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Issue 12
Towards an Ecology of Care

Editors

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Editorial: Towards an Ecology of Care

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Overview

The Ecology of Care (EoC) as a field of research and practice originated in the Faculty of Engineering at the University of Southern Denmark. It was designed to research and promote the concept of Care (the prioritising of Human needs). Care is essentially about tackling societal challenges from a human and ecological point of view, something of a reversed perspective on the current paradigm driven by liberal Capital. We see this as an extraordinary opportunity for real and useful innovation on a global scale. An Ecology of Care examines the fundamental reasons why and how we do what we used to do naturally in an increasingly unnatural world. In this artificial condition the Ecology of Care provides many new opportunities before the future is foreclosed.

We have structured the project *An Ecology of Care* as a lens through which to investigate the way in which Care occurs in relationship to everyone and everything (not just health care). We have taken this perspective on the basis that Care describes and shapes relationships because we know we all Care and we do that through shared gestures of care and caring. We asked the people we invited to speak at the Congress to look closely at the gesture (or expression of intention) called Care.

We are also aware that delving into Care might point to core problems in our relationships because it is quite obvious we seem incapable of devoting adequate resources to care about the project for a better world, our one world. Which is baffling because we have no choice but to Care for it and to Care for ourselves and each other in the oikos of ecology ... our home on the one planet we share.

The belief that our shared future is getting better and is being made better by good people who are doing good things is now very tenuous. Regardless of our intentions or gestures, in an increasingly artificial world it is now very difficult to imagine applying Care on the scale of the better world. Therefore, we tend to think that an Ecology of Care is really about fostering a different relationship with the artificial world. It is about taking a special interest in the role of ideas in the production of this artificiality. Or just as people doing good things seem to be motivated by taking Care of what-might-become, an Ecology of Care entails that we take Care of what-might-not-become.

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Background to an Ecology of Care

In 2012, a small research group within the Faculty of Engineering at the University of Southern Denmark was involved in Denmark's largest Health Research project called Patient@Home; the application of new technological solutions to healthcare. Opportunities were rife for product developers but the project had skewed towards "welfare of technology" rather than "technologies of welfare". In 2013 it was noticed that Care was missing and the group went looking for it. With enough evidence the newly formed research group held their first international Ecology of Care event in February 2015 to explore the formulations of Care that were emerging. Twenty people from 7 nations and 14 disciplines came to Copenhagen to discuss various proposals.

This gathering determined that first, the Model of Care developed so far, was useful as a way of explaining the concept to others. Second, that an Ecology of Care could be considered a new field of study and practice. And third, that an Ecology of Care was worthy of further development in two directions: as a theoretical framework and in terms of instrumental application (forms of practice).

The Ecology of Care project today

After the 2015 symposium the Danish research group immediately started work on an international congress called *(In)forming an Ecology of Care*. They realised very quickly that they were hampered by two misunderstood notions of the two key concepts: that ecology was a "green thing" (when in fact it is derived from the Greek *oikos* for home), and that Care is more or less owned by the health industry. It can easily be seen from what has been accomplished so far that Care is a concept with a very sound philosophical basis but without a clear and strong communicable form. Thus, the Congress, (In)forming an Ecology of Care, was largely about giving Care a more substantial form. To be clear: what an Ecology of Care is therefore about is finding practical, applicable and humanly meaningful ways to explore and understand how we give and receive care; and to interpret this into and merge it with an increasingly artificial world, and by doing so establish patterns of behaviour that give agency to the role of stewardship for future generations.

In September 2017 the Copenhagen Congress was followed by a series of workshops at Lancaster University that set out to explore Care from the point of view of design. Titled *Does Design Care...?* participants explored 10 problems with the gesture of care. Their findings will take the form of the Lancaster Care Charter that will be published in 2018.

In this issue

This special issue stems from the Ecology of Care Congress in 2016 where very different professional fields were brought together to share how they see care operating within their disciplines (or how in their fields care is disciplined). This issue of *fusion* presents five very diverse ways of observing care. Other presentations at the EoC Congress probed care (and carelessness) from diverse positions and many of these will be

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followed up in subsequent disseminations; they include perspectives from health, peace and conflict studies, global sustainability, social economics and design. In this issue we are very happy to be hosting contributions from a broad spectrum of presenters from the Congress, that offer unique perspectives on Care.

- Ian Coxon's paper sets up a backstory to the Field of Care. He explains the origins of the concept of Care and the origins of the project, An Ecology of Care. Weaving together the philosophical background to Care and the many theoretical perspectives that have been proposed about Care, he describes a model of Care and a set of criteria for what an Ecology of Care is all about.

- Anders Sørensen's paper takes the idea of Care and applies it to emerging technologies in the field of robotics. Though a series of short case studies he exposes some of the flaws in the logic of these robot development projects and argues that 'self-reliance' is a core component that is missing in many developments.

- Harriett Balkind writes about the paradoxical world of advertising, political manipulation of trust, and a form of Care that lies within truth, asking why not just lie?

- Ian Hargraves considers the *doing* of modern healthcare through the lens of the Myth of Care showcasing its relevance to designing new and more enabling ways to *Do design* within the many fields of health.

- And Allan Barton presents his personal pathway to care as a "Journey of Discovery". Using his own experiences as a case study for how care and caring shape behaviour he discusses the role that Care (self-others-world) takes in shaping the paths we choose and the decisions we make in our work life and home life.

We hope you enjoy reading these diverse perspectives on Care and we welcome your feedback, suggestions and comments.

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Care as human *Being:* Introducing a new field of study and practice

Ian Robert Coxon[1]

Abstract

This paper serves to introduce a new field of theory and practice called an *Ecology of Care*. In briefly describing its history of formation, present status and projected activities, the process of establishing an *Ecology of Care* (EoC) can be seen as laying the groundwork for a robust and complex new field with real and relevant value to many of the most profound issues confronting modern human life. The author proposes that in establishing and promoting an ecology which is based on Care, change can begin to take place in some of the destructive thinking currently shaping a less than optimistic future. An ecology based on Care offers the possibility of a positive and generative mindset that will enable people and organisations to rebuild some of the ecological stewardship that has been eroded by rationalist thinking since the industrial revolution. With stewardship or social and personal responsibility as a core systemic value, it is proposed that this field and the many industrious forms it might take, offers a real panacea for the increasingly moribund institutions of capitalism and other antiquated belief systems that are now negatively impacting on human life. These ponderous institutions, themselves shaped by unrealistic aspirations for growth and greed, combined with ecological short sightedness can by their nature, offer no viable answers. An *Ecology of Care* or a Care-based ecology provides a sound, logical and realistic philosophical/theoretical basis for developing many practical solutions across any field of human endeavour; assuming there is the strength of commitment necessary to apply it. The role of this paper is to provide a record of the formation of this meta-theoretical perspective in terms of its early development as a platform or framework for change; a non-partisan movement designed to provide a focus for the collective efforts of many groups of people with many different interests. This story of the brief history of *an Ecology of Care,* serves to establish a credible foundation for a movement whose future development and application will attempt to address a multitude of challenges facing human beings as a species.

Keywords

Care; Ecology; Model of Care; Myth of Care, Ecology of Care

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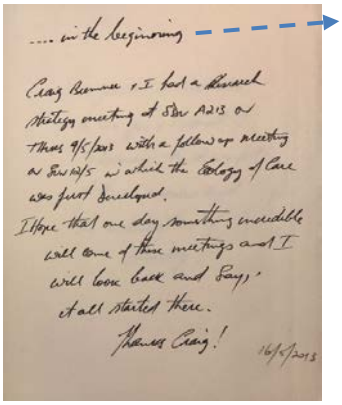
Prologue

Figure 1 shows an entry in my work journal marking the date when the *Ecology of Care* project was first mooted.



...in the beginning
Craig Bremner and I had a research strategy meeting at SDU A213 on Thurs 9/5/2013 with a follow up meeting on Sun 12/5 in which the Ecology of Care was first developed. I hope that one day something incredible will come of these meetings and I will look back and say, it all started there. Thanks Craig! 16/5/2013

Figure 1. Journal entry.

Introduction

In this paper, I will introduce a new field of theory and practice called an *Ecology of Care* (EoC) [bearing in mind that the ideas expressed here were derived out of the contributions of the many people referred to below]. In briefly describing its history of formation, present status and projected activities, I propose that the process of establishing an *Ecology of Care* has laid the groundwork for a robust and complex new field with real and relevant value to many of the most profound issues confronting modern life. I further propose that in establishing and promoting an ecology which is based on Care, human beings can begin to change some of the destructive thinking currently shaping a less than optimistic future. An ecology based on Care offers the possibility of a positive and generative mindset that will enable people and organisations to rebuild some of the ecological stewardship that has been eroded by rationalist thinking since the industrial revolution.

With stewardship or social and personal responsibility as a core systemic value, the *Ecology of Care* as a research project further proposes that this field and the many industrious forms it might take, offers a real panacea for the increasingly moribund institutions of capitalism and other antiquated belief systems that are now negatively impacting on human life. These ponderous institutions, themselves shaped by unrealistic aspirations for growth and greed in combination with ecological short sightedness, by their nature, can offer no viable answers.

An *Ecology of Care* or a Care-based ecology provides a sound, logical and realistic philosophical/theoretical basis for developing many practical solutions across any field of human endeavour; assuming those who adopt its challenge have the strength of commitment to apply it. The role of this paper is to provide a record of the formation of this meta-theoretical perspective in terms of its early development as a platform or

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framework for change; a non-partisan movement designed to provide a focus for the collective efforts of many groups of people with many different interests. This brief history of *an Ecology of Care* serves to establish a credible foundation for its future growth and development so that one day our group (and others) might say ... this is how it all began.

The genesis of "an Ecology of Care"

In 2012 as a small research group within the Faculty of Engineering at the University of Southern Denmark, we were involved in Denmark's largest Health Research project called *Patient@Home* (P@H). This project was strongly focused on the pursuit of efficiencies in the Danish hospital system, mostly through the development and application of new technology solutions. Their primary focus was to move healthcare from a "bricks and mortar" base towards patient self-management. Some pundits had described it as a systematic process of "hospitalising the home". Within the project, opportunities were plentiful for product developers and at a time of economic downturn in Denmark, it was seen as providing abundant opportunities in design and manufacturing to a struggling economy. It offered an alluring economic boon. Across the P@H project, many R&D activities within partner companies, organisations and research groups had become heavily skewed towards what might be termed *welfare technologies* (activities promoting high-tech solutions, agile innovation and profit driven invention). Because of this bias toward artificial solutions, the P@H project had largely stopped looking for opportunities to create *technologies of welfare* or systems that focused on the life-enhancing aspects of health treatments for individuals that also encompassed a notion of home which valued the support systems provided by friends and family.

In 2013 our research group began to notice that Care (actions that improve the experience of humans in their processes of living) appeared to be lacking in or even missing from many of the projects being undertaken. Over the following year we confirmed our suspicions and began a project to better understand the notion of Care that we were proposing as an additive to the welfare/technology mix, or even an alternative approach to the popular technological direction that thinking in the P@H project was taking. In delving into the history of the notion of Care we quickly realised that some of the most influential philosophical and theoretical minds of the last two centuries had attached significant (and significantly different) importance to this relatively simple semantic metaphor *Care*. Influential thinkers such as Heidegger (1962), Mayeroff (1971), Reich (1995), Boff (2008), Bateson (1972), Bronfenbrenner (1979) and many others had discussed differing interpretations and connotations of Care with one notable commonality; none of them were referring to it as belonging exclusively to the domain of healthcare and all attributed significantly more substance to its meaning than its current usage conveyed.

We began to realise that the notion of *Care* had a more universal significance in relation to understanding humanity than its adoption and popular usage as a catch-all, health-related term. The phenomenon of the term Care in its ordinary, "abducted" form is only very recent and has tended to significantly underrepresent its true value as

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communicating the foundation for all human action described by generations of theorists. We began to see this as a valuable concept missing in many fields. This universal form of the word and meaning of Care has for hundreds of years carried a deeper, more fundamental meaning for human beings. Following Heidegger and many others, we elevated the importance of this more universal notion of "Care", adopting the protocol of a capital C in all our communications. We did this to differentiate *Care* as we now understood it from the popularised and banal forms of ordinary care (day-care, car-care, health-care, take care). Within our research group, some suggested we should distance our project from the term Care because of these associations, however we had come to realise that the heritage of the universal form of Care (originally Greek: *Sorge;* see also German usage in Dye, 2009) was so undeniable that there was no need to shy away from it simply because of its popular usage that was largely trend-based. The undeniable gravitas of the term Care is so fundamental to human self-understanding that it cannot and should not be trivialised. Our group felt a responsibility to support a universal connotation of Care which would revive a meaning that reflected the complexity and wonder of humanity as a species.

Heidegger, in his complex linguistic style, refers to Care in the following way:

> *The formal existential totality of the ontological structural whole of Da-sein must thus be formulated in the following structure: The being of Da-sein means being-ahead-of-oneself-already-in (the world) as being together-with (inner-worldly beings encountered). This being fills in the significance of the term care, which is used in a purely ontological and existential way ... being-in-the-world is essentially care. (Heidegger, 1962, p. 193)*

Simply stated, *Care* is essentially and essential to who human beings are. It is the way they are caught up in life (being-in-the-world) and the way in which they choose to act in their life (*Being* or *Da-Sein* as Heidegger refers to it) and the way they live it (their ontological/existential stance).

A universal notion of Care

The following statements represent an attempt to synthesise a universal notion of Care drawn from the ideas and propositions developed over many centuries by many minds including those mentioned briefly above. Philosophers, theoreticians[2] and many unnamed others have perhaps described universal Care in different terms to these but essentially, they contain the same messages.

- To Care is what it means to be human, to be humane, to have humanity (Humans cannot, not Care or else they would not be human).

- Care is a human in the process of Being (Living) – Not simply a human being but a human, *Being*.

[2] To mention a few: Gregory Bateston; Leonardo Boff; Urie Bronfenbrenner; Fritjof Capra; Pope Francis; Martin Heidegger; Milton Mayeroff; Warren Reich; John Thackara; Francisco Varela; and many others.

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- Care is the meaning humans make in and out of life.
- Experiences shape the nature of Care that humans show to their self, others and the world in the form of their actions (responses).
- Care shows human response-ability (practical ability to respond) and the nature of response-ibility (moral and ethical nature of our response) that they direct towards their self, others and the world through their actions.
- Care is therefore who humans are, and they are defined by *how* they do what they do – how they Care.
- Care is much more than just another word for being nice.

From this standpoint, Care can be seen to be a vitally important part of understanding every living human being. It can be said all people are human and therefore all *Care*, but in different ways. The character of human responses or actions illustrates how each individual's Care is expressed. In this way, each person's response to the world is a measure of their *Care* and conversely the nature of their *Care* is described in the character (ethos) of their actions. Reflecting on Care offers a critical way of looking at the way people are acting in the world; it prompts them to ask, *what is* my *Care like?*

To summarise this: if a person is to say that they truly Care, then this requires a conscious self-examination of what their Care means to their *self*, which in turn directs attention towards how they are enacting their Care with others and their interconnecting worlds. People cannot Care in isolation but this also means that individual Care (*my Care*) starts and ends with the individual.

The importance of oikos, ecology and home

When we (the EoC research team) were initially formulating the project *An Ecology of Care* in 2013, we adopted the term ecology as a way of reflecting and supporting the scale of meaning inherent in the universal form of Care that was beginning to emerge from our research. The universal notion of Care has a foundational value in the human world and can also be recognised (perhaps with different values) in the animal, plant and geological worlds. It is as difficult (though not impossible) to separate the term Care from its place in the wider ecology as it is to separate the global ecology from the presence of Care (human living). These two terms go hand-in-hand with considerations of a world in which people live in harmony with the planet and each other. An Ecology of Care as we would have it.

The Greek term o*ikos* has been variously interpreted but is most commonly accepted to infer notions of home (interestingly, *oikos* provides the same root for the English terms economy and economics, meaning: the management of home). The term ecology is a reminder that human beings are always and essentially just a small (but significant) part of the wider ecological system bounded by the planet that all humans live on (Bateson, 1972). In our group's research, the use of the term ecology also reflects the primordial relationship that human beings have with the notion of home and the way in

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which it is different for all individuals; the way in which humans can "make home" anywhere that they happen to be and the way that they manage or show Care for themselves and others within what they call home. Home is where the heart is, as the saying goes, meaning that home (the meaningful context of Care) and heart (the spiritual form of Care) are inextricably linked.

Phenomenologists Gadamer (1975) and van Manen (1997) refer to the space that people share with others and things as the *life world*. These are "worlds" that intersect as people interact with each other and the wider ecology. Seen in this way, the term ecology is a very valuable way of communicating the scale of the project that is in front of all of humankind and the inseparable relationship that exists between people and planet.

> *In the context of globalization, there are two relevant communities to which we all belong. We are all members of humanity, and we all belong to the global biosphere. As members of oikos, the Earth Household. (Capra and Luisi, 2014, p. 390)*
>
> *Oikos is the basic institution of human coexistence, in which the 'necessities of life' are produced and provided, without which people can neither live nor live well. (Praetorius, 2015, p. 9)*

Both of these words – *Ecology* and *Care* – have become diluted and distorted by differing fields of interest over many years and this has created barriers to clearly communicating the relatively simple message that an Ecology of Care carries.

> *Care is intrinsic to everyone. All people are human and therefore all Care, but in different ways. How people express Care illustrates the character of their response or actions.*
>
> *Putting this another way, each person's responses to the world are a measure of their Care and conversely the nature of their Care is described in the character (ethos) of their actions.*

These are foundational concepts underpinning the terms used as the project of *an Ecology of Care* is being built. They help to highlight what is missing in the destructive forces currently undermining the ecology that supports humankind as a species – this is why, the species group, humans, needs to revisit and revive the notion of Care that they know they already have, one that will provide the soundest foundation for the changes that are necessary for immediate survival and for their long-term (symbiotic) future on this planet.

(Re)forming an Ecology of Care: The first international symposium in 2015

Armed with the developmental work described above, in February 2015 we held our first international *Ecology of Care* event to discuss the formulations of *Care* that had

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been emerging. Twenty people from seven countries and 14 unconnected disciplines gathered in Copenhagen to discuss our various, partially formed proposals. The University of Southern Denmark hosted this symposium of contributors specially selected from many institutions to bring diverse disciplinary perspectives to bear on a very important task: the process of re-formulating a revised conceptual notion of Care. By re-establishing the importance of this fundamentally human building block, which had lost much of its currency to synthetic interests, we could develop a sound basis for future practical actions under the banner of an *Ecology of Care*. Our aim was to develop a cohesive meta-theoretical platform, which would assist a very broad spectrum of disciplines to better coordinate actions that would advance human interests of the highest order and importance.

Key outcomes from the 2015 symposium

1. A working model of Care

This gathering made three major recommendations. First, the *Model of Care* (see Figure 2) developed in the lead-up to the symposium and presented to the group for discussion, could be useful in understanding and communicating an abstract conceptualisation of the universal notion of Care (described above). The model of Care could be applied as a practical means of structuring understanding within situations involving any form of human engagement across many fields of activity and should not be limited to those within the health industry.

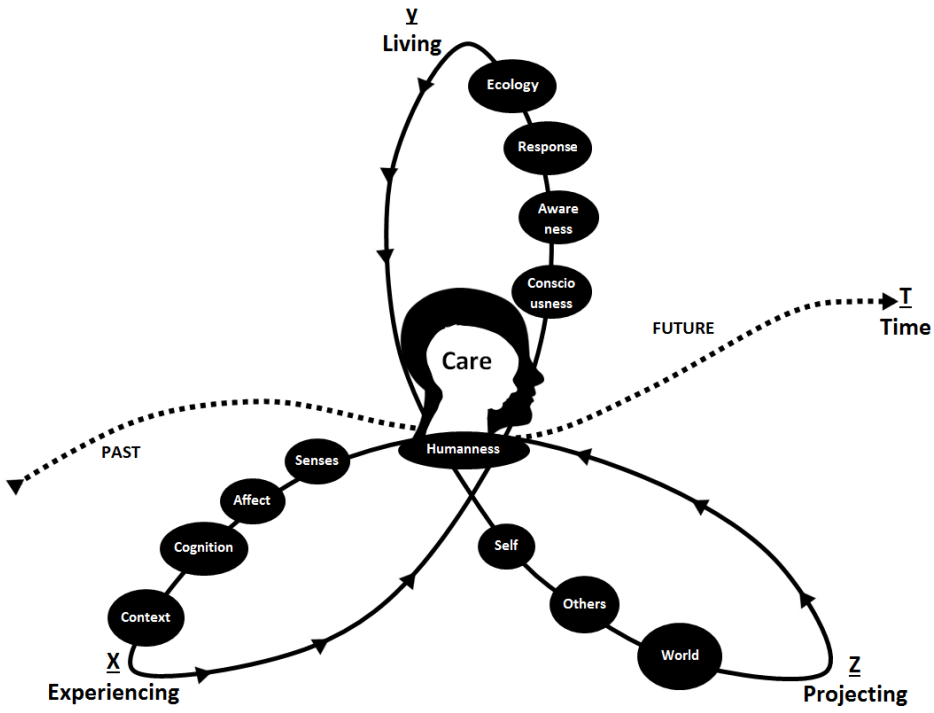

Figure 2. The 2015 Model of Care.

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The Model of Care (Figure 2) can be summarised in the following way:

> *Care is a product of everyday experience; it is constituted over time in consciously aware responses that impact on the individual self, others and the worlds they share in ways that change the earth's ecology.*
>
> *Care therefore, is first originated in and projected at a self, then at others (including objects) within an immediate world.*
>
> *Care takes place and is made intentional within a time continuum based on a past that shapes a present; that in turn projects a future.*

2. An Ecology of Care, as a new field of study

Second, and perhaps more importantly, the 2015 symposium contributors found that the notion of Care proposed within the *Ecology of Care* project was significant and would benefit from being developed further as a new field of study and practice. While based upon an older notion of Care than is currently being used within health and other fields, it was nevertheless a concept that had a substantial heritage of previous study and brought with it a body of knowledge that could be built upon and further developed in many different and useful directions. Many of the very concrete and foundational elements of Care (as seen in the Model of Care above) were still largely unexplored and highlighted the potential complexity of the field as well as the many opportunities that further development would offer.

3. New streams of theory and practice

Third, a new field of study referred to as an *Ecology of Care* was worthy of development along two principle streams: as a theoretical framework to guide further exploration of the constituent elements contained within the Model of Care and as a structural methodology for advancing Care as a platform for change.

This would be accomplished instrumentally through researched application within education, industry and governance as well as within society by raising awareness of the benefits of critical engagement with everyday life (as a mode of self-reflective practice and self-management). Studying the instrumental application of the platform would also provide opportunities for additional theoretical development as well as practical methodological improvements that researching new forms of professional practice would bring.

(In)forming an Ecology of Care: An EoC International transdisciplinary Congress in 2016

Following the 2015 symposium we immediately started work on a larger meeting of minds, a congress called *(In)forming an Ecology of Care* designed to build on the ideas generated during the 2015 event. We realised very quickly that we were still hampered by a significant level of misunderstanding around our two key concepts, namely: that

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ecology was largely seen as a "green thing" and that *Care* was more or less owned by the health industry. We were still being regularly asked: "What is the *Ecology of Care* about? What is it for? What are its goals and how do I apply it?". We could easily see from the work we had done thus far that *Care* was a complex concept with a very sound philosophical basis but without a singular, powerful and consistent, easily communicable (marketable) form. So, the 2016 Congress, (In)forming an *Ecology of Care* was largely about finding a more substantive form for *Care*. The event was described as, "A gathering of experts with a vision for Care" with 12 specially selected leaders from 12 different fields of research and industry who were invited to present their practical visions for *Care*, focusing on innovation opportunities within some of the biggest challenges facing contemporary societies. As well as their insights, and as a counterpoint to their views, an audience of "collaborators" was invited to discuss and debate each of the speaker perspectives in forum so as to further develop their ideas into actionable pathways.

A key goal of the congress was to reconsider Care in terms of the fundamental reasons why and how people do what they do in relation to the many challenges they face as a species within a finite and fragile human ecology. This provides many new opportunities for innovation and the advancement of science and culture. Technologies that have exponentially enhanced communication systems worldwide have also resulted in unprecedented levels of individual social isolation and community disconnection. The world's economic systems in most cases are built on inequality in terms of quality of life, education and material comfort. The human world is dealing with epidemics of domestic and international violence producing unprecedented numbers of displaced and traumatised people. Globally, an aging population is acting as a driver for often hidden psychological issues such as loneliness, depression and suicide, as well as physical health concerns such as diabetes, hypertension and heart disease. In the natural world some of the greatest challenges humans face include unrenewable resource depletion, air and water quality, habitat degradation, catastrophic loss of biodiversity and the unpredictable effects of climate change. These are all symptoms of the state and nature of the human world's collective Care.

Many of the biggest contemporary issues (described above) can be directly linked to the Care with which the *artificial* (human interventions in an otherwise natural world) in its multitude of forms has been applied by people during what has been an outstanding but very short period of human development (roughly the past 250 years). Human beings have certainly developed complex answers to many of the world's greatest questions but in the process and as a result, have given birth to many almost insurmountable problems. They have made a human world that changes so rapidly, so significantly and in such complex ways that they have seldom taken the time to carefully consider the reasons why they develop and implement their interventions (inventions); nor to properly evaluate the future consequences of their actions; nor to fully respond to the unintended impacts (side-effects) that these actions have brought with them (Jackson, 2013). Major social innovation on a global scale is needed to address the scale of issues that confront human beings in the artificial and natural worlds that they have developed but fortunately, they are well equipped and more than capable of achieving what is needed. The technological know-how needed to make

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these changes is already available. The secret to making the scale of change that is required lies within *humans themselves*.

> *Technology (the artificial world) is neither good nor bad – it has no agency but that which human beings give it. People can continue to be the architects of their own demise or begin to build a better world. This can only happen if they Care.*

The opportunities and inescapable need to make important changes in social attitudes and behaviour have never been more obvious than they are now. So the most urgent imperative is for realistic and practical guidelines (frameworks, platforms, systems, networks) that can help initiatives that capitalise on the opportunities for real and urgent change that are present in the world right now – this was the genesis for the *Ecology of Care* project.

Findings from the Ecology of Care Congress

At the Copenhagen Congress in 2016, the attendees wrestled with questions such as What does an *Ecology of Care* stand for? What is important in an *Ecology of Care*? What does an *Ecology of Care* believe in? What does an *Ecology of Care* need to achieve?

The passages below present summarised findings from written material generated by all of the contributors, from diverse disciplines, organisations, fields of research and practice who attended the congress. This material was subjected to a rigorous open-coding analysis (Strauss and Corbin, 1990) and further scrutinised by the congress committee. It should be read as a qualitative synthesis of the thoughts and ideas expressed by all of the contributors and collected in many forms during the event (van Manen, 1997). This material was also gathered with the intention of developing an *Ecology of Care Charter*, a reference point for future activities under the EoC banner.

An Ecology of Care is about...

Guidance and processes

An Ecology of Care offers guidance across fields of industry and academia with strategic tools promoting holistic ecological thinking (Care) directed towards a socially just and ecologically sound way of helping organisations, society, communities, families and individuals to help themselves. With this guidance, new systems, new economic goals, new business models, new policy options can be developed that support sustainable, flourishing people in sustainable socio-spatial ecosystems at habitat and planetary levels.

Networking with networks

An Ecology of Care provides a framework upon which a network of networks can be built. The network brings the collective knowledge of like-minded (Caring) individuals

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and communities together to provide new perspectives on common problems. Also, by joining interrelated networks, connecting people who Care about different but related topics, it provides a platform for sharing ideas and practical knowledge.

Sense-making and conflict resolution

An Ecology of Care enables individual and collective sense-making. It takes a leadership role in understanding, interpreting and representing human needs in fields like health, industry, business and conflict to better address issues they have in common from a human perspective. In this way, an Ecology of Care provides protection against manipulation by vested interests that would showcase their lack of Care for people and places by taking unjust and unscrupulous advantage; using convenience, ease of use or efficiency as a justification.

Response-ability and response-ibility

An Ecology of Care encourages people to reconsider and re-evaluate their ability to respond (response-ability) and to also recognise that response-ibility comes with all of their actions. It promotes doing what is *good* for people while at the same time encouraging them to take ownership of the form or shape that this *good* takes. It promotes awareness of "my care"; i.e. the meaning intrinsically formed in that person through their individual actions and how those actions impact on others.

Supporting new thinking

An Ecology of Care provides a positive and purposeful framework for the kind of mindful, complex thinking and social behaviour that is required in the 21st century for all people to survive and thrive in long term sustainability and equality. It promotes a socially just and ecologically sound framework for being, doing and organising at a personal, political and planetary level.

Embracing others

An Ecology of Care embraces and fosters a community of people who Care. It is comprised of people from diverse fields of interest who wish to share knowledge, collaboration and learning; building on what has been accomplished about Care and to move this thinking forward together.

Providing new ideas for change

An Ecology of Care represents an opportunity to make integrative and transformative change (responses) in economics, health, education, governance and other fields effecting social capital by reconsidering these institutions through the lens of Care.

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Practical solutions

An Ecology of Care develops research and practical projects that disseminate useful solutions to a broad array of problems through examples, pilot studies, tools and practice guidelines. Quality of Care metrics provide a basis for measures of ecological progress, guidelines or principles for developing healthy business cultures, structures for projects and programs which help to balance community and economic interests while empowering people.

Critical leadership

An Ecology of Care provides a way to critically evaluate and understand the health of each person's personal Care profile by reflecting on what their form of Care looks like in the leadership relationships they have developed with their *self*, others and the world. Through self-reflection, considering an Ecology of Care helps leaders to directly confront the difficult problems of modern times. Reflecting on Care makes the existence (or lack of) Care more visible, so that individual leaders can clearly demonstrate the value of their Care through their executive actions. By raising consciousness and awareness of what really matters to people, decisions considered through the filter of an Ecology of Care enable leaders to adjust the priorities they set to better align with their own responsibility (*my* Care).

Summary

The thoughts and ideas presented above are in no way exhaustive nor do they fully define what an Ecology of Care is or stands for. They are a work-in-progress; a way of understanding an organic concept; one that will undoubtedly grow and be more clearly understood over time and certainly be improved through retrospection. They are, however, important starting points for focusing our group's efforts towards building an Ecology of Care; a meta-theoretical framework which has as its sole intention to help make a better world for everyone and every-thing within it.

The future: (Trans)forming an Ecology of Care: Internationalisation

Turning Care into action

To this point our research about Care emerged from philosophical/theoretical investigations but to make the scalable social transformations needed, Care has to be translated into concrete, useful and actionable forms. The very idea of building an ecology based on Care inherently means significant change across large sections of society, as well as within the megastructures of economics, education, health and many of the largest institutions of wealth and power. These all contain very strong and resistant private interests and institutional inertia.

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To address this, we developed a mission statement for an *Ecology of Care*:

> *To find practical, applicable and humanly meaningful ways to explore and understand common [human] higher order needs; to interpret these into and merge them with an artificial world that human beings have already built and by doing so to re-establish ecologically resilient patterns of behaviour that can become a 'new 'normal' for future generations.*

This statement highlights a call to action and ethos for the actions (or responses) that an Ecology of Care as a movement will strive to achieve in terms of its response-ability (practical ways of responding) and response-ibility (the moral and ethical stance inherent in its responses). Thus, our guiding proposition is soundly based in consciousness of each person's individual responsibility through personal reflection.

> *The Ecology of Care holds as a first principle that, by considering human actions through the lens of Care, people are all brought back to their undeniable responsibility for everything they do in relation to their self, others and the worlds they share. This concept redefines the role of human beings in the earth's ecology over time.*

Strategic focus: A network of networks

Early in 2017 the Ecology of Care Network was registered as a non-profit Community Interest Company (CIC) in the United Kingdom. As well as developing its own programs of research and practice, a key strategy in building an Ecology of Care lies in linking the multitude of different organisations and groups who are currently doing work that might be considered Caring as we understand it. So that the power of a collective understanding of Care might be better realised, we will work towards bringing together these many groups working in economics, education, health, design, architecture, engineering, business and industry, food and agriculture, marketing, fashion, peace and conflict and many other fields. We propose to facilitate the aggregation of many of these Care groups and cooperatives into a network of networks, adopting a systems thinking approach directed towards nurturing a healthier human ecology.

> *I believe that to meet the challenges of our times, human beings will have to develop a greater sense of universal responsibility. Each of us must learn to work not just for oneself, one's own family or nation, but for the benefit of all humankind. Universal responsibility is the key to human survival. It is the best foundation for world peace. (Gyatso [14th Dalai Lama] in Keown, Prebish and Husted, 1998, p. xx)*

A common aim linking all of these networks of ecological stewardship (responsibility) is that they bring together activities that promote true human happiness, quality and equality of life for people, and the reduction of harm caused by human interventions in the global ecology.

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> *Our mission in promoting the Ecology of Care Network (EoC Network) is to raise conscious awareness of individual forms of Care at the core of all motivations.*
>
> '*My Care*' *(The quality and form of Care individual to who I am) is what shapes every action that each person takes within the communities they live in and contribute to as part of a larger society (ecology).*

The tactical process of building a network of networks will begin within education and the economic/corporate worlds. Studying and disseminating research and practice outcomes that feed back into each other will build a healthy and organically productive cycle of growth in the Ecology of Care platform. Building a global Ecology of Care will eventually require a very broad base of activities, so initially at least, not all areas in which Care is needed can be planted at the same time nor can they all be advanced equally. Applying Care theory will require pilot activities that can be built upon. The early years of this process will need to focus resources and intent within a number of key tactical arenas, namely education, economics and governance. We take the view that these foci will provide the most solid basis for establishing the Ecology of Care as a global entity and also that these foci will open pathways for other branches of activities to be seeded and develop. In the short term, they will provide us with the best return on our investment of resources and effort. We also anticipate that capillary understanding of our work will spread via various media channels to a broader public audience through the visibility and presence that EoC activities and events generate.

Primary tactical arenas (education, economics, governance)

Care in education: Care studies

> *Within institutions of learning, the EoC Network will provide education, training and research in aspects of Care for self, others and the world.*

Initially developing university courses under the rubric of *Care Studies* will enable us to investigate the most effective means of delivery and develop new forms of adoption/adaption so that we begin a process of continuous improvement. Learnings here will enable further dissemination of Care Studies through basic courses in general education as well as undergraduate level and non-educational institutional opportunities such as corporate and government groups. At a point in the near future we see Care Studies providing a strong foundational base at the beginning of a student's life in any discipline; shepherding learning within those disciplines towards a positive and productive notion of Care.

A common avenue for knowledge exchange in education is the conference format. Starting with the first general conference, we will promote a series of international public events in many countries that will enable participation by the broadest possible range of disciplines, interest groups and social strata. At the first international conference we will begin the development of dual streams of history/theory, research

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and practice. Over time, we expect understandings of an Ecology of Care will mature as Care evolves to become a more normalised mode of practice.

Care economics: Care in business and industry – Care corporations

For people in commercial, government and non-government organisations, an Ecology of Care Network will provide programs that promote self-reflection, self-realisation and self-actualisation in the workplace. We will assist organisations (companies and institutions) to develop and implement programs that help their employees to embrace a stronger sense of purpose as they become not simply "cogs in a machine" but people who take an active role in designing a more fruitful and fulfilling work/life balance. This will increase the levels of satisfaction they derive from their time spent contributing to the success of a business in which they are personally invested.

For organisations this will facilitate change in behaviour towards Caring and sustainable business practices which foster loyalty, ownership, cooperation and a sense of belonging across all members of the work community.

> *The shift from quantitative to qualitative growth will require deep changes … at the individual level. It will mean overcoming … materialism and turning from finding satisfaction in material consumption to finding it in human relationships and community. (Capra and Luisi, 2014, p. 372)*

Strategically, the business and industry sectors are crucial to developing and adopting new forms of business practice and organisational structures which promote *Care based Economics* as a fundamental operating system for a more sustainable future (Praetorius, 2015; Hinton and MacLurcan, 2016).

> *Care in business is about shifting towards a generative culture; one that supports people and planet while reducing inherently destructive aspects of production and a harmful focus on profit to the exclusion of all else. Business can no longer operate on the basis of limitless material inputs nor can it simply take its workforce for granted as a production resource.*

Care in governance and community

The Ecology of Care Network is a non-profit, non-partisan organisation with no political ties or financial affiliations; this is the basis of its charter. This neutrality does not mean that it cannot or should not participate in helping government organisations or groups to achieve goals that are consistent with the ethos of an Ecology of Care. Within areas of policy and governance we will provide consultancy services as well as training and guidance that advance the adoption and application of the primary principles of Care as outlined in the EoC charter. We will actively contribute to deliberations and debates that influence decision making, policy and the social impact of proposed changes in community amenity and our response will remain in keeping with the ethos of Care.

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In places where there are already the beginnings of legislative and social change, such as Bhutan, Equator and Bolivia, even though they are small in comparison to the larger more dominant countries, we will study advances they have made in the legislative process. The ideals of *Sumak Kawsay* or *Buen Vivir*, meaning good living/living well, as well as the National Happiness Index, are good starting points for new forms of legislation that foster ecological thinking and support the nurturing of human wellbeing (Praetorius, 2015; Thackara, 2015). We will continue this process with a view to building better guidelines for transforming social attitudes towards Care within local and global communities.

Conclusion

All of the work undertaken thus far and the proposed Ecology of Care activities described above have been designed to enable the concept of Care to grow, to evolve, to develop in the organic ways it needs to do in order to foster a central vision; that is, an ecology that Cares for people as much as people Care for it. Craig Bremner (Director of the Ecology of Care CIC) summarises the task ahead of us succinctly when he says, "we aren't saving the environment, the planet has always determined what lives and what does not; all we are doing is re-learning to be together" (Bremner, 2016).

In this paper, I set out to introduce a new field of theory and practice called an *Ecology of Care*. By outlining the sequence of events and actions that have led to its current state of development, I have exposed the foundations of this new field and the moral/ethical stance to which it aspires. An Ecology of Care is a meta-theoretical project designed to provide a starting point for addressing many of the issues facing people of any economic strata or geo-political orientation throughout the human world. An Ecology of Care offers an alternative way of considering human-based activities; an antidote for many of the synthetic maladies effecting the natural world that are well entrenched and have become increasingly destructive over the past 250 years. The project of Care offers a way of rethinking the role of people in the planetary system of systems if they are to regain an optimistic future. An Ecology based on Care suggests a practical way forward; one that provides logical, desirable and viable alternatives to many of the moribund social, economic and political institutions that are struggling to cope with the complexity of human needs in the 21st century. We therefore urge our readers and leaders to support the project of an Ecology of Care in whatever form they care about. Whether it is in the economic world, the health field, the education sphere or any field of human endeavour, Care needs to be at the heart of all of our efforts ... if people Care, human beings will not only survive, they will thrive.

> *An Ecology of Care means Caring for our Home and everyone within it.*

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Dr Ian Coxon is currently an Adjunct Associate Professor at Charles Sturt University, Wagga Wagga, Australia. After a career in marketing and project management, mainly within the services sector, he re-engaged in academic life with a degree in industrial design. His subsequent research into the structure and epistemology of human experience formed the basis of his doctorate. His current research and teaching centres on the development and dissemination of an Ecology of Care as a field of study and practice across all disciplines and fields of economic endeavour.

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Care in healthcare

Ian Hargraves[1]

Abstract

In this paper the author argues that an undue emphasis on understanding healthcare in terms of what it does – the activities of care – limits appreciation of what those activities make, or fail to make, in people's lives. As a result, clinicians and healthcare organizations have very little grasp of how human lives are reconfigured through their interaction with healthcare, and the harms that these reconfigurations often introduce. In order to look for another way of understanding the contribution of care in human life and living in terms other than activities of care, the author turns to an ancient account of care. This myth discusses care in terms of its contribution to how human beings have life and are held in life.

Keywords

Care; Medicine; Healthcare; Myth of Care; Ecology of Care

Care, competent doing

There is a heavy emphasis in discussions of contemporary healthcare, at least in the United States context where I write from, on the *doing* of healthcare. Healthcare is done in many ways; care is provided, patients are engaged, decision making is shared, evidence is applied, medicines are prescribed, guidelines are issued and followed, measurements are taken, outcomes are sought, imaging technologies are used, records are kept, patient preferences are elicited, medicines are adhered to or not adhered to, risks are communicated, bad news is broken, wishes are respected, patients are put at the center.

Behind the emphasis on doing is a very sensible idea, that if all the things that healthcare needs to do are done well, i.e. competently, respectfully and kindly, then care will follow. Of the three listed above, competence currently subsumes respect and kindness. We instruct our young clinicians to master respect and kindness as a competency in their training, so that they can do respect and kindness when the time comes. In so doing, the very sensible idea becomes a notion that care arises from competency, or, care is competent doing.

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Yet something is amiss in the idea of care as competent doing. Patients and families may be, and often are, competently treated – inter-personally, in communication, scheduling, surgeries, hospital stays, prescription of medicines, etc. These patients will commonly report that they are satisfied with their care, and will rate their experience of care highly. When they leave the enclave of the clinic, however, what was done to them, with them, and for them too frequently fails to work in their lives.

Figure 1. Maria-Luisa. (Image credit: Ana Castañeda Guarderas)

This is an image of Maria-Luisa (Figure 1). Maria-Luisa is the grandmother of a colleague who works with our research group. She is 87 years old and for most of those years she lived in her native Peru. Currently she lives in Alaska with her son who takes care of her. Maria-Luisa has hypertension and kidney disease. For the last five years she has organized her life around dialysis three times a week. In addition to living in a part of the world that doesn't speak Spanish, or offer Peruvian food, Maria-Luisa has been told by her doctors that she must follow a diet that is low in sodium, potassium, phosphorous, protein and water. Sometimes when she doesn't follow this advice, she finds herself in the emergency department.

A remarkable set of competencies has allowed Maria-Luisa to be in this situation. In earlier times, she likely would not have lived to be 87 years old. While the achievements of medicine may be remarkable, other, often invisible, aspects of medicine's competent doing manifest here – in a home full of medicine in which she is alive but not happy. Her healthcare has no, or very little, appreciation of this. It is not just that healthcare hasn't looked to see what her life and living looks like, it's also that healthcare often fails to recognize that Maria-Luisa's current way of life is in large part the product of its competencies.

I wish to argue that in complement to the necessary continued development of competency in medicine, that appreciation and understanding of what is made by the competent practitioners of care also develop. This requires, in part, a way of understanding medicine in terms of what it

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makes, or produces, rather than in terms of what it's doing. The limited facility within contemporary healthcare with a language of care as *made* real in people's lives is perhaps best demonstrated by the prevalence of the term "outcome". Outcome or outcomes is the dominant term used to indicate the end result of all the doing of healthcare, whether that be the doing of a surgeon or the doing of a new drug. Outcome is a term that allows a doctor to review all the medications before Maria-Luisa and say, given the outcomes that we're trying to pursue, these medications are the right ones for Maria-Luisa. The doctor might also go on to say that when Maria-Luisa adheres to her medications, dialysis and diet we see satisfactory outcomes for an 87-year-old woman with kidney disease. Outcome, however, is an inadequate term and idea for beginning to think about what has been made of, and in, Maria-Luisa's life through the competencies of healthcare, yet "outcomes" remains dominant among the very few limited ways currently available to practitioners for accounting for the adequacy and contribution of medical competency in human situations such as Maria-Luisa's.

The Myth of Care

Living in a time and a culture that pre-eminently values the doing of people and technology, and which typically critiques practice in terms of what practitioners are doing with and to other people, I struggle with finding language appropriate for understanding what healthcare and the decisions of healthcare make in human lives. Rather than attempting to advance a new way of talking appropriate to current circumstance that might help us understand care as it's made in human lives, for the remainder of this paper, I wish to reflect on an ancient account in which competency and the ability to do find their proper relation to what is made. This is done through the theme of care in the form of a myth.

The Myth of Care comes to us from the notes of a young Roman scholar, Hyginus. Its exact origins are unknown but it dates to Greco-Roman times. The myth has two parts:

Part 1

> *As Care (Cura) was crossing a river, she thoughtfully picked up some mud and began to fashion a human being. While she was pondering what she had done, Jupiter came along. Care asked him to give the spirit of life to the human being, and Jupiter readily granted this. Care wanted to name the human after herself, but Jupiter insisted that his name should be given to the human instead. While Care and Jupiter were arguing, Terra (Earth) arose and said that the human being should be named after her, since she had given her own body. Finally, all three disputants accepted Saturn as judge.*

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Part 2

> *Saturn decided that Jupiter, who gave spirit to the human, would take back its soul after death; and since Terra had offered her body to the human, she should receive it back after death. But, said Saturn, "Since Care first fashioned the human being, let her have and hold it as long as it lives." Finally, Jupiter said, "Let it be called homo, since it seems to be made from humus (Latin for earth)".*[2]

It is striking that this myth does not begin by locating care in healthcare, nor in interpersonal relations – two commonplaces of care today. Rather, Care enters as a thoughtful fashioner – one with the capacity to make. Care's competency in making is not alone; other gods or experts soon join. By the end of the first part of the myth four gods each make claims on the human being, and those claims are based on what each has given out of their particular competencies (see Figure 2.). These gods remain with us today in healthcare; each has a valuable contribution to make, but each faces conflict in its capacity to contribute.

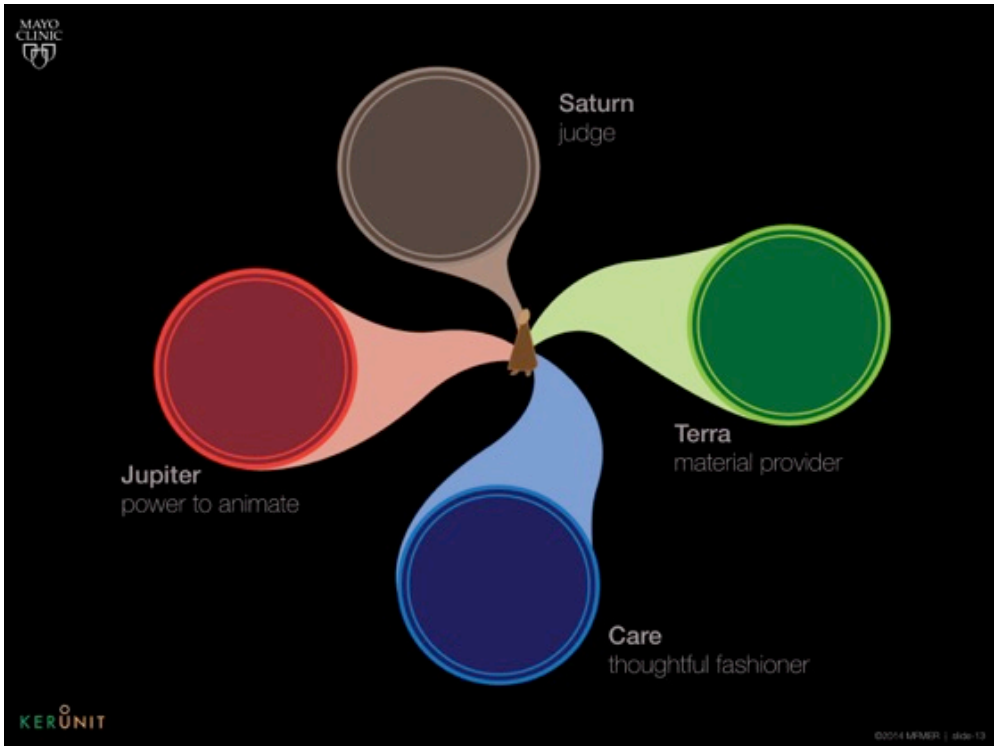

Figure 2. The Myth of Care: The four gods.

Terra, the provider of materials, is present in the vast array of materials that clinicians must develop competency in working with. Materials are chemical, biological, psychological, linguistic, social and environmental, to name but a few. One of the most

[2] Reich, Warren T. "The History of the Notion of Care." In *Encyclopedia of Bioethics*, edited by Warren T. Reich. New York, London: Macmillan Pub. Co. Simon & Schuster Macmillan; Prentice Hall International, 1995.

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dominant materials in contemporary healthcare are the intellectual materials that clinicians must work with – data, information, evidence. Healthcare is challenged not by a dearth of intellectual materials but with the problem of what to make of the material it has. The vast majority of the research produced by biomedical sciences is neither useful nor usable in contributing to care. Even research that may be potentially useful is often not refined into a form that patients and clinicians can make something of. Beyond this well-produced evidence suffers another problem – evidence alone does not care. Each of the many medications and devices present in the image of Maria-Luisa are there as a result of an evidence-based guideline, each of which is the product of multiple randomized control trials. Yet, the fact that the intellectual material behind the prescription of these drugs – evidence – was of high quality does not help us understand what contribution the medications are making or failing to make in Maria-Luisa's life.

Jupiter, with his power to animate, has always been a part of the care of the ill. He is the god that brings warmth, cheer, humour and hope to enliven the afflicted. The spirited Jupiter is challenged in healthcare in a number of ways. A history of paternalism has distanced doctors from those that they care for. The speech of medicine can often alienate rather than animate patients and their loved ones. Clinician burnout fuelled by demanding working conditions and expectations is a growing problem, sapping the spirit from clinicians who spent year upon year to be in a position to care for people. At the same time clinicians are directed to "engage" their patients with little direction as to what this engagement is. Jupiter is also at play from the patient side. Patients are encouraged to be empowered and let their voices be heard rather than acquiescing to whatever the doctor directs. Yet when patients seek to animate care through their voice, healthcare and family members often do not know how to make something of it. Recently I spoke with a critical care doctor who said that 90% of advanced directives – written expressions of what a person wants when they are very ill and can't speak for themselves – are practically useless for the situations that patients and their families are in when they're in an intensive care unit.

Saturn, the judge, is very much present today also. He is present in the many judgments by which care proceeds. A lot of my work as a designer involves creating tools to help patients and clinicians together decide on what to do – in a process called shared decision making. This decision aid (see Figure 3), for example, is intended to help in deciding whether or not to begin a class of medications called statins to reduce the risk of heart attack. While these decisions can be important, at other times they do not matter at all. I recall a haunting story told by Dr Iona Heath from the United Kingdom[3] of a newly trained colleague eager to share his new understanding of statins with his patient – a woman in her early seventies. After explaining the ins and outs of the medication and asking her what she thought, the woman turned to her doctor and after a lengthy silence said "But, John is dead and the boys have moved away". What the doctor was trying to decide on was not at all the situation that mattered for this woman.

[3] Recounted in a keynote address given at the International Conference on Communication in Healthcare in Heidelberg, Germany, in 2016.

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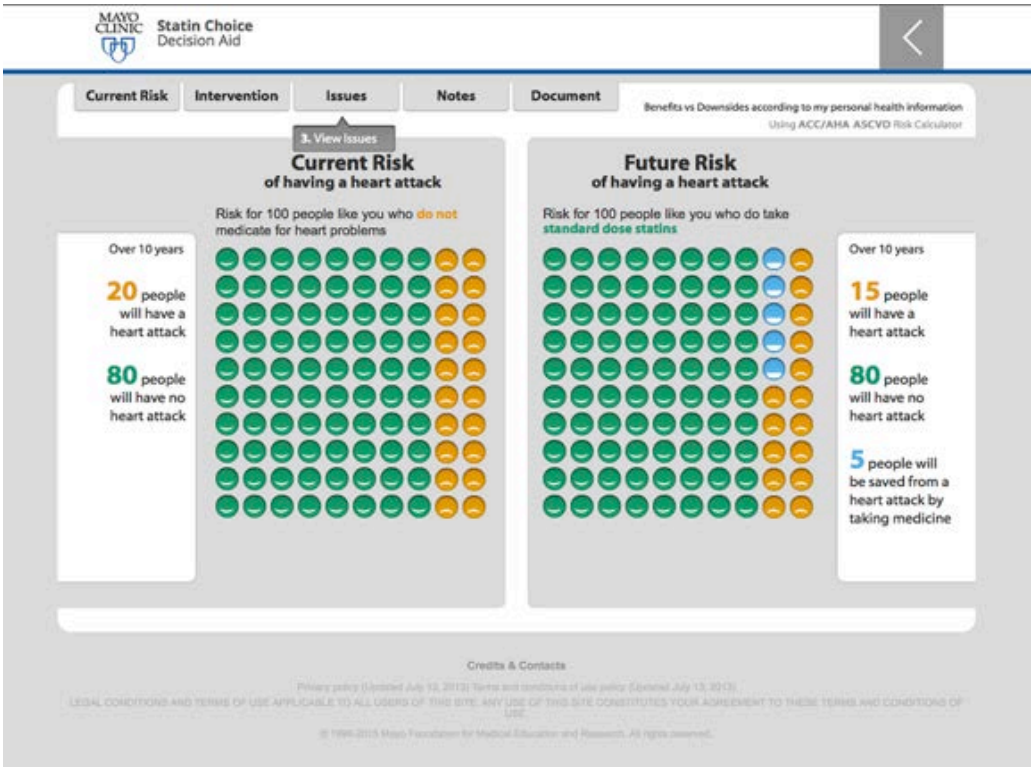

Figure 3. Shared decision making.

The first part of the myth ends with the competences of the various gods in conflict with one another. In the second half of the myth, conflict resolves when attention is turned to what is being made through the contribution of each god – the human being and a human way of life. In so doing the character of each god is subtly transformed.

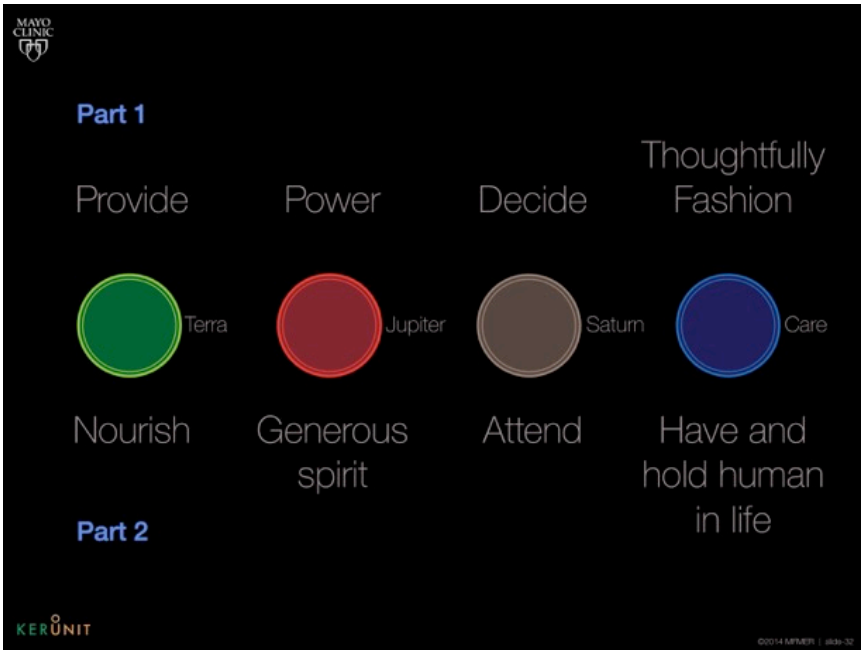

Figure 4. The Myth of Care: The transformation of the four gods.

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In the naming of the human after Humus, there is recognition that the life of the human is in continuity with that of the earth – that there are materials that are properly human during life, and the place of those materials in care is to nourish life. Terra transforms from a giver of material to a contributor in the nourishment of human life and living.

It is Jupiter, not Saturn the judge, who says that the human should be named for Humus. In this act, Jupiter's character shifts from a power to animate according to his will to a generosity of spirit that enables other gods – contributors – to bring forward their best in care for the human being.

Saturn the judge is transformed also from a competency in deciding to a fostering of resolution – of bringing forward a just peace that attends to a troubling situation, such as illness. The goddess Care is transformed too, the significance of her thoughtful fashioning shifts from a competency – a skill in craft, to a responsibility – that of having and holding of the human in life. The object and significance of care moves from formed mud to how human beings have and are held in life.

Through the Myth of Care, it possible to catch a glimpse of care in healthcare, not as many competent doers (the gods from the first part of the myth), but as what those competencies contribute to make in care, Maria-Luisa and her life and living.

About the author

Dr Ian Hargraves is an Assistant Professor of Medicine and Principal Health Services Analyst at the Mayo Clinic, Rochester, Minnesota. His expertise is in design and patient-clinician interaction in shared decision making. Dr Hargraves holds a Bachelor's degree in Industrial Design from Victoria University in Wellington, New Zealand; and a Master's degree in Interaction Design along with a PhD in Design from Carnegie Mellon University, Pittsburgh, Pennsylvania. His doctoral research considered design as care.

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Robotics and Care: A personal engineering journey

Anders Stengaard Sørensen[1]

Abstract

This paper presents the author's experience of gradually applying robotic technology to traditional areas of Care, along with relevant observations on how Care for technology and processes converge with Care for people in the field of *welfare-technology*. It describes an evolution from experimental industrial automation to almost commercial welfare-technology over a 15-year period. It is driven by the author's gradually increasing curiosity and Care for physical interaction between humans and robots, combined with an increasing awareness of the potential of caring technology in welfare.

Keywords

Robotics; Care; Ecology of Care

Introduction

During 25 years of experimental robotics, my projects have gradually changed from showcasing the potential of mechatronics and robotic servants (replacing human effort), toward technology that acts as an extension to humans, in welfare-technology (expanding human effort). As I was introduced to the Ecology of Care (EoC) framework, it became clear that my experience and journey through experimental engineering was closely entwined with the Care concept. By considering the following project portfolio through the lens of Care, it becomes evident that I have started by caring about technology for its own sake, and then, project by project, changed my focus to how technology can be applied to Care for people.

My current position on technology and Care can be summed up as:

- technology has always been about Care;
- technology never cares in itself;
- Care is in how people use technology;

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- in welfare-technology, Care is a prime objective; and
- contribution to "self-reliance" is an important measure of Care in technology.

Background

With a Master's and a PhD degree in computer systems engineering I am a very geeky engineer. I find great joy in studying, teaching and using engineering mathematics such as how Euler and Fourier used imaginary and complex numbers to unify the exponential function with sine and cosine, the benefits of using hexadecimal numbers when programming robots, or the finer differences between different types of transistors.

Figure 1. 10 degrees of freedom hybrid robot.

Most of my career has been dedicated to experimental robotics, developing the electronics and control software that enable extremely complicated robot mechanisms to be controlled accurately enough to perform useful processes. A passion for connecting the physical world of reality with the virtual world of computers (Cyber-Physical systems) is my primary driving force. I have no formal education or experience with Care, and hence no strong professional opinions on the topic. My opinions and observations are entirely based on experience and the observations obtained from developing technology intended to assist humans in various ways.

The *DockWelder* and *SmartPainter*

From 1998 to 2003, I was involved in the development of a robot technology with long horizontal reach, based on combining off-the-shelf robot arms with a "variable

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geometry truss" mechanism originally devised by NASA for space-robotics. The basic concept is clearly visible in Figure 1 and the most complex setup is shown in Figure 2.

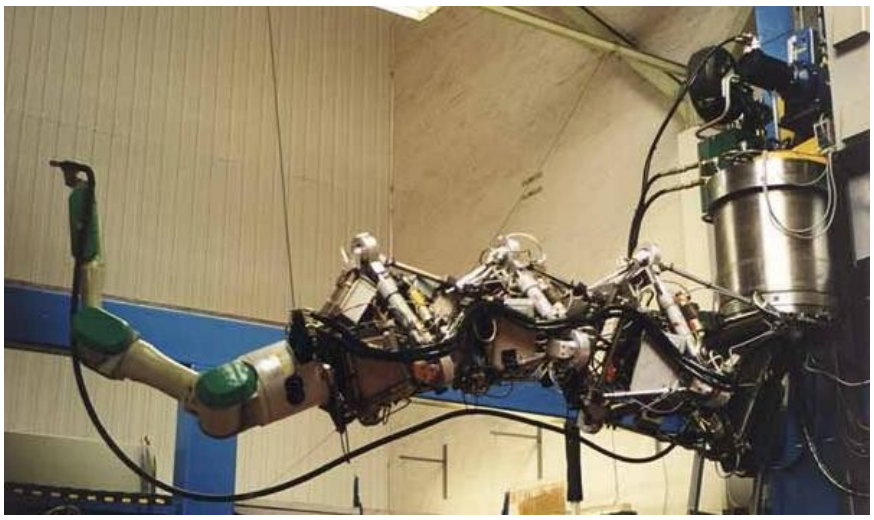

Figure 2. 18 degrees of freedom hybrid robot.

The projects were an ambitious attempt to automate the dock assembly and painting of prefabricated ship sections, and were named *DockWelder* and *SmartPainter*. The projects proved that the concept was technologically feasible, but was not an attractive business case due to its vast complexity. With the clarity of hindsight, these projects expressed an almost desperate imbalance between technology and practicality. If we crudely consider the "focus of Care" in these projects, it can be claimed that:

- engineers Care about enhancing and demonstrating skills and creativity;
- company and public investors Care about maintaining productivity through automation; and
- public investors Care about increasing technical knowledge in society.

In these cases, any Care "about people" is indirect, accomplished by maintaining and creating new jobs using technology. We are clearly considering an attempt to create "robots that do something for people", i.e. welding and painting ships.

RoBlood: A blood sampling robot

From 2006 to 2011, I headed *RoBlood*, an effort to develop a robot to automate the process of drawing blood samples in hospitals. The number of samples had increased steadily by 7% annually and was at that time a strenuous 9-to-5 job for 5 to 20 people at each major hospital. Most employees changed jobs after 2-4 years, due to the physical strain involved in doing the job.

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The *RoBlood* project was co-funded by the Vejle Hospital, the University of Southern Denmark and Kolding Design School. It was conducted in an open, transdisciplinary project environment, including personnel and students from all three institutions.

Many interesting lessons about detecting blood vessels, inserting needles, transfixing arms etc. were learned, but the most interesting were the lessons about psycho-physical interaction. It was proposed that a person's discomfort about blood samples stem from the violation of their preferred body language. During blood sampling, patients are asked to sit with arms apart and forward; a completely open "come and bite my throat" posture (see Figure 3). The design students proposed a system that allowed users to partially fold their arms; a reserved and reluctant posture adopted during each procedure. They made a procedural "mock-up" to demonstrate the psychological difference. Although it was never formally tested, the students had made a good point. It did feel much better.

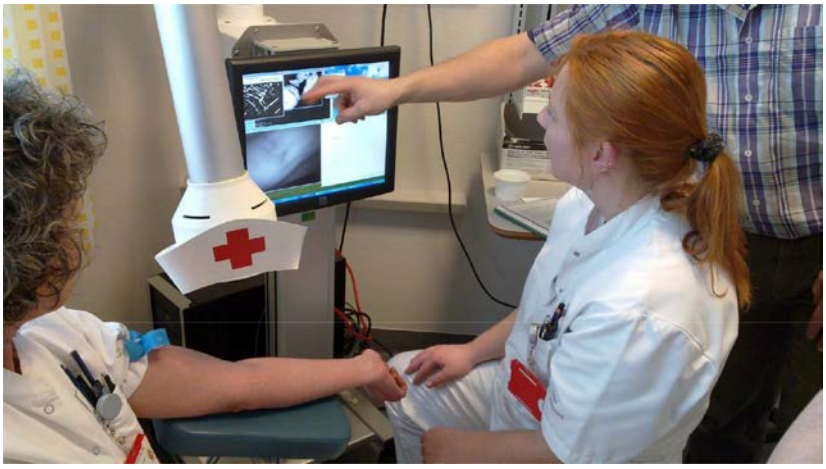

Figure 3. PhD student Thiusius Rajeeth Savarimuthu, demonstrating his vein detection prototype, using the traditional posture for blood sampling.

During the project, it became increasingly apparent that successful automated blood sampling would have to be something the patient did with the robot, rather than something the robot did to the patient.

Considering the "Focus of Care" within the *RoBlood* project, it can be claimed that:

- hospital administrations Care about maximising efficiency, decreasing cost and increasing productivity;
- hospital departments Care about reducing strain on personnel and improving conditions for patients;
- a large segment of experienced patients Care about maximising efficiency and decreasing waiting time;
- the smaller segment of inexperienced patients Care about comfort and support;

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- the engineers started out caring about a robot applying a process to an arm, but ended by caring about how to create an interaction between the robot and the user;

- Care for the personnel is indirect, as they are merely relieved by technology; and

- Care for the patients was originally concerned about comfort, pain and anxiety when the robot was doing something to them; it changed to concerns about how to get patients to interact with a robot that did something to them.

Butler robots

In 2009-2010, I was briefly involved in a project to develop an advanced service robot, a *ButlerBot*. The intention in this project was to help disabled people in their households; not unlike a service dog or personal assistant. Such projects are very important as they are the only way to eventually derive robot servants that might be actually useful and worthwhile. One particularly interesting feature of the project was the participation of rehabilitation therapists. They were very clear about the dangers of robots providing too much service as they pointed out that this could pacify patients and inhibit rehabilitation. It was very surprising to meet project partners who seriously tried to restrain the ambition level of the project, out of Care for the end users, while everybody else seemed frustrated that the level of ambition in the project was perhaps too high for contemporary technology.

The project was successful in reaching important conclusions regarding remote control of robots, and clarifying the need and possibilities for remotely moving personal objects in private homes. However, it will still be some years before flexible service robots will be able to compete with human assistants both in the lab and most certainly in everyday situations.

The “Focus of Care” when I left this project appeared to be:

- municipalities Care about boosting patient's self-reliance, to reduce the need for personal assistance;

- therapists and caretakers Care about boosting the patient's self-reliance, to improve the citizen's quality of life;

- some patients cared about boosting their self-reliance to improve their quality of life; others cared about reducing the daily physical challenges to a minimum;

- engineers Care about increasing the ability of service robots, by solving a small and well-defined subset of challenges that occur to robots in private homes;

- behaviourists Care about the technology’s ability to instigate changes in patient behaviour; and

- the Care for people was disjointed as some project participants were motivated by the technology’s potential to directly increase a patient's self-reliance. Other

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participants were motivated by the potential to avoid physical challenges. Some were motivated by the sheer challenge of getting robots to work in private homes where the patient and their possessions could get in the way.

Figure 4. *ButlerBot* demonstration.

Rehabilitation robots

1. *RoboTrainer*®

The therapist's notion from the *ButlerBot* project (see Figure 4), that "robots should not pacify users with too much assistance", prompted a deeper question: should robots actually provide patients with resistance? The immediate answer was "Yes, it's called training and it's great for rehabilitation". A short time later, in 2010, I was approached by Allan Lauritsen (a patient recovering from a serious injury), who wanted a robot training partner to help with his strenuous and monotonous rehabilitative training program.

Together, we created *RoboTrainer*®, an automated biceps/triceps training machine, with a powerful computer controlled motor replacing the normal weight load. Meeting Allan brought my academic and theoretical skills together with his specific personal needs, ideas and focus. Allan has been a tremendous inspiration and catalyst for my decision to focus on technology that is available to ordinary people, in terms of simplicity and cost.

During 2011, *RoboTrainer*® was made available to a student – Jesper Kiersgaard – who had suffered 90% paralysis in his left arm and shoulder, due to a traffic accident (see Figure 5). He had previously attended three years of normal rehabilitative training, which was terminated by health authorities due to lack of progress. *RoboTrainer*® was programmed to counteract the gravity on Jesper's arm, allowing him to perform full curl repetitions, almost indistinguishable from normal training. Over a period of six months, Jesper trained 3 x 20 minutes a week. In that period, the strength of his upper arm progressed from 1 kg to 7 kg, constituting an almost full rehabilitation of the arm

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(see Figure 6). After the first training session he exclaimed: “For the first time in three years, I feel tired in my arm”.

In this project the focus of Care can be summarised as:

- the user cared to participate in effective training, hoping to improve;
- the engineer cared about applying his skills to the specific problem and helping the patient; and
- the training expert cared about embodying his knowledge about training in a robot that could be a training partner for himself and others.

It is important to note that the technology in *RoboTrainer*® is really quite simple. *RoboTrainer*® could easily have been created 25 years ago or even earlier. This constituted the first project where I was not driven by my Care for new technology. It was still driven by curiosity, but for a new way to use a robot, rather than by the novelty of the robot itself. This robot only does something with people.

It is also interesting to reflect on whether the training expert and the engineer’s “Care” for the patient has been embedded/embodied in the robot. Especially since the “interesting” part of the robot behaviour is only a few lines of code.

Figure 5. Jesper Kiersgaard using *RoboTrainer*®.

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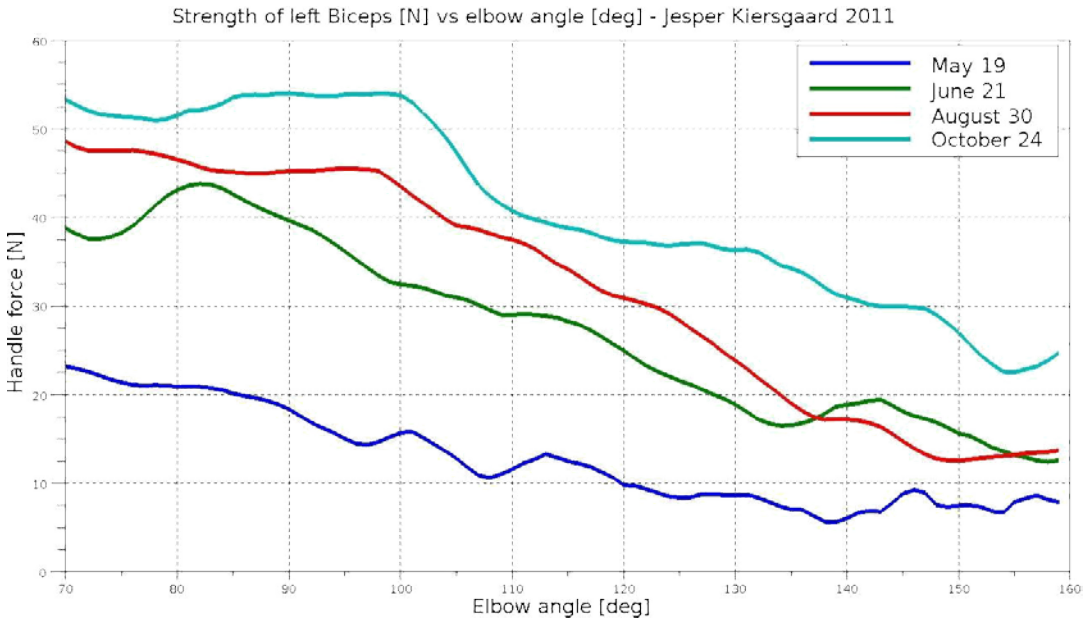

Figure 6. Graphing Jesper Kiersgaard's progress.

2. Universal *RoboTrainer*

From a practical standpoint, *RoboTrainer*® (described above) is limited to one function: biceps/triceps training. To address a reasonable segment of patients, we would have to construct a whole spectrum of similar machines dedicated to shoulders, wrists, hips, knees, etc. This would be highly impractical and expensive for the health sector and for patients. Since the training is constituted by the interaction of the user and the "handle", we simply moved the handle to a commercially available off-the-shelf robot arm and programmed it to move the handle along any path desired by the patient or training expert. After three years of advanced mathematics and programming, a patient or therapist can now teach the robot a path by demonstrating the desired path using the patient's own arm movements, perhaps assisted by a therapist. The robot can then repeat the path over and over while mechanically counteracting gravity on the user's arm. We expect to enable patients with up to 90% paralysis to train any repetitive motion that they or their therapist desire.

The focus of Care in this work can be summarised as:

- hospitals Care about the ability to improve rehabilitation results and/or reduce therapy costs;
- therapists Care about contributing to future tools for rehabilitation and learning about new possibilities;
- engineers Care about developing and improving the robot control to enable the motion and interaction specified by the therapists; and

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- patients have scarcely been involved yet, but are assumed to Care about participating in effective training.

The need for a large technical effort has offset the focus of Care in this project with respect to its origin. When the project enters a phase with more patient interaction – deploying and testing the robot – Care about the patient's perspective will become more focused; however, we are concerned that the technical complexity of the robot will inhibit the robot in "projecting Care" in the same way as the original *RoboTrainer*® did.

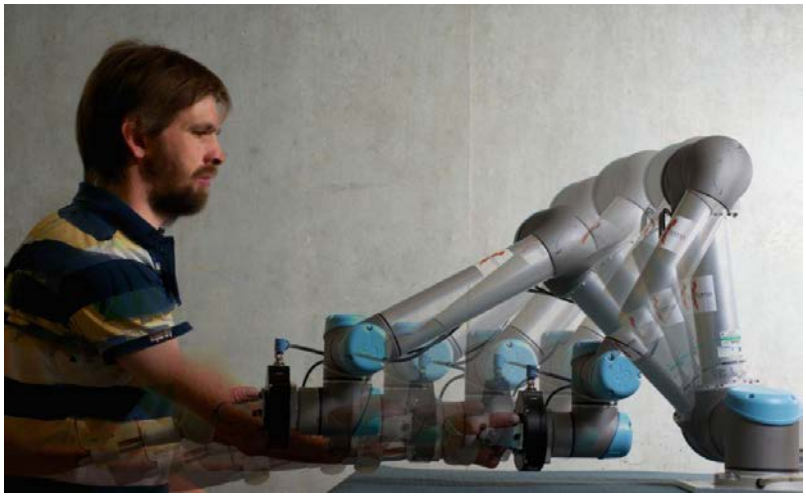

Figure 7. Jacob Nielsen and Universal *RoboTrainer*.

3. *RoboTrainer*-Light

As Universal *RoboTrainer* (see Figure 7) is likely to be too expensive for decentralised deployment, we fear that it will only be part of a patient's daily training, as long as the person is in the hospital. We would like to develop a technology that is simple and cheap enough to be used in private homes. Thus, the challenge became: what is the cheapest possible training robot?

RoboTrainer-Light was our answer (see Figure 8). It is simply a motor pulling a string, using a fast and precise force, position and speed controller. In mass production, it can be marketed for a few hundred dollars, and thus become available as daily training for a large number of people with partial paralysis, from accident victims to stroke patients. The simplicity of *RoboTrainer*-Light has enabled us to demonstrate and test it with a large base of users, therapists, doctors, technological experts, students and so on, while developing ideas, applications and software for it.

The focus of Care in the *RoboTrainer*-Light project can be summarised as:

- the users Care about participating in effective training;

- doctors and therapists Care about keeping patients active across the transition from hospital to home, as well as monitoring and evaluating training remotely;

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- therapists Care about the ability and motivation to train at home as well as the potential for increasing and documenting the effectiveness of home training; and

- engineers Care about enabling patients to train with the simplest possible equipment, in order to maximise availability.

Making the robot simple is a prerequisite for enabling users to afford and operate the equipment. Making it work is a prerequisite for the robot to have an effect. The drive toward simplicity and availability is partly a technical challenge, catering to the engineer's Care for challenges. This happens to coincide with Care for helping the user rehabilitate by making the equipment feasible and available.

Figure 8. Jørgen Maagård and *RoboTrainer*-Light.

Conclusion

Everything we do is motivated by Care, including the development of technology. Technology has always been about Care. The development of a baby's pacifier is motivated by Care for the baby's and adults' comfort, and probably also by Care for producing, marketing and earning money from it. When discussing and evaluating Care in the context of welfare-technology, we need some more specific benchmarks.

The impact on "self-reliance" is an important benchmark in any health ecology based on Care. It is an underlying theme in all the cases presented above. Every case has been about technological solutions with the potential to offset or augment self-reliance in some way. Industrial automation (like *DockWelder*) enhances the self-reliance of the company and hence employees and owners, as manufacturing processes become faster, cheaper, more reliable and less straining.

RoBlood enhances self-reliance for chronic patients, by reducing the amount of time and hassle spent on blood sampling. It also enhances the self-reliance of the health service in the same way as industrial automation. Home automations like *ButlerBot*

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enhance the self-reliance of the person they serve, as more processes in the home come under that person's influence/control. Robot training devices enhance the self-reliance of patients by restoring strength and mobility. All four case studies can be said to exert "Care" linked to "self-reliance", but our valuing of Care varies with our perception of the way the robots service us: specifically, whether they do something for people, do something to people, or do something with people.

Another important benchmark for technology and projects versus Care is practical feasibility, as it can be useful in resolving the balance between caring for knowledge/technology/equipment/process and caring for the people that need it. I do not advocate any particular balance, but I find it extremely important that the balance is consistent with the expectations of all the stakeholders in a particular project. Many of the projects presented above have been very successful, even though they were obviously unfeasible. They were successful because their stakeholders were interested in new knowledge, rather than the specific application. Others were partial failures, as people-focused stakeholders were disappointed by the excessive technological ambition coming from technological stakeholders. This resulted in a lot of learning, but little direct caring.

Adherence to the goal of achieving an Ecology of Care is a deciding factor for the success of technology and related services. In practice, technology will only be meaningful and hence useful, to the people who use it and the stakeholders, if the technology satisfies their needs and expectations. It is, however, vitally important to realise that Care is in fact a part of a wider ecology, not a single definable goal all stakeholders can agree about.

Developing a framework for discussing, and perhaps even comparing Care and different aspects of Care, will be an excellent supplement to existing project and technology assessment tools. It is especially valuable when technology enters into areas where Care is focused directly on people, rather than abstractly via processes and tools.

About the author

Anders Stengaard Sørensen is an Associate Professor in training technology electronics and robotics. He is Head of the University of Southern Denmark's Training Technology Lab and founder of the startup company BandCizer, who develop and market sensors for resistance band training and other widespread home-training devices.

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Why not just lie? Tips on "trust" from (gulp) US political campaigns; aka successful ways to communicate persuasively

Harriett Levin Balkind[1]

Abstract

Using traditional and social media, politicians (and it would now seem countries) have become quite adept at bringing audiences around to specific ways of thinking based on falsehoods rather than facts. This paper focuses on the techniques politicians use for persuasion, codified after reviewing 200+ television political ads and online media from US Presidential elections dating from their beginning in 1952 up to 2012 while curating the exhibit "I Approve This Message" with the Toledo Museum of Art. The paper states "persuasion" is not necessarily malicious – to persuade is "to induce someone to do something through reasoning or argument" – and demonstrates that the same methodologies politicians use to distort truth can be used in the service of truth as a way to gain support for any initiative. It demonstrates that rather than use a purely rational approach to achieve your goal, which an abundance of research shows does not work, you will be more successful doing what politicians do – not to lie – but to build in emotional elements as a way to influence your audience.

Keywords

Advertising; Political Advertising; US Presidential Elections; Exhibit I Approve this Message; Toledo Museum of Art; Persuasion; Trust; Ecology of Care; HonestAds; HonestAds.org

Trust is a critical component of care. Is truth also an essential element? Recent elections in the United States and the United Kingdom clearly demonstrate that answer to be "no". Voters trusted that their candidates would work in their best interests – even when they knew those same politicians were spouting fictions

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over facts.[2] This was clear in the political campaigning that won Brexit and in the US presidential surprise where Trump lied with his statements more than 70% of the time, while his opponent Hillary Clinton lied 26%[3] of the time. In fact, lying in US elections has become so much a part of political campaigning that an industry of nonpartisan fact-checking organisations has evolved. Voters who disagree with their findings believe that the fact-checkers are lying, too.[4]

So, why not lie and win? Lie to your business associates; lie to your friends; lie to your mate; lie to your kids. Get what you want. You'll find that the same political rules don't apply to business and day-to-day life, unless you want to land in jail or in the doghouse. (In the US there are Truth-in-Advertising Laws for consumer products, but it is perfectly legal to lie in national political campaigns. This is "free speech", a Constitutional first amendment right, as interpreted by the US Supreme Court.)

It's taken many decades for that nasty word "lie" to become accepted nomenclature for a US politician's claims. Manipulation. Persuasion. Fib (smaller than a lie). Out of Context. Misrepresentation. Historically, these have been the polite and useful euphemisms.

This paper focuses on the techniques politicians use for manipulation, using the softer rubric "persuasion" which is not necessarily malicious. According to the Oxford Dictionary, to persuade is to "induce someone to do something through reasoning or argument",[5] thus, these same political methodologies can be used in the service of truth – to gain support for an important initiative.

Emotion rules

Since Americans know that politicians are not being truthful in their campaigns, why would someone actually vote for a candidate who they know isn't telling them the truth? They would never accept that behavior from a business associate or a romantic partner or a child. A review[6] of research papers, 60+ books by

[2] Trump Voters Don't Care If He Exaggerates, Lies, *Washington Examiner*, Paul Bedard, June 7, 2017.

[3] Clinton Fibs vs. Trump's Huge Lies, *The New York Times*, Nicolas Kristof; Trump's Lies vs. Your Brain, Politico.com, Maria Konnikova, Jan/Feb, 2017.

[4] Dishonest Fact-Checkers: How fact-checkers trivialize lies by politicians and undermine truth-seeking, Capital Research Center, Barbara Joanna Lucus, March 10, 2017 [NOTE: the preceding is a Republican group considered right-wing]; Fact-Checking the Fact-Checkers, TheCodex.io, Kevin Wright, January 9, 2017.

[5] Persuade. (n.d.). In *Oxford online dictionary*.

[6] *Advances in Political Psychology*, Vol. 38, Suppl. 1, 2017, "The Nature and Origin of Misperceptions: Understanding False and Unsupported Beliefs About Politics" by Flynn and Nyhan (Dartmouth) and Reifler (U of Exeter; "Taking Corrections Literally But Not Seriously? The Effects of Information on Factual Beliefs and Candidate Favorability" Nyhan, Reifler, Porter (George Washington University, Wood (Ohio State University) among scores of other research reports. Nobel prize-winning psychologist Daniel Kahneman, author of "Thinking. Fast and Slow"; neuroscientist Antonio Damasio, author of "Self Comes to Mind" and "Constructing

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neuroscientists, political scientists, cognitive psychologists and biologists, and speaking with academics, fact-checkers and politicos, provided six critical learnings:

1. **Facts don't necessarily change minds**, and even the most educated among us may be the least likely to be moved by facts.

2. **We vote based more on emotions than we do on issues.**

3. **We are predisposed to think certain ways.** Some scientists believe we are predisposed to lean right or left based on certain gene-based attributes, such as the desire to take risks versus being more traditional and safety-oriented. We may also be raised or live in an environment that builds on those attributes – home, school, peer group, religious affiliation.

4. **We feel before we think**; emotions frequently override reason. Neuroscientists tell us that it is not possible to have a purely rational thought. Possibly this evolved as a survival technique allowing us to react quickly in moments of danger.

5. **It is more important to be part of a community than to counter it**. The hypothesis is that this, too, represents survival of the fittest as the thinking is that groups who stick together are more likely to survive. And it is more emotionally satisfying to be part of a group, than to be the smart one who is shunned or discarded.

6. **An experience can open a mind and, maybe, even change it**. An experience can provoke thinking. It can induce curiosity; or a recognition of implications; or pure attrition from waiting for something to improve that never does. A tip of our hat to mothers, who in exasperation for centuries have exclaimed: "Wait until you have your own children!" That is a call for experience. When advertising people reference the importance of telling stories to sell a product or service or idea, they are really talking about creating relevant imaginary experiences to elicit emotions.

The question

Could an experience be designed where the visitor is immersed in emotion and, therefore, motivated to reason more critically? Would people move out of their comfort zone to see things in a new way – through feeling? How ironic if you could move people into an emotional experience that would, then, make them think differently.

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the Conscious Brain"; political scientists and authors Milton Lodge and Charles S. Taber, "The Rationalizing Voter", among scores of other books.

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Experience + emotion = seeing things differently

These questions inspired the museum exhibition "I APPROVE THIS MESSAGE: Decoding Political Ads" conceived by HonestAds and launched just before the national political conventions at the Toledo Museum of Art in the political swing state of Ohio – considered a precursor for presidential elections because of its track record of correctly predicting national elections (only wrong twice since 1988). Designed with creative partners, Thinc Design (exhibit), Jet Design (video), Madhouse (identity and marketing) and the Toledo Museum of Art, the plan is for it to travel across the country. The exhibit primarily focuses on using historical political ads from 1952, when they were first broadcast, up to today. Those ads that most compellingly make emotional arguments are shown. An independent researcher in the political arena was brought in to find out if the "I APPROVE THIS MESSAGE" experience made a difference in changing the way people think. While all the data is not in at this writing, two important findings are: 1) The exhibit provoked thinking among 78% of the visitors; and 2) visitors recognized the power and entertainment attributes of the ads without assuming they were accurate or misleading.

A brief walkthrough of the exhibit

Along with images and captions at the end of this paper, this video walkthrough (https://vimeo.com/204596831) provides a much better "sense" of the experience.

As visitors walk into the exhibit, an introductory wall lets them know the content is about the voters and their emotions – Hope, Fear, Anger, Pride – rather than about political candidates or issues. The visitor continues towards Hope and Pride Theaters or Fear and Anger Theaters. At each Theater a panel explains the impact of a particular emotion and why it is relevant within the context of an election; for example: "HOPE. If it's worth fighting for, you have Hope. Hope is a positive emotion and crucial to a campaign. You feel good about events to come even if you have anxiety about an unknowable future...". The footage in the individual theater cycles you through ads that make you feel fear; ads that make you feel anger; ads that make you feel pride or hope – the idea being that from 1952 to today (60+ years!), politicians say the same things, talk about the same issues, and use the same types of words and images as well as the same music genres to provoke emotions. On theater walls, panels of 17 ads are broken out frame-by-frame with the narration to the left and the persuasive techniques – utilizing specially created graphic icons – to the right that point out the persuasive techniques at work.

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In the center is a mood room that cycles you through the same four emotions using video and a custom soundtrack that demonstrates how, with the appropriate stimuli, you literally cannot stop "feeling" the emotion that is triggered. Interactive experiences with blackboards provide "prompts" for a visitor to write about what they are thinking or feeling.

In the back gallery is a 50-foot timeline,[7] beginning with the 1920s when radio emerged as the first mass medium. The timeline illustrates how things don't exist in a vacuum but evolve over time, impacted by: News Events, Advertising and Politics, Laws and Political Spending, and Technology. For example, political ads were first broadcast during 1952 because it was only then that enough Americans had televisions in their living room to make advertising viable. Presidents have always been opportunistic about using the latest technology to make their case: Roosevelt was the first President to use radio; Kennedy, television; Obama, the internet; Trump, Twitter. An interesting aside: During the televised Nixon/Kennedy debates, those who watched on TV thought Kennedy won; those who listened on radio, thought Nixon did.

The Change Theater focuses on cultural shifts and how over time we speak differently to different groups: women's issues, civil rights, immigration. In the Interactive area, visitors can create their own ads, applying what they've learned so that it becomes ingrained in their consciousness.

The persuasive techniques

After watching hundreds of political broadcast and YouTube ads, the most emotional and compelling were selected to compare similarities and differences – the objective being to determine the persuasive techniques that were most frequently used. These resulted in six categories outlined alphabetically below.

1. Association

> *Association links the candidate to something or someone the viewer emotionally connects with from a past personal experience.*

The association may be negative, like putting the opposing candidate in the same image as someone else who has negative connotations; for example, a well-known swindler or some other "scandalous" figure. Or an association may be positive, i.e. images of all the young people who have benefited from a political party's policies or, common to all parties, Americans gathered together to celebrate the fourth of July.

[7] 50 feet is just over 15 metres.

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Authors and cognitive linguists George Lakoff[8] (Democrat) and Frank Luntz[9] (Republican) have written about the impact of words in terms of "framing". You may feel sympathetic towards an "undocumented worker" but frightened of an "illegal alien" – even though they are the same thing. Republicans hate "Obama Care", but may feel good about the "Affordable Care Act", not realizing they refer to the same legislation. You feel differently depending upon the description attributed to that person or thing or the communities who support it, but frequently without understanding the facts behind it.

In politics one key question people ask themselves is: "Does this person care about people like me?" Association helps imply that the candidate does, indeed, care.

2. Confusion | Clarity

> *Confusion ignores the real concern and replaces, juxtaposes or makes inferences in order to distract from the original concrete issue.*

Candidates may confuse you about their own stands or confuse you about those of their opponents. Rather than confuse, clarity builds confidence and assures people. Phrases steeped in indecipherable acronyms or "inside" nomenclature can intimidate. Put yourself in the shoes of the people with whom you are talking. What do they care about? Listen carefully. This isn't about you. If you want to gain support, it has to be about them, as Nelson Mandela wisely related: "If you talk to a man in a language he understands, that goes to his head. If you talk with him in his language, that goes to his heart".

3. Contrast

> *Contrast uses opposing elements to clarify and drive a point home based on actual or perceived differences.*

The contrast can be real or it can be deceptive, for example, taking words or photos out of context or simply comparing non-existent facts. Contrast used honestly is highly effective which is why, for example, when Al Gore talks about the impact of climate change, he doesn't just refer to how many tons of ice are melting. He shows an image of the before and after. This is because dramatic contrast tells stories; sets a desired mood; quickly cuts through the clutter of unrelated irrelevancies.

[8] Don't Think of an Elephant: Know Your Values and Frame the Debate, George Lakoff, September, "The All New", 2014.
[9] Words that Work: It's Not What People Say, But What People Hear, Frank Luntz, *First Edition*, January 2007.

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4. Omission | Inclusion

> *Omission ignores the key parts of a story that weaken the case and may add unrelated information to strengthen it.*

Conversely, particularly in today's climate, transparency and responsibility are highly valued. If a mistake is made, own up to it. If something goes wrong, acknowledge it. Avoidance and a lack of information diminishes trust, believability and, ultimately, the confidence of key constituencies.

5. Repetition

> *Repetition is showing and saying the same thing over and over again so that it becomes "sticky", gaining traction and becoming believable.*

Repetition increases impact and aids memorability. Whether fact or fiction, audiences remember the content but not where it originated, so, even when it may be retracted, it is remembered as truth.[10] Marketers have always known: Frequency. Frequency. Frequency. Marketers believe in repetition because it works. This does not mean that everything has to look exactly the same, but it has to "feel" as if it is coming from the same place. Strong brands typically have that attribute – you know the messenger before ever seeing their name. Consistency in word, deed and promise counts.

6. Transformation

> *Change something to make it seem like something else or, actually, do make it something else.*

Transformation uses all the creative tools in the visual and audio arsenal to alter a person, situation, comment or image so that it is changed to seem like something it actually is not. This is used sometimes by candidates, subtly and not-so, and to the outrageous ultimate in political parody ads and in late night comedy shows.

Transformation can also be used to find solutions to problems large and small. Think out-of-the-box. For example, in New York City, without a lavish budget for architecture, our since-acquired agency Franfurt Balkind took a large school that housed 5,000 students and turned it into five smaller ones using graphics and paint. For a major museum in California, we used the parking lot walls to highlight permanent exhibitions while simultaneously helping visitors to way-find. Post 9/11, when time was of the essence for a major corporation who managed mailrooms, we created posters relating to safety that could be output on

[10] Repeated exposure to disinformation leads people to believe it even when they know the truth, *Business Insider*, Lisa Fazio, December 6, 2016.

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letter-size paper and easily distributed internally for their employees and externally for their customers. Communication isn't always just through talking or imagery or argument. You can use your environment in many ways to transform the way people think and feel.

7. Creative execution

> *Creative execution uses the appropriate tools available – words, imagery, movement, audio – to be a compelling (and even entertaining) presence while making a strong experiential case.*

The worth of creative execution is not quantified by its costs, but by its ability to help meet the goals that have been set and the promises made. When it comes to budgets in today's digitally-driven environment, it is possible to do a lot with a little. However, a worthy idea can be lost if it is executed poorly and a poor idea can make a difference if it is well executed. When a statement of concern, effort and care is undoubtedly being made – be sure it is the one you mean to communicate.

In summary

The next time you need to bring people over to your way of thinking, here are two equations:

The first

Logic is, of course, necessary to understanding, but people will not be enthusiastic unless they can relate. Creating experiential communications with emotional impact bridges that gap.

Experience
+
Emotion
=
Seeing things differently

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The second

Don't fall in love with your words or your communication. Over time, there is inevitably a need to re-ideate, refresh, rethink and re-message.

Maintain
the best of what you've got

Subtract
the least of it

Add
what you're missing

Remember ... emotions rule. Emotions are critical to trust. And trust is the embodiment of Care.

• • • • •

The following figures (Figures 1–4) present images from the "I APPROVE THIS MESSAGE: Decoding Political Ads" exhibit.

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Figure 1. Group 1 (left to right).

Orientation panels set-up the logistics and theme quickly, and images demonstrate the nonpartisan nature of the exhibit while introducing visitors to the "persuasive techniques" icons. Shown here is Fear & Anger; the adjacent entry sign showcases Pride & Hope.

The exhibit is about all of us; thus, an introduction wall shows faces of our fellow citizens as we enter the space and are immersed in an experience that showcases the four key emotions that impact our vote: Anger, Fear, Hope, Pride.

Figure 2. Group 2 (left to right).

The Mood Room entrance introduces viewers to the idea that they can't control their own emotions.

Visitors are free to roam; make choices; interact as little or as much as they want. The "V" wall divides the positive emotions, Pride & Hope, from the negative emotions, Fear & Anger, and provides historical background on classics of political advertising.

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Figure 3. Group 3 (left to right).

In the Mood Room, hot button video imagery on screens 9 feet tall[19] and an original soundtrack cycles the viewer through their emotions. Even an expected image continues to elicit pride.

The emotion-themed theaters – Fear, Anger, Hope, Pride – show 6 to 8 minutes of ad loops curated for emotional impact and dating from the first 1952 political ad broadcast to today. Viewers feel each specific emotion for themselves. Seventeen-foot panels[20] break down ads with frame-by-frame imagery. Icons call out persuasive techniques. A panel provides historical context.

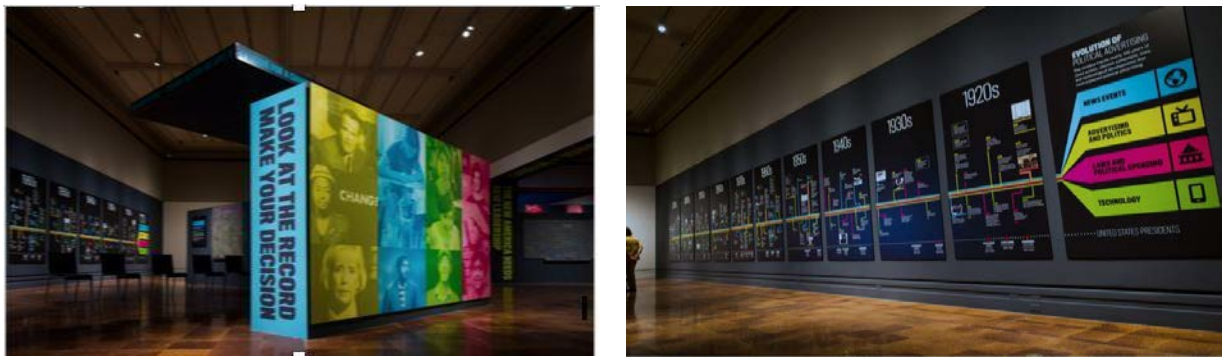

Figure 4. Group 4 (left to right).

The Change Theater shows historical ads on a video loop that demonstrate how we speak differently about cultural issues over time.

A timeline shows evolutionary forces since the beginning of mass media (radio, 1920s) up to 2016.

[19] 9 feet is almost 3 metres.
[20] 17 feet is just over 5 metres.

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About the author

Harriett has spent a career carving out critical meaning, decoding and creating messaging in ways audiences can relate to and understand. Starting her branding career in San Francisco at strategic consultants Landor Associates, she became a partner and principal of one of the first integrated communications agencies, award-winning Frankfurt Balkind, headquartered in New York with offices in Los Angeles and San Francisco. Following Frankfurt Balkind's acquisition, Harriett pursued a personal passion and founded nonprofit HonestAds.org, focused on bringing people into-the-know about political advertising and messaging by working together with organizations who care about political literacy. She and HonestAds have been featured in political, advertising, art and news media as well as in the New York Museum of Modern Art's experimental online "Design and Violence" exhibit and book of the same name.

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Personal development: A voyage of discovery

Allan Barton[1]

Abstract

This paper begins with you being asked a question: "What is the purpose of your life?" It then tells the story of Allan's personal voyage of discovery. On his voyage he found his answer to this question, and answers to many other difficult questions. This led him to the firm belief that people should consciously develop themselves and be able to answer difficult questions about and for themselves. Looking at his journey through the lens of care, he realised his voyage started with his personal development. As his career developed, and he became a business leader, he realised his role was to work with others to make work a life enriching experience for all involved. He is now working to help change the way we use the planet's resources. His journey follows the model of care through self, others and the planet. He uses examples from his journey to demonstrate how he has come to his firm belief that "If more people took personal responsibility and consciously developed themselves, maybe they too would come to the conclusion that working with and for others we could live in harmony once again with our wonderful planet." Finally, he shares his personal answer to the question: "What is the purpose of your life?"

Keywords

Why; Purpose; Personal Development; Enriching; Wonderful; Shine Wisely

Introduction

> *Dear Reader*
> *This may well be a very unusual way of starting a paper, but I want you to do something for me before you start reading. Set your timer for 3 minutes, sit comfortably, close your eyes and just focus on your breathing. As thoughts drift in just let them go and focus on your breathing. When the timer goes off, stop it, and focus on the question: "What is the purpose of your life?" It may be worth making a note of your answer. Thank you for taking the time to do this exercise.*

✉ Allan Barton: barton@ecologyofcare.net

[1] Arup Group Limited, London, United Kingdom

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> *What follows is the story of my voyage of discovery towards answering this question. In this paper I make statements I will not support in the typical scholarly fashion. What I say I say from experience and the belief that my experience and the story of my voyage of discovery, are worth telling in the context of moving towards an Ecology of Care.*
> *Allan*

We all develop over time. Some people develop without much conscious thought; others develop with conscious thought. What separates human beings from the animals we share our amazing planet with is our ability for conscious thought.

It is my belief that people should understand and consciously develop themselves, to the point where they ask and answer meaningful questions, such as:

- Why am I here?
- What is the purpose of my life?
- How much wealth do I really need?
- What part do I play in this world?

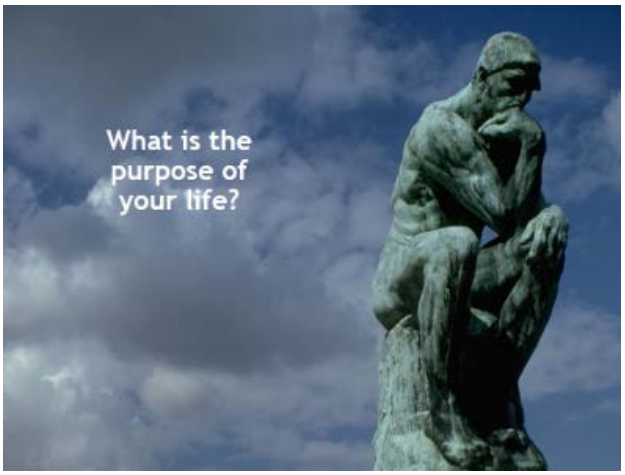

Figure 1.

I also believe that if people did consciously develop themselves and answer such difficult questions, they would care for themselves and realise that by working with and for others, great things can be achieved and we can live in harmony with our planet.

Self

What follows in my personal voyage of self-development that leads me to these beliefs. My voyage starts with the big bang as the atoms that form me were there at that moment. Through millions of years my ancestors developed and lived in harmony with the planet, by hunting and gathering. Then, around 8,000 years ago they started

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farming and living in communities. Around 250 years ago they joined the Industrial Revolution and started to use their ingenuity and innovation to transform the planet's resources into goods.

My genes passed down through my grandparents and my parents and finally to me. Events in my grandparent's lives helped to shape my parents, and events in my parent's lives helped shape me as they cared for and nurtured me in my early years.

Figure 2.

My time at school and everyday experiences helped shape the foundation of who I am today. One area of particular influence was my involvement in the Duke of Edinburgh's Award Scheme where over five years I learned the importance of being physically fit, having interests, working for society and doing adventurous and demanding activities.

Education complete, my first job was in the nationalised electricity supply industry where we were passionate about keeping the power and lights on for others. When the lights went off we worked tirelessly to get them on again. We worked hard and played as hard. We had tremendous fun socially as a group.

Figure 3.

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Serendipity played its part and I was encouraged by an ex-colleague to join him in a petro-chemical company. The lure of a higher salary, to help fund a reasonable lifestyle for my wife and our two children, was too great. There I quickly realised that to progress to a higher level I needed to become a "Chartered Engineer" (the United Kingdom's highest engineering qualification). So I embarked upon five years of part-time study. Balancing family, work, education and a social life was challenging but progressively I became more knowledgeable and enjoyed the process of learning tremendously.

In my final year, one subject involved the topic of management in which I learned about Maslow's hierarchy of needs, the Volvo experience, Herzberg's motivation theories and other management approaches. However, when I asked the question "What is the most modern approach to management?", the answers from my lecturers were not satisfactory and I embarked on a voyage to find out for myself. Over time, as my understanding grew, the question changed to "Why be a leader?"

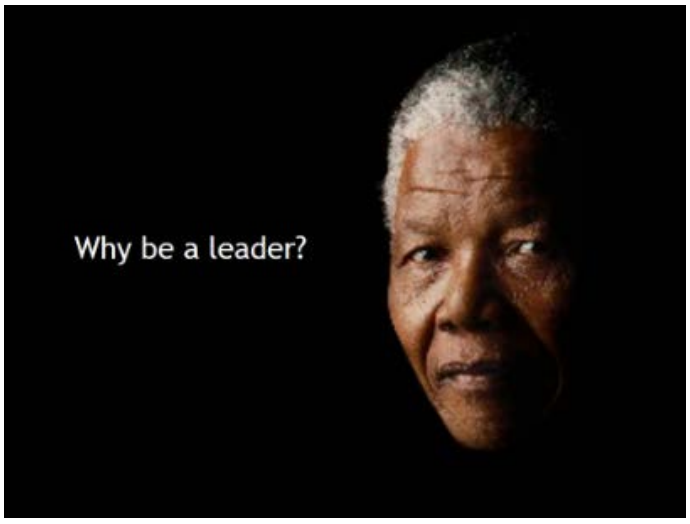

Figure 4.

This was the start of what has turned out to be an incredible voyage of discovery. A voyage requiring much thought and self-reflection. A voyage that has developed me significantly along the way. One that I now realise was the start of me consciously caring for myself.

Self and others

Serendipity played its part again and I was encouraged to join a waste management company to build hazardous waste incineration plants around the world. I was appointed to be a project manager and was very successful. The management style I adopted was the "honey badger approach". The honey badger is recognised as one of the most ferocious animals in the world. It doesn't take prisoners whilst getting the job done. I got the job done even if it meant "attacking a lion".

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Figure 5.

The approach worked, as I was asked to become a "Director" of the company. I felt that I had made it: large salary, big car, great pension and attending the Board Meetings. Life was going to be good from here.

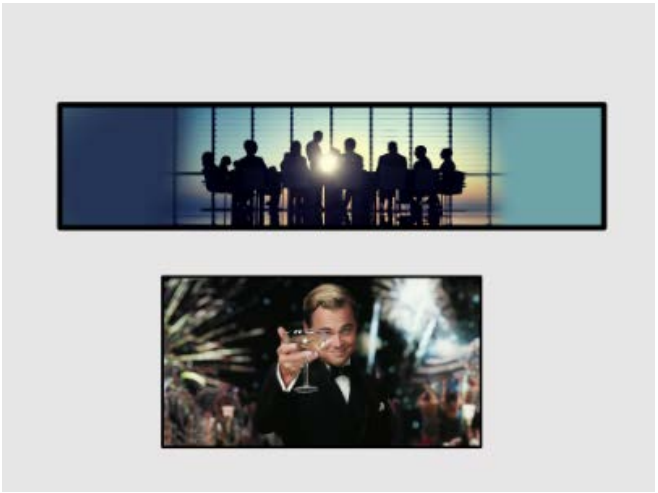

Figure 6.

I joined another new division of the Group, the Board was new, and we experimented with all sorts of business strategies and tactics, personal development activities, management approaches and leadership theories. One technique included 360-degree feedback (feedback from your boss, peers and subordinates) into our personal appraisal process. I read my feedback and was devastated. My reports and some colleagues obviously hated me. I was too task focused, didn't understand their needs and put them under incredible pressure.

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My initial reaction was 'sack them all'. On further reflection I began to realise that it was really my problem. I started to consider that maybe I should try another leadership style after realising that a 'command and control' approach was acceptable for a brief time but not in the long term. I became aware of John Adair's action centred leadership approach where tasks, individuals and teams are as important as each other – I decided to give it a try.

During this period, I continued my quest to understand why I wanted to be a leader. I read excellent books about leadership and high-performance teams such as the Red Arrows (the UK Royal Air Force's display team). I attended many lectures on leadership, self-understanding and personal development, applying what I had learned to the way I led my team. My team became more successful and they were certainly happier. After two years I was encouraged to move into another division of the Group and my team were sad to see me go.

More and more I realised that I enjoyed leading a business. This enjoyment came from using my logical intelligence: to achieve tasks and business processes; and using my emotional intelligence: to build teams and develop individuals.

These all working together as a whole, with me being at the centre, was fun and very rewarding. These six reasons were my initial answer to the question of "why I wanted to be a leader".

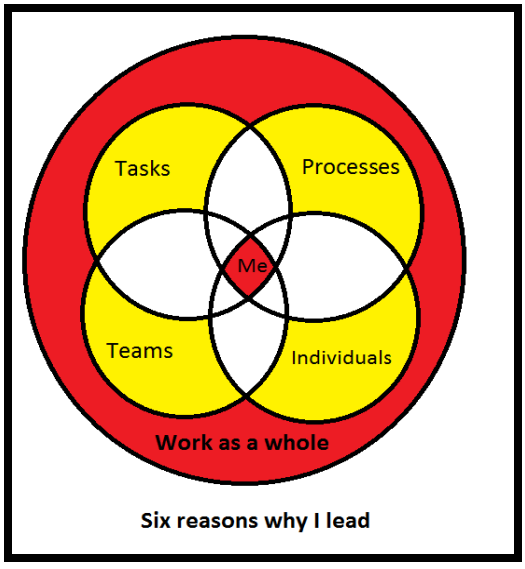

Figure 7.

More and more I realised that I could only succeed if my team was successful and we needed to be high performing over an extended period of time. Around this time, I read Stephen Covey's *Seven Habits of Highly Effective People*. This book had a significant impact on me; prompting me to ask myself many deep questions. It is probably the most important personal development book I have ever read. My reading continued and I learned more about neuro-linguistic programming and started to understand the concept of coaching others.

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Once more serendipity struck and I met someone who became my mentor: a magnificant fellow by the name of Ray Noyes. Ray would ask me really difficult questions, like: "Was my leadership style like the Grand Old Duke of York"? (Why did his men follow him up and down the hill?)

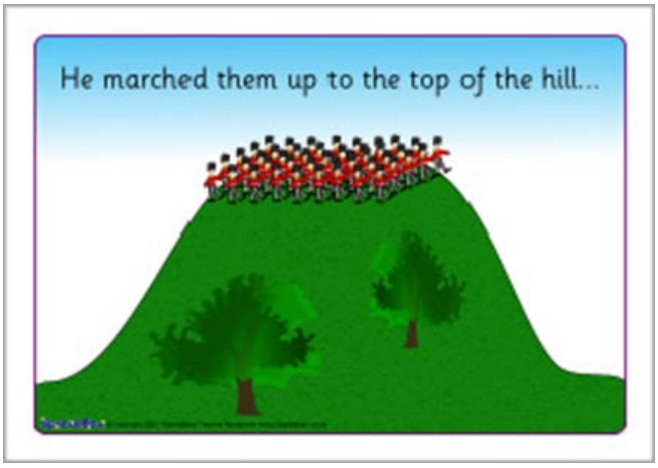

Figure 8.

These questions would normally take a while to understand and even longer to answer. He would not let me off till I had truly understood them and given him a satisfactory answer. His questions also strayed into deeper topics like "Why are you doing this, Allan?" and "What is really important to you?" He would often say "If you are not working on yourself, you are not working".

Once every six months, I used to visit Ray at his place on a mountainside in the middle of Wales. I would go there to review all we had achieved in business, how my team was performing, what we needed to do and to refresh myself for the tasks ahead. On one of these ocasions, in the afternoon, I sat and thought to myself: business was good and we were being successful. I was quite pleased with myself and what we had achieved. Then I thought "there is no point ringing my wife as she isn't speaking to me" as "yet again" I was away from home on another business trip.

I then started thinking about my life overall.

This developed into a long afternoon and an even longer dark night of the soul. If I wasn't careful my marriage would suffer even more, I didn't really know my children, I had little social life, drank heavily and had little exercise. Yes, business was good, but the rest of my life was not as wonderful. I will always remember Ray coming into the room all enthusiastic to hear how I was doing. His face dropped when I told him what was happening and that this was something I had to sort out for myself.

Fortunately, I rejected the whisky bottle and remembered Steven Covey's metaphor about going to a funeral and walking up to see who was in the coffin. Then, to your horror, you see it is you. You are aware that three people are going to talk about the person in the coffin. The question to ask yourself is: "What would you like them to say?"

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Figure 9.

The night turned into a mammoth task of understanding the roles I had in my life, deciding what was really important in each of them. I thought about what I should do in each role, prioritising them, and then ensuring I would spend the right amount of time on each one. To this day I refresh the list I produced that night and try (not always successfully) to find the right balance.

The list of roles in my life that I produced that night and have updated since are as follows:

Husband	Friends	Self development
Father	Self food and drink	Self enjoyment
Grandfather	Self exercise	Worthy tasks
Relatives	Self spirit/soul	Business and career

Figure 10.

Just after this event, Ray gave me a book titled *The Heart Aroused* by David Whyte – a book of poetry and the preservation of the soul and work. My voyage started down a different path, one of understanding the more spiritual side of what we do and who we are; realising that our supreme form of intelligence is our spiritual intelligence. The intelligence that sets us aside from the animals. The intelligence that makes us ask deep questions, like "What is the purpose of my life?"

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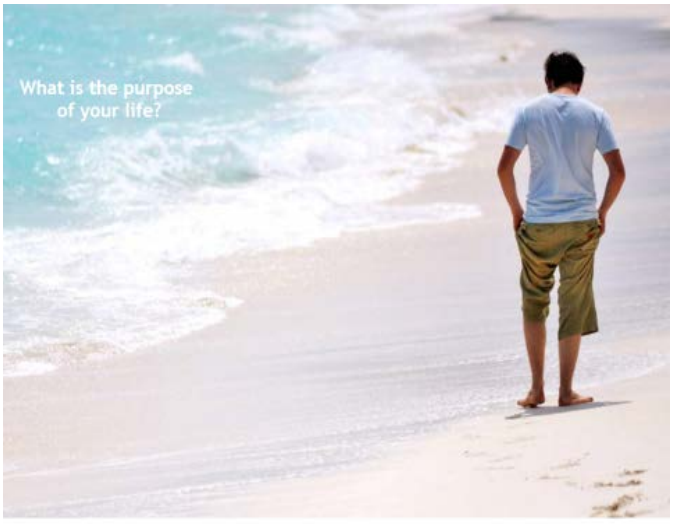

Figure 11.

I read about acting with integrity within the corporation, the inner path to leadership and about spiritual capital, the wealth we can live by. I realised that my goal was to understand and be able to answer the questions posed by my spititual intelligence.

Then Ray, bless him, said, "I think you should be a team advisor at Runge". He explained this was the Work Foundation's[2] premier leadership programme run at Balliol Colllege in Oxford. Delegates were put into teams where they experienced a week of the most inspirational leadership speakers. They were pushed to achieve incredible tasks and encouraged to ask themselves deep questions; whilst all the time being challenged by a team advisory who sat in the corner and asked them difficult questions, to ensure they really did challenge themselves individually and as a team.

One example of the quality of the speakers was Richard Olivier (director and author of *Inspirational Leadership: Henry V and the Muse of Fire*). Richard presented Shakespeare's *Henry V*, a play about leadership. He acted out Henry's speech to his troops the night before the battle, to demonstrate inspirational leadership. He received a standing ovation at the end of his presentation, the first time I have ever witnessed a standing ovation for a business speaker.

All the people I have talked to find this week at Balliol to be a life changing event. I wrote the following note a few days after returning home to record my thoughts at the time:

> *At Balliol I was privileged to help facilitate a group of people coming together and forming an entity. An entity with its own being, purpose and meaning.*
> *One where people worked for themselves and for the others. One where processes were developed, implemented and refined; and exceptional tasks were achieved for the good of all.*

[2] The Work Foundation is a UK foundation orginally set up improve working life.

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> *One where people shared their experiences, fears and dreams, in an open and honest way. One where there were no ulterior motives, no striving for personal greed. One where everybody trusted each other and all became better from the experience.*
> *One where people pledged themselves to each other and offered their support to each other for the remainder of their lifetimes.*
> *One where everybody worked hard to make things exciting and better for everyone.*
> *At Balliol I had the extreme privilege of impacting on the true essence of individuals, watching their light shine, and the light shine from the group as a whole.*

One of the Balliol programme leaders, Ann Paul, was there solely to help and support the team advisors. Ann and I would walk around Balliol's quadrangle most evenings to discuss the events of the day. We started off left or right depending on the difficulty of the day. At the end of the programme I said we needed to walk around in the difficult direction. I shared with her what was happening in my business life. Our division of the Group was going through a very difficult period. We were striving to achieve profits for our shareholders and due to a significant downturn in the market we were actually making a loss.

Figure 12.

We were making very difficult decisions, including driving our people very hard and finally having to close one of our operational sites and make a large number of people redundant. Much as I thought there was a light at the end of the tunnel, the light was fading and things were progressing in a way I found very hard. I was in a very dark place, wondering what I should do.

I told Ann that what I had witnessed at Balliol was truly wonderful and that it had changed my life. Also, that after years on a voyage of discovery, I had finally found the answer to my question "Why be a leader?"

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I told her that:

> *I wanted to be a leader.*
> *Leader of a business whose prime purpose was to provide a life enriching experience for its people.*
> *A business that CARES.*

Fortunately serendipity played its part again and whilst at Balliol it was confirmed that I would become the Managing Director of a new business in the Group. We had won a large contract to look after the north-east corner of London's waste and help them turn their rubbish into a resource.

Figure 13.

"Great", I thought, I would be left alone to put in place what I had learned at Balliol. Having selected my senior management team, I took them away and we identified what was important to us and how we would behave. We generated a vision of a "Flagship Service for 25 years" and a mission statement that encapsuled everything I had seen at Balliol. We also set about building cutting-edge technology for our sector and running our business with the ethos of providing a life enriching experience for the people involved.

On starting we tranfered the existing council employees, who were obviously concerned for their future, into our company. We involved them very quickly in our decision-making processes and treated them as people, showing them they were important and that we cared.

Three months into the business we took everyone to dinner and watched the dog racing at Walhamstow Dogs Track. The purpose was to celebrate how successful we had been thus far. One 6'8" operator who was twice my width came up to me and said, "I want a word with you". With trepidation I asked him to go on. He said, "I wanted to say thank you. I have worked for the council for 15 years and this is the first time anyone has ever said thank you". I replied, "It is I who should thank you".

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Six months into the business, I received a letter from a member of the public praising our team of people at the site he visited, and saying how he wished his team were as good as ours. Twelve months into the business, one of the transferred managers came up to me and said "Thank you". I asked him why he wanted to thank me, and he replied, "Before the takeover I came to work exactly at 0900 and left exactly at 1700, not enjoying a moment of the time in between. We were achieving great things and everybody was enjoying themselves. I now arrive at 0730 and leave after 1800 because I am enjoying myself so much". I left the conversation with a smile on my face.

Yes, we met and even exceeded our business profit targets, and yes, we made hard decisions about people who did not want to work to our ethos, but we placed a higher importance on people finding work a life enriching experience, even those who had to perform quite manual and unpopular tasks. We were fortunate that our work was helping the area turn its waste into a resource – a worthy goal to work towards.

My voyage had brought me a greater understanding of myself and my role in working with and for others. I realised that my needs and the needs of others – such as food, safety, somewhere to live and meaningful work – had to be satisfied. Also, I realised that my and other's wants had to be tempered, as they had the potential to cause great harm to myself or others.

I had realised lasting contentment and happiness did not come from wanting the Western dream of boundless wealth and unlimited possessions. A dream with little care for others. A dream that can cause great unhappiness, as it can never be fully satisfied.

Self, others and world

The Group of companies I worked for had been focused on profit for their shareholders and business growth. Returns and growth had fallen and decisions were made to sell off the "family silver" to fund growth in other areas. This approach failed and the business was in decline.

I left the company and was fortunate to join an engineering consultancy called Arup. Ove Arup, the founder of the company, obviously developed himself and he was also an insightful philosoher. He cared about others, as he gifted his partnership to the employees for no reward. He was passionate about the world and established a vision: "We shape a better world". He believed that doing interesting things and doing them well was more important than profit. So growth and profit were not the key targets at Arup. Ove also said that if you ever find someone good, employ them and then find them something interesting to do.

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Figure 14.

We now have amazingly clever people working in a wonderful ethos and doing remarkable things. Yes, we have made a profit every year and we have grown into what is now a global company of 14,000 people without an acquistion, but what is more important is the values and ethos Ove established.

In 1970, Ove wrote a key speech, setting down his beliefs. (See the Arup web site and "Key Speech" if you want to read more: https://www.arup.com/publications)

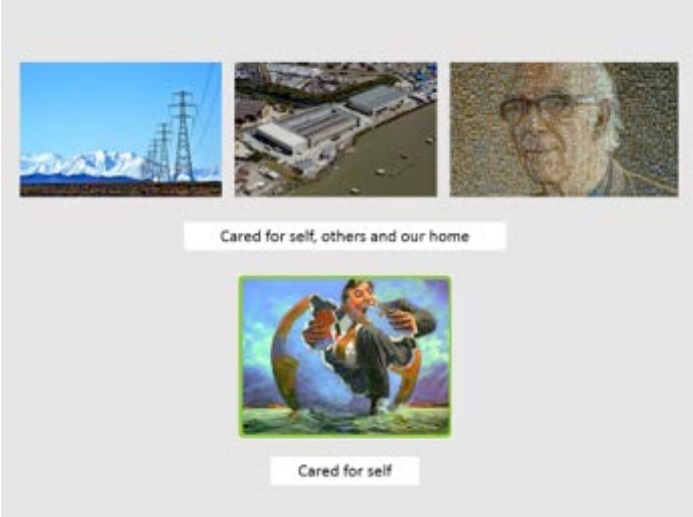

Figure 15.

What strikes me about the three businesses I have descibed above is that they all care for the individuals, others and the world in which they work. They have also been very successful in whatever way you choose to look at them because they cared. The businesses I have been in that have been focused primarily on profit for the shareholders have struggled in the long term. Yes, profit is important as without it the business and the work would disappear. Also, businesses' part in providing wealth for society to fund its needs is vitally important. However, profit should not be the prime

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goal, especially when it is at the expense of individuals, others and our world. When I look back at those businesses which focused on care, they have been the ones I enjoyed the most.

Figure 16.

My current role in Arup is to lead their resource and waste business globally, which means I have experienced the joy of travelling the world helping people understand how we can treat the resources of the planet in a better way.

Using resources in harmony with our planet is a global and incredibly complex challenge. I often wonder how this challenge can be solved. I conclude that if more people consciously developed themselves, then maybe those that gain positions of power and influence would ask themselves difficult questions like:

- What is the real purpose of my organisation?
- What are the main issues facing our society?
- What are the main issues facing our planet?
- What can I do to make things better?

Then maybe we could start moving towards using our planet's resources more wisely.

Ecology of Care

Serendipity plays its final part in my voyage to date. I was on a plane (flying to see my 92-year-old uncle, a man who was still learning and developing himself till his death) and started talking with the man next to me. Our conversation moved to what we did at work. I told him about my work and about a thought leadership vision I had just presented, on "The future of waste and what it should look like in 50 years' time". He suggested I meet his colleagues from Copenhagen, who had a new concept that may have an impact on the world.

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This led to me discovering the concept of an Ecology of Care. What instantly struck me was that my voyage of discovery, and hence my personal development, had very closely followed its concept of self, others and the world. (Figure 17 shows the Model of Care developed for the 2015 Ecology of Care symposium.)

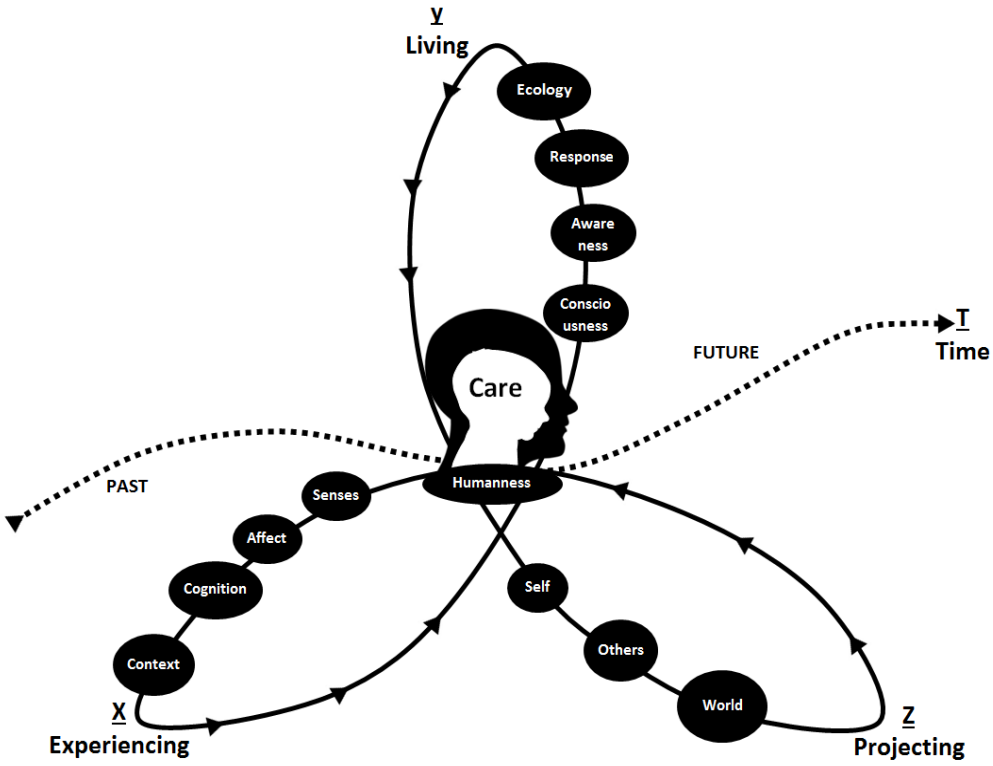

Figure 17.

Finally

Mankind lives on a wonderful planet with the most amazing diversity of people, animals and plants. We are right to focus on providing the needs of people, such as food, water, security and a home. Wanting reasonable prosperity and a comfortable life based on having enough is fundamental.

However, wanting everything and more, and the Western dream of boundless wealth and unlimited possessions, is proving harmful to the planet, to others and definitely to ourselves. It is a dream that is unsustainable as wants can never by fully satisfied and will finally result in great pain for all living things on our wonderful planet.

My view is by consciously developing one's self, and truly answering difficult questions like:

- What is the pupose of my life?
- What is really important to me?

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- Am I really happy?
- What do I really need?
- If I died tomorrow would it be too soon?
- What can I do to make society and the world a better place?
- What would I like three people to say at my funeral?

In answering these questions, I believe we would all realise the importance of caring for self, caring for others and caring for our world. Then hopefully more people would contribute towards making our world a better place.

> *It is my firm belief that if more people took personal responsibility and consciously developed themselves, maybe they too would come to the conclusion that working with and for others we could live in harmony once again with our wonderful planet.*

Figure 18.

Hopefully you will have seen how I have grown on my voyage of discovery. You may have noticed that I focused on difficult questions and found that via conscious personal development I have managed to answer them for myself, the benefit of others and hopefully the world.

At the start of this paper I asked you to think about the question: "What is the purpose of your life?" It is only right that I now share with you my current view of my answer to this question, in the form of a vision and mission (see Figure 19).

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Figure 19.

Hopefully, three people will say I have achieved this when my atoms are returned to our amazing universe.

> *Thank you for reading my words.*
> *Take care*
> *Allan*

About the author

Allan is passionate about individual personal development, the role of business being to provide reasonable prosperity and a life enriching experience for the people involved, and protecting our wonderful planet. He has been a company director for over 22 years. He is now Arup's global business leader for resource and waste. He has held a number of non-executive director roles, and is on a number of advisory boards including chairing the Sustainability and Resource Efficiency Knowledge Transfer Network, and the UK Government's AgriFood Technology Council.

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Stormy weather in healthcare: A new ecology

Jane Clemensen,[1,2,3] Pernille Ravn Jakobsen,[2] Charlotte Myhre Jense,[2,6] Kristina Garne Holm,[1,3] and Mette Rothmann[2,3,4,5]

Abstract

This paper discusses how the roles of patients and health professionals have changed over the years. It also explores how accelerated courses of treatment and busy staff have turned healthcare services and hospitals into "factories", where care and relationships now exist in very cramped conditions. The paper discusses the gap between patients' need for care and the care received. The analysis and discussion focus on how health professionals can be empowered to re-find care in their daily practice. We reveal how different health paradigms can affect care, and the relationship between patients and healthcare professionals, by a dominant paradigm. We suggest a shift in focus from valuing the neo-liberal approach, to focus on care by linking an Ecology of Care (EoC) approach to the healthcare context, as EoC can be used as a complementary philosophy to help change the paradigm and thereby secure a holistic approach to one another.

Keywords

Ecology of Care; Care; Participatory Design; Future Healthcare; New Hospitals, Change of Mindset.

Introduction

The Danish healthcare system is based on public welfare provision and decentralised welfare administration (Vrangbæk & Christiansen, 2005), as in many other Western

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countries. The entire society and thus also the healthcare system is organised as services based on neoliberal bureaucratic regulations and ideas (Holen & Ahrenkiel, 2011; Mik-Meyer & Villadsen, 2007); that is, political ideas based on minimising public costs, privatising as many welfare services as possible, and emphasising individual freedom, especially in acting and exercising one's choice freely (Glasdam et al., 2015).

Background

Developments, such as new super small hospitals that are replacing far bigger hospitals with more beds, have an inbuilt need to reorganise courses of treatment. Accelerated courses of treatment are increasing within all specialties (Moffatt, Martin, & Timmons, 2014). At the same time, due to broader economic pressures brought on by changing demographics, there is a general demand to minimise the expense of treatment (Weiner & Schwartz, 2015). This calls for a shift in paradigm – a shift that has already begun.

In tandem with these developments, the role of patients in terms of their own care is changing rapidly. A new, more active role is being pushed onto the individual by a healthcare sector that, through new technologies, is able to diagnose and treat more patients. At the same time, being a health professional often includes a close relationship with patients and relatives, in which care is one of the core values for a successful relationship. Accelerated courses of treatment, increased focus on data collection and risk aversion, plus very busy staff, has turned healthcare services and hospitals into "factories", where care and relationships now exist in very cramped conditions.

Given this picture several questions emerge. Is it still possible to create a valuable relationship during the short meeting between staff and patient, or has the system overtaken the life of the patient? Can this gap be overcome by moving treatment and care to the homes of the patients through the use of technology? Are we overlooking important issues by pursuing better economies? And are we in fact creating a new gap – a gap between needs and capacity? Another issue at stake is the complex question of whether another gap is emerging in the healthcare system versus the system's strategies and its practice? And perhaps most importantly, how do we ensure care remains in our relationships with patients and their families? These questions are made more pressing by changes in the roles in healthcare, an area where patients and citizens demand involvement.

Aim

The aim of this paper is to discuss the gap between patients' need for care and the care received. The overall perspective is to discuss a new mindset for health professionals by empowering them to find and focus on the suppressed areas in their daily practice.

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Theoretical framework

Care

The word “care” means “To have feelings like: concern, responsibility or love for someone or something”.[2] The United States psychologist Rollo May described care in regard to being a human being in this way: "When we do not care, we lose our being; and care is the way back to being". Thus, being human is constituted in attitudes to care (May, 1969, p. 290).

In the book, *Nursing: The Practice of Caring*, Bishop and Scudder refer to Heidegger in explaining how care can be taken away in an attempt to provide care; in other words, it can be the opposite of care when someone "jumps in" and takes over for the other, who then is dominated and dependent in the caring relationship. Doing what the other can do for himself or herself, the "solicitous" person is actually taking "care" away from the other. In contrast, Heidegger says, there is a solicitous care that "jumps ahead" of the other, anticipating his or her potentiality not in order to take away "care" but to give it back (Bishop & Scudder, 1991).

John Gregory was a prominent Scottish physician-philosopher, who applied the ethics of "sympathy" and "humanity" to the medical care of the sick. Gregory held that the chief moral quality "peculiarly required in the character of a physician" is humanity; namely, "that sensibility of heart which makes us feel for the distresses of our fellow creatures, and which, of consequence, incites us in the most powerful manner to relieve them" (Gregory, 1817, p. 22). Moral quality paired with humanity is sympathy, which "produces an anxious attention to a thousand little circumstances that may tend to relieve the patient" and "naturally engages the affection and confidence of a patient, which, in many cases, is of the utmost consequence to his recovery" (Gregory, 1817, p. 22). The thousand little circumstances might be a way to describe and understand the nature of what Ian Coxon calls “an Ecology of Care” (EoC)[3] and how complicated it is meeting your patient when he or she is in need of care and treatment.

Ian Hargraves, a researcher at the Mayo Clinic, has worked with Care in an EoC context. He maintains that the future of care in healthcare involves both honouring material conditions while developing the capacity to change those conditions and live well amongst them. At the same time that future must resist the temptation to insist that individuals alone are authors of their lives and that we are all in need of healthy relationships. Self-care must go beyond an insistence that individuals make something of themselves, to recognition that it is in relationship and community that people breathe life into one another. The future of care in healthcare is not the power of healthcare to shape human lives, but rather the shaping of our institutions, disciplines,

[2] www.yourdictionary.com
[3] All references to Ecology of Care come from the website of the Ecology of Care Network: http://www.ecologyofcare.net

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and practices of care to remembering, raising and celebrating what is good in human life and living.[4]

Ecology of Care[5]

The EoC Network began as a research group based in the Faculty of Engineering at the University of Southern Denmark. Today it is a Community Interest Company (CIC) registered in the United Kingdom whose aim to network ideas and theories regarding development of the concept of EoC.

In Figure 1, Ian Coxon has illustrated EoC in relation to being human. To challenge this figure we, the authors of this paper, question the placement of "Ecology" and suggest it could be replaced with "Compassion", since it is a core element in successful interaction with others. We would also take "Ecology" and create a circle around the "Human" illustrating everything's connectivity.

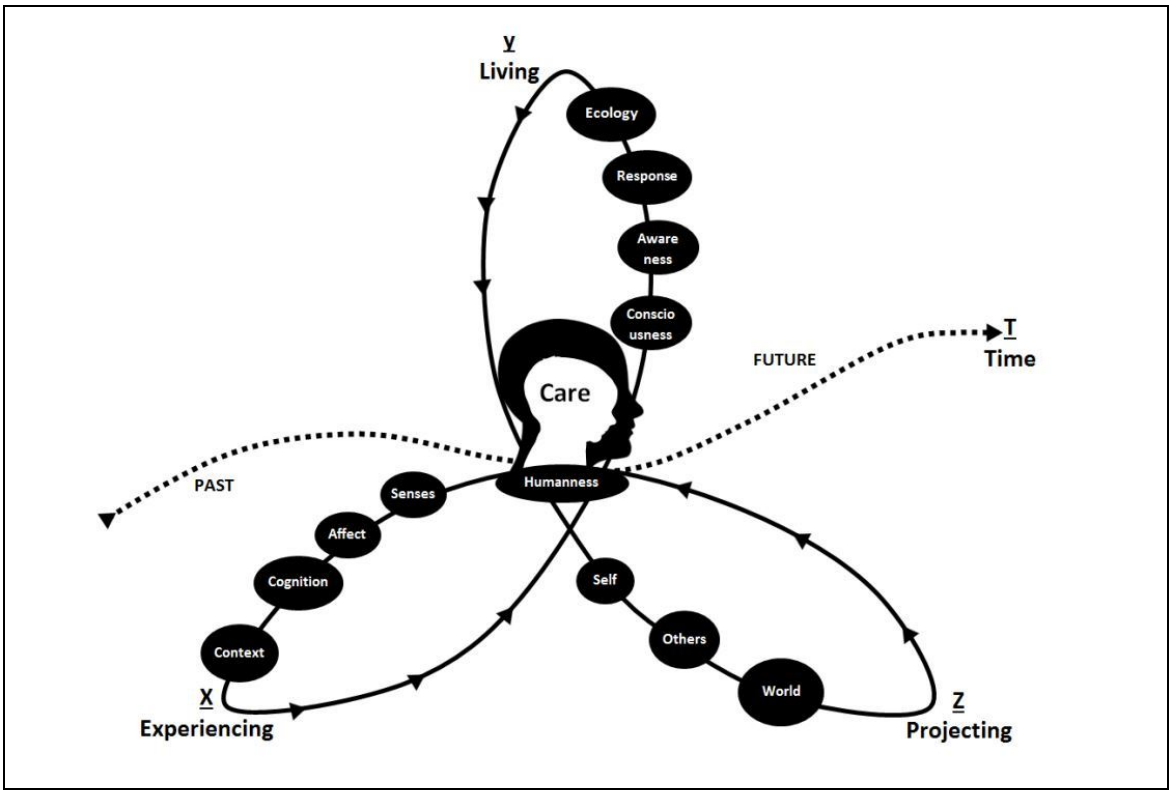

Figure 1. The Ecology of Care Model
(developed for the 2015 EoC symposium).

[5] This section draws on information from the EoC website and related material.

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Ian Coxon describes the concept: "An Ecology of Care means Caring for our Home and everyone within it". Freely translated into the context of healthcare, EoC establishes that the patient belongs to "a home" including everything and everyone that belongs to it – next of kin, pets, parents, neighbours, the shelter you live in, your economy, your job and education, and so on. When treatment is needed, the healthcare system tends to focus solely on the symptoms. Hence, the system does not take important matters from the patient's daily life into account – things that might be the cause of the illness or affect the treatment and care around it. Today's healthcare system is divided into pillars/sectors, each monitoring and addressing what is considered to be its own area of responsibility; therefore, it tends to ignore a holistic approach.

From Health 1.0 to Health 3.0

One way of describing the development and the belonging paradigms in healthcare is the evolution from Health 1.0 to Health 3. Characteristic of the Health 1.0 area were the defined roles between healthcare staff and patients. The doctor was the unquestionable expert and authority while the patient was passive, waiting for the doctor solely to decide treatment and regimes. Nursing and other staff were functional assistants to the doctors' domain, and care was still the duty of the nursing group. When admitted to hospital, the patient was placed in a bed and the body was treated. At the same time, nursing staff also focused on creating a relationship with, and caring for, the individual. It is also important to note that the role of the patients' relatives was not yet defined and included in health services.

Health 2.0 might be the area we still belong to (possibly with a foot in both Health 1.0 and Health 3.0 depending on the culture and the persons who provide the care). In Health 2.0 we discover more active and responsible patients who collaborate with staff and do not necessarily accept the experts' advice. Technology is used for self-monitoring and self-diagnosis. Blood pressure, weight, steps and sporting activities are captured on mobile/cell phones and shared with networks (Steele, 2014). New technologies empower individuals and new knowledge is created and shared in new ways, intruding more and more on professionals carrying out their work. A good example of how patients share knowledge and use the new common knowledge in negotiating with experts is the website *patientslikeme*.[6]

In Health 3.0 the focus is moving from the individual to an attempt to capture the health ecosystem, including both mental and physical health and wellbeing. The body and mind are no longer divided. Instead, the body and mind are increasingly connected and a holistic approach aims to create a "life balance". There is a shift in roles between professionals, and patients and their relatives, and patients often consider themselves to be the experts. Hence, professionals are increasingly seen as coaches. In this context, knowledge will not only be shared but also often used in relation to research, and patients' fears will be conquered by peer-to-peer education and coaching. Furthermore, patients and relatives themselves will participate in educational activities with staff and healthcare students. In this paradigm, patients in general will not be given

[6] https://www.patientslikeme.com

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responsibility but will take it as a natural matter-of-fact (Clemensen, Clemensen, Syse, Danbjørg, & Coxon, 2016; Gagnon & Chartier, 2012; Nash, 2008).

Exemplary cases as a basis for the discussion

For the last 14 years we, the authors, have conducted research together with our patients, their relatives and our staff using participatory design research method (Clemensen et al., 2007; Clemensen, Rothmann, Smith, Caffery, & Danbjørg, 2016). The findings from all of our studies show a gap between the hospital services and the needs and wishes of the patients and their relatives. Initially, the aim was to empower the patients to help them to improve quality-of-life but as time has gone by and experience increased we realised that we might need to start the empowering process somewhere else: namely, within the system, the management and the staff.

The following three cases are taken from our research.

Case 1: The need for care

A hip fracture is a serious injury, with complications that can be life threatening. A systematised guideline including rapid mobilisation was introduced as a tool for quality recovery and improvement of efficiency in pathways with a short stay in hospital. The aim of this case study was to describe the experience of patients with a hip fracture and explore if they felt empowered and able to perform self-care in pathways with a short stay in hospital.[7] Field studies were conducted in hospitals and in patients' homes, and interviews were performed with patients, family members and health professionals.

In order to implement pathways with a reduced stay in hospital, the health professionals' in the hospital said that their tasks required standardised preparation with stringency and conformity. While the standardised and systematised pathway was described as effective by health professionals, patients felt they were not seen as human beings. Our study demonstrated that patients recovering from hip fractures have a strong desire to be in charge of their own lives and to remain autonomous. Acquiring a hip fracture is a reminder of the frailty of life. This stressful situation complicates the ability to comprehend and retain important information provided during treatment with a short stay in hospital. Our study challenged the conventional method of informing and educating patients in fast-track treatment as a means of recovery, and suggested that new and improved methods of communicating health knowledge and promoting and enabling patient-empowerment are required to support autonomy and self-care (Jensen et al., 2017).

Case 2: The need for empowerment and change of roles

How can women newly diagnosed with osteoporosis without preceding fractures be supported in self-management of the disease? By identifying their needs, designing and developing a solution, exploring how they experience it, and evaluating whether

[7] http://dx.doi.org/10.1080/17482631.2017.1307061

mHealth (mobile health) can engage the women in treatment decision making and ensure a sense of self-management after being diagnosed. Our findings show that in general the women felt as if they had been left "in limbo" when diagnosed with osteoporosis. In general, the women requested targeted and tailored information about the disease, and said that they were willing to manage the disease themselves. However, they asked for more information in advance to prepare for their consultations and to consider treatment options, so that they could ask qualified questions and participate in treatment decisions. A 62-year-old woman expressed it this way:

> *It would have been nice if I could have some knowledge before I went to see the GP. If I would have had the opportunity to be more prepared about having osteoporosis and treatment options, then we could have had a dialogue.*

To close the gap between the needs of the women and what the system had to offer, we designed an "app" solution "My Osteoporosis" which gave the women targeted information about osteoporosis and focused on the advantage of being diagnosed before a fracture has occurred. Through the app, women are able to receive important information before seeing their GP's and also obtain information regarding different treatment options. We anticipate that women will then be better prepared and able to participate in treatment decisions, putting them on a far more equal basis.

Our pilot testing revealed an interesting finding: the change of mind-set gave the power (through knowledge) to the women, and as a consequence, disempowered the GP's since the GP's were now the ones who were not prepared for the consultations. One of the GP participating in the study stated:

> *As a doctor I must have the opportunity to be prepared for seeing the patient and find out beforehand how I can help the patient the right way in the treatment decision-making process. If the patient arrives at my consultation better prepared than I, I will become very irritated. This kind of surprise we have to avoid. We have to make sure that both parts are prepared for the consultation to achieve a good dialogue. (Jakobsen et al., 2017)*

Case 3: How to create changes involving the users

Preterm infants are reliant on hospital admission for optimal treatment and care in order to achieve an ideal outcome. In the hospital in our study, infants are closely monitored in the neonatal unit by hospital staff in close cooperation with the parents. The hospital admission disrupts family routines and separates families, leaving the parents longing for home. To optimise the family conditions, we gathered parents and health staff for interviews and several workshops to identify their needs so that the parents were better able to manage nutrition, tube feeding and breastfeeding at home. The interviews and workshops resulted in the development of a telemedicine device – Neonatal Tele Homecare (NTH). This device provides close contact between the neonatal unit and family homes, including the options of videoconferences, chat messages and infant growth monitoring. When infants receive NTH parents experience

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a growing feeling of empowerment in caring for their infants and being at home allows them to be together as a family "around the clock". Offering NTH has had a great impact on the organisation in the neonatal unit as well, with the hospital staff feeling safe leaving the responsibility of infant care to the parents (Holm et al., 2016, 2017).

During NTH there is room for dialogue and the hospital staff see more empowered parents. Further, care for the families at home through the telemedicine device leaves the families with feelings of being united as a family:

> *It's not until the last two weeks that … We haven't done anything but sit, look at each other and talk. Because … Here at home … there was room for us to talk about what the hell had happened the last 4 months in the hospital [father of preterm infant]. (Holm et al., 2016, 2017)*

Discussion: Analysing the Ecology of Care

With the "Talking Stick" as a starting point for the discussion, we now investigate how the EoC issues are expressed in the cases presented.

> *The Talking Stick is an ancient Aboriginal tool used for centuries to help heal relationships through learning to listen to others and to speak your truth. It is used as a way to help connect people to one another and to begin a healthy dialogue through active listening.*[8]

Being a human: The necessity of relationships

In Case 1, we meet patients who feel they are reduced to a hip, a problem, and not seen and treated as a human being in need of care.

> *You know people with a hip fracture are often old people … even if you are old, they ought to see you as a human being. It is not our fault that we have become old and got some flaws. There should be room for us as individuals anyway… (Woman, aged 74 years)*

The same woman also asked for just a little loving care as she stated that it is a basic need of a human being.

In Case 2, the women cry out for a more equal dialogue when meeting their GP's. The system is divided into sectors and the women feel like they are "being left in a jungle" without anything to do because they do not know how to prevent future fractures.

In Case 3, we discover families that no longer feel like families when admitted to the hospital: "It wasn't until we came home I felt that I had become a mother" [parent]. Being at the hospital, the culture and habits of the staff reduces people to being patients and forgets "the thousand little things..." [patient].

[8] http://www.inclusion.com/tttalkingstick.html

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Healthy dialogue through active listening

In 1927 a Boston doctor wrote in the *Journal of the American Medical Association* (*JAMA*) this holistic approach to his patients:

> *...all your patients whose symptoms are of functional origin, the whole problem of diagnosis and treatment depends on your insight into the patient's character and personal life, and in every case of organic disease there are complex interactions between the pathologic processes and the intellectual processes which you must appreciate and consider if you would be a wise clinician. (Peabody, 1927)*

Dr Peabody not only extended a holistic approach to his patients but he also saw the beauty and maybe necessity of gaining satisfaction in practising care for patients:

> *The good physician knows his patients through and through, and his knowledge is bought dearly. Time, sympathy and understanding must be lavishly dispensed, but the reward is to be found in that personal bond which forms the greatest satisfaction of the practice of medicine. One of the essential qualities of the clinician is interest in humanity, for the secret of the care of the patient is in caring for the patient. (Peabody, 1927)*

When looking at the pressure the system puts on the staff in Case 1, it becomes clear that knowing the thousand little things about your patient has no foundation in a modern course of treatment for elderly people with a hip fracture: "We have to think about discharge on the same day the patients are admitted otherwise we cannot maintain the flow which is needed" [nurse]. The system becomes more important than caring for your patients.

In Case 2 it became clear that there is a gap between clinicians and their patients – maybe due to lack of healthy dialogue and active listening.

In Case 3 we found how a change of mindset in parents with a neonatal child can change the EoC for the family. As Heidegger described (Bishop & Scudder, 1991), the negative side of care occurs when we (the professionals) take over care.

> *And the thing about coming home ... out there [in the hospital] ... you know, we don't know anything about preterm infants so we put all our trust in the nurses. But being at home, you get to make decisions on your own, you experience a bit more courage to say okay, let's do that. That you don't do in the hospital because you're left with the feeling that the nurses know best. (mother of preterm infant)*

The question is: Why do the parents experience this? Talking to the parents and investigating their needs and wishes, we revealed that the families were at the hospital because the system had decided so and not because of the need for hospitalisation. The consequences of changing the organisation and the mindset not only more empowered families but also more empowered nurses who consequently developed proficiency and

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increased work satisfaction. In conclusion, the new way of offering healthcare services is a path to a Health 3.0 approach.

Speak the truth: Change of mindset

In 2016 Danish politicians asked healthcare professionals if they would speak up if they experienced something critical in their clinical practice. Thirty-three per cent (33%) had experienced conditions of critical standards and 29% answered that they would be silent about it. 33% would not speak up for fear of being sacked.[9] So what does it take to make the necessary shift in paradigm? First, we need to create space for a healthy dialogue, so both staff and patients/relatives dare to speak up when needed. In addition, how do we change the mindset to foster a new paradigm? In our studies we discovered a gap between the staff and patients, but what has been clear is the gap between the staff and the management. How can a healthcare system survive severe distance between those who should be the creators of a healthy healthcare system? We need to shift focus from valuing documentation over care. Hence, the question is: If we, as health professionals, can survive without care in the relationship with our patients – what will be left? Will hospitals be reduced to factories? Instead, leadership must be more inspirational than controlling and more about coaching than managing. Leadership must be courageous in letting care take the place of evidence – since evidence does not care.

The question, then, is where to begin? Indeed, it might not be the patient or the staff that needs empowerment but the management to begin with.

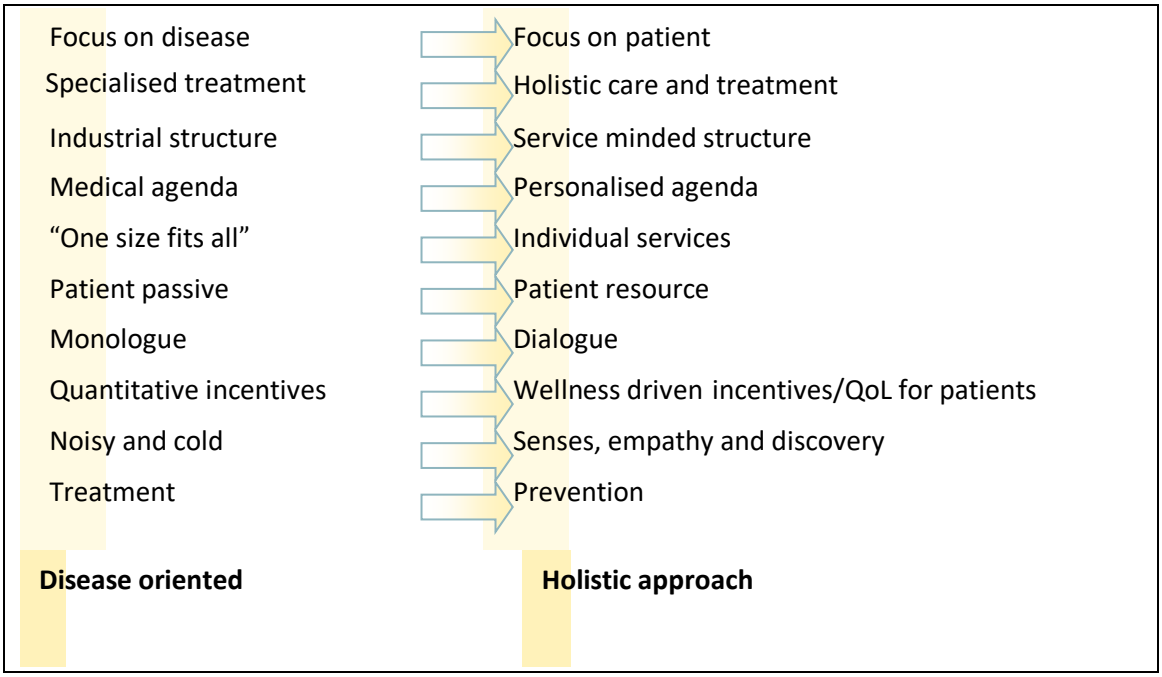

Figure 2. Change of mindset: The need for a new paradigm.

[9] https://dsr.dk/sygeplejersken/arkiv/sy-nr-2016-12

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Linking EoC to the healthcare context and to participatory design research methods, where the core values are participation and involvement of all stakeholders, could be an answer. Mutual learning and technology can be tools for change and EoC might be used as a complementary philosophy to help change the mindset of the stakeholders involved and thereby secure a holistic approach to one another (see Figure 2).

Perspectives

All of these conditions combine in the dawning of Health 3.0 and showcasing the value of using a patient's own resources as a way of facing the challenges described above. A person meeting these needs in this way can be described as Patient 3.0, namely, an empowered patient who is recreating the healthcare system in a more empowering way once he or she becomes a part of it. In this case empowerment may be referred to as enabling individuals to take control of their own health, wellbeing and disease management, and participating in decisions affecting their health and care (Faber, 2015). Furthermore, patients try to help each other to translate biomedical information into practical and useful knowledge (Dhillion, Lutteroth, & Wiinche, 2011; Pols, 2013; van Uden-Kraan et al., 2009).

In parallel to these developments, patients' usage of the internet and broader social media as an information-seeking platform, seems to serve two distinctly different purposes: The first is to get facts about their disease which will assuage their need for information. The second is to create communities where people are able to share experiences about their everyday life with an illness or disease, in order to be more active and empowered participants in the process of their own wellbeing. The *caules* from the tale ("moral of the story") about the Talking Stick tells us of the need for moving from the historic fixation on "the individual" and "the disease", to instead shift the focus to the holistic and complicated ecosystem each of us is a part of. Until then the care of the human will not be at the centre for our attention.

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About the authors

Jane Clemensen is a professor and head of clinical research at the Centre for Innovative Medical Technologies (CIMT) at Odense University Hospital with more than 13 years' experience with telemedicine research and participatory design. She is currently associated with six PhD students of whom she is the main supervisor for five. Jane's research projects all have their starting point in clinical practice, and involvement of all stakeholders including patients and relatives. They all revolve around the participatory design (PD) approach to research. Projects that use PD start by identifying and analysing the clinical problem or challenge and from that develop a solution or technology. This is in contrast to many projects that start by identifying a technology and then seek to find a clinical environment to test it in. PD is a well-known research design, especially within computer science, and it has also proven to be appropriate within health technology. Jane applied this design for the first time in a health science context in 2003 in her own PhD project, and she is a pioneer both in the fields of health technology and participatory design in health sciences. The co-authors of the paper belong to her research group and all have a clinical background.

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