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Transforming leaders to transform hospitals

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Introduction

Recognizing the importance of caring and character education is essential for engaging in moral development, allowing healthcare professionals, patients, and caregivers to flourish. A flourished character, as literature shows, allows sick people to respond better to illness and suffering (e.g. Kidd, 2012; Navarini, 2020; Ruini & Vescovelli, 2013). Also, it gives healthcare professionals and caregivers the opportunity to take good care of their patients/family members, without forgetting to work on self-care, avoiding the risk of burnout (Beauchamp e Childress, 2001; Marcum, 2012; Ricci, 2020). Identifying patients, healthcare professionals, and caregivers' virtues is thus crucial to designing programs that will allow them to work on their character.

Although all of this is important, it is unlikely that hospitals and clinics will foster such work if they do not recognize and thus focus on the right values. In order to favour so, health facilities' leaders and managers need to be aware of the significance of these aspects. However, their character education has been often neglected. The absence of clear ethical references and systematic guidance has led the majority of our hospitals and clinics to embrace models in which the only criteria seem to be efficiency, productivity, and profit, moving from a patient-centred model to a bureaucracy-centred or even worse, a profit-centred model. These criteria are supplanting and eliminating "the value or ethos of humanistic, compassionate care" as David R. Graber points out (2009, p. 518).

Bureaucracy, productivity, and profit are important elements, but these are not the values to be placed at the centre. Changing perspective is important first because focusing just on the latter elements might prevent taking good care of patient's needs – a goal that should be the primary focus for hospitals and clinics. Moreover, as a large body of literature shows, focusing mainly on productivity or profit does not make facilities more effective (e.g. Tran, 2017).

The commitment to the "humanisation" of the healthcare environment is consequently urgent today. This does not mean arguing for the futility of organizational aspects, which are crucial elements of every industry, including the health industry. Yet, I would like to suggest that only by concentrating on the right values, facilities will achieve their goals, which are both to take good care of their patients and to make the company more productive.

In the first section, I will show what "humanistic hospitals" are and what are their guiding principles. In section two I will discuss the importance of virtue care ethics (Ricci, 2022) in trasforming leaders, and I will argue that to transform leaders is to transform hospitals. In the third section, I will defend the hypothesis that teaching them practical wisdom (De Caro et al., 2021) might be the turning point for humanising the healthcare environment. Practical wisdom (i.e. *phronesis*) is an essential virtue for leaders, as it is the ability that allows people to make the right decisions, even in complex situations, or to understand which is the guiding value when there is a conflict between many (De Caro et al., forthcoming). With this paper, I thus intend to emphasise that it is only by helping leaders and managers to flourish through dedicated programs that it will be truly possible to positively transform our hospitals and clinics.

1. Humanising the healthcare environment

The term "humanistic hospital" is relatively recent and dates back to around the 1960s (Graber, 2009), although it is possible to find the characteristics that were later attributed to humanist hospitals in some facilities of the past[1]. The idea of humanising healthcare facilities was born in opposition to modern medicine. Medical progress has had a huge impact on the improvement of technologies, but it has also been responsible for the impoverishment of caring practices. Barbara Korsch writes about this: «For the past century, the more rapid the advance has been in technology, the less emphasis there has been on the caring and human aspects of medical practice» (Korsch, 1978, p. 832). This topic has thus begun to be increasingly debated

[1] Particularly interesting in this respect is the example given by Bates concerning Victorian design, especially Florence Nightingale's engagement in visual stimulation, nature, and colors in the wards (cf. Bates, 2018, p. 8).

in the literature because while it is true that today's high technology offers a better chance of survival, it has also led to a "medical dehumanisation". «Patient's body was reconceptualized in modernity as a system, with its faulty parts to be identified and repaired in the hospital (now a 'machine for healing')» (Bates, 2007, p. 9), and patients started to be treated more and more from subjects to objects. This is one of the reasons why researchers in this field hold the need for hospital reform. Another reason is that studies have demonstrated that non-medical aspects, such as providing caring and compassionate care, but also architectural choices and environmental design,[2], have a strong impact on patients' and families' well-being. These also influence the healing process (e.g. Ulrich, 2003; Christianson et al., 2007; Bates, 2018) and patient's response to their illness and to treatments (Graber, 2009). It has thus been demonstrated that proper care has a crucial impact on the quality of living and on the quality of dying.

A model such as the one proposed here might appear impossible to achieve. However, literature accounts for several examples of humanistic hospitals, starting with St. Christopher Hospice in London. This facility was founded by Cicely Saunders who was responsible for establishing modern palliative care. Saunders, back in the 1940s, advocated the importance of ensuring "total" care, i.e., attentive to all patient needs. She recognised that the smallest details could facilitate the best patient care and was thus committed to the creation of a patient-friendly facility. In her biography, the details of the hospice she designed, St. Christopher Hospice in London, are described: she decided to divide the wards into rooms with up to six beds, arranged so that patients could observe life taking place outside without running the risk of getting sick; beds were equipped with casters so that they could be easily moved, allowing patients to reach the chapel, the common rooms, the garden, or to be approached by another sick person. Common rooms were equipped with a fireplace and comfortable, straight-backed chairs; furniture was to be colourful, pleasant, and homelike (Du Boulay, 1987). Every element was conceived to optimize the inpatient experience. St. Christopher Hospice, which is still one of the largest providers of palliative care and palliative care education in the world, represents a concrete example of humanistic hospitals. It also demonstrates how important is to be guided

[2] As Bates points out «Humanizing medical practice and care in hospitals was inseparable from the environment in which that care took place» (Bates, 2007, p. 10).

as leaders by a clear ethical framework.[3] The alternative to being guided by ethical values and principles is to devote this task to criteria such as performance, efficiency, productivity, and profit, moving from a patient-centred model to bureaucracy-centred or profit-centred models. What Graber (2009) writes about today's hospitals is particularly insightful from this point of view and helps us understand why it would be crucial to find a new arrangement:

> Modern hospitals are typically large organizations or members of corporations, with a management that is focused on efficiency, productivity, and profit. A "high-tech" workplace, overseen with a corporate, business-centred concept of management are key elements in the culture of today's hospitals. Such a culture is not necessarily deficient or dysfunctional, unless it has supplanted and eliminated the value or ethos of humanistic, compassionate care. In that event, high proportions of patients will experience neglect, be ignored, and not feel respected or satisfied during their visit. (Graber, 2009, pp. 517-518)

As Graber writes, although profit and productivity are not dysfunctional elements per se, the risk of focusing on them is that this can lead to forgetting patient's good and their needs. The right thing to do is therefore not to deny the importance of them. Hospitals are large organizations and thus leaders and managers need to balance the budget, deal with bureaucracy, and ensure that their facilities are efficient. However, the latter criteria should be treated as outcomes, not as drivers of decisions and choices. This is important both to provide patients with the best possible care and because it allows hospitals to perform better. A large body of literature shows, for example, that healthcare professionals' efficiency and productivity can be achieved not by investing directly in them (e.g. requiring higher productivity or more working hours of employees), but rather by working on elements such as healthcare facilities design (e.g. Keddy, 2009) and quality of work-life. For example, a healthy working environment can reduce job stress[4] and influence efficiency and productivity (e.g. Mosadeghrad et al., 2011; Yadav & Khanna, 2014; Lowe, G. S., 2003). Establishing a healthy and enjoyable environment is thus crucial to improve productivity, but also to ensure that practitioners can take the best possible care of patients.

Furthermore, it is also crucial that leaders provide healthcare professionals with the right tools to understand others' needs and respond most appropriately to them. In fact, as I have

[3] St. Christopher Hospice is only an example of caring and humanistic hospitals. For an overview and models of humanistic hospitals see Graber, 2009.

[4] Reducing work-related stress is essential to prevent health workers from incurring the risk of developing burnout syndrome which can limit or make it impossible to provide patients with caring actions. Practitioners need to have cognitive and emotional availability (Ricci, 2020) to be able to take care of others.

pointed out elsewhere (Ricci, 2022), for a long time it was assumed that human beings have a natural tendency to take care of others. However, experience suggests that this is not true. Following an example suggested by Joan Tronto in *Moral Boundaries*, a physician might, for example, have developed empathy for the poor and malnourished children of Somalia, but be indifferent towards the patient who rings the nurse call bell at night (cf. Tronto, 1993, p. 106). In this sense, it is important to increasingly introduce into the medical system training paths that promote humanised medicine and teach practitioners not only to be good technicians but also to develop those character traits that are essential in clinical practice.

2. Virtue care ethics: an essential tool to transform hospitals into humanistic hospitals

At this point, it should be clear that the role of leaders and managers is essential in the process of humanising hospitals. As Graber points out, «to spread caring and humanism and institutionalize it, management must become actively involved and transform the organizational culture» (Graber, 2009, p. 532). In fact, it is unlikely that hospitals and clinics will foster such work if they do not recognize and focus on the right values. To favour so, health facilities leaders need to be aware of the significance of these aspects, including the importance that care has for every human being. Thus, what emerges is that *to transform hospitals is to transform leaders*. To be a good leader is not sufficient to know the healthcare system of a certain country and the existing laws, to take care of the administrative and financial management, to have a basis in lean management. It is equally important to have guiding ethical principles and an educated character which are key aspects to take the best choices, to meet the needs of patients, families, healthcare, and non-healthcare personnel, and to respond to the constant changes in healthcare. One approach that can help managers and leaders from all these perspectives is virtue care ethics.

Virtue care ethics is a framework that aims to combine and integrate the ethics of care with virtue ethics (Ricci, 2022). The importance of a collaboration between ethics of care and virtue ethics has been defended by many authors (e.g. Sander-Staudt, 2006; Mortari & Ubbiali, 2017; De Panfilis, 2019). Care ethics is a fundamental resource in healthcare as it focuses on the

primacy and centrality of care for every human being. Ethics of care bases its premises on the primacy of care, which is regarded as the heart of human existence and also the fundamental element for the development and flourishing of every human being. According to the theorists, since human beings are vulnerable and fragile, they need gestures of care throughout the entire course of their life. In fact, ethics of care conceives people as interdependent. This focus on the primacy and necessity of care is a fundamental resource for healthcare leaders. As Alasdair MacIntyre emphasises (2001) for a subject to be able to guarantee closeness to the other, they must have accepted their nature which is first and foremost animal and therefore is fragile, vulnerable, and always dependent in some way on others. Only by recognising that everyone as human being is vulnerable and not self-sufficient, managers and leaders will understand the importance of caring and will succeed in introducing models of care in their hospitals that are truly patient-oriented.

Care ethics, as shown in the literature, is a fundamental resource, but has several structural limitations (see, for example, McLaren, 2001; Halwani, 2003). Thus, it is not self-sufficient especially when it comes to moving from theory to practical contexts. The latter ethical framework, for example, holds that every human being is, as such, capable of taking good care of others. Hence, rather than focusing on character education, it dwells exclusively on the importance of the patient-operator relationship. The latter element would be necessary and sufficient to make any caring practice a good practice. Care ethicists have therefore focused on identifying those character traits that can foster it, and on the importance of practice to acquire such traits[5] (e.g. Tronto, 1993; Van Hooft, 1995; Noddings, 2013), but no philosopher of care suggested a concrete idea about what kind of work needs to be done to develop those dispositions. However, a systematic guidance is essential in care settings as practice must be directed to produce effects, and a lack of counsel might lead the carer to act on the basis of sentimentalisms and intuitions which are tricky resources. Feelings are unable to represent a safe guide in moral action, while intuition is a useful tool only when the subject has already reached a high level of expertise, as authors like Matt Stichter (2018) suggest.

The ethics of care has some other problems that do not make it a suitable ethical framework for caring settings if left alone, but I will not delve into them for reasons of space. A theory that was considered by the literature as ideal to collaborate with the ethics of care is virtue

[5] For example, Tronto (cf. 1993, p. 127) identifies these traits in attention, responsiveness, competence, and responsiveness, but each author pinpoints different ones.

ethics (see e.g. Stander-Staudt, 2006). Virtue ethics identifies the focus of moral action in character. In fact, according to this ethical framework, in order to understand the best way to act in a situation is not for example enough to rely on norms or maxims, as deontologism suggests. As Angelo Campodonico and colleagues write: «one needs a properly trained character, that is, equipped with what the tradition calls virtue» (Campodonico et al., 2017, p. 10, my translation). This is particularly important for leaders and managers. Understanding what the best behaviour or the best decision is when different principles or virtues are at stake or in particularly complex situations - tasks that are continually demanded of these professionals - requires a flourished character. Therefore, the collaboration between care ethics and virtue care ethics might be a key resource as it would both teach them the importance of care and would provide though character education the necessary tools to take the best possible care of their facilities.

3. The importance of phronesis for virtuous leadership

Now that it seems clear why virtue care ethics could be an important resource for leaders and managers, one question remains unanswered: how can we help them to become more caring and acquire those ethical tools necessary to their practice? An extremely extensive philosophical debate has tried to identify the best way to educate character. However, as far as leaders and managers flourishing in concerned, it seems to me that a good intuition is provided by the Aretai group (De Caro et al., forthcoming). De Caro and colleagues' proposal is an alternative to more traditional models (e.g. Carr, 1991; Kristjánsson, 2015; Arthur, 2019) that understand flourishing as a matter of habituating distinct character traits. According to them, character education would consists of two moments: (i) first, agents acquire different character traits through repetition and emulation, (ii) second, they acquire practical wisdom which helps agents to deliberate and act well by suggesting them what kind of virtue should be activated (and to what degree), to resolve conflicts between virtues, and to regulate emotions so that they act in synergy with the other virtuous traits.[6] Thus, practical wisdom would be capable of

[6] These types of models have some structural shortcomings, especially regarding the relationship between virtue and practical wisdom. We have addressed those in a recent paper (Niccoli et al., forthcoming).

"helping us figure out what to do when we get 'stuck' [...] particularly (or perhaps exclusively) in the moral domain" (Kristjánsson, 2021, p. 1303).

On the other hand, the Aretai model has a monist approach to virtue. This means that it considers virtue as one and identify it in practical wisdom. In this sense, being virtuous would correspond to possessing practical wisdom in the widest variety of contexts. It follows that other traits such as courage, hope, tact, or honesty would be emanations of phronesis. According to the Aretai group, character education would thus consist of educating the subject in phronesis.[7] A wise character would in fact, according to them, correspond to a virtuous character. Therefore, possessing practical wisdom would also mean possessing all the other traits which are nothing more than ways through which phronesis presents itself in various contexts. This hypothesis seems to be particularly suitable to forming leader's character. According to De Caro and colleagues an essential characteristic of phronesis is that it is a «cross-situational competence» (De Caro et al., 2021; De Caro et al., forthcoming) that is capable of helping the agent to deliberate well and act well. It provides them with the ability to discern in various situations what kind of action is required, even in the most complex ones, in cases of moral dilemmas, and emergencies. In this sense, practical wisdom can be defined as excellence in making the right decisions and actions in practical life circumstances (Niccoli, forthcoming). This kind of expertise is crucial for managers and leaders who are called upon to make complex choices where different values at stake on a daily basis. Learning *phronesis* from the very beginning would allow them to immediately grasp what is the best way to deliberate in a given context or to understand how to act, even when the decision to be taken is particularly difficult. Think in this sense of decisions that are asked of hospital managers such as whether to avoid spending money in order to balancing the budget or to invest in design choices that would cost a large sum of money but would also make the hospital more suitable for patients' needs, or choosing who to hire between an extremely efficient but tactless doctor or a less efficient but more caring professional. It is easy to understand from this example why practical wisdom is so important for leaders. It also seems evident that one of the keys to

[7] The authors in particular suggest that since practical wisdom is a multi-component form of expertise, it might be possible to teach it by educating its features (De Caro et al., forthcoming).

making hospitals more humanistic is to establish programmes that focus on educating leaders' character, in particular fostering practical wisdom.

Teaching practical wisdom from a monist perspective, however, is not only a useful resource for leaders and managers but also for practitioners. *Phronesis* would allow them to make the best decisions, even in the most complex situations such as deciding whether to offer an old and dying patient another antibiotic treatment to prolong their life for a few days or not, or more simply understanding how to communicate bad news to a family. A wise character would also make it possible to avoid "compassion fatigue". Compassion fatigue is defined by Pfifferling and Gilley (2000, p. 39) as "a deep physical, emotional, and spiritual exhaustion accompanied by acute emotional pain". Developing practical wisdom could help healthcare professionals not only to make the best decisions and the most appropriate actions but also to provide the right amount of care. In fact, it is both crucial to devote patients with the right closeness and to learn to protect themselves. Virtuous care cannot be separated from meeting one's own needs as is impossible to take a good care of others if practitioners are completely lacking in the necessary mental and physical energy. This again calls for virtuous leadership. Providing healthcare professionals with the right tools to do so and the necessary support requires leaders and managers to focus on their employees' needs. Leaders, as Graber emphasises, "have the responsibility of recognizing, assisting, and perhaps counselling these clinician" (Graber, 2009, p. 532). It is precisely in this sense that character education is crucial for them.

Conclusions

This paper has described the importance of humanistic and compassionate care to our modern, technological society and defended the idea that the transformation of our hospitals and clinics first requires the transformation of managers and leader's character.

In the first section I defined what humanist hospitals are, what are their history, and their characteristics. In the second section, I defended the idea that transforming facilities require to adequately form leaders, and that to do so, professionals need to be guided by a clear ethical

framework that I identified in virtue care ethics. Virtue care ethics is in fact able to help leaders and managers to understand the ontological primacy of care, without which human beings cannot aim at flourishing. On the other hand, it focuses on their character education. A virtuous character, as we have seen, is crucial for leaders as it enables them to make the right decisions and to make the best choices even in the most difficult contexts. In the third section, I advanced the hypothesis that the best way to shape their character is to cultivate practical wisdom. In this sense, I defended the relevance of a monistic approach to virtue and to character education for this context.

The challenge that remains lies in the transition to the empirical level. Trasforming our facilities is crucial today to avoid medical dehumanization. However, this step will never be achieved without training managers and leader's character. In this sense, it is fundamental to design virtue care ethics protocols that aim to provide not only technical training, but also "human" formation. As we have seen, the most important resources in this respect are to teach them the value of care and educate them in phronesis. It is thus crucial to understand how to teach it. The Aretai model currently provides some interesting suggestions from this point of view. However, empirical work needs to be done in order to assess this hypothesis.

It is clear that transforming healthcare facilities' leaders is only one step in humanising the healthcare system. As Graber points out, what is needed today is a «radical and permanent new culture for the hospital» (2009, p. 533). To achieve this, it is also necessary to train political leaders, so that they can be driven by the right values. Unfortunately, that is a topic for another paper.

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