

# Movement competence leads to an increased quality of life

By Stefan Knobel

The health care system in Europe is based on a paradigm for treatment which came from a perspective of pathophysiology: The goal is to 'fight' diseases and their causes. This view has created a lot of good things: The life expectancy has risen, many illnesses which were life threatening 50 years ago can be treated today with a high rate of success. The increased expectancy of life and societal developments in Europe lead to problems and challenges which cannot be solved with the findings of pathophysiology. The attempt to guarantee or even improve the quality of care through quality management systems leads usually to impressive mission statements, treatment standards, and care records – but much less to real improvements of the actual situation and quality of life of the person cared for and the health care professionals.

New ideas and approaches are needed. The author suggests based on a training paradigm to put the movement competence of the people involved as the center of the focus. Movement competence is a very basic and broad factor affecting the quality of life of a person.

## The basic problem

The health care system all over Europe and especially the Geriatric care will see big challenges in the next years. There are many well known reasons: the increased life expectancy, the increase of the number of people with dementia etc., increased migration and emigration, the constantly increasing cost of the health care system, a rising lack of able employees etc.

It is beyond dispute that given all this factors it is difficult to keep or even improve the quality of the health care system. There is a lot of discussion how care providers or society as a whole should react to these challenges. In many countries there is one health care reform after another. But rarely concrete measures are taken which benefit the people who are really affected. This is true for the geriatric care and home care in Western and probably also in Eastern Europe.

For the future not just reforms are needed but also new innovative paths which have an effect on the health and quality of life of people who work in care as well as people who need care.

## The quality trap

In Western Europe the welfare and health care system have been turned upside down in the last twenty years. This was done with management systems and management tools which were developed for the industrial production process. A number of quality management systems, standards, goal oriented leadership structures, etc. were introduced. All these with the aim to improve the quality of the services.

The implementation of these management tools takes a lot of time and is expensive. So of course there is the hope that the desired effect will be actualized. Many executives believe that the introduction of a quality management system or a quality development system completely ensures and improves the quality of an institution.

On one hand it is undisputed that such quality systems and management tools have an influence on the quality of the services in an organization.

But as studies have shown these measures can directly or indirectly only influence 30 to 50 % of the actual quality. 50 to 70 % of the quality of the work with and for human beings are a result of the competence and the sense of responsibility of the particular employee.

In other words: The blind trust in management tools holds big dangers. At a certain point quality measures lead to the always more accurate collection of data, the constantly refined standardization of procedures, the more and more detailed documentation to the opposite - the quality decreases:

- At some point the effort for documentation becomes so immense that the employees spend so much time writing that the actual work with the client becomes secondary.
- At a certain point one can see that the most competent employees (department heads and specialist with the highest qualification) spend most of their time at work behind the computer. The actual work with and for the client is delegated to assistants.
- At a certain point standards and rules encourage the employees to feel less responsible. The people follow the rules and no longer the requirements of the particular situation which is often not standardized.

It is possible that in Eastern Europe you have not encountered this quality trap. In Western Europe you can meet the results of this Q-madness daily. Here is an example:

- In Switzerland the oversight authority sporadically checks the work of the nursing homes. For that the auditor visits the institution. And how does the auditor go about it? He asks for the documentation of the cases, the standards and guidelines of the institution. He studies these papers thoroughly and then writes a report about the quality of the work done by this institution. Of course the idea is pretty naive that all these papers can give you information about the quality of the care in a particular institution. This can be compared to a carpenter who would like to prove that he is able to build a good kitchen by presenting blue prints on a scale 1 to 10. No house builder would trust the blue print. One would want to see a finished kitchen by the carpenter and check how the handling of the drawers and cabinets feel. Documents about care can in the best case inform you about how well the nursing staff can write about its work. Standards and quality manuals show the intention of an institution. The actual effect of the work in the sense of subjectively experienced quality of life cannot be derived from it.

In my opinion it is very dangerous and irresponsible if care personnel spend a disproportional amount of time documenting the care: And doing this for the main reason to please funding and oversight authorities. The primary mission of a documentation can only be one function: The improvement of the quality of life of the people cared for. Anything else is for ethical and economical reasons not justifiable.

Also dangerous is the unquestioned believe that standardization per se improves the quality of work with human beings. "Do it as simple as possible – but please not simpler!" This is a quote from Albert Einstein which is summing up the biggest challenge in care work. Care work involves interaction among people. The attempt to standardize this interaction often means a dangerous simplification and is therefore counterproductive. Human beings do not behave like trivial machines which show on a certain input a predictable reaction. The opposite is true: the reaction of human beings is not predictable. Therefore it is the wrong path to provide people in care with a universal formula.

## From the treatment to the training paradigm

After so much criticism let us turn to alternatives.

If we remember that quality and management tools only affect 30 to 50 % of the quality action we have to ask how the remaining 50 to 70 % can be influenced.

### From a treatment paradigm...

The welfare and health care systems are still based on a treatment paradigm. The treatment paradigm can be seen in the following way: When old or handicapped people experience a limitation in their ability to move relatives and professional staff respond in a certain manner. Often they use a technical devise (weel chair, crane, etc.) or they step in and take over. This kind of support

has an effect: On the part of the patient the serious consequences are a loss of independency, an increased sense of dependency and eventually incapacitation.

On the part of the care giving relative this approach often leads to physical and mental overload. As a consequence the well intended support leads to an increase of the need for care and support and to a overload for the care giver.

The results of this are known. Substantive studies show that about 70 % of the care giving relatives are physically overloaded (pain in the small of the back and shoulders); about 80 % are overloaded psychologically.

Let me put it another way: As long as there is a danger that the care giving people ruin their own health through their task and the people cared for make no progress or even regress because they are handled like an object: there is something fundamentally wrong.

### ...to a training paradigm

The training paradigm as it is represented by Kinaesthetics is based on the latest knowledge on lifelong learning and health progress. In this the actual encouragement of moving competence of all people involved plays an important part.

What do I mean by that? I would like to illustrate this with an example:

Getting up from a chair.

- Help a colleague to get up from a chair by lifting. Act like you would want to bring an inanimate object into that position.
- Help your colleague to get up from the chair by supporting his or her movement. Do this by waiting for a reaction after each little support and by following the movement of the colleague.

You noticed – I can help a person to get up in tow different ways

- I can erect the person like an object. If the person complies he or she really stands in the end: But cannot comprehend the process of getting up. The person has learned nothing how to get in an upright position on his own. (treatment paradigm)
- I can guide the person in a way that he or she can comprehend in the body what happens; the person can comprehend the possible movements and the scope of movements. When I am able to do it like this every little assistance turns into a training process.

You know your are dealing with the training paradigm when

- the care giver is able to perform each activity in a way that the other person can comprehend the action in his or her body.
- the care giver and the relatives are able to adapt the assistance every time to the current condition of the other person.
- instead of treatment guidelines (it has to be done like this) there are learning and development goals defined.
- the assistance leads to more alternatives for action not less.

And this leads us to the 50 to 70 % of the quality in the work with people which are about competence and self-responsibility of each care giver.

Only if the care professionals (and also the care giving relatives) are assisting the care receivers in a way that the person still feels operative can the he or she improve the moving competence. That means that the care givers have to be able to act viably. By that I mean they have to do the right thing in the right moment. No Standard, no rule, no care plan can replace the self-responsibility. This means: I look myself for the answers to the question that are posed by the interaction.

In the future if the care giving is based on a training paradigm it won't be any longer understood as a sacrificing assistance but as a an act of teaching and learning. The institutions and outpatient

organizations become training organizations for older people, handicapped people, sick people, but also for relatives and for professionals and for the management.

## Body moving skill as a key factor

For 20 years the European Kinaesthetics Association is engaged in a process of field research in the German speaking part of Europe. In that the meaning of moving competence for health and lifelong learning are studied. The aim is to bring the findings of behavioral cybernetics and modern biology to a level of daily activities of the body. The question is how movement is experienced subjectively and how such experiences can be described systematically.

I would like to mention some aspects which are relevant to this debate. Some may be surprising:

- We humans cannot stand tall – what we are able to do is not fall over. The standing tall of an object (for example a lamp) and the standing tall of a person is a fundamental difference. We are busy every second of our lives to control our weight vis-a-vis gravity. This happens in a constant circular error correction process. The quality of my ability to do this has an important impact on all physiological processes.
- Our ability to perform daily activities is not based on a fixed script stored in our brain – also the everyday activities are constantly shaped newly while we are doing them and are subject to a cybernetic error correction process. In other words the control of these activities is not in our heads; the control is based on countless cycles between the relevant factors which interact: The activity, the perception, the error calculation, and the error correction. This is performed by the central nervous system. Only the interaction of these factors make up the control.
- The assistance for another person will lead to a bigger radius of operation and competence if the assisting person is able to adapt and vary his (or her) movement in the process of doing it (when the person is able to act viably).

## How can the moving competence be improved?

Moving competence cannot be taught through the usual professional teaching methods. A cognitive understanding of human movement is not the key but the individual experience of ones own movement. The experience of the last 20 years have shown that the learning processes are productive if the own experience is analyzed and reflected. Instruments or perspectives are needed which help a person to systematically process and understand his or her experience. A differentiated understanding of one's own movement arises from the opportunity to become an observer of oneself – to take an inner perspective. This leads to the understanding of the movement of other people.

In order for you to have an idea of what I am talking about we will do together a short learning sequence like they happen in Kinaesthetics courses.

### *Time, Space, and Effort*

Let us take again the activity 'to get up from a chair'.

- Once again help your colleague to get up from a chair. Describe to each other the quality of the support experienced.
- Now we get to know the conceptual perspective about our experience: Also in a perspective of experience movement always consists of time / space / effort  
You get up from the chair and observe the change if you alter one of the three elements (time / space / effort)

- Now you vary time, space and effort in the interaction with your colleague. You help her or him to get up from a chair by varying time, space and effort. While doing this you observe yourself and the colleague observes himself. After you discuss the effect of the change on the assisting person and on the assisted person.
- Now we apply time / space / effort in a playful way: while walking. Afterwards you describe your colleague which interesting differences you have encountered.
- Finally help your colleague once again to get up from the chair. What has changed? Have you gained new perspectives to describe your own action and your experience around 'getting up from a chair'?

## Body moving skills create quality of life

At the beginning I claimed that the future challenges of the health care system require new approaches and innovative ideas. You have experienced an approach in that direction – the approach of 'moving competence'.

In the German speaking areas in the last 15 years this new approach has led to new perspectives particularly in the care for older people. Slowly the image of the task of caring for older people is changing. Care givers discover their profession in a new way by helping people to develop their moving competence. Care giving becomes more and more a teaching profession.

It can be proven that by developing the moving competence of the care giving professionals and the care giving relatives the dependency of the assisted people decreases. Of course certain disabilities and certain limitations because of an illness or a disability remain. But the people and their surroundings can learn to play better with a 'bad' hand.

That this approach is effective not only in countries with a sophisticated health care system was demonstrated in the project 'Kinaesthetics Alba Iulia' already after the pilot phase. Based on my experiences in Rumania it is my opinion that the progress towards a training paradigm can go even faster in such countries. The obvious lack in material resources is more than replaced by an openness towards innovative ideas by the management and the care giving professionals. This openness and creativity is unfortunately often lacking in the affluent societies in the German speaking world.

We all experience that the human culture is turned on its head by technical advances. Many of these developments make life simpler. Many of these developments contain danger.

High tech needs a counter part: and the counter part of high tech is high touch. Human beings who interact for alternating benefit – and who do this with an excellent moving competence.

About the author:

Stefan Knobel  
Nordring 20  
CH 8854 Siebnen  
stefan.knobel@kinaesthetics.net

Professional background:

Registered nurse / Master in nursing / Kinaesthetics trainer EKA / training specialist

Current projects:

Head Respool Curriculum development and research for the European Kinaesthetics Association – [www.kinaesthetics.net](http://www.kinaesthetics.net).

President of the foundation 'stiftung lebensqualität' – [www.stiftunglq.com](http://www.stiftunglq.com).

Managing and developing a range of projects related to health development / quality of life / moving competence