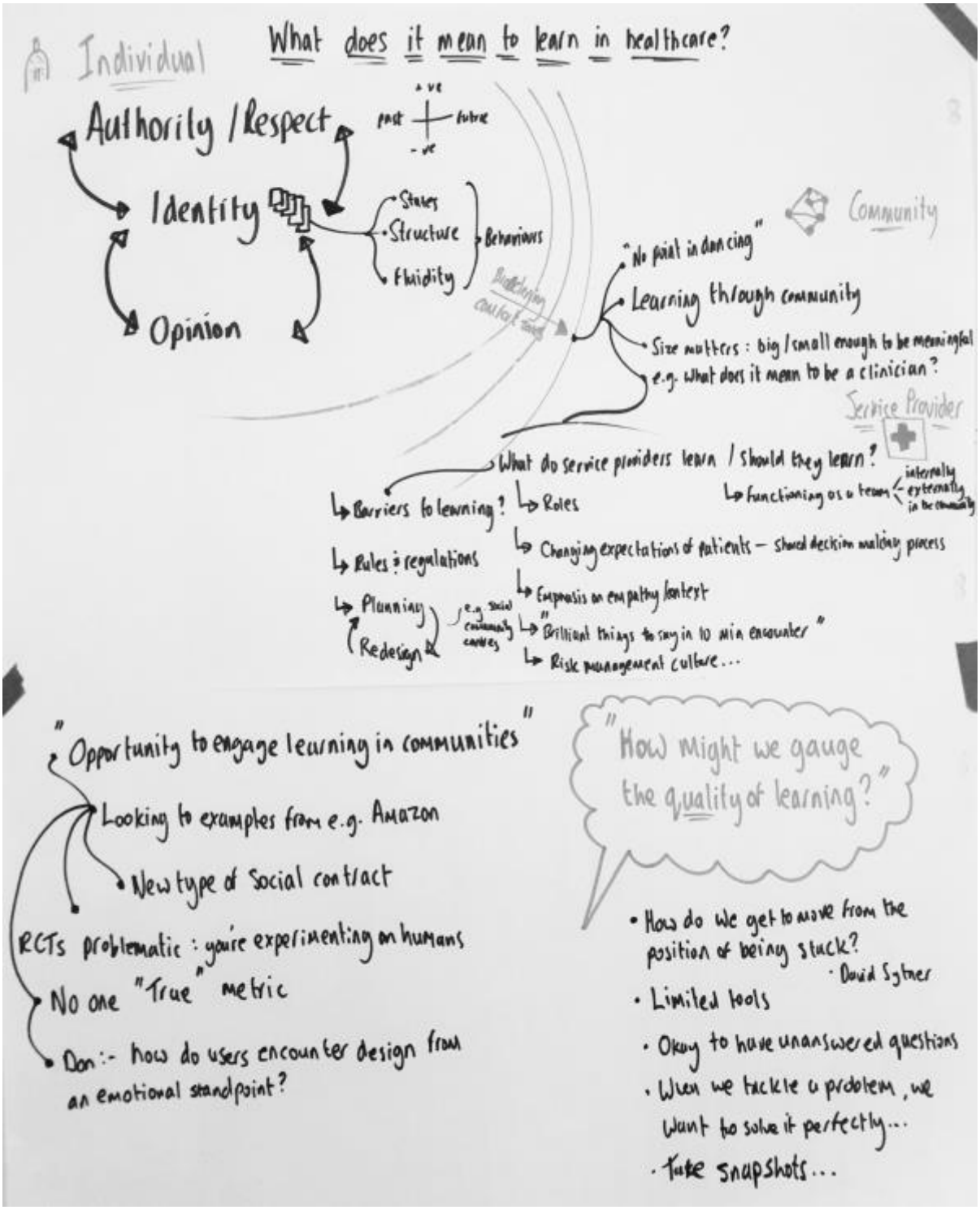

Figure 2 – Sketchnote of group synthesis discussion

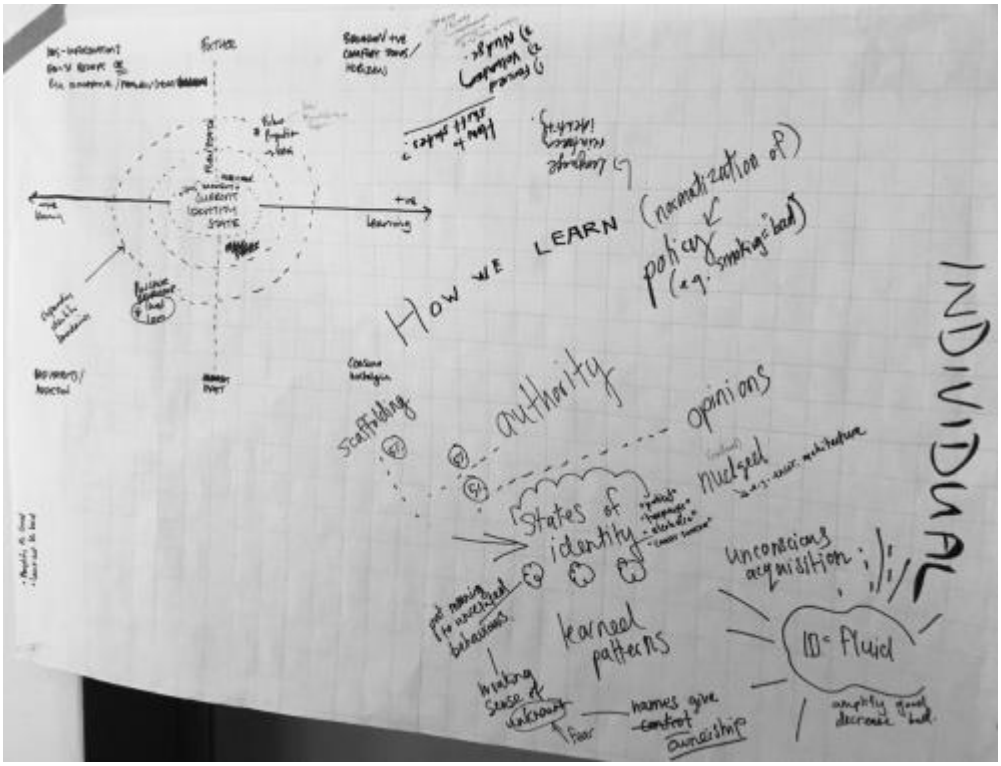

Figure 3 – Group output – learning for the individual

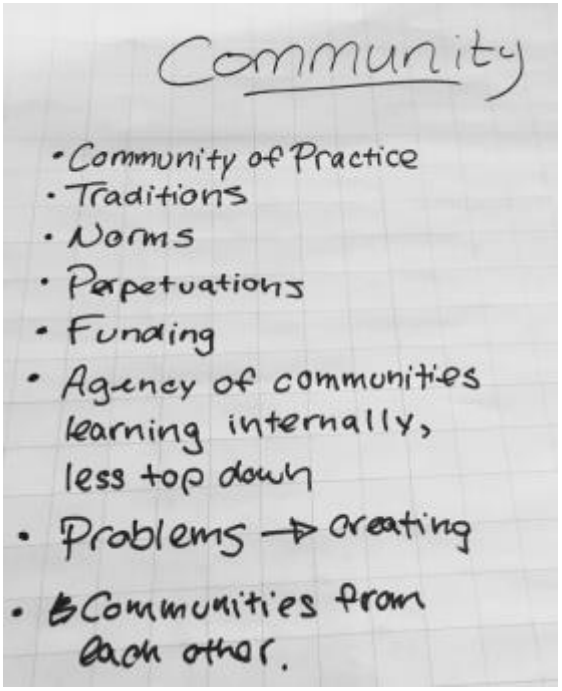

Figure 4 – Group output – learning for the community

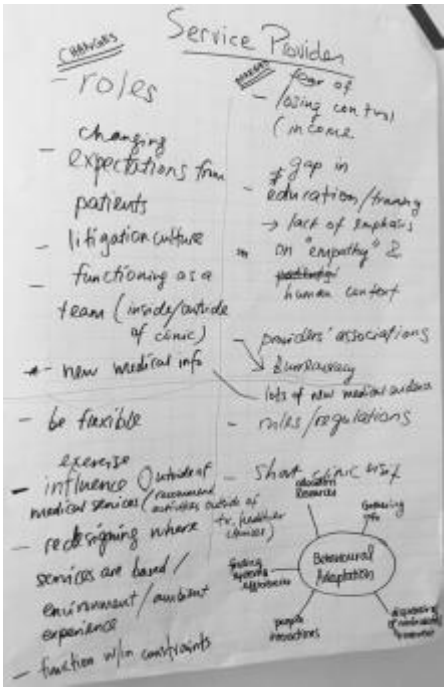

Figure 5 – Group output – learning for the service provider