The Care Factory

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Dedicated to Marcia Ogunji

‘You cannot, after all, commit a bigger outrage than you do when you enter into, or seem to enter into, a person’s mind.’
—W.R. Bion, ‘Four discussions’ (1976a)

‘Care is like pain: it’s what the person concerned says it is... ‘
—Senior Lecturer in Children’s Nursing, U.K. University (2015)

CONTENTS

Care (*kɛː*)

noun
1. the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something.
2. (British) Protective custody or guardianship provided by a local authority for children whose parents are dead or unable to look after them properly.
3. serious attention or consideration applied to doing something correctly or to avoid damage or risk.

verb
1. feel concern or interest; attach importance to something.
2. look after and provide for the needs of.

Factory (*ˈfakt(ə)ri*)

noun
1. building or group of buildings where goods are manufactured or assembled chiefly by machine.
2. (historical) an establishment for traders carrying on business in a foreign country.

(Oxford English Dictionary)

INTRODUCTION

The Care Factory consists of six provocative and ruminative essays on the subject of care. Each of these is an invitation to the reader to form an opinion on what care happens to be. What do we mean by *care*, and how do we know it when we see it, when we feel it, or when we miss its presence? In order to address this question, each chapter looks at care in a different setting – some professional, some social and some familial – and a variety of psychoanalytic frameworks are employed on which to hang arguments.

The first chapter, 'The Care Factory', is both eponymous and introductory. The emphasis is on healthcare settings, and also on Higher Education. The chapter investigates the reality of undergraduate courses in nursing and midwifery that contain care on the syllabus. In universities all over the world, students are taught the values and importance of empathy and care as part of nursing and midwifery educational programmes. But how can care be taught? Is it *possible* to teach care to students (and by implication, to anyone)? What if the person teaching the care is not someone who cares? This chapter contains an interview with a Senior Lecturer of Midwifery who has chosen to remain anonymous; in addition to what we find in this chapter, four further interviews with Senior Lecturers stitch together consecutive chapters of *The Care Factory*.

The second chapter is 'Banquet of Crumbs'. If care can be experienced in any setting and at any time (a proposition with which most people will agree), is there anything that happens to those who care, in or after the operation of giving care, that we might regard as generic? Or to put it another way, when care takes place in changing professional contexts, what does caring do to the practitioners who care, and is this reaction something that the care-givers have in common? At its heart, this chapter embraces the theory of emotional labour as devised by Arlie Russell Hochschild (who is interviewed). Here, we are not so much interested in 'Who cares?' as 'Why care?' Barring psychopaths, sociopaths and the most committed of loners, everybody cares about something or someone; and our provision of care for others is inbuilt and programmed. In 'Banquet of Crumbs' I also interview a Professor of Occupational Health Psychology (Gail Kinman), and I allude to a situation in which portions of care are freely available.

The focus of ‘The Breaking of Wings’ is prisons and secure settings for children and adolescents. How do such institutions endorse and exhibit care (and for whom do they do so, the offenders or the staff who work there)? What professional dynamics are in place in a children’s prison? While contemplating the contents of this chapter, either the reader will feel comfortable with the notion of children in prison (the caveat accepted that the child has been proved guilty of a serious crime); or the reader will be fundamentally opposed to the incarceration of minors (with the understanding that he is aware of the ‘correct’ fate that child criminals should face instead). To deem the matter ethically murky is a masterpiece of understatement for many, but there are those who have much more definite views. One of the latter is Carolyne Willow, a tireless opponent of child incarceration, and she is interviewed here.

‘Nostalgia’s Engine’ guides the reader away from the professional workplace. The focus is on the care generated by successful group assimilation, on the one hand; by the manufacture of nostalgia, on the other. What we internalise and usefully corrupt into nostalgia is not quite real, but it *is* a form of care – or self-care. ‘Nostalgia’s Engine’ aims to convince the reader of this much, as well as exploring notions of care that result from social inclusion. Using the example of the burgeoning punk movement of the 1970s (in the UK), this chapter describes how organisations offer their participants communities of care – safe havens – irrespective of their outward appearance of hostility or defiance.

At face value, ‘Caring for Our Creations’ is about writing, and about one’s (psychical, egotistical) responsibilities for what one crafts and drafts into existence. This chapter is not so much about a narrative of care as the care of a narrative. It was conceived as the result of negative feedback that I received for a paper that I co-authored, about the surrogacy industry, at a Writing Retreat that I facilitated in 2015. This chapter draws interesting parallels between written creativity and biological processes; the question of what care happens to be remains pertinent.

‘Take Care: A Coda’ is intended to be a lesson – or a *description* of a lesson – on how one cares for oneself in an atmosphere of tension and bereavement anxiety.

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As with most longer writing projects (at least for me), *The Care Factory* had a number of influences that seemed solitary and lonesome at the time of composition; but which I realised, predictably enough, were shackled and chained to one another, on consequent inspection.

I CARE is an initiative that was devised by the dedicatee of this book, Marcia Ogunji, at the University of Bedfordshire in 2014. To quote from the website: 'I CARE is an initiative with a long term view, designed primarily for Healthcare students. It is also relevant and open to all those who are preparing for caring professions' (I CARE, 2015).

I was pleased (in fact, flattered!) to be invited to participate in the first conference, and the experience scattered seeds that I would take my sweet time in harvesting. By the time I had attended a meeting of a Psychoanalysis and Education Working Group in Canterbury, over Halloween 2014, I was ready to move to my own next chapter. I had published *Fragile Learning*, and I had discussed it, in part, over that (scorching) weekend; the fact that I was spurred to write something new was only partly a result of the participants' submissions. Very easily I remember taking a bus from Canterbury to Whitstable, where I was staying with my brother. On that one bus journey, so pumped up with enthusiasm was I, that I filled a page of my notebook with ideas for titles and chapter contents.

By the end of the thirty-minute journey, I had settled on *The Care Factory*.

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A good title is important – we would surely agree on this much – but what makes it good? What do we mean by *good*, in this context? Arresting, thought-provoking, poetic, enigmatic or strange? Any of the above? Any combination of the above?

'I'm not being flippant,' writes Stephen Fry in *Paperweight* (Fry, 1992, p. 100): 'titles are very important to writers, and to readers too.' Fry was reviewing *The Book and the Brotherhood* by Iris Murdoch. He continues: 'The words of this title pound like distant drums in the mind as you read, just as they pound in the minds of the novel's characters as they live.'

By modest extension we might submit that the words of any title should pound in the skulls of readers and writers alike. A title is your constant companion, and the relationship is not always straightforward. For me, the image of an isolated factory, crowning a hill, in the rain, is a striking one: my equivalent of jungle drums. And the central paradox of the existence of a place (and a business) that manufactures an emotion akin to compassion and kindness is crucial. Not only should it be impossible to create sympathy from raw materials, in a manned facility; it should also be impossible to produce something that is so embedded in the

heart and the psychic apparatus in a way that it is consistent with the next batch. When it comes to care, the question of quality control is complex and debatable.

Ultimately, titles mean what you want them to mean... just like the concept of care means what you want it to mean (to paraphrase the Senior Lecturer whose words form an epigraph at the start of this book). For me, there was never another title: while the title might have shaped the contents, and not the other way around, it was always *The Care Factory* – my unconscious never wavered.

Originally, however, the book had a different focus. I was several thousand words into a chapter entitled 'Lieutenant Columbo's Pockets' before I realised that the project required more inceptive labour. As there is next to no chance that I will ever write the book that I had intended to write at the time, it does not seem like a self-betrayal to reveal what it was.

My original plan was to follow a person's life – to tell a person's story, from birth to death – by exploring his or her interaction with the relevant healthcare services. A *Bildungsroman* anchored in a succession of healthcare mirrors, as it were, with each mirror telling a part of his or her story in chronological order. For example, the book would have started with a chapter that was both 'about' and 'from the point of view of' midwifery services. By telling its own story (a tale full of intrigue, heroic triumphs and dismal failures', the character of midwifery itself would have been revealed, and a picture of my patient character would have emerged... Or something like that.

My problem was, although I knew people to talk to about midwifery, child nursing, adult nursing – even mental health nursing – the book refused to evolve and slither out of the psychic slime to clean its own wounds and limbs. It's still there now, for all I know, awaiting its chances to appear... although my references to it this very bright Spring morning might have killed it, once and for all.

'Lieutenant Columbo's Pockets' did not really fit into the plans I had for the book. However, because I liked the title, I persevered with the absolutism of its inclusion. Not only did I intend to pay tribute to the greatest fictional detective who ever lived (yes: lived), I would have used John Steiner's *Seeing and Being Seen* (Steiner, 2011) as the chapter's core text, thereby paying homage to that masterpiece of psychoanalytic literature at the same time. Or something like that. I wanted to throw light on a comparison between Steiner's psychic hideaways and Columbo's tendency to store, lose and then conveniently find and re-find objects (scraps of paper, receipts, chewed pencils) at junctures that are most

unnerving and unsettling for his interlocutor in the scene, who usually happens to be the murderer.

Our beloved field of psychoanalysis (which we adore, which we find maddening) is built on the prospect of things changing – or rather, on the tension between things changing and things remaining steadfastly in stasis. No less than is the case with psychoanalysis, the creative act is riddled with similar internal, Kleinian and post-Kleinian conflicts. As a writer, one is torn between acceptance and denial, more or less on a minute-by-minute basis: certainly on a sentence-by-sentence basis. What you hold in your hands now (or what you read on a screen) is not my first take, necessarily. Some clauses needed urgent and immediate midwife intervention, to keep them breathing.

As the pen slips from left to right, across the page, abandoning a deposit of cyphers and shapes in what is called my handwriting but what always seems more like my brainwriting, I long for the perfect construction – the exemplar sentence, the flowing paragraph, the dream page. And sometimes, of course, they arrive: ideal children; full of life without being cocky; articulate offspring, and not a single sloppy vowel movement between them.

Other times, it is more problematic. For example, having failed the quality control inspection, ‘Lieutenant Columbo’s Pockets’ was dropped; and yet, this omission notwithstanding, here I am, discussing it. By writing about not-writing-about a subject, one is both writing about the subject and is writing off – or expelling – the very nature of there being a not-writing-aboutness in the first place. Although I maintain an uneasy balance with some of Jacques Lacan’s thinking – some of the time believing I have understood it; at other times feeling like a dog that is being shown card tricks – I am fairly confident that what I am discussing is a Lacanian construction – a Lacanian epiphany. After all, Lacan was arguably the greatest mapmaker of the hypothetical that we have so far discovered. Granted, his cartography was occasionally smudgy; and if we wanted to extend the metaphor further, we might even claim that some of his discovered countries were improvably distant – or even ‘imaginary’, in the sense of non-existent. Lieutenant Columbo might return to solve another case in due course.

It is not true to assume that Columbo was my only casualty, of course. When I first settled into the early idea for this book, Chapter 2 was going to be called ‘Hollow Bones’. It would have compared the care offered by parent birds to their young in the animal kingdom with that provided (for a hefty price) by organisations that train people not to be frightened of flying on planes. The impetus for the chapter was my sister-in-law, whose

behaviour on aircraft had always called out for a new definition of the term *nervous flyer*. Sharon had always been less a nervous flyer than a woman pathologically terrified of take-off and landing (and truth be known, not all that happy about the cruising part either, but at least numbed and muted by vodka and Valium by mid-flight).

For my sister-in-law, the training course was successful: she no longer dreads flying – nor plummeting from the sky. The care worked. And it is only in retrospect that it occurs to me that my asking my sister-in-law to go through what she learned at the Fear of Flying workshops was almost cruel. While she might not have minded (or claimed to have minded, or even believed that she minded, none of which are the same thing), my asking will have reminded her of the fear of flying that had sent her there in the first place. In which case, have I exhibited care?

In which case, do *I* care? And other than me, *who* cares?

THE CARE FACTORY

Let us abandon metaphor.

For a limited time – for the time it takes the reader to absorb these words – let us be nothing but literal, and assume the existence of an *actual* Care Factory, a building in which Care is manufactured.

What does it look like? What image does *the Care Factory* conjure up?

We think first, perhaps, of an *anonymous* factory, the products of which are unknown (though debatably important). Out of the psychic darkness and into our conscious thoughts, we drag a photograph that we have long since introjected and internalised as an object, be it a good or a bad one. It does not matter if we have ever seen such a building with our naked eye; if it is a composite of interbred memories and televised footage; if it is entirely of our own creation (however unlikely this might seem); or indeed, if it is the product of a cross-contamination of others' dreams and cultural expectations – in other words, if it is what we are *supposed* to think of when we exercise the word *factory*. We are caught in an image that is likely black and white. Smoke billows from vast chimneys. The skies are stained the greys of your worst headache; the skies are full of dark eyes, surrounded by the puffy flesh of the true pessimistic insomniac.

This is *the Care Factory*. Its product is Care... Do not confuse the Care Factory, please, with a care superstore – nor even with a care market. Here in the Care Factory the emphasis is on mass production; on quantifiable outputs of Care. With samples fabricated in perfect packaging (identical in size, endurance and goodness), we have Care by the pallet-load; Care by the barrel-load… Take a look inside the Factory's noisy walls, and you will see where Care begins its crucial life. Care slides through chutes and rolls by on belts. Care Factory Operatives, decked out in sober uniform (with long hair tied back and a mask over mouth and nostrils) monitor the production of parcels of Care; their fingers pluck out substandard examples and discard them into the scalding throat of a nearby incinerator.

But who are they, these workers? What else do they do in the Care Factory, and how do the internal structures interrelate? Furthermore (and hypothetically), if the existence of the Care Factory depends on its ability to manufacture Care, does it follow that those who work inside its walls are caring people? Does it follow that they have pride in their work, or do

some employees merely go through the motions? Although we might hope for a workforce of likeminded individuals, delighted to be small parts of an entity much larger, who are striving together to tackle the Bionian primary task (Bion, 1961), we must accept the possibility that this is not the case. Perhaps the workers play their part with due diligence – maintaining the smooth running of a specific cog – but have little interest in the overall outputs, the running or the maintenance of the working world in which they labour..

Perhaps they do not question what Care is... but *we* must.

***

What is care?

This is but one of a plethora of questions that I ask my reader to consider. While the question of what constitutes care is one that the reader might be able to answer right now – or might *believe* that he can answer right now – the ambition is that *The Care Factory*'s six chapters will confirm some ideas but challenge others; and of course, a by-product of this ambition is that this book will provide some notions and conjectures that the reader has never so much as contemplated. If *The Care Factory* does nothing else, it should at least make the reader think about our core query: what is care? In order to have six other questions answered (we will come to these shortly), we have invited some experts to help us with our enquiries. These experts are Senior Lecturers who teach healthcare in Higher Education institutions. As I shall explain in more detail shortly, these Senior Lecturers will act as guides on our tour of the Care Factory. Additional experts who give voice in the following chapters (Arlie Russell Hochschild and Gail Kinman, for example) are involved in the study of emotional labour; another expert (Carolyne Willow) campaigns on behalf of children in prison, and in her book, *Children Behind Bars* (Willow, 2014), she argues persuasively that an institution for the detention of children, in this day and age, is emphatically a Care Factory too far.

Together, all of us – author, experts and readers – we will work towards an answer to the question that I have posed several times already, and will pose again and again. *What is care?* The question is worth repeating, though perhaps it is too vast, too nebulous. Perhaps it needs breaking down and refining. Or perhaps it is too frightening and we do not want to face it without holding a collective breath.

Rather than attempting to define it without a context, we might ask different questions about it, perhaps, thereby approaching the matter by stealth. For example, we could ask what it means – *what it means to me.*

What does it feel like when I know I am being cared for? What does it feel like when I am caring for someone else? Of what is care constructed and how do we show it?

In universities all over the world, students are taught the values and importance of empathy and care as part of nursing and midwifery educational programmes. I CARE is an initiative that was devised by the dedicatee of this book, Marcia Ogunji, at the University of Bedfordshire in 2014. To quote from the website: 'I CARE is an initiative with a long term view, designed primarily for Healthcare students. It is also relevant and open to all those who are preparing for caring professions' (I CARE, 2015). When Marcia asked me to join the team in preparation of the first conference (which took place in the summer of 2014), it was pleasure to accept the invitation. At the time of writing (October 2015), we have had two successful I CARE Conferences at the University, the most recent in the summer of 2015.

Shortly before the conference, in May 2015, several of my I CARE colleagues led a day-long workshop for nursing and midwifery students at the University of Bedfordshire. The event was entitled 'Assumptions About Caring' and during the day, the group's task was to answer the question of what we are talking about when we are talk about care. What the students produced on that day provides an interesting shorthand summary of thinking on the subject. 'What words do you think of when you think about care?' the students were asked. The following responses were noted: *giving life, support, respect, safe, transparent, nurturing, intuition, genuine, responsive, empathetic* and *enquiring*. 'Where does this come from?' *Our own experiences – negative and positive. It is…self-referential – we treat others as we would wish to be treated. It is inspired by significant others in our lives – those others who have inspired us to become nurses.*

What else was revealed?

Caring hurts sometimes. Caring is NOT necessarily benign – for either patient or carer. 'Doing' may not mean 'caring' for the patient. Previous negative experiences are powerful motivators for us to come into a caring environment. We want to prove that caring can be done right. 'Caring for' and 'being cared for' may feel very different and be defined differently. There is a site of potential fracture of perception in the relationship of care. Caring practices may, in themselves, cause trouble within relationships between healthcare practitioners and patients.

And what questions spill out of such congregations?

If it doesn't feel like care, is it care? Is it caring to manage expectations of care on the part of patients? Is there a hierarchy of care

and caring practices? Can you feign caring? Is it possible to measure care? SHOULD it be possible to measure care? Is it caring to do something someone needs but doesn't necessarily want? Patients may define acts as caring only in retrospect. Doing the right thing may not feel like caring at the time. Bad care equals the opposite of your own conception of what care should be.

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While researching this book, I lost count of the number of people (family, friends and colleagues) who busked and said something like, 'I can't *define* care exactly... but I know what it is when it happens.'

We know what care is and what care is not. Agreeing on such elements as compassion and empathy is an important first step; but care must include more, mustn't it? Otherwise, wouldn't we stick with the words *compassion* and *empathy*? A Senior Lecturer in Children's Nursing (whose thoughts fill the space between this chapter and the next) had the following to offer: 'An aspect of caring in my teaching role is akin to quality; it's defined in part by culturally expected standards upon which good (or otherwise) is acknowledged. Perhaps more personally, caring in my role is demonstrating that I am interested in what others have to say, how they may respond to the methods I choose to facilitate, actively listening and finding a way to read their position, promoting opportunities for discussion, and sharing and expressing values. Caring is a qualitative consequence of an interaction between two people, not always tangible nor conscious by either party' (Senior Lecturer in Adult Nursing, 2015).

Later in this book, in 'The Breaking of Wings', I suggest a connection between the words *the Care Factory* and a children's prison; later still, in 'Take Care: A Coda', the comparison is with the human body itself – the *body* is the Care Factory – working full-time, in systems that involve full immersion in the care of others and oneself, on a non-professional, entirely familial basis. (In *The Spooky Art*, Norman Mailer writes: 'Your factory is yourself. You are always examining the mill for potential breakdowns, anticipating troubles, and so you become alert to the relation not only between yourself and other people but between yourself and your body. Writing impinges on that body; writing depends ultimately on that body. Proust, with his asthma, was like an important industrialist who manages to get out an extraordinarily consistent product even if one wing of the plant is notoriously subject to breakdown' (Mailer, 2003, p. 126)). For now, however, we might stay with a more 'orthodox' reading, and stick

with care in the context of what many would think of first when directed to picture a situation involving care.

Madeleine Leininger describes care as 'the essence and the central, unifying and dominant domain to characterise nursing'; furthermore, 'to care about someone suggests an attachment or an emotional relationship but implies little about carrying out practical activities or devoting time to that person…' (Leininger, 1988, p. 3). Jan Savage affirms that 'caring for someone implies providing for that person's needs without necessarily suggesting anything about affection or affinity' (Savage, 1995, p. 50). And why do we need such care in the first place? Adam Phillips propounds a theory that depends on our unignorable helplessness. 'Helplessness is the precondition for human bonds, for exchange; you have to be a helpless subject in order to be helped, in order to be understood, in order to become a moral creature' (Phillips, 2010, p. 139). Furthermore, the author states: 'we are not born helpless, we become helpless' (Phillips, 2010, p. 156); and referring to our shift (or climb) into adolescence, he asks: 'how do you start to look after yourself after you have been looked after for so long? Human beings, after all, are excessively dependent animals, relying on their parents far longer than any other mammal' (Phillips, 2010, p. 37). Or to put it a different way, It is the very process of ageing that delivers us into the bosom of a caring symbiosis (as indeed we retreat from the physical bosom of Mother) and the acceptance of the *need* for care is what validates its existence and explains its idiosyncratic exegesis in each of our lives.

Jean Watson wrote a well-respected book on the subject that we are discussing, called *Nursing: Human Science and Human Care* (Watson, 1985). This book is so crammed with useful information that the challenge, while reading it, is to leave a page untouched by pencil or marker pen. She writes:

> The process of human care for individuals, families, and groups is a major focus for nursing not only because of the dynamic human-to-human transactions, but because of the requirements of knowledge, commitment, and human values, and because of the personal, social, and moral engagement of the nurse in time and space (Watson, 1985, p. 28).

'Preservation and advancement of human care,' the author continues,

> is a critical issue for nursing today in our increasingly depersonalized society. The mandate for nursing within science as well as within society is a demand for cherishing of the wholeness of human personality (Watson, 1985, p. 29).

While insisting on the importance of consistency of care ('What we call caring on one occasion must be the same as what we call caring on another occasion' (Watson, 1985, p. 33): a sentiment with which one might take issue, if we consider changing healthcare contexts), Watson leaves the reader in no doubt about her views on the interaction between nursing and caring and the wider implications of the place where the two overlap. She tells us: 'Since nursing is a caring profession, its ability to sustain its caring ideal and ideology in practice will affect the human development of civilization and determine nursing's contribution to society' (Watson, 1985, p. 33). Furthermore, a

> recognition and acknowledgement of the value of human care in nursing comes before and presupposes actual caring. A nurse may perform actions toward a patient out of a sense of duty or moral obligation and would be an ethical nurse. Yet it may be false to say he or she cared about the patient. The value of human care and caring involves a higher sense of spirit of self. Caring calls for a philosophy of moral commitment toward protecting human dignity and preserving humanity (Watson, 1985, p. 31).

If Watson's ambitions seem lofty, do they also seem out of date, or have they endured? Such a query is more for the reader to decide, once the supporting evidence of the rest of this book has been used either for the prosecution or for the defence. Either way, what we are missing up to now is a *how?* (*How* care? How do *we* care? How do we *show* care and how do we *receive* it?) Staying with Watson for a moment longer, we have a continuation of her professional good spirit and optimism. She writes: 'Human care can be effectively demonstrated and practiced only interpersonally. The intersubjective human process keeps alive a common sense of humanity; it teaches us how to be human by identifying ourselves with others, whereby the humanity of one is reflected in the other' (Watson, 1985, p. 33). Other commentators on the field, needless to say, are less altruistic or fulsome with their optimism. Darian Leader, for example, mentions institution-shaped obstacles in his excellent book, *What is Madness?* (Leader, 2011). His contention is that 'treatment is often considered an almost mechanized technique to be applied to a passive patient, rather than as a join collaborative work, where each party has responsibilities' (Leader, 2011, p. 4). 'There is increasing pressure today to see mental health services as a kind of garage, where people are rehabilitated and sent back to the jobs – and perhaps to their families as soon as possible' (Leader, 2011, p. 4).

Leader argues, moreover, that there is something almost unethical about modish styles of (specifically mental health) care. 'It is easy to miss the violence at play here,' he writes, 'yet it is present each time we try to

crush a patient's belief system by imposing a new system of values and policies on them' (Leader, 2011, p. 7). According to Leader, the challenge is 'not to adopt them to our reality, but to learn what their own reality consists of, and how this can be of use to them', not least because 'the seemingly 'healthy' person may have delusional beliefs or symptoms that generate no conflict in their lives and hence attract no attention' (Leader, 2011, p. 7).

Of course, the place where we work and the rules under which we contrive to do a good job are nothing new when we consider hindrances. For example, in *Containing Anxiety in Institutions*, Isabel Menzies Lyth (1988) protests against institutional guidelines that she feels stop a nurse exercising a duty of care, by all-but forbidding the element of physical contact on the wards or during treatment. She writes: 'the organization of the nursing service militates against close and prolonged contact between the individual patient and nurse, although nurses often want such contact and teaching emphasizes its importance' (Lyth, 1988, p. 102). Theoretically echoing this point is a line (once more) from Watson: 'Human care, at the individual and group level, has received less and less emphasis in the health care delivery system' (Watson, 1985, p. 33). I was interested in Lyth's comment, and I decided to conduct an impromptu straw poll on the subject, in order to see if things were broadly the same or broadly different from the time when Lyth wrote her words. The respondents taught in Higher Education institutions, and their emailed results were intriguing. In no particular order, I shall begin those who teach Adult Nursing.

'I would say it was true,' one replied, 'because a Registered Nurse looking after ten patients with varying health needs doesn't promote close contact.' An Adult Nurse with a specialism in Learning Disabilities wrote: 'Touch can be important, although in Learning Disability some people on the autistic spectrum may find physical touch, even light touch very painful, so it may cause behaviour issues. If contact is talking to someone, then this type of contact is essential to find out about what is happening to the individual.' A third Adult Nurse replied: 'It is not the nursing organisation, i.e. the NMC (Nursing and Midwifery Council) or the RCN (Royal College of Nursing), but the NHS (National Health Service)which being a business, subconsciously undermines the nursing need for that contact to happen. This is done in a number of ways – lack of staff, paperwork, other responsibilities such as meetings, staff appraisals, *et cetera*.'

Other notable contributions from Adult Nursing colleagues arrived as follows:

> ‘I have to say that in Adult Nursing in hospitals, the quotation would be absolutely true, less so for Mental Health and Child and also less so in community and specialist settings. And yes, we do emphasise the importance of appropriate contact.’

‘I was teaching on Compassionate Care on Thursday, and the importance of the ‘human factor’ in nursing and the caring professions. In my opinion it would be impossible to provide Holistic Care to patients and relatives when one is distant and disassociated. Students are encouraged to embrace the emotional aspects of care, but also to know when to protect themselves from the burden of that emotional involvement. This is something that is learned through experience and time. As practitioners we have an inherent desire to alleviate others’ suffering, and this should not be discouraged. Surely the caring professions should be encouraged to care and to build relationships, however short, with their patients and relatives. One of the last things I said to my class on Thursday was this quote: ‘They may forget your name but they will never forget how you made them feel.’’

‘It’s the disorganisation of the nursing service that prevents nurses maintaining a closer communication with patients. We used to manage this well in the 70s! I’m not wearing rose coloured specs, honestly! We had more staff on duty (and less unregistered staff,) who made physical caring where you do become close a priority.’

A Senior Lecturer in Mental Health wrote: ‘In Mental Health we talk about the therapeutic relationship with the patient, which aids both the patient and the nurse in planning and giving treatment. The downside to this, of course, is the fact that patients can become institutionalised. I always remember in practice that my aim is to discharge the patient at the appropriate time. In fact, the discharge plan should always be part of the assessment. So in relation to the statement, the contact you have with patients, especially in the Mental Health field of practice is a balancing act.’

The Children’s Nurses who replied had the following comments to offer.

> ‘Certainly the mind boggled about why a nursing service would prevent one of the essences of what makes nursing unique from medicine. The quote suggests a fear of the risk of adverse events arising from familiarity, so there must have been something at the root cause. I also suspect this was the era of the awakening of the open nursing conscience, where congruence between how people felt yet felt forced to act started to raise philosophical attention. Was this when professional fatigue started to be described as a condition rather than the blanket ‘burn-out’ accusation?’

A second professional also wondered about the origins of Lyth's statement. 'If this is the case,' she told me, 'I would look closely at the reasons this may be the case. Also, what is meant by *close*? Would this be in a physical or a spiritual/emotional sense? I would agree that often an excuse is made that nurses are no longer able to spend time with patients, but often this is about the time to carry out the many tasks that are required. Should contact be close and prolonged? Perhaps it should be about *appropriate*. The trouble with many words is that they are open to a wide variety of interpretation.'

This same professional continued: 'In hospital, nurses are so pressured due to the number of patients and the number of staff (usually run on low staffing levels), and we would like to spend more time with patients, pick up any issues, *et cetera*. However, I do know in the child community, they have time allocated per patient and one patient I can think of was having problems about having an injection. The choice was to have the injection quick, then the nurse would play computer games with him for the rest of the hour, or delay and not get as much time on the computer with the nurse. Needless to say, the child is ready for the injection as soon as the nurse arrives and they spend nearly an hour together playing computer games. It's lovely when you do get a chance to do that in hospital, but when it's quiet we seem to find other things to do rather than spend time reading a bedtime story or playing syringe water fights (we used to do this but it's not seen as *professional* now).'

A specialist in Perioperative Critical Care wrote: 'Unfortunately, for the surgical patient this is somewhat true. Although, in my own practice I have found a few ways around this... when working in the recovery room, I sought to interview the patient before surgery and then I knew a bit about them when they returned after surgery and they recognised me as someone with whom they had previously established a rapport. My clinical role in the U.S. allowed me to work with *frequent flyers* who came for successive plastic surgeries. That was satisfying.'

My poll concluded with staff who teach midwifery. 'In the context of emergency care and critical care,' one opined, 'it may be harder to form long-lasting relationships. In other areas, such as care of the elderly or medical wards, it is easier. Also I think it is a gross generalisation to state that often nurses desire that type of contact. It requires emotional energy to stay connected to a patient for a protracted period of time. Many nurses are glad to have achieved a therapeutic relationship over a short period of time and then say goodbye.' A second practitioner added: 'Organisation is, necessarily, about getting stuff done in the quickest time available. Most nursing as we would think of it (taking time and being with) seems to be

done by Health Care Assistants these days. Spending time with people is relegated to an activity that is not (or no longer) deemed ‘work’. It holds things up.’

‘I would say it depends on the speciality. I once spent twelve hours with one patient for up to four shifts in a row. Whilst sometimes they were sedated, they were often awake and being weaned from mechanical and chemical support, meaning you got to know the patient and their families very closely. I would say it is the same for any high dependency unit, but also for palliative care areas, *et cetera*. However, having nursed on acute surgical wards with forty patients to two nurses and one Health Care Assistant, you are spread very thinly and just getting the 'tasks' done is often difficult, and whilst we are compassionate and caring during these interactions, it is often for short periods.’

I did not share another Isabel Menzies Lyth quotation with my correspondents from the fields of healthcare practice, but if I had I might have chosen this one. ‘Many nursing tasks,’ Lyth insists (1988, p. 101) ‘are by ordinary standards disgusting, distasteful and frightening. Physical contact with patients may be over-stimulating and disturbing. Patients are sometimes difficult and nurses find themselves getting irritable or resentful. Such feelings seem unworthy of their profession and arouse guilt and anxiety.’ And although I did not mention it then, I would like us to park this idea at the back of our collective head.

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‘What passes for hip cynical transcendence of sentiment is really some kind of fear of being really human, since to be really human... is probably to be unavoidably sentimental.’ So writes David Foster Wallace in *Infinite Jest* (Wallace, 1996, p. 694-695). Before we move on to our next question, let us consider this line in the context of care and care-giving, incorporating into the mesh of our understanding everything that we have heard so far from the practitioners in the field of healthcare education. Shall we assume that those who practice great care are those who transcend sentiment, the better to be able to do a good job, or those who wallow in sentiment, unabashed and all the psychically richer for it? Can it be that those who care (via the twinned professions of nursing and of healthcare education) are those who identify with the patient’s damaged psychic apparatus, and is able to do something positive with what she finds and excavates from there? Or, to put the matter another way, Watson (1985, p. 27) contends: ‘Just as the mind is inseparable from the body, the scholarly activities of nursing should not be divorced from its clinical

practice. The new model of nursing for education, research, and practice is that of a scholar-clinician. Likewise, the new wave in health care is an individual approach, directed toward the person that integrates all the parts into a unified and significant whole. Quality nursing and health care today demand a humanistic respect for the functional unity of the human being.'

Longing to be cared for is a basic human requirement. If we have been nurtured as babies or youngsters, we have introjected acts of kindness as good objects, and years later, in times of illness, we project onto our care-giver either elements about ourselves that we do not wish to acknowledge on a conscious level (bad objects), or pleasant recollections of having been cared for in the past (good objects) that we fully expect to be reciprocated and returned by said care-giver. If the healthcare practitioner in question actually does start to exhibit the behaviours that the subject has unconsciously formulated, then project identification has occurred and the situation has become a self-fulfilling prophecy.

But who is this care-giver? Who is this healthcare practitioner? 'Who cares?' is another question for which we will seek an answer on our journey through the Care Factory: and the question is not meant with any sense of irony or sarcasm. It is meant seriously: who cares? Well, who does care? Not everyone cares, and not even those who care often (or who are paid to care more often still) care all the time. 'The most abstract characteristics of a caring person,' Jean Watson writes (Watson, 1985, p. 34), 'is that he or she is somehow responsive to a person as a unique individual, perceives the other's feelings, and sets apart one person from another from the ordinary.'

We might agree that it is necessary for the healthcare practitioner who teaches students to care to be someone who cares. Or is this so? For some, perhaps, the notion of *teaching care* – or of teaching *others* to care – is for some as problematic and inherently self-defeating as the notion of explaining a joke. It could be argued that it cannot be done: that care is either within a person (say, a student) or it is not. To consider the point in the most charitable light of all (for such doubters), the very best that might happen is that an education specialist might draw out of the student certain latent sensibilities, and via elicitation and tasks set, might prompt the student to make connection and confirm opinions that are at odds with a presumed earlier position of apathy or *ennui*.

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Wanting to learn more about how a healthcare professional works in a Higher Education setting, I interviewed a Senior Lecturer in Midwifery.

(This is not the same professional as the Senior Lecturer whose interview separates 'Nostalgia's Engine' from 'Caring for Our Creations', later on.)

'As students, educators and as practitioners,' she told me, 'you are constantly told to work inter-professionally, work as a team, you know it makes sense, you know it makes everything safe, it's good for the patient, but it's something we find incredibly difficult. It's not made any easier by the fact that most of our resources are discipline-specific. And it doesn't matter how many times I tell our students to look outside midwifery, they don't. They stick in midwifery, so they think that notions like empowerment or autonomy – they don't even consider them outside midwifery. So they miss out on one of the things that education should be about, which is lifting concepts out of one specific context and integrating them somewhere else.

'Holistic care still looks like a collection of bits, but I think there is something above – something bigger that I can't quite name. It's why I get so bored with my particular profession's blinkers. I want my students to consider more than only the midwifery stuff when they're out in practice – more than the application of their skills. I want them to leave the classroom with bigger ideas and to feel part of those bigger ideas – it's the notion of there being something larger than the sum of its parts. Holistic care is not just a conglomeration of all those bits that you put together. It's a different perspective. It's not just thinking mind and body. It's thinking *beyond* mind and body. I struggle to get students to see that the way they parcel up the care in their head affects the care they give; that as soon as they consider there's a mind and there's a body, it has a real impact.

'Right at the beginning I take the students into a hospital and say, 'What do you see?' You see a body parcelled up into systems. And in midwifery it's difficult because the hospitalised woman who is also pregnant falls down the cracks and no one wants her. It is indicative of the way that we've already parcelled her up in our heads. This is understandable to a certain extent because you need a great depth of knowledge to merge these things together – to merge the broken leg or the heart condition with the pregnancy. So I understand people's anxiety about managing this case – this woman – but it doesn't do her any good... I've expected, over the years, that these barriers would start disintegrating and dissolving, and many years ago, the idea of the patient pathway was an attempt, I think, to fuse all of these separate assembly lines within the factory; but it doesn't seem to have worked. In fact, I think it's even worse. This is only a notion and I have no substance to underpin it, except what comes back from our students – which is a reluctance to get involved with any other part of the factory. I think what generates that and what

strengthens that reluctance is fear and anxiety. ‘I can’t deal with anything that I don’t know enough about because I might do something wrong.’ The risk society has something to say – the notion of the lack of tolerance of risk – and the continuance of blame and shame, all that stuff has made people retreat even further into their silos. And care has got more complex. It’s technically more complex because we can do more stuff. In midwifery it’s frightening because women are getting older and fatter and sicker, so the Midwifery Mission, if you like, the expert of the norm, is getting harder and harder to hold onto – or even to justify, I think.

‘Midwifery is a hugely contested profession. It’s incredibly difficult to care holistically for people in a system that splits them into bits and pieces – and splits them into different systems – and increasingly, as our specialisms become more and more specialist and narrower, we become anxious at having to step out of these narrow but deep specialities.

‘I was running a listening service for women who were traumatised by their birth experiences. What that did was put me back in touch with the me I had been before I went into midwifery – I’d forgotten that. It gave me a chance to reinvestigate the things that had taken me into midwifery in the first place – a passion for the process. I had done a Sociology degree and then I’d done a teaching qualification. I hadn’t gone on to teach because I was scared witless of thirteen year-old children *en masse*. But I had kids, so I had experienced midwifery services and I thought: That’s it! I wanted something that was an art and a science and a craft. Then I saw a local ad: Beat the Midwife Crisis. They were reinstating the three-year course at the time, which had been dead for decades.

‘Over the course of a few years in midwifery, one thing that worried me was responsibility – the levels of responsibility. And this created anxiety. This is why I look at students now – because I’m attuned to it – and I see them having to manage anxiety. Part of having to manage anxiety is having to fall in with the crowd... but the crowd is not always healthy. The crowd is traditionally one where there has been quite a lot of bullying; quite a lot of naming and shaming. So, I’d lived with that and I’d developed a kind of ten-thousand-metre stare, where you walk through a ward and you don’t look left or right, because if you look right, Mrs Smith will catch my eye and I haven’t managed to get her drugs yet, or whatever it might be. There was that permanent sense of not doing what you need to be doing makes you a little bit hard-nosed, I think.

‘I became expert at assessing risk. I could spot risk at ten thousand paces! I was becoming all those things that took me further and further away from the midwife being the expert of the norm – the midwife being the expert of normal physiological processes. The profession creates the

problem, then pats itself on the back for *solving* the problem. You make things more complicated than you need to. You are operating out of a position that is riddled with anxiety and riddled with risk assessment. I created a role that meant that I was taken away from the core business of being a midwife. And it's easy to forget the passions and the values that brought you in there in the first place: you become expert at doing all this other stuff.

'This is still typical now – and there's lots of fall-out from this process. One thing is bullying. Another is – 'You wait' – to an enthusiastic student. 'You wait till you've been here six months! Call this hard? You'll get used to it!' There's a lot of martyrdom – and this isn't just about midwifery but I can only talk for midwifery. It's something about the work and something about the context of where the work takes place that mitigates against the maintenance of the midwifery mission, certainly in large industrial hospitals, which is why you've got birth centres and smaller spaces – attempts to humanise the process of birth, in many ways – in physical ways but also in our relationships with women. There's been a long, long, very proud tradition in midwifery of trying to resist this.

'I set up this listening service, which no one had run before – I don't think. Word of mouth got out that there was a woman, a midwife, who would listen to your birth story. I expected that I would be contacted by women who had had traumatic births – interventions and forceps and haemorrhages and emergencies. And of course there were a few of those. But as this listening service gathered pace, it was equally popular – if that's the word – with women who'd had what we would call *normal* births... but who were still traumatised. We had post-traumatic stress disorder; I was making referrals to GPs... I would go out and I did sixty visits in a year. A woman would phone in and I would make an appointment to go and see her – I didn't do this at the hospital – I'd go to her home. So I had a lovely amount of freedom with this as well.

'I made some records, but they were only my own records. They were never part of the woman's official hospital records, though they probably should have been. They were my own feelings, in a sense, they were my own journal of what this visit was about. My own reaction was that I started to see myself from the outside, because I started to see what the women were seeing when they were coming into the unit. I started to see the agendas of protection that we were guilty of, and that actually we weren't empowering a lot of women, we were dis-empowering them by this process of normalising, by saying 'Oh, you think *your* story's bad, well, you know Miss So-and-so down... ' You detract from their reactions and their stories because you've seen it and you're immune to it, so you

expect *them* to be. So, in fact, I started listening differently. I used to go out with their records and after a while I realised they were useless. The story that women were reacting to was nothing to do with the records. It was the story they took away with them. And that, of course, is part of the bigger story of what it's like to give birth in the UK. It's the story that's told in front rooms and in coffee shops and all the rest of it.

'I ended up putting myself on call for women, when I really shouldn't have done that, because I stopped trusting my colleagues. I heard so many stories of women who were damaged by, what I would call, anti-care. And I didn't know what to do with it. And actually, this thing that'd started as, 'That'll be a nice thing for you to do; why don't you go and listen to women's stories of birth?' ended up with me thinking, 'What do I do with it now?' When I came to passing it on, I had to wonder what it was that I was passing on, because I had created a whole underground theory of what I should be doing with these women's stories. For fifteen years, I've been banging on about the same sort of stuff. That's really my mission in the classroom. It's about self-awareness, self-knowledge in the interest of the patient, surfacing your assumptions and your prejudices. I mean, I teach foetal circulation as well and all the other stuff, but really, that's what I think the education process should be about. Although for the first few years in this job I felt very underground. I feel less so now because I think the agendas are more open, people are talking about culture, the official rhetoric. The official line is we should think about culture and values, but for a long time that wasn't very popular.

'Students expect the nuts and the bolts and a lot of them struggle to get what I'm on about. Some of them never get there. But I think by the third year, judging by the essays that come in, the philosophy essays in the third year, where they articulate their values. A lot of them are descriptive and very superficial, but there's a good chunk which are deeper than that. The essay brief is, through reflection on your three years of becoming a midwife, examine your experience and articulate your values for practice. The end point of the essay should be an expression of a personal philosophical position. I feel more confident with my crusade now, and it's an interesting phrase, but it has been a crusade and it continues to be one. I feel more confident in it... it can be a real struggle to keep believing because it's less measurable. How do you measure it? It's long term. It's not like me telling you how the kidney works and being able to write that out.

'I had a student who left at the end of the first year because she failed a load of stuff. She wasn't up to it academically and she accepted that. I had an interview with her and she said, 'The trouble is, I can't read *OK!*

magazine anymore; you've made me think.' To me, that's Hallelujah! That's all I need. During the induction block, when I'm talking about what does it mean to do a degree, I have a slide that says 'We spend a lot of time telling students what to think when we should be teaching them how to think.' There's another one that says, 'I write to find out what I'm thinking.'[1] So right from the word Go, I feel like I'm picking them up and saying: writing is a skill, but it's not mechanistic, it's creative and learning how to do it won't be quick.

'It's what I'm passionate about. This is what education is about for me. It's not training. Yes, there have been many times in fifteen years where I wonder what the point of me is, because sometimes you feel like you're shouting into the abyss. But as a team, it's great that there are others who are really good at the nuts and bolts, and I feel that as a team, I'm valued. It's probably taken me a long time to believe it, because there's a load of esteem stuff in there. I suppose in essence what I'm trying to do is pass on what I found in education, what I got actually from A-levels up to degree. What happened to me was lasting, lifelong and it was a shift of perspective and I think it made me a better person. In fact, I know it did. I know it's made me a better midwife and a better teacher. It is about *ought*s and *should*s, and there are values, and it's not enough, I think, for someone to leave university with a degree unless they have some ability to think and something transformative has happened.

'There have been moments in the past fifteen years, murmurings of going back into schools of nursing and midwifery in hospitals and I've been running for the hills. Because actually, I don't mind there being a theory-practice gap. I don't mind there being a tension between theory and practice because that's the creative tension. A school of nursing or midwifery suggests, and I think quite often, a school of little 'Mini-Me's' in hospitals. It was sort of, the culture was feeding itself... I'm an educator, not a midwife, and yet I still have to sign up as a midwife every year. I'm not a midwife. I have midwifery knowledge and midwifery experience, but if you put me on a delivery suite right now I'd need supervision. I don't have a problem telling my students that. But a lot of midwives have a big problem when admitting that. It's almost sacrilegious to admit that, because 'a midwife is a midwife is a midwife'. She should able to practice wherever you put her and she should never lose her skills.

'It takes a lot of self-discipline to be a free-spirit. You have to be making those decisions all the time. In my perspective, I have to remake

[1] In her Foreword to Bion's *Cogitations* (Bion, 1992), Francesca Bion writes that her late husband used to do something similar. 'The physical act of writing was, he found, an aid to his thinking,' she writes in the first paragraph.