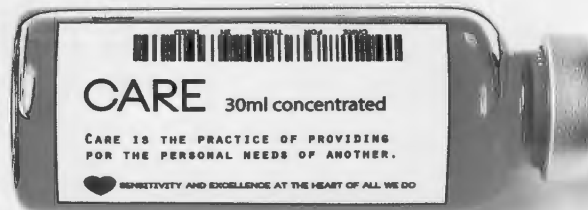

IMAGE: VALERIO LOI

HOSPITALS: HUMAN BODIES?

Medical institutions must not let the drive for greater operational efficiency undermine the essential qualities necessary for organising care

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The Francis Report on the failure of the Mid Staffordshire hospital describes in detail a form of organisational hypertrophy: a state when some organs of the body are overnourished and grow at the expense of the whole. This condition prevails in organisations when a limited number of a rich complex of concerns and practices are singled out for special attention. As a result, the chosen aspects become vested with undue significance, while other equally important features are overlooked.

As organisations, hospitals are susceptible to hypertrophic disorders, because much of what is important is conducted below the level of conscious attention and is prone to be overlooked or forgotten in any event. The exercise of care is particularly at risk. Nurses, doctors and other hospital workers come to exercise care through a network of practices and fundamental beliefs

"HOSPITAL WORKERS COME TO EXERCISE CARE THROUGH A NETWORK OF PRACTICES AND FUNDAMENTAL BELIEFS THAT ARE LARGELY TAKEN FOR GRANTED"

that are largely taken for granted. Think of the embodied know-how that goes into the surgeon's operations, or into the touch of the doctor or nurse when examining a patient. Care is grounded in skilful micro-practices that healthcare workers have absorbed and carry out without freshly thinking them through on each occasion.

Collectively, this body of practice forms a shared world that supports the continuance of care practices, or 'the way we do things around here'. It is not a fixed world of blind habit. When aspects of practice become problematic, they are raised for debate and can be changed. However, thoughtfully tackling specific issues or reaching for particular targets – even if these are directly productive of greater care – can have a distorting effect on unarticulated practices. Such distortion is especially liable to occur where no voice is given to the richer context, either because of a climate that is unsupportive of speaking up, or because high levels of staff turnover have destroyed memory of the organisation's tradition. The explicitly articulated targets and their associated activities then have a tendency to become detached from the broader complex of concerns and practices in which they are embedded. Care is then in danger of being reduced to a small number of ideas being realised through a project. What is not included in the targets is considered less important, decays and is eventually forgotten. Commitments to focused action and specific changes are rational: they also carry the risk of hypertrophy.

As a kind of institutional over-focusing, hypertrophy has another implication for the exercise of care, as illustrated by the Mid Staffs case. In addition to the decay of important aspects of practice, hypertrophy may also call up darker aspects of the practice world that are inimical to care. The Mid Staffs report illuminates a mood or atmosphere of callous indifference, where patients were objectified and treated in ways that lacked any dignity, even in death. It is useful here to contain our anger and to recognise that objectification is, indeed, an aspect of the practice of medicine. When we are ill, we submit to being drugged and manipulated like biomechanical machines that need fixing. The latent tendency to treat the patient as an object may exist partly thanks to language that addresses patients as abstract parts of a drive for efficiency. The consequences may then, as at Mid Staffs, stretch far beyond any deliberate intention to harm. Out of such an objectifying atmosphere or mood, all kinds of vagabond practices may emerge and, ultimately, patients will simply fail to show up as human beings. Once this happens, cruelty is normalised.

Sustaining organisations of care depends upon recognising that reason is rooted in a shared world that is already preconditioning and motivating people before they come to think about it. It touches and moves them into shared action, creating affective moods that condition how patients are perceived and how healthcare professionals think. Taking on board the embodied nature of organisational life provides healthcare professionals with a unique opportunity, based on their own preoccupation with human bodies. How can they build on the subtle correspondences between the living body and the living spirit of care in an institution such as a hospital to develop their own theory and practice of sustaining the organisations that care? How can an understanding of the embodied nature of organisations feed back to reinforce healthcare professionals' understanding of the dignity and wonder of human embodiment?

Such questions demand an inquiry into how to listen out for what is silently shaping care. The paradox of listening for what is silent only makes sense by having an empathetic 'ear' for the unspoken ways in which the hospital touches and attunes the human participants. Listening with such increased sensitivity discloses anomalies of both privation and abundance that demand inquiry, articulation and thoughtful response. These anomalies are the ways in which the hospital's historic tradition of care 'speaks' to the human participants, whose role is to continuously complete this tradition, even by transformation where necessary. Superordinate goals – such as the ones that became omnipresent in Mid Staffordshire – have a role to play, but they also feed the dangerous idea that anything might be possible as long as it is rationally thought through. Hypertrophy and grief will flow from such a belief if it is not accompanied by an understanding that, because a hospital always exceeds our grasp, it calls out to be continually listened to: this is the first law of care.