

An introduction to Intelligent Kindness

Summarising ideas from *Intelligent Kindness: Rehabilitating the Welfare State*: Ballatt, J., Campling, P., Maloney, C., Cambridge University Press, 2020

Preamble

Clinical practice is, at one and the same time, technical *and* relational, whether it is the work of an individual, a team, or a wider system. It is important not to relegate the relational to a secondary position, to a mere question of ‘being nice’, ‘patient satisfaction’, or ‘bedside manner’. The quality of practice, its efficiency, the safety of the ‘patient’ and the outcomes of the work depend at least as much on the relational, psychological dimensions of practice as on the ‘evidence base’, the system design, the technical skills or the equipment and facilities available.

Before exploring this argument further, let’s take a moment to recognise that it is a little surprising that it has to be made at all: but it *does have to be*, as the stories of many professionals, services and the people they serve attest. Every sports fan knows that the mental state of the players, their relationships with their colleagues, and their attitude to the work are crucial to their ability to apply their skills effectively, collaboratively and consistently. After crucial games, in bars, coffee shops, living rooms and workplaces across the world, heated and opinionated discussions occur about such psychological matters as attitude, attentiveness, cooperation, motivation and management of anxiety. At the top level of most sports, the sports psychologist’s input is increasingly regarded as being as important as that of the coach. People *know* that the relational and psychological is the ‘game changer’.

In healthcare such matters can be readily eclipsed by over-privileging the (of course necessary) scientific, technical, design aspects of practice or service. Given the enormous strides in knowledge, interventions and technology, and the mushrooming of demand, over the last fifty years or so, given the sheer scale of the enterprise, this is not entirely surprising. It is, nonetheless, alarming. Rhetoric alone about ‘putting the patient first’, ‘co-creation’ (with fellow professionals or with ‘patients’), or the importance of resilience and psychological well-being for clinical staff, will not restore the necessary balance. Alongside the vital structural and technical work, concerted intelligent attention must be given to the psychosocial nature of the enterprise. The concept of ‘intelligent kindness’ is, we hope, one that can help with that aspect of the task.

What do we mean by intelligent kindness? In essence:

- Working to recognise and bear in mind *kinship* – being ‘of a kind’, ‘in it together’, depending on each other for survival, wellbeing and success – in our relationships with each other, and with those we work to heal or treat
- Understanding and valuing the way such an awareness, and consequent attitude to others, can build productive and effective relationships and direct our attention, responsiveness, decisions and actions – in our work as people, as colleagues and as skilled clinicians
- Understanding and working with the factors that *promote or work against* such a stance, or approach, in individuals, groups, organisations and communities

- Recognition and promotion of what is involved in integrating this perspective into training and continuous education, clinical practice, professional supervision and service design, development and management

Our book, *Intelligent Kindness: Rehabilitating the Welfare State*, explores these issues in detail, drawing on many perspectives, including ethology, social psychology, psychoanalysis, sociology, organisational theory and research in health and social care. What follows here is a necessarily condensed summary of some of the main themes and arguments in the book.

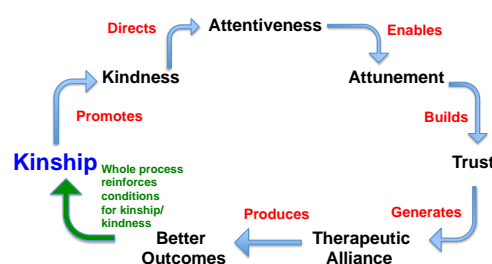
The core idea

We'll begin by examining what the kinship/kindness dimension looks like in practice. First, let's consider the bond between a parent and child, or indeed cooperating hunter-gatherers, soldiers or soccer players. It is driven by *kinship*. Responding to the other as 'kin' means that we bear them in mind as valued others, with vital needs, strengths and vulnerabilities, with experience and things to contribute. This is more than the compassion felt by the strong for the vulnerable. We bring to bear an understanding that we depend, in various ways, on each other for satisfaction, safety, success and wellbeing: we matter to each other, we're 'in it together'.

That recognition generates the concern, readiness to respond, to help, to mitigate suffering, to meet need, that is *kindness*. Kindness, in turn, focuses and energises our *attentiveness* to the other – we pay close and concerned attention to them, looking for signs, for information about their experience and needs. As we become attentive, *attunement* develops, in which eyes, ears, reason, intuition, empathy all help us to develop a deeper understanding of the other, an anticipation of their needs and wishes. This sense of being there for each other promotes a sense of safety: it nourishes *trust*. In clinical relationships, the colleague or the 'patient' can trust us, and we can trust them. Openness, honesty and cooperation are bred. Such trust nurtures what psychotherapists call *the therapeutic alliance*: clinician and patient, nurse and doctor, or leader and led work together intelligently, constructively, collaboratively and mutually supportively. As a result, *outcomes* are optimised.

As this process proceeds over time, a virtuous circle is established, in which the positive experience and its outcomes reinforce the sense of kinship, promote optimism and commitment, and continuously improve the working relationships involved. It is important to recognise that this virtuous circle is not simply about the felt experience of participants. Accuracy of diagnosis, responsiveness to need, timeliness, quality and efficiency of intervention, and safety are all improved. The figure below summarises all this.

A virtuous circle



From *Intelligent Kindness: Rehabilitating the Welfare State*, p46

Our core argument is that, in planning, designing and managing care, and in supporting and developing the practice of individuals, teams, and systems, we must apply everything we know about what fosters this virtuous circle, and, just as importantly, what works against it.

Beginning to apply the idea

In considering how to promote intelligent kindness, we must bear in mind several things:

- how to promote and sustain positive ‘bearing in mind’ of the other, in the individual and in the collective
- how to generate imaginative understanding of the contribution people’s actions can make to others’ well-being – colleague or ‘patient’
- how to instil and support a confident belief in a person’s own value and freedom to act along with readiness to collaborate – a sense of agency amongst other agents
- how to ensure that individuals have the knowledge, repertoire and resources to act skilfully and compassionately according to circumstances.

To address these challenges, there are a range of ways of thinking and intervening that can be brought to bear alongside application of the science, design of systems and roles, etc. None will bear fruit, however, unless we keep firmly in mind what we are asking from the human beings working as healthcare practitioners. We need to apply a clear understanding of the psychology of individuals and the dynamics of groups and social systems, in the context of the nature of the clinical task. We can all be guilty of forgetting, or minimising the significance of, the fact that the practice of health care involves constant engagement with often alarming and deeply distressing symptoms and human experience, with uncertainty and risk, with vulnerability and mortality. We have to overcome urges to turn away, to distance ourselves too much, to shut ourselves down. We often have to work hard to find kinship with others, across differences, or in the face of hostility and mistrust. There is an often-under-acknowledged cost to doing the work. Our personalities, the conscious and unconscious motivations and ambitions we bring to our work, and our social circumstances influence how we engage with these things.

As individuals, we need to remain aware of these factors, to understand ourselves and each other, what we bring to the work, our vulnerabilities and how we tend to manage ourselves. For example, the bereaved child who grows up to be a doctor may well have to recognise underlying omnipotent aspirations to overcome death, and maybe guilt, frustration, excessive grief, even rage, when patients fail to thrive. The clinician from a poor background, or an oppressed minority, even a competitive family, may have unrealistic expectations of themselves, be driven to overwork, hide the cost to themselves, be excessively concerned about failure. Heroism, or its opposite, shamed helplessness, can profoundly disrupt measured engagement in the virtuous circle. These are, of course, simply examples: we *all* have our own baggage, psychological vulnerabilities and ways of managing that can help or hinder both our individual practice and our collaboration with others. Rates of depression, alcohol and substance misuse and suicide amongst doctors, at least in the UK, suggest that how individuals manage both the stress of the task and such personal factors requires more attention. Too many narratives of failures and abuses in healthcare services also reinforce the urgency of doing so.

When we bring ourselves into a working group, or a team, we join a collective that has to manage these issues in self and in each other in order to carry out its task collaboratively and effectively. Of course, factors such as personality, gender, ethnicity, hierarchy and profession all influence how individuals contribute to, and work together on that task. Groups have, in addition, dynamics relating to such matters as how authority is exercised and responded to, how difference and conflict are managed, especially how *anxiety* is processed and contained. There are rich and helpful traditions of thought in social psychology, in psychoanalytic theory, in ethology and anthropology that can help us develop more sophisticated ways of understanding and addressing these aspects of the work.

In thinking about the experience of individuals and groups it can be tempting to see it all as a matter of our own strengths, weaknesses and behaviours. But just as significant, key influences on how we engage with the task, individually and together, and on how we manage ourselves as communities of kinship, are factors in the wider *culture* within which we work. Such factors originate in several inter-acting dimensions, including:

- the languages and cultures of the professions involved, and in their attitudes to each other
- how leadership manages anxiety, about performance, risk, activity, resources, errors, etc
- how mistrust, from society, politicians, leaders, regulators, and ‘patients’, affects expectations, ways of monitoring, managing and evaluating performance and outcomes, and the emotional climate of care services
- how much health care and its interventions are seen, or presented and sold, as simply commodities, as industrialised processes, by the public, by policy makers and planners, by managers and leaders
- how regulation is framed and carried out – with the problems of targets, number counting, etc, often skewing attention in the system, having unintended consequences, promoting less than honest, thoughtful attention; and with the damaging effects of often punitive or unrealistic regulatory systems
- how competition, especially within a cash-strapped economy, can generate toxic effects, with unrealistic demands for ‘more for less’ from already stretched services, insensitive or punitive management of pressurised people and systems, dishonesty about errors, or limits to capacity or capability
- how the fit, or lack of it, between expectation and what can be achieved within the human and technical resources available is managed

All these factors are to some extent present, even in danger of predominating, in any system. But when they are recognised, intelligently and honestly addressed, and when their potential toxic effects are mitigated, there is the chance that the kinship culture that will combine with technical excellence to produce humane and effective healthcare can be cultivated. Behind all such factors lies the question of how well all involved resist what we have called ‘the pull towards perversion’ in organisations. Thinkers like Susan Long have drawn attention to the dynamics of systems where the culture is one in which others are simply seen as objects, as

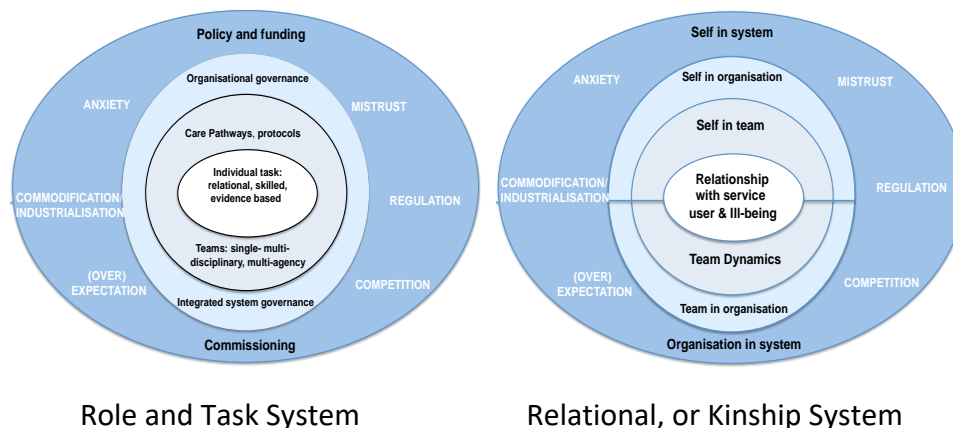
tools for meeting one's *own* needs. The service is there to meet the organisation's need for profit, reputation or market position; the team is there to meet the performance targets of the leader; the colleague is there to ensure one's own interests and goals are met. Leaders – and staff - turn a blind eye to the real experience of others, to inherent problems and failures. This is an ever-present risk in the modern world, and is the diametric opposite of the collaborative kinship system and culture that will provide optimal care and support the ongoing well-being and effectiveness of the people who offer it.

Integrating intelligent kindness into the picture

The challenge, then, is to be able to bring an understanding of the relational, the kinship dimension of our work together with attention to technical knowledge, skills, role and pathway or system design. This will only happen if there is a genuine recognition, a real valuing, of this perspective, and honest, intelligent and consistent attention to the challenges involved in applying it. No amount of posters telling objectified and overworked staff that they are 'our greatest asset', no invitations to lunchtime mindfulness or dance events for staff unable to take lunch breaks, no 'resilience training' when working conditions are unhealthy, will suffice.

What is required is a systemic view of two dimensions of our work: first, what might be called the 'role and task' system, and secondly, the 'relational, or kinship system'. Both are vital, and both depend on each other. A role and task system designed and managed without sufficient attention to the relational will become over-industrialised, factory-like, even robotic. A relational system without appropriate science, structure and organisation may be warm, collegiate and well-meaning, but ultimately ineffective and inefficient. In essence, attention to the relational optimises the application of the technical, and vice versa. The health, or otherwise, of the relational system influences how well the aims of role and task system are realised, and the design of the role and task system influences the quality of the relational system.

Both ways of looking at the work involve several levels: the individual, the team, the organisation and the societal or system-wide. Both are influenced by the cultural factors summarised at the end of the previous section, that need constant attention and management. The figures below represent the two inter-relating systems, and can be seen as two 'lenses' through which the work needs to be viewed.



From Intelligent Kindness: Rehabilitating the Welfare State, p207

If being able to view the work through both lenses is vital, so, too, is to take a 'whole system' view in both, *and* of their influence on each other. We might call this a 'bi-focal' view.

To equip an individual with skills, roles, etc, without properly organising and resourcing the team and the wider care system would, of course, be pointless. Designing a care pathway or protocol without ensuring the right mix of roles and skills in teams and individuals would be ineffective. To offer support to the individual to manage the emotional pressures of work with patients, without addressing the health of their team, or of the relationships between that team and others in the system, would be next to pointless. Building relationships between teams, while neglecting those within them, would have little positive effect. Attention is needed to all levels of the system in both perspectives.

Developing this 'bifocal' view, integrating and getting the best out of these two ways of seeing, involves understanding how they interact and influence each other. For example, failure adequately to staff one team in a system, upon which another team depends, or making the referral system between them too bureaucratic, will sour relationships between them. Similarly, if the tendency of one team to blame another for problems in the work is not addressed, internally and between them, a well-designed system will not work properly. Introducing a new model of care into a system where relationships have not been properly managed is unlikely to reap optimal benefits. It should go without saying that failure to engage staff properly in system review and change will mean problems with implementation and effectiveness.

Similarly, the influence of the wider cultural factors – mistrust, over-expectation, competition, regulation, commodification/industrialisation and anxiety – can affect either or both of the systems. For example, unmanaged anxiety about performance, or costs, can lead to impractical expectations, or inadequate resourcing, of a service, as well as to frustration, lack of 'buy-in' and troublesome relationships between professions, teams, etc. Competition can lead to over-promising, under-pricing, under-resourcing, etc, with consequences for performance, collaboration, morale and the quality of face-to-face work with patients.

The key is to keep our eyes open to all parts of both systems together and separately, and to strive to remain aware of, and ready to manage and mitigate, the dangers of these cultural factors. This, crucially, involves leaders, at all levels, individually and as a community, managing anxiety, the tendency to pass it to each other or 'down' towards the frontline in the system, and the way it can lead to turning a blind eye to problems. Promotion of openness, honesty, and conscientiousness, in individual leaders and in the dialogue between them, is vital.

Cultivating an 'intelligently kind' and effective system

If the relational dimension is properly valued, and the bifocal view espoused, then there are many ways in which the training and development of staff, the design and planning of care systems, and the management and support of on-going practice can be enriched. Outcomes for 'patients', retention, morale and wellbeing of staff will be substantially improved. Efficiency, patient safety and satisfaction will increase. Design and development of new, or modified, services will be much more likely to take staff along with such change, promote more intelligent commitment and practice, and bear fruit in implementation.

Our book surveys many ways of thinking and intervening to bring the relational dimension into 'parity of esteem' alongside the more technical, 'command and control', 'architectural' or 'industrial' approaches to the improvement and organisation of health services. To conclude, let's briefly summarise some of the key dimensions, principles and practices that will help.

If it hasn't become clear already, there must be *genuine understanding and continuous assertion of the value of the relational* alongside the technical. We should not underestimate how easily that can slip, into platitudes, into marginal importance, into relegation to 'soft', secondary status, in the minds of clinicians, leaders, managers, educators and policy makers.

Throughout training, and critically in continuous professional development and work across the lifetime of careers, *reflective practice*, at individual, team and system levels, needs to be valued and provided. This should not be an option, but a requirement. The tendency in busy, anxious systems, for supervision, even when lip-service to reflection is given, to slip into something much more like performance management, needs to be managed. Of course, the latter dimension of supervision is important, but it is immeasurably more productive if the reflective is given its due importance. Reflection at individual, team and system levels is vital, and, if managed consistently and well, highly productive.

Dialogical exchange, at team, inter-team and whole system levels, should be promoted. In such collaborative, listening, mode, the lived narratives of staff, 'patients' and 'carers' can be shared, to promote mutual understanding, to identify strengths and weaknesses in systems, to ensure leaders understand issues. Crucially it builds and sustains, at all levels, a sense of community and agency, of being valued and heard. Dialogical exchange promotes and invites the diversity of perspective that will underpin more intelligent decision making and design. It is important to see such a dialogical approach as being a necessary pre-cursor, or vital underpinning dimension, to more *dialectical* exchange. In the latter approach, people are engaged more with debating options, and proposing solutions, often in the absence of true understanding of the circumstances, the diverse experiences and perspectives of participants, and what work is required to strengthen collaboration and common purpose. Participants can feel as if they are there to meet someone else's purpose, rather than being invited to own, think about and identify issues that require attention, in their work.

Recognition of the value of the relational, reflective and the dialogical in clinical practice means that time needs to be made for it, costed, and funded. Though this can be a challenge for services which have not traditionally done so, courage and confidence is needed: apparent upfront costs are likely to be more than repaid in staff health and well-being, retention, service quality and effectiveness and consistency over time. One way of reducing costs is to ensure that staff in the system are trained in organising and facilitating such approaches as part of the 'the day job'. This will minimise, though not completely remove, the need for specialist staff, or people brought in from outside. If supervisors, team leaders, clinical leads and managers have the skills, this both reduces costs, and integrates attention to the relational perspective into everyday life.

The following boxes, which appear in *Intelligent Kindness: Rehabilitating the Welfare State*, offer a digest of some of the work that will make the difference at the individual, team and system levels. Interested readers are encouraged to explore the book more thoroughly. The first two boxes focus on the individual and the team.

Promoting relational practice by individual practitioners

- **Radically refocus education and training**, integrating sensitive relational practice into the core attitudes, skill-sets and professional identity, of trainees
- **Make space for continuous learning about relational practice**, supported by reflective practice in post-qualification training and continuing professional development
- **Provide skilled reflective supervision, in protected time**, for individuals and groups of practitioners
- **Organise roles and practice to enable deeper relationships** between staff and service users or patients, especially those with continuing and complex needs

Box 1 – the individual

From Intelligent Kindness: Rehabilitating the Welfare State, p224

As we have seen, such an approach to supporting the individual – often there, either in reality or lip-service in services, is unlikely to bear much fruit, indeed merit the investment, unless similar attention is given at team, and inter-team levels.

Cultivating healthy and effective teams

- **Recognise the central task** of cultivating the team as both a healthy psychosocial, and ‘task and role’ system
- **Develop a comprehensive strategy** for supporting this work, and engaging senior leaders in it
- **Adopt tools** to evaluate the climate and effectiveness of teams. These can be used by teams themselves, and/or for monitoring
- **Make time for**, and invest resources in, developing and sustaining teams and inter-team relationships
- **Train and educate** staff in what being part of a team means, both as people, and as skilled and effective practitioners
- **Recognise, and develop** approaches to managing, the complex politics of multi-disciplinary teams
- **Value and allocate resources to reflective dialogue** about team experience – of practice, and of working together and with colleague services
- **Understand and value the role of the team leader**, providing the appropriate breadth and depth of training, supervision and support
- **Provide external facilitation and support** to augment the role of team leader in convening reflective dialogue and cooperation, and to allow reflection upon how leader and team are working together
- **Create a community of dialogue and reflection** for the leaders of teams across systems
- **Make all of this a routine requirement** of everyone’s role, with senior leaders explicitly responsible for supporting it

Box 2 – The Team

From Intelligent Kindness: Rehabilitating the Welfare State, p219

The wider system is considered in two ways. The first box addresses what will help with what is called ‘commissioning’ of services in the UK – but which, whatever the language in different cultures or countries, encompasses everything from consultation, to service design and specification, costing, contracting, etc. The second summarises aspects of a strategic, whole system approach, without which there is always the danger of inconsistent focus, fragmentation, relegation of the agenda, contradictory messages, etc.

Key principles for commissioning, planning and service change

- **Prioritise the quality of relationships**, from the front-line to top management, within services and between organisations. This promotes effectiveness and efficiency as much as the models and systems developed
- **Narrow the gap** between commissioners and providers, between managers and their practitioners: promote collaboration and co-creation
- **Avoid top-down planning**, and trust the value of promoting dialogue about, critique of, and ideas about services, by communities of practitioners, service users and citizens. Make the required time available
- **Seek narratives about lived experience** from clients or patients in their social context: this will help understand their needs, but also identify resources that can be brought to bear, or developed, alongside service interventions
- **Actively attend to the experience of practitioners**. Not only will this provide vital information, but the ensuing dialogue will build collective ownership of and commitment to any eventual change
- **Manage the 'politics'** of this dialogue, facilitating commitment to common values, and a diversity of perspectives, without promoting premature debate about, or negotiation of, options
- **Be aware of skewed thinking** arising from contracting relationships and models, especially 'payment by results'
- **Plan for whole systems and outcomes**, not fragmented duties, inputs or outputs
- **Aim for 'community rootedness' and local relevance** of any plans
- **Recognise the diversity of desired outcomes** for communities of people with particular needs, and for ordinary local communities.
- **Allow agency and creativity** by designing-in flexibility, and avoiding over-specification
- **Be honest about resource limitations**: if money has to be saved, be clear about this and involve people in finding solutions, but never pretend that 'more for less' is inevitably possible
- **Value, build and strengthen relationships between leaders** of collaborating organisations, within a common commitment to leading co-creation and cooperation at every level in the system.
- **Recognise the cultural impact** of commissioning, service planning and change implementation: and also how a healthy culture will improve both planning and implementation.

Box 3 – Commissioning, planning and service change

From Intelligent Kindness: Rehabilitating the Welfare State, p215

In our book we stress the importance of leadership, from the top, being committed to, modelling and facilitating the integration of the healthy relational, the kinship, approach into their organisations. The following extract points to some of the qualities of such a leader.

It is a strong and wise manager who recognises that a large part of the job is to manage their own anxiety and restrain their tendency to pass it on to staff below them. The effective leader understands what their staff's work involves and can listen well enough to identify the barriers that make it difficult to do. The mature leader can ask, rather than tell, staff how to achieve difficult targets. An intelligent and honest leader recognises that saying that something is so ('we are a people-centred organisation', for example) does not make it so: resources, attitudes and skilled behaviour do. It is a principled and brave leader who is honest enough to accept and defend the real limits to what staff can do within the resources they have. A leader acting as a principled representative of a society concerned about its well-being will remain open enough to acknowledge problems, errors or abuses in the services they lead. Leaders with intelligence will hold in mind both their identity and responsibilities as members of an organisation, service or team and their equally important responsibility to collaborate as part of a wider community. Above all, a courageous leader will resist the lure of the role of hero or ruler of an organisation and instead strive to be the convenor of its community, the guardian of its conscience and the servant of its purpose.

From Intelligent Kindness: Rehabilitating the Welfare State, p225

Personal philosophy, qualities, commitment, however, are not enough, as the split between the personality, professed intentions, ethics and cheering words of many a leader and the lived experience of working in the organisations they lead sadly attests. A thoughtful, genuine strategic, approach to the enterprise of embedding intelligent kindness is also required. Our final box summarises elements of such a strategy.

A strategic approach to a healthy culture

- **Authorise from the very top** of the organization or system, especially engaging commissioners in developing, sustaining and strengthening it
- **Cost the work** into organisational budgets, costs of contracts, etc
- **Ensure time** for involvement is budgeted for and authorised
- **Ensure proper training and freeing up of skilled staff** to facilitate dialogic work.
- **Engage widely** – practitioners, leaders and managers, administrative and technical staff. Avoid relying simply on the attendance of the ‘immediately willing’, the very vocal, or the seniors.
- **Ensure service users and patients are included**, in settings where they are properly supported, and able to bring their stories and take ‘centre stage’ should they wish to. **Avoid** turning them into spectators at professional dialogue.
- **Employ approaches** like revolving representation by teams across the system in organisation-wide events. Everyone in the system will never get into the room at any one time. For example, having two representatives at one event, with one of them at the next, with a new representative, can work well.
- **Ensure feedback and reflection** in ‘home’ teams: their leaders must be fully engaged with the spirit and detail of the process
- **Authorise and facilitate ‘co-creation’** of ideas or proposals for development by sub-groups mandated by the community of staff, but always tie their work back into wider system engagement to ensure critical review, understanding, ownership, and trust.
- **Collective ownership** means quicker and smoother implementation of any idea than when un-engaged staff are asked or told to change what they do.
- **Don’t despair** if the process seems slow: developing and sustaining culture is a long-term project with real benefits
- **Don’t be afraid of the cost**: the benefits in performance, staff morale and retention, effective collaboration and even sickness levels are likely to repay it.
- **Use external facilitators** where neutrality may be vital, but don’t rely on them to be the motive force.
- **Ensure continuity**, as a strategic, coherent, and sustained programme of attention to the relational health of the system; not just a series of sporadic events.

Box 4 – Strategy

Adapted from Intelligent Kindness: Rehabilitating the Welfare State, p211

Afternote

It is to be hoped that this, necessarily condensed, whistle-stop, introduction to intelligent kindness, and our book, has offered some useful ideas, perspectives and pointers to people committed to improving, sustaining and enriching the quality and effectiveness of health (and indeed social care) services. Inevitably, much of the supporting evidence has had to be omitted, and much of the detail of the argument left out. There are so many factors that influence the lived experience of staff and ‘patients’, the quality of the relational system, the culture of the work, and the outcomes of services. How quality and performance management, and external monitoring and regulation are organised and carried out is a key determinant, for example. But we cannot ignore, especially in the time of a pandemic, the effects on services and those who work in them, of the priorities, demands, and attitudes of politicians, civil servants, and, indeed, the general public, itself very diverse and often unpredictable in its attitudes, expectations and relationship with healthcare.