

COMMENTARY

The two cultures of health and social care might perhaps be brought together by assets

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Abstract

Arguably, there are two sides to the frailty “coin,” with only one culture dominated by deficits. Certainly, as cells age, they develop deficits as a result of the accumulation of unrepaired cellular and molecular damage; however, the factors that make people well or healthy are important in defending against deficits and building up resilience, and need to be routinely discussed with patients. I argue that all health and social care professionals should feel confident in exploring assets or more “positive aspects” of living, and this common language could even drive integration between person-centered services.

1 | INTRODUCTION

The historic “Two Cultures” speech was the first part of an influential lecture by British scientist and novelist C. P. Snow, delivered on 7 May 1959 in the Senate House, University of Cambridge. Its overriding thesis was that “the intellectual life of the whole of western society” was split into the “two cultures”—namely, the sciences and the humanities—and that this conflict was a major hindrance to solving the world’s problems.¹ So far, we have heard a lot about one “culture” to do with frailty, the culture of *deficits*. We are, however, yet to hear so much about the other co-existing culture of *assets*, and yet assets are pivotal to understanding resilience.

Can “routinized care” cope with the complexity of frail older patients? A starting point is that routinized care can, at worst, produce “a tendency for patients to become the partially depersonalized objects of task-centered routines.”² Calculation of the electronic frailty index (eFI) might indeed be viewed by its critics as merely facilitating routinized care, but this key innovation has undoubtedly led to an effective, popularly adopted way to identify those individuals at risk of frailty. However, it is very telling that collecting quantitative information about deficits is only possible because data about deficits are routinely collected *anyway*, and so a new derivation of information about risk of frailty through deficits is not viewed as especially resource intensive.

The eFI tool was never intended to be used in isolation anyway, or to reduce complexity unjustifiably. Rockwood himself identified that “the actions that might arise... require assessments and care plans. How best to translate these skills into primary care will be a challenge requiring further developments, including in community/interface geriatrics.”³ A holistic review is clearly a necessary first step, but what happens next is equally important.

That next part involves personalized care and support planning, envisioned as a process occurring between equals, whereby people with health and care needs, along with their family and/or care partners, work together with care practitioners to discuss what is important to them, setting goals to live well and stay well.⁴ These care and support plans could prominently feature “health assets.” Identifying only deficits does *not* explain why some frail older adults have a good outcome following hospital admission. Two people with exactly the same eFI could have very different disease trajectories. Therapists tend to be more interested in assets, but physicians tend to be more interested in deficits. Somehow the two cultures need to integrate.

Health assets are protective factors that support health and well-being, rather than risk factors, which are associated with disease.⁵ Health assets have been shown to play an important role in mitigating the effects of frailty for older adults in the community setting. Further theoretical and pragmatic challenges exist as to whether assets can be really and realistically quantified, whether a decline in

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TABLE 1 A proposed schema of “MONTAGE-7”: An *example* of a suggested assets-based set of short questions to discuss with persons who are frail

M. Are you on four medications or fewer?
O. Do you feel optimistic in moving around easily?
N. Do you have a good number of relationships with friends and family?
T. Do you make use of any technology to improve the quality of your life?
A. Are you able to carry out daily activities, such as going to the toilet or taking a shower, without help?
G. If you need to, are you able to see the same GP team in a timely way?
E. Do you enjoy your mealtimes?

assets could ever be modeled mathematically, and whether a model of decline in assets would ever be able to predict phenomena such as perioperative morbidity or mortality.

Take the example of PRISMA-7,⁶ a well-known brief tool with a series of seven questions used to identify levels of frailty.⁷ The emphasis here is yet again unashamedly on deficits. It might be equally useful to monitor the implementation of a more “positive approach.” Why not, then, use a simple bedside clinical tool, such as MONTAGE-7, at the same time (see Table 1)? (It is important to note that I am not promoting a *fight* between two different assessment tools, but merely suggesting an *example* of how to ask about different dimensions in regards to living better with frailty.)

The evidence base for asking about these domains of health and well-being in the frailty literature is substantial. But, as Table 1 illustrates, specifying a cutoff for assets might be fraught with difficulties; for example, what is a reasonable size and quality of a social network?

2 | MONTAGE-7: MEASUREMENT OF ASSETS

M is for “medication review.” A recent review of 110 articles concluded that the most commonly reported definition of polypharmacy was the numerical definition of five or more medications daily.⁸ A fewer number of effective medications, but where the benefits outweigh the risks, comprises an important asset.

O is for “optimism.” Whether patients feel confident in walking, rather than being subsumed by a fear of falling, could be very instructive.

N is for “networks.” Social frailty is, thus far, a relatively under-explored concept, but questions have now been proposed to inquire about social frailty as a protective effect.

T is for “technology.” An increased awareness of, interest in, and use of assistive technology presents substantial opportunities for many citizens to be meaningful participants in society.

A is for “activity.” It is known that physical activity has a positive influence: on functional outcomes and muscle strength; on psychological factors, such as memory and mood; and on activities of daily living.

G is for “GP team.” Community assets are the positive capabilities within communities that can be used to promote health.⁹ Continuity of care, especially of general practice, has been described as having a number of diverse benefits for health and well-being.¹⁰

E is for “eating (and drinking) well.” There is certainly increasing awareness of the protective effect of nutrition and hydration against decline, and the quality of mealtime environments adds an important dimension to well-being.

3 | CONCLUSION

Compared to counting deficits, the measurement of assets is much more subjective and difficult to capture. It is hard to know what the cut-off might be for the size and quality of a reasonable social network, compared to, for example, an acceptable creatinine level in kidney function. A questionnaire to probe predefined assets might still miss what is important or “of worth” to any one individual. The danger is that we “force” a model of positive living; for example, a person might even feel that a number of close friends is not relevant to his well-being.

Are “assets” merely the opposite of deficits? Love is not the exact opposite of hatred, and so forth. In a similar vein, the World Health Organization principle that “health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity”¹¹ is indeed profound. It means that people with illnesses can be considered “healthy” even in the presence of illnesses.¹² Similarly, assets may need to be flexibly defined to include positive personal experiences of living with conditions. The “choice” of assets needs careful consideration. Over time, we may need to introduce a certain degree of flexibility into the evaluation of assets to better capture the inner biological, clinical, and social reserves of the individual, and to make this positive assessment different from those currently used without simply converting negative into positive features.

It is possible that discussion of some of these assets (eg, technology) is not as important or “serious” as discussion of some deficits (eg, organ failure); however, the potential rewards for this collective endeavor might be huge—beyond “screening tests.” If a decline in assets could be modeled mathematically, the model would need to be interrogated as to whether assets are quantifiable in a meaningful way, and whether actual interventions to arrest a decline in assets exist to mitigate against the accumulation of deficits. At the first instance, a desirable position is where all health and social care professionals feel confident in asking about assets. That will help to promote the health and well-being of individuals living with frailty, and could be a major driver towards integrated person-centered services.

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CONFLICT OF INTEREST

None.

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REFERENCES

1. Snow CP. *The Two Cultures*. Cambridge, UK: Cambridge University Press; 2001.
2. Towell D. *Understanding Psychiatric Nursing: A Sociological Study of Modern Psychiatric Nursing Practice*. London, UK: Royal College of Nursing; 1975.
3. Rockwood K. Screening for grades of frailty using electronic health records: where do we go from here? *Age Ageing*. 2016;45:328-329.
4. NHS England, Person Centred Care/Coalition for Collaborative Care/Medical Directorate. *Personalised Care & Support Planning Handbook: Core Information*; 2016. <https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf>. Accessed August 29, 2018.
5. Gregorevic K, Hubbard RE, Peel NM, Lim WK. Validation of the health assets index in the Australian inpatient setting: a multi-centre prospective cohort protocol study. *BMJ Open*. 2018;8:e021135.
6. Hébert R, Durand PJ, Dubuc N, Tourigny A; PRISMA Group. Frail elderly patients. New model for integrated service delivery. *Can Fam Physician*. 2003;49:992-997.
7. Raiche M, Hébert R, Dubois MF. PRISMA-7: a case-finding tool to identify older adults with moderate to severe disabilities. *Arch Gerontol Geriatr*. 2008;47:9-18.
8. Masnoon N, Shakib S, Kalisch-Ellett L, Caughey GE. What is polypharmacy? A systematic review of definitions. *BMC Geriatr*. 2017;17:230.
9. Charles A, Ham C, Baird B, Alderwick H, Bennett L. Reimagining community services: Making the most of our assets; 2018. https://www.kingsfund.org.uk/sites/default/files/2018-01/Reimagining_community_services_summary_0.pdf. Accessed August 29, 2018.
10. Pereira Gray DJ, Sidaway-Lee K, White E, et al. Continuity of care with doctors: a matter of life and death? A systematic review of continuity of care and mortality. *BMJ Open*. 2018;8:e021161.
11. World Health Organization. *Constitution of WHO: Principles*. <http://www.who.int/about/mission/en/>. Accessed August 29, 2018.
12. Sartorius N. The meanings of health and its promotion. *Croat Med J*. 2006;47:662-664.

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