Making sense of Paradigms: the health and social care paradox

Paradigms as intellectual and abstract objects are often difficult to 'make real' without their application to an example. This is certainly the case with the diametrically opposite concepts of interpretativism in its many guises (social constructionism etc) and positivism (empiricism etc).

Of particular interest in this regard are the approaches taken by social work organisations and healthcare organisations to the development and implementation of interventions since 1968 (Social Work (Scotland Act)).

Medicine is a science, or so it's practitioners believe, where the application of solutions to health problems are 'evidence based' and empirically tested to such an extent that questioning their efficacy can seem, at times, to be heresy of the first order. As such the dominance of the 'medical model' in healthcare interactions assumes a very hierarchical structure where the decisions (or more correctly, opinions) of a qualified doctor or consultant are seen to be inviolable. Where they are proved or seen to be incorrect then it is most likely this infraction will be ' proved' to be a failure to apply effective evidence to decision making resulting in incorrect diagnoses. At its core is the assumption that the data, reviewed by peers and recommended as a result, is rarely wrong, although, as Richard Feynman (1964) pithily puts it, 'a correct theory has not, yet, been proved wrong'.

 A positivists view of the world suggests that what we see is real, can be measured and brings us closer to the truth. The medical model, which is also bound up in status driven structures within health services where the authority and declarations of senior members of staff is almost sacrosanct (until it isn't) appears to deal in a higher level of certainty. However from a theoretical physicist's point of view, i.e Richard Feynman this level of certainty and the assurances that are implicit within it are misplaced. This 'gap' has caused lots of hang wringing in medical circles, particularly when things go wrong. When they do investigations are undertaken, often with the purpose of finding 'the culprit', whether that is a process or an individual or a group of individuals or indeed a group of individuals applying an aberrant process. Most recently the Francis Report – the investigation of Mid-Staffordshire Hospitals higher than usual death rates – identified a management obsession with achieving 'Trust' status (a level of managerial and financial independence from the NHS as a whole) and the meeting of internal and external targets. The targets were important as this was how the ability of the hospital to achieve and maintain 'Trust' status was to be measured and proved. Targets now rule public services: as a means to 'prove' to tax payers that they are getting good value for their taxes, for politicians to 'prove' their policy objectives have been met and for the different professions to 'prove' how professional, and perhaps scientific, their professions are. However in the case of Mid –Staffs the targets became the reason for the service's existence. The targets superseded the needs of patients. The targets removed professional judgements and replaced them with algorithmic systems to 'reduce the chance of human error'-something which, more overtly, lies at the heart of the systems we have come to rely on when we contact NHS24 for advice.

There are parallels here with social work. To return to Richard Feynman, he talks of exploring why a man may hate his mother to explain the scientific method. The vagueness of the question prompts the answer 'he wasn't loved enough', but also the answer 'he was over indulged'. So he suggests:

"If it was possible, ahead of time, to determine how much love is not enough and how much love was over-indulgent exactly, then there would be a perfectly legitimate theory against which you can make tests. It is usually said when this is pointed out that how much love is and so on…'oh you are dealing with a psychological matter and things cannot be defined so precisely"…yes but then you can't claim to know anything about it." (Feynman 1964).

And this is the quandary for a nascent profession such as social work, or social care as it is also known. To be established as a profession required the establishment of a body of work to underpin it that outlined the key characteristics of social workers and the range of psychological and practical skills required to be admitted to the profession. Social care has been under greater scrutiny than its health counterpart due in no small part to a range of inquiries in to failings within the social work system to care for or protect the vulnerable. Each inquiry adds additional safeguards to the management and oversight of social workers, which is normally represented by an increase in documentation and bureaucracy. This has, in turn, contributed to what has been termed the 'MacDonaldisation' of social work (James 2004), the drive towards performance measured, standardised services, where targets have, he argues, led to the replacement of professional judgement for algorithms, guidance and regulation. Regulation, to some extent, brackets the risk of a fall in professional standards, or at the very least, provides a framework for identifying the failings that occur when professionalism is undermined. However, higher levels of regulation- or confidence-in the completion of a task or a series of tasks, reduces risk but it also removes autonomy from the person competing the task (Smith 2001). Richard Feynman seems to suggest that these 'countable and defined' metrics allow us to know certain things, whereas the indefinite, softer information cannot provide 'knowning' to the same degree. Yet, to return briefly to the health service, it was the obsession with numbers (as a result of failures to meet targets) and the drop in 'care'-a difficult to define, softer, subjective, piece of information-that are highlighted in the Francis Report as being the key to the failings in Mid-Staffordshire (Francis 2013).

The ability to engage with clients, the bedside manner of doctors, the ability to forge partnerships with people and as a result effect and support change are key elements to the social care and health professions. However the skills required to do this are rarely measured in any meaningful way, except by proxy and normally as a result of some form of investigation. And yet 'care' is at the heart of both services. However the obsession with the measureable, with positivism, ignores the importance of the lived experience of the patient or client in co-creating their future, or the lived experience of the social worker or nurse and its impact on how they respond to patients and clients. We may standardise processes, but we have yet to perfect standardising people.

However, how much care is too much? How much care isn't enough? How can we ensure that the caring services are indeed caring? And how, then, can we help them improve? These are much more difficult questions to answer with statistics such that it is tempting to use proxy measures. Client and patient satisfaction for instance. However, whilst it is possible to use questionnaires to produce numerical values which can represent 'satisfaction', that in itself tells us very little. It does not tell us whether the person who completes the form is concerned that by giving a negative answer they might lose what little service they currently receive. It also doesn't tell us that a particular nurse, or a particular social worker, takes a little more time with the client and as a result understands what makes them feel better or well.

The suggestion from so many public inquiries on health and social care failures suggests that systems have to improve. As the Francis report demonstrates, systems alone are not sufficient. Care, that difficult to define and measure subjective element, has to also exist for 'caring services' to be effective.

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