We Need Darwinian Simplicity

Is it possible to create care that fits people, rather than people that fit care?

Carl May Ph.D
Acknowledgements

EXPERTS II

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Minimally disruptive medicine: a clinical methodology that puts the patient at the centre of care (their values, preferences, realities of life)
(May et al, 2009)

Question: what stands in the way of realizing care that fits?
(All of us, right now)
Care that does not ‘fit’ is structurally generated, usually with the best intentions.
Almost nothing in the care of the patient is simple.

- Health services are shaped by powerful forces of institutional change.
  - proliferation of financial and clinical thresholds that control entry;
  - subdivision of professions into ever-narrower specialisms;
  - multiplication of sociotechnical systems and infrastructures;
  - complex organizational structures.
- These arrive in practice through an unstoppable torrent of policies, payment structures, projects, initiatives, and interventions.
Even small changes can be hugely disruptive.

<table>
<thead>
<tr>
<th>Policy Inertia</th>
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<tr>
<td>• Healthcare Providers (usually) wish to be dynamic and responsive but need to share a direction of travel so that they maintain integration.</td>
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<tr>
<th>Structural Obduracy</th>
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<td>• Healthcare Providers are structured around spending policy + bureaucratic control mechanisms + professional hierarchies + growing populations seeking care.</td>
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<th>Systemic Entropy</th>
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<td>• complex economic, political, and legal frameworks characterised by a battle with rising demand and expectations, rising relative costs, and the search for efficiency savings.</td>
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For patients and those who care for them, healthcare can be experienced as complicated, uncertain, and fragmented.

- Lived experience of care is shaped by powerful forces of institutional dominance
  - Fragmentation of care in time and space
  - Uncertain access to the contexts in which care takes place;
  - Increasingly structured and inflexible pathways through care
  - Uncertain personal relationships through which care is realized.

- These are revealed in an unstoppable torrent of appointments, office visits, web-enabled apps and portals, questionnaires, tests, texts, emails, letters.
Care that does not ‘fit’ is care that generates health inequalities, often without noticing.
When we design complex interventions, care pathways, service reorganization, and systemic change we tend to start with the question *what needs to be done?* And then we define patients and caregivers around it.

But what if we started with a different question?

When we design complex interventions, care pathways, service reorganization, and systemic change what if we started with the question *what will patients and caregivers need to do?* And then we defined innovations around it.
Patients and caregivers need to **work in the moment** within and for health services: they must overcome **structural disadvantages**; demonstrate legitimacy; & act effectively.
None of this is accidental: actively designed, sanctioned, implemented, and normalised policies and practices institutionalize outcomes that seem natural and inescapable.

The cumulative effect of complexities, expectations, demands, burdens, and disparities, is too great for some individuals to resist or reshape.

Experiences of complexity, burdens, and disparities in care are not inevitable and are always modifiable.
Care that does not ‘fit’ is not inevitable
Four micro-principles for service development and design

- There is no single answer to any of the problems we have described above.
- Micro-principles that can be applied to new developments in the organisation and delivery of healthcare are useful for us.
- Micro-principles we can walk towards as we shape and reshape services

<table>
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<tr>
<th>Civility: when services are respectful of providers and users they reinstate moral meaningfulness of healthcare work.</th>
<th>Simplicity: when services are simplified they encourage clarity of purpose, ease of navigation, and continuity of care.</th>
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<tbody>
<tr>
<td>Subtraction: when services reduce workload, they restore agency and capacity to patients, caregivers and professionals.</td>
<td>Dependability: when services rethink the number and density of intervention components, and the interfaces between them, they eliminate opportunities for systemic failure.</td>
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Translational co-design cycle (1):

- Micro-principles form a *mutually respectful* foundation for co-design & co-creation of interventions, pathways, and services.
- Give direction to translation and mobilization of innovations in practice.
## Intervention components

- An intervention is never a thing-in-itself but is always composed of many components intended to lead to highly organized, institutionally sanctioned, and systematically regulated changes in the structure and delivery of services.

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<thead>
<tr>
<th>Intervention components</th>
<th>Interaction strategies</th>
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<tbody>
<tr>
<td>(how are concrete and virtual ensembles of of beliefs, behaviors, practices, expected to be formed around objects and procedures?)</td>
<td>(how are real and virtual relations between participants expected to be formed in ways that define their assumed capabilities?)</td>
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<tr>
<th>Rules and resources</th>
<th>Organizing logics</th>
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<td>(how are formal and informal changes in norms and roles, information and material resources, expected to shape practice and participants’ delegated accountabilities?)</td>
<td>(patterns of formal and informal agreements and values expected to give cognitive authority to participants and assign meaning to their actions)</td>
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Translational co-design cycle (2):

- Intervention components are realized in the lived experience of their users
- Intervention components are enacted through implementation mechanisms that can be observed and measured
Implementation outcomes:

Outcomes are the practical effects of implementation mechanisms at work.

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<th>Intervention Performance:</th>
<th>Relational Restructuring:</th>
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<td>(What practices have changed as the result of interventions and their components being operationalized, enacted, reproduced, over time and across settings?)</td>
<td>(How have working with interventions and their components changed the ways people are organized and relate to each other?)</td>
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<th>Normative Restructuring:</th>
<th>Sustainment/Normalization:</th>
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<td>(How have working with interventions and their components changed the norms, rules and resources that govern action?)</td>
<td>(How have interventions and their components become incorporated in practice?)</td>
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Translational co-design cycle (3):

- Implementation outcomes are measurable, but we also need what they mean to patients, caregivers, and professionals.
- Evaluation is less important than learning, learning can lead to local reinvention.
Conclusion
Translational Design Cycle for Complex Interventions

• Working together to design minimally disruptive interventions, pathways, and services
• Unpacking the elements and implications of interventions, pathways and services through exploring lived experience of the work the call for.
• Appraisal, meaning, and learning are part of a constant feedback loop.
We need Darwinian simplicity: *it is possible to create care that fits people, rather than people that fit care*

*Survival of the easiest… (after Darwin)*

*Evolution mainly happens at the margins (Steven Jay Gould)*
Thank you!

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“We tried forming a collective—no leader, no structure, no power dynamics—but we just ended up flying in a circle over Winnipeg.”