

Caring about carepaths: on locus of control, holons and weltanschauung

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Stakeholders in acute care experience problems at various levels and in many places. Numerous critics have pointed to flaws in the system such as fragmentation, structural deficiencies, lack of clinical governance, insufficient resources, serendipitous rather than planned outcomes, poor systems and neglect of health promotion, prevention and education, to mention only some. It is not surprising that the Australian Senate has conducted two enquiries into aspects of the health sector over the last two years (Senate Community Affairs References Committee 2000a; 2000b; 2001).

A current topic receiving a lot of attention in acute care is how to improve safety and quality. The establishment by the Australian health ministers of the Australian Council for Safety and Quality in Health Care is a crucial part of this strategy (ACSQHC 2001a). The Council, reflecting on its work to date, has identified several emergent lessons: a systems improvement approach is needed, as are greater openness, incentives and sanctions, and collaboration (ACSQHC 2001b).

In the minds of many, improvements in safety and quality will be actualised largely by promoting a more systematic, shared approach to care processes at clinical unit level. There is a concept from psychology and another from systems theory that may be useful to help our thinking about this. The former is about locus of control. The latter is about the holon.

Locus of control

First, there is locus of control. Where does accountability for a problem, and for its resolution, lie? Rotter (1966) proposed that those with an internal locus of control believe their lives tend to be self-determined, while those with an external locus of control believe that their destiny is largely governed by other more powerful agents, or luck. At the individual level links have been found between locus of control and behaviour (Hampson 1988). Colloquially, you act on the world or it acts on you.

However, the health sector is not only a series of discrete individuals with varying degrees of locus of control providing services, but is a social system as well. Too often in a pluralist undertaking like health, it is not clear whether responsibility for a particular task is individual or shared. Of course, the doctor's name is at the foot of the bed, and he or she admits, treats and discharges patients, but responsibility is both personal and multi-disciplinary simultaneously. And in a complex system, it is not always obvious who is doing what, when and to whom. Sometimes we find not only cost-shifting but also responsibility-shifting. This is commonly called blaming. When people indulge in this kind of response they may feel good for a while but their behaviour is no substitute for taking steps to do something sustainable about the problem. Blaming reflects an external locus of control – it is someone else's fault. Taking charge demonstrates an internal locus of control, and is about leadership.

The holon

Second, from systems theory, the notion of the holon has become prominent (Checkland and Scholes 1999; Wilson 2000). Systems thinkers like Checkland (1972; 1981) have long been concerned with the term 'system' as it is used in common parlance. In such usage the system roughly equates with a part of the world – one's clinical unit, say, or a health service, or even the whole health sector – which has (or is projected by the perceiver to have) some amount of interconnectedness.

This is often more assumed than actual: if you observe health sector behaviour (indeed, any kind of organisational behaviour) ethnographically, it becomes apparent that there is less interconnectedness than stakeholders typically think. Each actor in the system relates intensively to a surprising few organisational others. To avoid confusion, systems theorists have proposed the use of the term 'holon' in place of system. A holon is "a representation of a part of the world that has emergent properties, a layered structure, and processes of communication and control" (Hindle and Braithwaite 2001).

The case of Cairns Base Hospital

The point of this excursion into psychology and systems theory is not to raise obscure but possibly interesting epistemological accounts cleaved from health sector problems. Time is too short for that. In this issue of the Australian Health Review, a paper by Pearson and Macintosh (2001) neatly exposes some of the central issues of taking responsibility for care processes in a systematic way. In response to the tacit question: "where is the locus of control?" they implicitly respond "with us". They discuss their experience with the implementation of clinical pathways at Cairns Base Hospital. They are careful to outline not only some of the benefits in this experiment, both anticipated and unplanned, but also some of the risks. The tendency to report success in published work is well known to both the scientific and social scientific research communities, and balanced accounts – and even reports of plain old failure – should be encouraged.

Their experience is not about failure but of grappling with change successfully, against various constraints and challenges. In the course of their paper Pearson and Macintosh also draw to our attention some of the holonic features of acute care processes. They are emergent, by which systems thinkers mean that processes never end, and they constantly throw up new and interesting events and issues. The processes are part of a layered social system such as the clinical pecking order. A central process issue that requires attention is communication (and the relationships that go with it). Another, as the cyberneticists point out, is control (Weiner 1948). Processes do not run themselves and need constantly to be monitored, managed and improved, although Plsek and Wilson (2001) maintain that we need less command and control and more creativity. Without using technical systems language, Pearson and Macintosh show how they are acutely cognisant of the notion of holon – that health care processes are human activity systems and need to be organised and systematised, otherwise they are prone to failure, or at least to produce uncontrolled outcomes. This can be a matter of serious consequence. Neglect to organise your processes and the path may lead to Bristol, as the final report into the most famous recent breakdown in the system in the United Kingdom argues (Kennedy 2001).

There are many health sector issues that local practitioners cannot address directly: State-Commonwealth structural impediments, how funding is organised by purchasers and what technology will come next, for example. But they can act existentially and concertedly within their own domain. With an internal locus of control and an appreciation of their own holon, health professionals working together can impose order on what otherwise can be poorly controlled processes of care.

A final concept drawn from soft systems theory might help in interpreting Pearson and Macintosh's contribution. Hindle (2001) has raised it in his complementary editorial. Philosophers of systems are apt to talk about *weltanschauung* – the world view of any stakeholder in the system (eg, Churchman 1971). We can imagine that Pearson and Macintosh were not always interested in organising care processes, systematising work and analysing the very social system in which they are embedded. Their *weltanschauung* has shifted to the point where they see this as crucial for patients and central to their professional concerns.

We have a long way to go, but might we be observing the early stages, and in the very act of it unfolding, a change in the *weltanschauung* of a critical mass of people within health to one predicated on organising care for safety and quality? This is an empirical question, and we will need to see more evidence than the occasional case study, no matter how well done. But experiments like the one Pearson and Macintosh have run may suggest it is time to begin to be quietly optimistic.

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