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Title:

Cultivating Quality Awareness in Corona Times

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Abstract

The Covid-19 pandemic is a tragedy for those who have been hard hit worldwide. At the same time, it is also a test of concepts and practices of what good care is and requires, and how quality of care can be accounted for. In this paper we put our Care-Ethical Model of Quality (CEMQ) to the test. Instead of thinking about care in healthcare and social welfare as a set of separate care acts, we think about care as a complex practice of relational caring, crossed by other practices. Instead of thinking about professional caregivers as functionaries obeying external rules, we think about them as practically wise professionals. Instead of thinking about developing external quality criteria and systems, we think about cultivating (self-)reflective quality awareness. Instead of abstracting from societal forces that make care possible but also limit it, we acknowledge them and find ways to deal with them. Based on these critical insights, the CEMQ model can be helpful to describe, interrogate, evaluate, and improve existing care practices. It has four entries: (i) the care receiver considered from their humanness, (ii) the caregiver considered from their solicitude, (iii) the care facility considered from its habitability and (iv) the societal, institutional and scholarly context considered from the perspective of the good life, justice and decency. The crux is enabling all these different entries with all their different aspects to be taken into account. In Corona times this turns out to be more crucial than ever.

Keywords

Quality of care; Covid-19; relational caring; care ethics; practical wisdom; mismatch; humanness; solicitude; habitability doi:10.20944/preprints202006.0267.v1

The Covid-19 pandemic is a tragedy for those who have been hard hit worldwide. At the time of writing, the total number of confirmed cases is above 5.6 million and more than 350 thousand people have died.[1] Many people are experiencing difficult times, not only physically but also mentally and socially. Large numbers, not suffering from Covid-19 itself, are also experiencing hardship because of the measures taken, measures that make them unemployed, kill their businesses, isolate them from relatives and leave them without the care they need. That is the case in Europe and the USA, but even more so in poverty-stricken and bombed Yemen, the overcrowded favelas of Rio de Janeiro, the slums of Mumbai or the townships of South Africa. At the same time, the Covid-19 pandemic is also a test of our concepts and practices of what good care is and what it requires, and how quality of care can be accounted for. However understandable, it is also significant that in the Netherlands the Healthcare and Youth Inspectorate has temporarily taken its own quality system out of operation. It raises the question of what this system actually serves. In this article, we put our Care-Ethical Model of Quality (CEMQ) to the test.

1 Assessing quality of care

After decades of research into a range of care practices in healthcare and social welfare, we have become convinced that good care requires relational caring. For many years now we have been publishing on relational caring, and providing training and supervision for (teams of) care professionals (Baart 2001; Baart et al. 2011; Baart and Vosman 2011; Baart and Vosman 2015). Over time we have come to realise that, however helpful training and supervision may be, they make little difference when care professionals are evaluated, judged and rewarded by quality systems that are not equipped to perceive, recognise and acknowledge relational caring. This has led us to develop a new way of thinking about quality that is able to do justice to relational caring as well as a model to guide inquiry into and critically determine the quality of care received. This thinking and the resulting CEMQ model is based on more than ten years of research, study and deliberation with caring professionals and their organisations (Baart 2004b, 2008, 2014, 2018; Baart and Grypdonck 2008; Vosman and Baart 2011). The wider, normative context of our thinking is a political take on care ethics (Timmerman et al. 2019; Vosman et al. 2018). We start now by looking at what was learned from the analysis of a particular case in a meeting of what we called the ‘Workshop Quality’ with representatives from different caring organisations.

Analysing the quality of care for Pia

> To enable discussion at the meeting of our Workshop Quality, a case description about a young adult with intellectual disabilities was thematically analysed. The

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[1] According to the Coronavirus Resource Center of the John Hopkins University: https://coronavirus.jhu.edu/map.html (accessed 27 May 2020).

> detailed case description was about Pia, a young female adult with a sturdy build. It was supplied by the organisation caring for her at that moment. Pia has mild intellectual disabilities, the emotional level of a toddler, and autism. She has little faith in her own abilities and needs guidance throughout the day to initiate any action. Pia easily builds up tension that she expresses by screaming, biting and pulling on hair, aimed at both herself and others. She is sensitive to constipation. According to the case description, Pia needs safety, security and warmth as well as predictability, clarity and structure. This requires regular coordination and fine tuning by the team. Carers need to recognise and correctly interpret the signals issued by Pia. Until recently, Pia lived in a home with children and young people. Her development stagnated there. At the time of the meeting about this case, Pia was living in a home for adults. The team was working primarily on providing a stable living and day environment that would give Pia a feeling of safety. So much for the summary of the case description. From a thematic analysis by an experienced researcher, the participants in the workshop concluded that the sources of knowledge about which the description reports, were mostly oriented at Pia's malady. They also found that the reported handling of these sources was mostly oriented towards the implementation of interventions. Little was said about relational sources of knowledge and about relational caring for the client. The case description told something about the client as a person but only from an outsider's perspective. It said little about the client herself as a relational and vulnerable person, someone who has also paid a price for her admission to the facility. From the description, the participants in the meeting gathered that the organisation was chiefly concerned with the environment it offered the client; nothing was said, for example, about the organisation's view on good care. The participants concluded that a more substantive idea of quality, using a greater variety of perspectives, could be helpful in gaining a more diverse and richer picture of the care Pia needed. (Taken from Baart 2018: 259-268. The thematic analysis was carried out by Andries Baart).

The usual method for determining whether care receivers receive good care is to ask them afterwards: are you satisfied? They are systematically asked, for example by filling in a survey, for their patient or client experiences regarding different aspects of the care provided. The answers given by care receivers to these kinds of questions, however, are often ambiguous. Care receivers can express satisfaction despite results that others would judge as unsatisfactory or even bad because they deem a pleasant relationship with the care provider more important. Care receivers can also articulate dissatisfaction because they did not get what they wanted. Determining the meaning of expressions of satisfaction or dissatisfaction therefore requires a careful look into the case, and interpretation of and deliberation about these expressions. Although satisfaction, dissatisfaction and discomfort of care receivers should be taken seriously, the outcomes of customer satisfaction surveys are not a good measure. Care receivers certainly have a voice in determining the quality of care and should be allowed to speak out. But the way to enable this, we think, is by perceiving them carefully, connecting with and attuning to them, and deliberating with them during the entire caring process itself.

In mainstream quality systems, care professionals are generally evaluated and judged according to whether they adhere to the prescribed system, and follow rules, guidelines, protocols and procedures. These systems, rules and so on originate in the wish to improve care, to share helpful knowledge, to make transferable good practice, and to prevent harm. However, over time they have begun to dominate, pushing into the background the question: 'but is this, here and now, good care?' This shift in emphasis has led to much improvement in the quality of care since the nineties of the last century but also to an increase in the administrative burden for professionals, which in turn has led for many of them to loss of motivation, burn-out, moral fatigue and so on. In addition, incidents with casualties still occur as well as not-so-good care. This has of course been noted in many forums, studies, reports, newspaper articles, documentaries and so on but the question still remains of what went wrong and how it can be tackled.

Our point is that good care is not simply a matter of following rules, however helpful in general those rules may be, and nor is care meted out strictly according to rules necessarily good care. Many quality systems are unable to perceive 'mismatches': care given according to external rules without being attuned to the care receiver (Baart 2002; Baart and Steketee 2003; Baart 2013; Goossensen et al. 2014). This is where practical wisdom comes in, because this is what is required to be both guided by rules and, at the same time, be well-attuned to the care receiver involved and find out what good care may be for them.

At the moment of writing, we are still in the middle of the Covid-19 crisis and it is too early to have a complete overview. What we see is quite ambiguous, showing at least two contradictory sides to every issue. On the one hand relational caring is easily put aside when social distancing is being used to fight a threat to the physical health of particular groups of people labelled as 'vulnerable', especially those living in institutionalised settings. But on the other hand, we also see a growing realisation that social distancing is detrimental to the physical and mental health of other groups of vulnerable people, particularly those living at home and deprived of their usual care, and that people are finding ways to be physically near them. Across the world, we see the criterion of safety becoming dominant, overruling all other quality criteria and shutting off political-ethical thinking. However, at the same time we also see people standing up for other quality criteria based on relationality, not only in regard to their family but also on a macro level, for instance in regard to refugees. We see how social forces have been operative, for example in the introduction of (limited) market competition and just-in-time production and delivery in healthcare, but we also see firms finding ways to help healthcare organisations by producing protective equipment for free or at cost price. We see care organisations being judged on whether they have followed rules, especially when mortality rates are well above average, but we also see, in the Netherlands, the Inspectorate and the Care Assessment Center putting their rules and systems aside, and providing room for the practical wisdom of care professionals. In many countries around the world, we see variants of a total lockdown, based on distrust and repression of the population. In other countries, we see variants of an intelligent lockdown, built on trust and encouraging a sense of responsibility among the population within a guiding framework. We do not know yet which kind of lockdown will turn out to be most adequate, but the crisis raises questions about the kind of society we want to move forward to.

The crisis and the way it is handled, also raises questions about the kind of ethics we need. The Dutch care ethicist Frits de Lange points out that in the Covid-19 crisis the two fundamental moral approaches of modern society hold each other in a stranglehold: Kantianism and utilitarianism. Whereas Kantianism, with its focus on the absolute value of the individual, was leading in the first phases of the Covid-19 crisis, utilitarianism, with its emphasis on the greatest utility to the greatest numbers, becomes leading in het next phases of the Covid-19 crisis. Both, however, have no eye for how we as humans are physically entangled with each other and with our environment (de Lange 2020). With De Lange, we think we need an ethics that has an eye for this and that takes the practice of caring as a starting point to think about society. Care ethics is such an ethics.

In this paper we present and elucidate a way of thinking about quality that can:

- do justice to relational caring, also in times of Covid-19;
- give voice to care receivers and those closely involved with them according to their concerns;
- perceive mismatches, without disregarding rules, guidelines, protocols and so on;
- appreciate the practical wisdom of care professionals in view of the uniqueness of each and every case.

At the same time, we present the CEMQ model, a model to guide inquiry into and critically determine the quality of care received.

2 Stagnating quality thinking

Reviewing the literature about quality of care and quality policy in healthcare and social welfare, we see a lot of thinking that is stuck. We will mention four factors contributing to this stagnation. First, as soon as designers of quality systems start to think about quality in healthcare and social welfare, substantive thinking seems to disappear into the background. What care really is – a moral practice through and through that receives its guidance from the situation – and what social interventions actually serve – organising the political-ethical order of society – no longer receives attention. While the important normative aspects of health care and social welfare are constantly covered, moral issues tend to be transformed into existential and psychological issues.

Second, quality thinking and the systems that we build to guarantee quality seem irrevocably to end up with a heavily rigged set of checks and balances. According to Thomas Schmidt (2017), our fixation on quality means that we become entangled in all sorts of paradoxes and that we initiate mechanisms that we can no longer stop (Shojania 2019). Quality policy is about an acceptable balance between what is good and what is not good at the same time. There is practically nothing to be found that is fully good and not at the same time, from a different perspective, not good.

Thirdly, in healthcare and social welfare, several logics and discourses are dominant that are not easily compatible with the 'logic of care' (Mol 2008), of which relationality is a key part. Quality policy often comes from the domain of the production of goods, serving the market, matching supply and demand, and binding customers to your product. This 'logic of production' does not fit care and nor does medical thinking, which is also dominant and not easily compatible with the logic of care. There is not only a difference in intentionality (cure versus care) but also in the underlying science, epistemology, conceptualisation, research methodology and normativity (cf. Mol 2008). In this paper we want to 'think care from caring' (Vosman 2014) and not from manufacturing or service providing.

The fourth factor refers to common ideas about organisation and management that often prove to be inconducive to solving the aforementioned problems. We need to consider the institutional embeddedness of the care offered: the style of management, the processes of policy formulation and, for example, all those routines, scripts, roles, conventions and expectations that take the obvious for granted. Such attention often falls outside the usual quality frameworks. Also, moral deliberations easily conform to what seems to be self-evident.

Thinking about quality should start with thinking about care. Care is not a set of separate care actions, but a 'practice' of 'sayings, doings and artefacts', crossed by other practices and involving many different aspects and levels. When it comes to thinking about quality, these all need to be covered. As pointed out by Joan Tronto good care is integrated care (Tronto 1993). Attention to quality is not an issue in itself but is interwoven with all kinds of learning and reflection processes (McPherson et al. 2001). Moreover, care is a complex practice in which care receivers and caregivers must deliberate to find out what good care is. Quality cannot be determined by general criteria but must be discovered locally per person and situation, and together with the person involved. Finally, care is a moral practice. Determining quality is impossible without considering moral issues, asking moral questions and making moral judgments, without disregarding the ambiguities of human life (Vosman 2018).

3 Relational caring, quality awareness, and practical wisdom

Mainstream quality systems are hardly able to perceive and appreciate relational caring because they are oriented to 'objective' norms and values. This is generally the case although most care practitioners themselves will acknowledge that care is mainly 'good' in a particular context, in a specific situation, and at a determined moment in the 'tangible' life of a particular person. In this paper, we present an alternative approach, based on three pillars: (a) relationality or situatedness of care and, thus, of judging quality; (b) the cultivated, self-regulating awareness of quality and (c) the practical wisdom of the professional caregiver.

3.1 Relational caring

In relational caring the source of action is the good that emerges within the relational network in which cared-for and carers find themselves and each other, and interact with each other (cf. Habran and Battard 2019). Two intertwined concepts are therefore essential: relationality and finality, not as principles but rather as two focal points.

Relationality is about: who is participating, how are they positioned, and how do they position themselves and each other, what is happening in the interaction between them and what is the meaning thereof for them. In the weak sense of relationality, relationships are conceived of as merely conditional or instrumental to good care and not themselves as an integral part of good care. Essential to relationality in a strong sense is that what is happening, emerging and discovered in relationships between caregivers, care receivers and the people around them has real consequences for what is done and aimed at, and not only for how it is done. Relationality also has consequences for how the context, the situation and the persons within this situation are perceived.

Finality is concerned with: what is the practice about, also from a historical perspective, and what are participants actually aiming at in what they do. Finality should not to be understood as what people or organisations set as their particular goals. Essential to finality in a strong sense is that what is aimed at is not aimed at without considering the concrete relationships between care receivers, caregivers, the persons around them and their lifeworld, life course, et cetera. In fact, a good relationship is a good in itself.

These two focal points and how we conceive of them make our conception of relational caring a radical, and in this radicalism a quite unique, conception with comprehensive and far-reaching consequences. On the side of the professional, relational caring requires holding back, being sensitive and attentive to what happens in everyday life, allowing emerging goods to show themselves. It also requires managing one's professional power and enduring one's professional powerlessness, in order to prevent professional and bureaucratic perpetuation of the suffering and neediness of the other. Professional power should be exercised in the perspective of the ‘broken good’ and as ‘relationship-oriented, professionally loving and sensibly muddling through’ (Baart 2001, 2013; Schaftenaar et al. 2018).

3.2 Cultivating quality awareness

Professional caregivers have been taught to follow rules, guidelines et cetera, and have learnt that they will become vulnerable to criticism if they deviate from those rules, guidelines et cetera. As a consequence, they have become unfree in their perceiving, acting, reflecting and judging. Assessing relational caring, however, inevitably has to be done (a) on the spot, (b) in the relationship between caregivers and care receivers and (c) momentarily. As care is a moral practice, assessing its quality is also a moral practice. This is a radically different approach from mainstream approaches.

What about public accountability? ‘Measuring’ is just one of four ways to determine quality. Others are the narrative or hermeneutic approach and the phenomenological approach (Baart and Willeme 2010; Burhans 2008; Charon 2006; Vosselman 2014). In this paper, we focus mainly on a fourth method: a developed and cultivated, (self-)reflective quality awareness. The other methods of quality determination mentioned above can be used within this frame.

In order to carefully examine the quality of relational caring, one does not only need external tools; one has to become a tool oneself, continuously and carefully inquiring into and in the concrete situation. This applies not only to the individual professional, but also to teams of professionals and the organisation as a whole. We propose that the cultivation of critical, vigilant quality awareness be made the core of quality policy. Permanent quality awareness maintains the connection between learning to perceive, to understand, to appreciate and to act. It looks at the entire process, including the person counting and accounting, and thus keeps together the different ways of looking at quality. Giving an account takes place at three levels: the internal level within the organisation including the care receiver, the internal level with third parties (*peer audit*) and the external level outside the organisation itself. Accounts are given first of all to the care receiver, on a continuous basis during the care given or proposed, and with an immediate response.

Regardless of which learning and reflection practices are chosen, sooner or later people need a substantive idea of what constitutes good care or at least questions in that direction. In the next paragraph, we will present, step by step, a detailed model of good care that both nourishes quality awareness and makes it concrete.

3.3 Practical wisdom of professional caregivers

In thinking about professionals and professionalism, scholars have moved from the classic professions of physicians, lawyers and clergymen to, first, technical-rational professionals with their evidence-based knowledge and practice, and then to normative-reflective professionals, aware of the different normativities intrinsic to their work. In response to the issue how to get from (formally, discursively and incorporeally) reflecting to acting, we developed the concept of practically wise professionalism. Practically wise professionals: (a) know what their profession is and what it is aimed at, and in concrete situations head for it; (b) accept that they must act, even if goals are contradictory, rules contradict each other and the outcome of acting is uncertain; (c) understand that complexity, dynamics and emergence belong to their profession and should not be unduly simplified or suppressed; (d) involve their entire personality, know their working style and realise which metaphorical positions they occupy; (e) conceive of rules and guidelines as indications of how to act based on the instructive experience of sensible colleagues in similar situations; (f) dare to take the leap to actually acting; and (g) respond to the question of accountability by telling the whole story from the inside out. In actual situations, practical wisdom implies making room for moral intuitions, moral imagination, interruption, finalising, deliberation and risking the leap to action (Bontemps-Hommen et al. 2019; Bontemps-Hommen et al. 2020; Timmerman and Baart 2016).

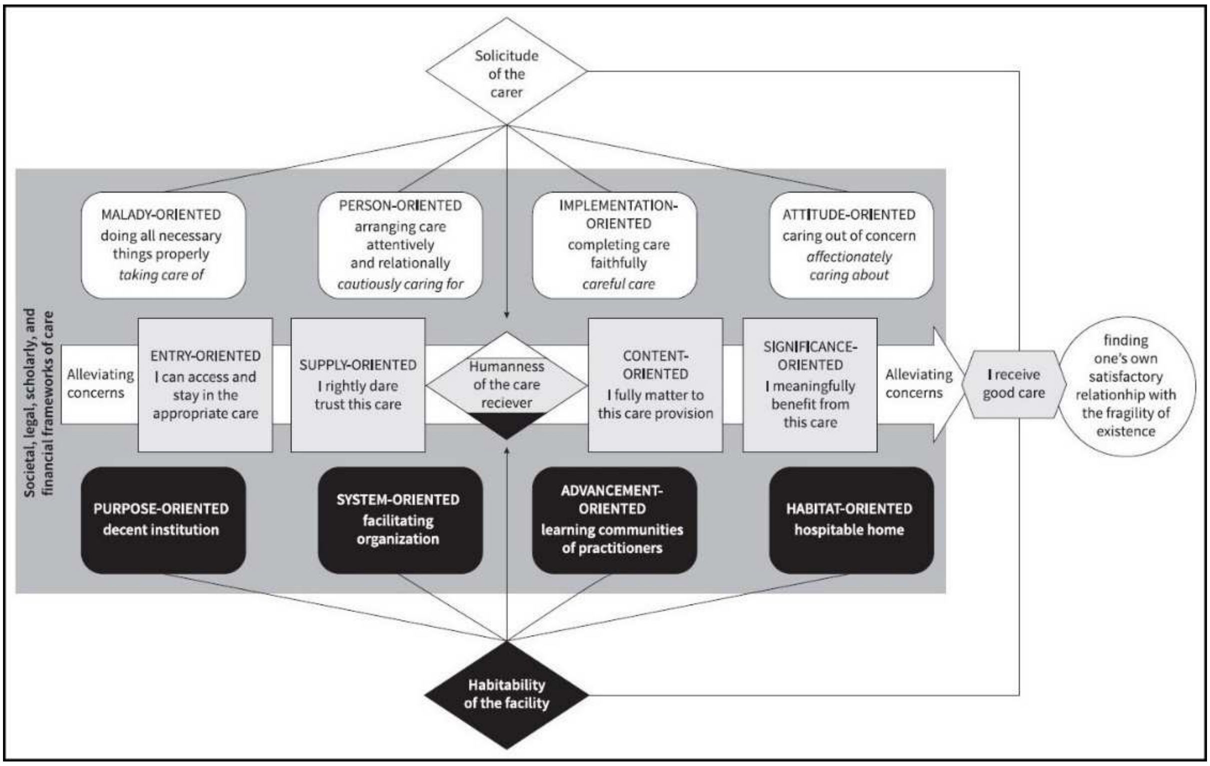
4 The care-ethical model of quality (CEMQ)

Drawing on the conceptual foundations of relational caring, quality awareness and practical wisdom, this paragraph deals with the presentation and operationalisation of a detailed and innovative model. It is a heuristic model that helps in describing, assessing and improving care, giving an account of good care, assessing existing quality frameworks and formulating quality policies. We have also found it helpful in evaluating complaints and incident reports. Our Care-Ethical Model of Quality (CEMQ) consists of four normative layers or entries (see figure 1):

- humanness at the level of the care receiver,
- solicitude at the level of the professional caregiver,
- habitability at the level of the care organisation and
- justice and decency at the level of societal care paradigms.

The fourth entry to the model concerns the embedding of care in society with its societal care paradigms that determine the societal, legal, scholarly and financial frameworks of care. The ultimate goal of good care, its *telos*, is to help the care receiver to find their own, more or less satisfactory relationship to, or handling of, the fragility, perilousness and transience of human existence: accepting, fighting, cursing, repairing, celebrating, undergoing or evading it (or a combination of these). Good care is care that helps the care receiver to realise their good. What care can contribute is the alleviation of the care receiver's concerns, though it can also aggravate those concerns. We will come back to that issue below.

Fig. 1 The Care-Ethical Model of Quality (CEMQ) [2]



In the following paragraphs, we elaborate on each of the four entries to the model. For each them, we start with a 'small philosophy' of a term that is the keyword for quality or the overall quality criteria at that level. In these small philosophies we draw not only on the literature about the concept involved but also sketch out our own conceptual space.

4.1 The entry of the care receiver

Care receivers are central to the quality assessment of care (Amelung et al. 2017; Carey 2017; De Chesnay and Anderson 2019; Hewitt-Taylor 2015). In our model, they are implicated everywhere, but explicitly present in this first entry. In figure 1 this entry is represented by the middle row, with the wide arrow and the grey 'buttons'. The idea of a button is that each 'activates' numerous questions and worksheets that inquire into that

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[2] Retrieved, slightly adjusted and translated from Baart 2018.

particular aspect of good care.[3] Because of the complexity of care, each button also activates other buttons.

The ultimate goal of good care is to help the care receiver find their own satisfactory relationship to the fragility of existence. What care can contribute is the alleviation of the care receiver's concerns. That is what the wide arrow at the centre is about. People who call on care, help and support, may expect the professional to do the work, but they have to do the work too – sometimes considerable work. Besides the issue that prompted them to call on care, help or support, they often have other issues they struggle with. We call them 'concerns'. In general, concerns have four aspects in common: they indicate a certain trouble, have a personal character, impose themselves with urgency and require an effort from the patient or client. Care receivers' concerns can be taken away and alleviated, but also created and aggravated by caregivers and their responses to what they perceive as the care receiver's concerns (Olthuis et al. 2014). The caregiver must come close to and seek a relationship with the care receiver in order to properly perceive their real concerns and give an adequate, fitting response.

> The overall quality criterium at the level of the care receiver is their, what we term, 'humanness'. It is not quality of life, or autonomy. With the term humanness, we enter a complex field of meanings, definitions and usages from different disciplines. Because we are interested in those aspects of humanness that can be affected by care, we deem four elaborations of the concept relevant. First, humanness is due to every person, does not have to be earned and cannot expire. Anyone who tramples on the humanness of somebody else will destroy something that we collectively find precious. Humanness is often a counterfactual concept. Second, human existence takes place in extensive networks of interdependencies and reciprocities, including relational autonomy, which implies having a voice in controlling one's own affairs and having (decisive) influence over them or at least being properly heard. Every person is part of the human family; humanness is fellow-humanness is citizenship. Third, humanness is also connected to general and deep-seated human desires, including the desire for recognition. These desires must be fulfilled in one way or another if people are to be 'human'. Customization is required in this fulfilment. Humanness in healthcare involves the demand not to add to suffering and to find the right balance between general supply and unique focus (van Heijst 2011). Humanness as an umbrella concept also introduces the idea of personal identity. Fourth, because humanness is connected to what is precious and one therefore prefers not to lose it, people are vulnerable. Vulnerability is inherent in humanness.

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[3] Worksheets, in Dutch, can be found at http://qr.presentie.nl/link.php?qrlink=1g7sj3s (accessed 11 May 2020).

> There are many types of vulnerability. You can distinguish between intrinsic and extrinsic vulnerability, and between potential and current vulnerability, but in many cases these distinctions fade away. You can also become more vulnerable through receiving care. The bottom line in all these elaborations is: do not increase or prolong suffering, do not expropriate the life of the other, and do not refuse access to health and/or social care.

The quality criteria pertaining to the level of the care receiver can be clustered into four categories according to their orientation toward the entry to, the supply of, the content of or the significance of the care offered or provided. When the entry-oriented criteria – the first category – are met, the care receiver could say: ‘I can access and stay in the appropriate care’. Good care is structurally, relationally and culturally accessible, findable and attainable. When the supply-oriented criteria – the second category – are met, the care receiver may say: ‘I rightly dare trust this care’. Good care is transparent, sound and reliable. Three issues are relevant: what does care do for me? What does care ask from me? How does care protect me, especially my privacy? When the content-oriented quality criteria – the third category – are met, the care receiver may say: ‘I fully matter to this care provision’. Good care is honourable, shared and steerable. This steerability is related to recognition: relational recognition of the unicity of the care receiver, discursive recognition of their knowledge, and political recognition of their position. When the significance-oriented quality criteria – the fourth category – are met, the care receiver could say: ‘I meaningfully benefit from this care’. Good care is appropriate – that is, helpful, tolerable, acceptable and fitting to the care receiver’s life – and beneficial – helpful in finding one’s own satisfactory relationship to the fragility of human existence. Is this care focused on allowing you to live your life in whatever modality that you can call yours?

In the Covid-19 pandemic the fragility of existence comes to the fore. How to deal with this fragility is of more concern to the care receiver than quality of life. This raises the question of proportionality, of knowing when to stop. Relational caring helps to find one’s own satisfactory relationship to the fragility of existence. Also, the concerns of the care receivers and their family become part of the equation. They turn out to be expanded and move towards more existential questions. In the IC for example, one of the main concerns may be daring to hand over oneself to the care of others, to be put to sleep not knowing whether one will wake up. Each of the four buttons ‘lights up’. It becomes clear that each of the various buttons in itself represents an area of tension. And that these different tensions influence each other.

4.2 The entry of the caregiver

The professional caregiver is envisioned in the second entry to the model, in figure 1 represented by the top row, with the white buttons.

> The overall quality criterion on the level of the caregiver is their ‘solicitude’, not their expertise, competence or ability to intervene, repair or cure. Solicitude is a relational concept: becoming involved with another person who is in need. It is also a reciprocal concept: involvement in another person’s suffering that has affected the caregiver. Solicitude includes a bandwidth of motivation: from worrying at a distance (worrying about) to feeling called on to take action (caring about). This raises an interesting dialectic: the practising of solicitude is itself also a vehicle for developing the idea of how solicitude can best be practised. Solicitude is not just an emotion, but also a will that must both become practical and be sustained. It is also an evaluative term – something or somebody else is in miserable circumstances – and it entails an element of moral imagination – refraining from doing something will lead to more misery. Solicitude is set against the background of social precarity (Baart 2020).

The quality criteria pertaining to the level of the caregiver can also be clustered into four categories according to their orientation towards the malady or the person of the care receiver, and towards the implementation of the care or the attitude of the caregiver. The malady-oriented criteria pertain to doing all necessary things properly, fairly, safely, competently, in a timely fashion, transparently et cetera (cf. Donabedian 2003; Hughes 2008; Moulin 2002). They ask whether what is happening in a specific situation is good care, given the available discipline-specific knowledge regarding the person’s malady, defect, trauma, need, damage or injury and the available remedies. Given the situation, the malady and the available remedies, what goals are we pursuing in a professional and practical manner? Good care means adequately taking care. What is assessed by these criteria is professional competence.

The person-oriented criteria pertain to arranging care attentively and relationally (Baart 2004a; Klaver 2016). They ask whether what is happening in a specific situation is good care, given the available knowledge about the suffering person’s lifeworld, life course, longing and concerns and, in that context, about the concrete meaning of this malady for this person? Are we adequately connecting with and attuning to their lifeworld, life course et cetera? Given their lifeworld, life course, longing and concerns and the significance of the malady, what goals are we pursuing for this person in an attentive and practical manner? Good care means cautiously caring for. What is assessed by these criteria is attentiveness and dedication (cf. Schaufeli 2013).

The implementation-oriented criteria pertain to faithfully adjusting and completing care. They ask questions about starting, giving and implementing care, about keeping on course, adjusting and completing care. Are we taking responsibility, even where those who should do so in fact do not? Good care is faithfully completing care. What is assessed by these criteria is responsibility.

The attitude-oriented criteria pertain to caring out of engagement. They raise the question of what form engagement should take in relation to how the client is being treated and which emotions are being shared? Is this being done in a way that both the person cared for and the caring professional benefit from it? Are professional carers emotionally involved in an appropriate, controlled and managed fashion? Are they preventing themselves from having a 'burn-out'? Self-care is part of good care. What is assessed with these criteria is engagement, being involved with the other person 'with distance' but not 'at a distance' (Stoopendaal 2008).

Good care is integrated care (Tronto 1993), that is care oriented towards both malady and person, both implementation and attitude. In the measures taken in response to the Covid-19 pandemic we see an emphasis on the malady and implementation-oriented aspects of care. However understandable this may be because of what patients are undergoing, the longer these measures last the more problematic they becomes. But we also see, among caregivers, more emphasis on person-oriented aspects of care and an increased engagement, not only in hospital care but also in nursing homes and home care. We see different ways of conducting meetings, working together, and providing 'care from-a-distance' being tested, promoted and developed. However understandable and even necessary at this moment, the question remains of how this relates to the necessity of physical nearness for good care. But we also see people and policy makers realising that the core of good care is relationality. The issue of self-care is particularly relevant in the trade-off between safety and dedication. Each of the four buttons lights up.

4.3 The entry of the care facility

The care facility is envisioned in the third entry – in figure 1 represented by the bottom row, with the black buttons.

> The overall quality criterion on the level of the care facility is 'habitability', not hospitality or safeguarding. Habitability is a relational concept. It refers to an organisation, finalised as an institution, that offers a space to live, work and entertain an identity to those who take refuge there and those who must be there because of their work. It is also a political concept: what room are we prepared to make for our guests, who are also strangers and often a kind of rivals, enemies or intruders? Is what is habitable for one perhaps excluding another? First of all, entering care entails crossing a border, going from an 'outside' to an 'inside' that has its own objective, regulations and logic. By immediately putting the emphasis on habitability when it comes to thinking about the organisation of care, the precariousness for the care receiver to enter another space and to put themselves under a different regime comes to the fore. Habitability can include bringing into a

> safe place and, in that place, preserving or sheltering. Sometimes habitability is contrasted with being uprooted.
>
> Secondly, in a habitable resort people receiving care are almost always guests. They live in someone else's world. The temporary sheltered place can easily become a 'total institution'. Erving Goffman describes the terrible 'mortification' of residents who have become embedded in a system of adaptation, gaining privileges and dodging (Goffman 1970). If care offers too much comfort and too little challenge, it can happen that care receivers give in, become dependent and ultimately lose themselves. The 'stranger' is aligned with the standard citizen and normal person, and thereby alienated from their inner world and lifeworld. Habitability is only habitability if it can control the totalising danger of care giving. Thirdly, habitability accommodates hospitality, disconnecting it from the feeling of 'being at home' that can also be accompanied by the exclusion of other people. We regard hospitality as the organisation and arrangement of an open reception of both care receivers and caregivers. Finally, habitability is also a keyword for a societal order in which potential caregivers and potential care receivers are already engaged in each other.

The quality criteria pertaining to the level of the care facility can also be clustered into four categories, according to their orientation towards purpose, system, advancement or habitat. Corresponding to these four categories, there are four materialisations or bearers of facilitating good care: the institution, the organisation as facilitator, the learning communities of practitioners and the organisation as offering a home. The normative colouring comes from the 'decent institution', finalised well. The articulation of the finality of the institution and maintaining it is a discursive achievement, the result of a deliberation of all involved in the institution. This is being fed directly, by the learning communities of practitioners, and indirectly, through the learning communities, by the organisation as facilitator and as offering a home. As opposed to similar approaches to caring organisations such as proposed by Moore and Beadle (2006), our approach is consistently conceptualised as relational. We conceptualise an organisation as a collection of practices that need to be connected. The concept of 'decent institution' is central. Organisations have an underlying goal (*telos*) and must contribute to a decent society. We conceptualise good care as solicitude. The four criteria bearers of habitability are dynamic practices that are connected. Habitability constitutes an embedding of solicitude, and solicitude makes demands on habitability.

The purpose-oriented quality criteria are oriented towards a decent institution that discursively is finalised and finalises. A care organisation must be able to find the right balance between, on the one hand, the finality or *telos* of the institution (what are health and social care ultimately about?), the political-public rules of implementation (governance) and its own actual possibilities and limitations. This means compromising but then ‘decently’ (Margalit, 1996). Finding and (for the time being) formulating its *telos* (its *raison d’être*, core business, internal goods, scope, inner destiny, tenet) is a difficult process in which three dominant practices – of the professional, the management and the board – all need to be involved. A supporting environment should also be sought.

The system-oriented quality criteria are oriented towards a facilitating organisation that organises its processes in a reticent way and provides a habitable house for its employees. Does the organisation provide room for its professionals in such a way that there is space for their knowledge and understanding, for them to search out what good care is, and learn to take responsibility and to manage themselves properly? This requires organising and managing along modest lines: simple structures, trust in craftsmanship, only rules that support, managers as ‘heat shields’ who shield professionals from incentives from above that do not help.

The advancement-oriented quality criteria are oriented towards creating learning communities that cultivate a shared quality awareness. This also implies facilitating vertically: consultation, feedback, deliberation, support, normative reflectivity, joint experiments, learning communities.

The habitat-oriented quality criteria are oriented towards offering a hospitable environment that offers a sense of being at home. Habitability implies compassion at the institutional level for both clients and staff. This translates into an organisational culture and practical, physical and organisational conditions and provisions.

During the Covid-19 pandemic, care facilities are under great pressure. The purpose of care becomes formulated in terms of safety: for patients and clients, for professionals, for society, for the country. Under the surface lie questions such as: which patients and clients, which professionals, which societies, which countries, and which not? In the name of safety, quality awareness comes under pressure or is even temporarily deactivated. Learning communities suffer from measures of social distancing and do get cancelled because acting takes precedence over reflecting. Institutional care settings take on the form of a closed bastion instead of a hospitable home, for both clients and their families as well as professionals. What kind of support do professionals receive from their organisation when they *reflectively* make decisions? How reticent and purpose-oriented are organisation and management able to stay during the crisis? How free or restricted becomes what can be aimed at? On the other hand, also the relevance and importance of a well-organised facilitation of professional caregivers come to the fore. We also see a greater focus on the issue of finality and in some contexts there is also more space for improvisation and practical wisdom. Again, each of the four buttons lights up.

4.4 The entry of society with its societal, legal, scholarly and financial frameworks of care

Society with its care paradigms is envisioned in the fourth entry to the model as represented in figure 1 by the grey plane, the background to the three rows representing the other entries. We call it the 'copper plate', as copper has the capacity to conduct very well. What counts as good care is to a large extent determined, made possible and limited by powerful forces in the background, which have an effect on relational caring but can hardly be seen by or manipulated by care receivers, carers and care organisations. The political ideal of self-reliance and participation, the paradigm shift in the way people with intellectual disabilities are perceived, from patient to citizen, and the system of financing health and social care are examples of these hidden forces. Ordinary quality systems can have little influence on these forces because such systems themselves are embedded in these frameworks. A political-ethical orientation of thinking about quality is much needed.

> This entry involves continuous and systematic thinking about whether the care provided contributes to 'the good life with and for others in just institutions' (Ricoeur 1992) 'in a decent society' (Margalit 1996). 'The good life' also implies the ability to live in a satisfactory relationship to one's own fragility. 'With and for others' entails a double recognition: I must acknowledge myself (*soi-même*), but also the others (*autrui*) who are just like me. 'In just institutions' expresses the idea that the good life takes place in an orderly society, in which institutions make living together possible, but also confine it. Justice also includes recognition. A decent society is a society in which people are not humiliated by its institutions.

For now, we confine ourselves to four categories of systemic frameworks of care. Societal and cultural conventions and hypes determine who and what is deemed worth caring for and who is fit to take care of themselves. The legal determination of rights and obligations, tasks and accountabilities determine who can claim care and who should provide this care. The scholarly and scientific paradigms determine what knowledge counts and should be applied, and what room is left for alternative modes of knowing and moral considerations. The system of financing healthcare and social welfare determines what care is available and attainable, and under what conditions.

During the Covid-19 crisis, we see the copper plate come to the fore, in the first place in the far-reaching measures issued by governments. But we also see it in the shortage of IC beds and nurses, masks and tests after decades of introducing and promoting free market and just-in-time production and delivery in healthcare. On the other hand, competition has now been suspended in favour of cooperation and mutual engagement. Patents have been cancelled in favour of open knowledge sharing. Another example is the dominance of medical thinking in the policy for controlling the Sars-CoV-2 virus and the way it has overruled the logic of care and, within the domain of medical thinking, how that of medical specialists in hospitals has overruled that of socio-medical specialists of the Municipal

Health Service. But we also see a public re-evaluation of professions such as those of nurses, care assistants and general practitioners. In deliberations with professionals, CEMQ helps to see a larger margin of manoeuvre than is often thought possible.

5 Conclusion

Although it is still too early to draw far-reaching conclusions, we believe the Care-Ethical Model of Quality (CEMQ) is indeed helpful and revealing by perceiving, organising, questioning, evaluating, promoting and giving an account of good care in healthcare and social welfare during the Covid-19 crisis as well as in post-Corona times. Its strengths are: the three pillars, its comprehensiveness and coherence, the centrality of the concept of concerns in relation to the fragility of existence, and the inclusion of the political-(care-)ethical dimension. The CEMQ model draws attention to aspects that may be temporarily suppressed, but even in times of crisis deserve much more explicit attention if we want to provide good care. The social experiment that the Covid-19 measures actually constitute, raises questions regarding the placement of quality awareness at the centre of the model. We see, on the one hand, that relying on it is mistrusted and associated with major risks. But we also see, on the other hand, that professionally loving and sensibly muddling through is promoted and practised on different levels in society. Muddling through, however, activates and requires quality awareness and we can now learn more about how to maintain and nourish it.

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