Faculty of Medical Leadership and Management

"Humanising Healthcare" Leadership Forum

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Better Conversations, Better Outcomes: Love over Fear in Health Care

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Firstly, may I say what a privilege it is to address this event. I also want to say thank you to all of you who are in any way involved in the front line - especially, but not only, during the pandemic. I know from my own experience carrying out the review in NHS Highland two years ago and from the many concerns expressed in recent times by, for example, the BMA, that being a health care professional in whatever role is not easy, is demanding and frequently must feel undervalued and not appreciated at the best of times. It is very hard for you to meet expectations, especially at the moment.

So, to my talk. I have chosen the title **Better Conversations, Better Outcomes: Love over Fear in Health Care** for two reasons: firstly, I think it nicely summarises what humanising working in health care is all about; and secondly and more randomly perhaps, the last music gig I managed to get to before lockdown began in March 2020 was a concert by one of my favourite progressive rock bands, Pendragon, who played the whole of their then just released and magnificent new album entitled: Love over Fear. We rocked the night away in the Green Hotel in Kinross.

There is a song from that album entitled "Who Really Are We?" with the following lyrics: "*So don't become one of the blamers, look deep within, and find love over fear".*

Let's pause for a moment, just to reflect on those words. "*So don't become one of the blamers, look deep within, and find love over fear*". Now, I invite you to think about a situation you face at work, at home, or with other people in your life: what do these words mean to you: "*don't become one of the blamers*"…."*look deep within*"…. *"find love over fear…"?*

I'd like to see this occasion as an invitation to ask yourselves some questions; after all it was Tolstoy who said something to the effect that most of us are trying to change other people when the only person we can really change is ourselves. Gandhi and Mandela said much the same. And yet we ourselves are probably the most difficult person to change.

As William Ury observes in Getting to Yes with Yourself:
"In the morning when I look at myself in the mirror, I like to remind myself that I am seeing the person who is probably going to give me the most trouble that day, the opponent who will be the biggest obstacle to me getting what I truly want."

Acknowledging that challenge, what might we need to change in ourselves as we contemplate the things that we don't like in life or as we seek to see changes made in our

workplace or home situation? I invite you to continue to think about that situation you face as we explore some ideas this morning.

Back to Love over Fear. The point I seek to make is a deliberately provocative one. Feel free to disagree with me. I hope to stimulate reflection.

As the OECD have said in a report a couple of years ago:
"We're beyond quick fixes to address the discontent of people. There is no returning to the past. Too many things are not working for too many people. The only way forward is not to patch up ..., but to shake it up.
We are confronting a …foundational moment: one that demands decisive cures, rather than palliatives. These times require the … boldness, innovation, and above all, the long-awaited action to recreate, with our employees and stakeholders, a fair and prosperous future for all."

I'd like first to talk about fear; I'll return to love later. That's because we need to address the symptoms and the diagnosis before approaching the remedies and prescription.

One of the catch phrases from my report into events at NHS Highland was this: "*Fear cannot be the driver*". What prompted that expression, I think, was wondering if a lot of the human difficulties which occur in the NHS are in reality driven by an underlying fear. Fear of being found wanting, of being found out, of failing, of being shamed, humiliated, of being blamed, of criticism, of not meeting targets, of being penalised, of not coping, of appearing weak, of just not meeting expectations, however unrealistic these may be… Might this seem familiar to at least to some of you?

Fear like this can be insidious, demoralising, tiring, demotivating, frightening even. It certainly is likely to lead to sub-optimal performance, especially if anxiety becomes widespread. We also know that fear can manifest itself in feelings of being threatened, of anticipated loss (whether that be loss of job, of earnings, of security, of status) and this can result in outbreaks of emotion, sadness and sometimes anger or other aggression towards others.

We understand all of this in terms of the neuroscience and the many cognitive biases that lie underneath, as it were, and which are highlighted in Nobel Prize Winner Daniel Kahneman's well recognised description of system 1 and system 2 thinking. The reptilian brain's fight, flight or freeze reactions into which we retreat under pressure; in contrast with the more measured thoughtful response generated in the neocortex.

(Incidentally, if you haven't read or skimmed Kahneman's Thinking Fast and Slow, it is probably a must read, as I suspect is Kahneman's new book with co-authors entitled Noise – especially if you work in any way in diagnostics and want to know why patients presenting with the same symptoms often receive different diagnoses).

Back to fear. When we are frightened, self-protection, a primitive and essential resource for physical survival but much less useful in social situations, kicks in and kicks in quickly when we feel danger. That may present sympomatically as anger. The angrier the mask, the more

threatened we may actually be feeling. This can so easily overflow into what is perceived by others as bullying or harassment.

And those perceived as the bullies tragically often feel bullied themselves as fear rebounds up and down and in and around the system. All of this can become institutionalised, especially if the example coming from the top is unhealthy as seems to have been the case in more than one NHS region. The dysfunction may fester and spread.

The writer Donna Hicks has said this:

"All human beings are unique; there is only one copy of us around. Something so precious deserves to be treated as invaluable, priceless, and irreplaceable.

Yet, not a day goes by when we don't experience some kind of violation to our dignity—a rude remark, a critical tone of voice, a dismissive gesture intended to make us feel small. We all know the crushing and intolerable feeling of being shamed.

We human beings have an uncanny way of knowing how to psychologically hurt one another, and the attacks are always aimed at the most vulnerable aspect of our being— our dignity, our sense of worth.

We share this vulnerability, just as we are all prone to physical attack and injury. Whether we are aware of it or not, when we inflict wounds on one another, they are meant to make us doubt the very core of who we are.

They leave us with the question, "Am I good or am I bad?"

The truth about wounds to our dignity is that they don't go away. They accumulate within us until we do something radical, like scream at someone, walk off a job, leave a marriage, or start a revolution."

And it can become chronic: this is from the Annual Report in 2018 from the Director of Public Health for NHS Highland on Adverse Childhood Experiences, Resilience and Trauma Informed Care:

"Essentially, unless an individual can view the world as being manageable and meaningful, they will experience a state of chronic stress."

All of this is exacerbated of course in a pandemic, where major political upheaval has occurred with Brexit and may occur again with an independence referendum, and in a world where climate change looms as the greatest ever existential threat to our species. It's quite a mix.

I suppose that this may mean that at times it might almost be as if the NHS is in a collective trauma. Those who understand these things will bring more wisdom than I can. But I know that some people in NHS Highland for example recognised that there were features of inter-generational trauma, traceable back to the Clearances. That is one illustration.

And for how many of us is the wounded or adaptive child worrying away in our limbic brains as we struggle with who we are and how we are coping, especially when under pressure, with limited resources and fear of failure?

These are comments from my report:

"*…medicine is now a team game in delivery for care. Constrained resources. Someone has to make decisions about prioritisation. Our doctors sometimes don't step up into that more modern role*. *If put under pressure, can retreat into that traditional role*."

"You see the management firefighting all the time. Their reaction under pressure is a bullying one."

There are all of these layers. We need to try to understand at a deep level. I sought to cover this in the chapter in my report on human nature. Underneath the symptoms of anger and aggression, we recognise those feelings of fear, induced by perceptions of threat, guilt, loss. Strip that away, we are told, and there lies a deeper need, the need to be loved, to be appreciated, acknowledged, accepted for who we are and for what we are trying to do.

I often condense some of what I understand from the once-fashionable ideas known as Neuro Linguistic Programming into the proposition that "everyone is trying their best in the circumstances in which they find themselves". Isn't that so true, of you, your colleagues, managers, consultants, civil servants, even the Cabinet Secretary?

And yet…..and yet… so often we look for scapegoats as we comfort ourselves in our tribes or echo chambers and seek reinforcement for our assumptions and beliefs, ignoring the often obvious alternative points of view – confirmation bias and wilful blindness kick in. They say we're not divided by our differences but by our judgments about one another. Them and us. Villains and victims.

The binary, adversarial world of right and wrong, black and white, in and out, win and lose, discipline and grievance. A transactional world in which we treat each other and are treated more like widgets than highly complex multi-layered human beings. Where what separates us is given more importance than what unites us, that which we have in common, which is always far greater.

A world in which authoritarian hierarchy and the language of command and control (I remember the word "grip" being used to describe financial discipline in the NHS), entitlement and status, deference and obedience, careful monitoring, coercion, even military titles, officers and of course uniforms, are still commonplace, and a blame culture may prevail. All of that, it seemed to me at the time, played a part in what went on in NHS Highland in the past and perhaps more widely in the NHS.

The economists, John Kay and Paul Collier, reflect on this in their excellent recent book Greed is Dead: activities in the public sector world, they observe, like health and care, are

high in intrinsic motivation but are hard to monitor, so workers are turned into automata, to be monitored and incentivised rather than trusted for their judgement.

That world seems to leave little, or not enough, space for nuance, ambiguity, paradox; and yet we now live in what is described as a VUCA world: volatile, uncertain, complex and ambiguous. Radical uncertainty as it has been called. How keen we are to assume that we can keep everything simple and control it from above or from the centre. That however is an illusion. It can't be done. Human relations are complex and human relations in the NHS are set in one of the most complex institutions we have yet devised. We need competence in that complexity.

So now we've described some of the presenting symptoms, at least provisionally, and carried out a bit of diagnosis too. What about the remedies?

Well, for me, this is where the love bit comes in. We're so afraid, embarrassed even, to use that word because of all the connotations of softness and touchy feeliness. But love, in its broad sense, is what makes the world go round, go round in a way which is liveable.

Or perhaps we should call it compassion… or kindness. It's good to hear these words being used so regularly now in the NHS. Whatever word we use, it is not soft at all. It's hard to do kindness and compassion really well. To love is demanding.

I like the way that that great character Archbishop Desmond Tutu puts it:
"Compassion is not just feeling with someone, but seeking to change the situation. Frequently people think compassion and love are merely sentimental. No! They are very demanding. If you are going to be compassionate, be prepared for action!"

The University of Edinburgh Global Compassion Initiative supports the imperative to be compassionate:
"Developments in neuroscience and psychology are providing evidence-based insight into the importance of values and character-building to health and well-being in an increasingly secular age. Compassion is a defining human ethic."

To see others, including those who do you wrong, through the lens of compassion, to seek to understand them, takes great courage and self-discipline. To understand that there are, almost invariably, two or more sides to every story. "They" may be just as "right" as you are. Or, as someone once put it, in retrospect, everyone is "wrong". It just depends on your perspective, your standpoint.

All of this should make us humble. Humility is a much-needed commodity in the world today. It is a source of much wisdom.

Let's pause: and consider that difficult situation again: what is the other side of the story? How does the other person see it? Might they be right from their perspective?

I mentioned kindness. As I mentioned, it's good to see kindness being discussed in the context of healthcare, not least by the excellent Carnegie UK Trust, whose latest podcast

The Courage to be Kind was launched last week, exploring the transformational potential of kindness in the recovery and renewal of our health service. I recommended it highly.

In practical terms what might this mean in the context of humanising healthcare? I am going to focus on caring for the carers. Much of what I say applies, rather obviously, to patient care too, but I sense that for patient care to be really optimal, it's the care that is afforded to and between NHS staff at all levels that also matters. Being people-centred in all respects.

I return to my main title: Better Conversations, Better Outcomes. The former brings forth the latter. A lot of this is about communication. And Better Conversations are founded on the rock of Better Relationships, the keystone to any functioning institution.

As someone said to me in NHS Highland:
"whatever change we seek to undertake, we are only as good as the relationships we are able, or capable of creating and sustaining."

If you go far enough into philosophy and science, it is now proposed that nothing exists apart from in the form of relationships, in the interactions of an entity with other entities at the moment in time when you observe it. Want to know more? Read the brilliant Italian physicist, Carlo Rovelli's latest book, Helgoland.

Back to the "real" world: To be able to talk openly and candidly, without fear, in safety and security, about what matters to you, to the patients and to the service you provide, is vital. To do so, you don't have to be great buddies with all those with whom you work but you do need to respect them and feel respected by them – and be able to work alongside them comfortably. I would argue that building relationships of respect and trust deserves, indeed demands, the same resources and infrastructure to be provided that the health service devotes say to technology, real estate and diagnostics.

I believe, and my experience of countless training courses shows, that building and sustaining relationships of respect and trust can be learned and practiced as a series of skills and competencies, honed and refined over time, supported by ongoing professional development just as you would, or should, experience as you learn to work with the latest innovations in medicine or equipment. This is fundamentally a skills issue.

As an NHS Highland Public Health report put it:
"*The key, then, is to pay attention to the emotional, psychological and spiritual resources that allow people to build relationships and establish social networks, so that people have opportunities to find what is meaningful to them, in a way that fosters optimism and control."*

Scotland's National Performance Framework tells us that the system stuff (the processes, the structures, the task in hand) can only operate effectively if we attend to the human stuff – the dynamics between people, personalities, perceptions, relationships. Incidentally, a colleague pointed to an article about the ecosystems of forests, with these words*: "they're*

built on relationships. The stronger those are, the more resilient the system." This applies to more than trees….

And as my friend and conflict resolution guru, Ken Cloke, puts it:
"...nearly all of our focus in solving ...problems and making decisions is on the content, and comparatively little is devoted to improving either the processes or the relationships. This is often because of pressure to deliver, achieve results, under great pressure. Short term gains [but] with longer term losses."

So, he says:

(a) *the substance or content of the problem must be successfully identified, discussed, addressed and resolved;*
(b) *the process for solving problems and making decisions must be inclusive, transparent, effective and fair; and*
(c) *the relationship between the people who are impacted by the problem, or trying to solve it, or make decisions about it, must be respectful, constructive, trusting and collaborative.*

This means that we should learn not to try to overcome others but to cooperate with them, even if the culture has been competitive and resources are limited. This also means encouraging and nurturing a culture of openness and learning, not of blame and fault.

The airline industry was transformed in the 1970s by moving to such a culture of responsibility rather than culpability. Too many aircraft were going down with significant loss of life. How often does that happen now? Perhaps not many aircraft are flying at all at the moment of course. But think of the years before the pandemic. A serious air crash has become a very rare occurrence. The Times columnist and writer, Matthew Syed, in his book Black Box Thinking, contrasts the openness of the airline industry with what he views as the protective health sector. As I recall, graphically, he cites loss of life in hospitals in a closed, protective culture, likening this to a jumbo jet going down on an almost daily basis. That may go too far, you say; but the point about culture is made.

And perhaps that takes us back to fear; to the Government official or the Health Secretary phoning the chief executive of a health board on a daily basis and demanding to know why targets, politically motivated, are not being met. The danger is that, in response, the focus turns to manipulating the figures to meet the political promises, to diverting attention to only that which is measured, or to concealment to avoid blame. That can't be the right way to get the best outcomes.

This cri de coeur in my report rather summed it up:
"It's the most unrewarding organisation I have ever worked for. How do you measure success? You're here to deliver care – how do you measure the care? I can tell you how many people are in a queue – how many we have failed. A good day is when you don't fail as much as a bad day."

There's something more here about trust and empowerment. About devolving decision-making, as Kay and Collier argue needs to happen in the NHS, in their book Greed is Dead. Shedding the illusion of centralised competence and permitting fallibility and vulnerability.

Ken Cloke again: *"there needs to be a shift from paradigms which are power-based (resting on hierarchy and status, win/lose, operating by command, with an expectation of obedience) and/or rights-based (resting on bureaucracy, operating by control, with a high expectation of compliance) to one of mutual interests, with shared vision and openness, where power and decision-making is shared, and distributed, wisely and thoughtfully."*

This suggests dispersing decisions and indeed leadership. "*We thrive when we have some purpose in our lives other than self-indulgence, and the ability to contribute to it*," argues Paul Collier. Do things with people, not to them. Recognise the dignity of mutuality and reciprocity, where everyone has an active role to play. Focus on shared interests and common objectives. We can see society, and the NHS, as a vast web of cooperative activity sustained by mutual kindnesses and reciprocal obligations. We can help people to flourish, thrive: eudaimonia I think the Greeks called it.

As a professional mediator, I am passionate about what empowering people to address difficult issues for themselves can achieve, in my case with the help of a skilled impartial third party. I see it week in, week out. So, as I did in my report, I'd also like to make a plea for better management and indeed containment and avoidance of conflicts and disputes. The complaints, grievance and disciplinary processes may occasionally be necessary but they are essentially backward-looking and unhelpful.

Far better to introduce early low level preventative measures than to engage in such invasive procedures. Catch it early, don't let it fester. Train teams to have conversations about difficult matters before they escalate, make time for this, have an in-team or in-department facilitator or mediator on hand, use mediation rather than an adversarial, accusatory process whenever people fall out. Nip things in the bud.

As with medicine itself, these early steps would save so much in stress, broken relationships, reduced morale, poor performance, and anger which turns into bullying.

I note that recently the conciliation service ACAS published a report in which it argues for these very things.

Their analysis estimates that "*the overall total annual cost of conflict to employers (including management and resolution) stands at £28.5 billion. This represents an average of £1,028 for every employee in the UK each year, and just under £3,000 (£2,939) annually for each individual involved in conflict."*

They go on: *"What is beyond doubt is that conflict, and its effective management, is a critical issue for organisations in maximising productivity and efficiency. More fundamentally it underlines the link between employee wellbeing and organisational effectiveness.*

*Overall, [*they say that*] their analysis has a number of important implications for organisational practice. First, investment in effective and early resolution designed to repair the employment relationship may have a very significant return. For example, if managers identify problems at an early point, then unnecessary resignations can be avoided and issues with conduct and performance are less likely to escalate to the point of dismissal.*

Second, organisations need to place much greater emphasis on repairing employment relationships in the event of conflict and taking action at early points to address issues of capability and poor performance.

*Third, [*their*] estimates provide support for approaches to disciplinary issues that focus on learning and avoid blame. [*ACAS*'] analysis shows that formal procedures are associated with high levels of resignation, dismissals and sickness absence. Therefore, they should be the exception rather than the rule.*

*Finally, [*they tell us that*] previous Acas research has identified 3 main barriers to effective conflict resolution which organisations need to dismantle if they are to reduce the cost of conflict: ….most importantly, low levels of management skill and confidence... The relationships between employee representatives and HR practitioners are also critical in helping to facilitate early and informal resolution. …But perhaps most importantly, managers need to have the core people-skills to have quality interactions with their staff*."

So, there we have it. And yet, this is all very easy to say. Many more before have said the same. But translating this into action is the tough part; as you know, changing habits, both personal and institutional, takes time and commitment. We need to reset the neural pathways, both individually and in the organisation.

What I'd like to say to this conference of the Faculty of Medical Leadership and Management is that this takes real leadership.

Recently, I noted this definition of leadership, or eco-leadership as it is described:

""Eco-Leadership" is very much the environment where we are concerned with emergent change, where we are no longer leading change in a traditional sense, but creating the leadership capacity under which we can handle ambivalence and uncertainty. In this situation, the leadership role is increasingly about interpretation and sense-making for the organisation."

Some people would call this servant leadership rather than the traditional heroic leadership of old. As Paul Collier, again, put it recently, an overarching moral task in a society, and perhaps of any leader, is to build organisational cultures pervaded by a practical ethic of decency.

And here I'd like to pay tribute to NHS Highland. From what I can see, that organisation is now making a real effort to transform its approach to its people. They have what they call a Healing Process. It is well worth going on the website to explore what they are offering. The

present leadership has the authenticity, humility and courage (and it takes all of these) to admit mistakes and to say sorry, without reservation. It is taking responsibility from the top down for what was once a dysfunctioning institution and which might yet become an exemplar for others to follow.

Part of this is about letting go, letting go of the past, of things that may have defined you, given you a sense of identity. Both as an institution and as individuals. Forgiving – and being kind to - others and yourself. Choosing not to let others determine how you see yourself. Learning to thrive in the present and to look forward.

I think we can see how difficult things have been in places like NHS Highland. And yet this is probably the only way. It is the way of compassion, kindness and, yes, of love. Indeed, that is our prescription for healing. We've recognised the symptoms, conducted our diagnosis, pointed towards the remedy. It's getting to that place of love over fear. Indeed, I read recently that once you start to choose love over fear, your world becomes infinitely more safe, loving and open.

As we conclude, I invite you to go back to that situation we thought about at the start, at work, at home or wherever. Ponder that situation again now and ask some more questions: What might you do differently tomorrow? What might you do differently to change things? What might you say? What acknowledgement or reassurance might you offer? What encouragement might you give to someone else, perhaps just by listening - with a kind heart? By the way, it's ok to take small steps – the real differences lie in the margins.

The following words have been attributed to Viktor Frankl, holocaust survivor and author of Man's Search for Meaning: "*Between stimulus and response there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom*."

Find that space, make those choices. And remember, there is no them and us, only us.

Thank you.