

The puzzle of changing relationships – comment



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Introduction

‘The puzzle of changing relationships’ is a Health Foundation publication (March 2013) containing research undertaken by RAND Europe³. In the introduction to this evidence review Adrian Sieff of the Health Foundation describes how “*in existing research attention is paid to process rather than to relationships: the interactions between interventions, relationships and quality have been poorly conceptualised, rarely described and most probably not even considered in terms of either their direct or indirect impact.*”

This research is therefore to be welcomed as part of the discussion, young as it might be, about how to bring relational thinking into the way we design and deliver our health and social care services. We need, as Sieff suggests, “*to have a more sophisticated understanding of the type of relationships that are most likely to facilitate high quality care.*”

Synopsis

The focus in this review is on ‘changing relationships’, i.e. interventions that change the nature of the relationships between patient and clinician. Seven such interventions were reviewed, all chosen because the change in the relationship between patient and clinician would further the goal of creating a more ‘person-centred’ system of care. Interventions reviewed included, for example, patient self-administration of medication, patient access to online health records and involving women in decision making in antenatal care.

Against these interventions evidence was sought for improvements in quality outcomes, defined as effectiveness, safety, person-centredness, timeliness, efficiency and equity. The approach provides an obvious matrix of interventions v’s outcomes in which a positive impact on quality would demonstrate the value of a more person-centred system.

The findings of the evidence review are expressed as follows:

“The evidence of how interventions to change relationships impact the quality of care is patchy and sometimes contradictory.”

The review highlights the challenges of evidencing impact in an area where explicit reference to, or consistency in conceptualising, the nature of changes in relationships in a system is limited. It did, however, find evidence of improved effectiveness following interventions to change relationships in self administration of medications, the use of peer support workers in mental health and interventions to improve services for

¹ www.thewholesystem.co.uk

² <http://www.relationshipsfoundation.org/Web/>

³ The document can be downloaded at <http://www.health.org.uk/publications/the-puzzle-of-changing-relationships/>

homeless people. However, even here, the report suggests that context will still be important in that certain interventions might not be advisable, for example for those with more chaotic lifestyles.

Evidence of improved 'person-centredness' were mixed across the studies and interventions explored, whilst efficiency and equity were less frequently studied and therefore difficult areas to determine evidence of impact.

In seeking to identify associations between changed relationships and the quality of care the study found that these were rarely made explicit: "*studies rarely described how a given intervention is expected to change a given outcome directly or indirectly, for example, through a change in relationship*". The review did, however, hypothesise that most interventions can impact the relationship between the patient and professional providers through "*enhancing the confidence and knowledge of service users and so re-balancing the power dynamic*".

The review concludes that "*where a change in a relationship was assumed to form the pathway by which a given intervention was expected to impact on the quality of care this was largely implicit*".

Comment

The importance of relational health: The question, therefore, is 'how do we make such pathways of influence that depend on relationships more explicit?' The following comments are offered as discussion starters building on or responding to the findings in the report. They are expressed in the context of a Health system that is coming under increasing pressure to demonstrate a culture and set of values that will safeguard patients from what Francis describes as the risks of relying on '*doing the system's business – not that of patients*'. The '*openness, transparency and candour*' that Francis calls for rely on a culture built on good 'relational health' – which means that exploring, measuring and monitoring the relational health of a system needs to provide the vital checks and balances to avoid the repeat (or continuation) of a culture in which risks to patient health continue.

The consequence of a focus on person-centredness when considering relationships: The goal of a 'person-centred' system is defined in the report as one that '*delivers care that is responsive to people's individual abilities, preferences, lifestyles and goals*'. This is consistent with the dominant and mainstream expression of liberal political philosophy, i.e. the belief that what matters is an individual's goals and the self actualisation of those goals through the opportunity and ability to make choices. It is also consistent with this starting point to derive the hypothesis '*that quality improvements will come from the re-balancing of the power dynamic of the relationship between the service user or patient and 'the service'*".

However, this hypothesis presents its own challenge in the context of relational thinking. A relationship is by definition between two people or entities. However, the interventions explored in the report are described as impacting at an individual patient or service user level, but the corresponding partner in the relationship is described interchangeably as 'providers' or 'professional providers' or sometimes as clinicians. Instead of the relationship being between two people it seems that the notion of a relationship being used is between a service user or patient and 'the service', or 'the system'.

This therefore stretches the prima-facia definition of what a relationship is and reduces it to an understanding of cause and effect that can be better described as 'connectedness' rather than relationship. What would be helpful would be a focus on understanding the nature of relationships themselves thus providing a richer seam of conceptual and methodological enquiry.

The emphasis on re-balancing power: Coupled with risks of an emphasis on one side of any given relationship outlined above the idea of re-balancing power risks over compensation and therefore the potential alienation and lack of recognition of the

second party to the relationship, in this case the professional or clinician. The 'social contract' between professionals and the public includes the giving up of a degree of power in decision making by the public. This is agreed to in the light of the expertise that arises from extensive learning and experience amongst a professional group, with the caveat that the ethical standards by which the professionals carry out their work safeguards the interests of individuals and the wider society.

This is not to suggest that disempowerment of individuals is desirable, nor that extensive and good quality information to inform choice is not important. It is simply to point out the potential risk of the erosion of an important component of the patient – professional relationship, namely the importance of trust. To ignore this is to go down the road of increasing prescription as to the behaviours and practice of both clinicians and managers – something we are at grave risk of achieving in the current climate.

The circularity of the focus on person-centredness: A further comment can be made about the methodology adopted as it relates to 'person-centredness'. There is clearly a risk of circularity in the role played by this central concept. The interventions chosen are those that are seen to encourage greater person-centredness whilst one of the quality outcomes is also described as person-centredness. The circularity and therefore limited worth of this part of the methodology, i.e. the inclusion of person-centredness as a quality outcome, is therefore clear.

Concluding remarks and possible direction of travel

An example of describing the impact of an intervention on the relational health of a system can be seen in a soon to be released independent economic evaluation of the implementation of Electronic Palliative Care Coordination Systems (EPaCCS). This was undertaken by the Whole Systems Partnership on behalf of the National End of Life Care Programme. In this work the nature and quality of relationships within local teams was explored to provide an indication as to whether the goal of improved coordination of care could be evidenced. The conceptual framework used was that of Relational Proximity and the tool was the Relational Health Audit⁴.

The findings of this study showed evidence of improved continuity⁵, a key component of co-ordination of care. It also, however, highlighted a reduced level of multiplexity, which is the dimension of relational proximity that provides opportunity to identify a richer contribution to the collaboration between team members in meeting patient needs. The use of this methodology, with its explicit conceptual framework for understanding relationships within a system, resulted in identifying practical steps to enhance the quality of outcomes in terms of coordination of care, whilst also warning against unintended consequences, i.e. that of the loss of opportunity to gather intelligence that could contribute to further improved outcomes.

We have already noted the values that are increasingly expected within the NHS; those of openness, transparency and candour, for example. These are by nature relational concepts in that they involve acting toward each other in ways that enhance the quality of care. Such values can be expressed, and therefore have the potential to be measured, using the language of relational proximity. The links to an understanding of organisational culture and the importance of the modelling of certain behaviours by leaders within these systems also suggests important avenues of enquiry. As we try to understand and manage complex systems in which we seek both resilience and innovation the importance of working to understand our conception of relationships and the part they play in improving quality and reducing risk is clearly vital.

⁴ Both Relational Proximity and the Relational Health Audit tool are licensed for use by Relationships Global (www.relationshipsglobal.net) who retain the intellectual property for these tools.

⁵ Continuity is one of five dimensions of relational proximity, the others being directness, parity, multiplexity and commonality.