GRESHAM COLLEGE

13TH MAY 2020

What Medicine Can Learn from Restaurants About Care

Professor Roger Kneebone with Jozef Youssef

Medical care often frames patients as the passive 'recipients' of expert professional knowledge and skill. This lecture explores what comes into view if we reframe clinical treatment as hospitality, and patients as guests. Drawing on collaborations with leading restaurants, their chefs and front-of-house staff, we explore parallels between the worlds of fine dining and medical care. In a hospital, as in a restaurant, what happens out of sight (in the operating theatre or the kitchen) must be matched by sensitive care at the bedside, in the clinic or at the table.

Notes from a clinician: Roger Kneebone

Introduction

I'm delivering this lecture remotely, during the coronavirus pandemic which is affecting people everywhere. Later in the lecture I'll invite Jozef Youssef, founder and Chef Patron of *Kitchen Theory*, to join me in a conversation to explore points of connection between our different yet complementary experiences. I'm a clinician, with experience in surgery, general practice and academia. Jozef has a longstanding interest in designing multisensory and and immersive dining experiences for the guests at his restaurant.

First, though, I'll set the scene. This series of Gresham lectures has focused on medicine as performance. I started by proposing that clinical care takes place at a point of intersection between scientific knowledge, procedural skills and performance - and that it is the performance that we are most aware of as patients. We often take for granted the knowledge and skill of the professionals who treat us - usually with good reason - but we experience their performance directly. In order to explore the idea of performance as a key element of clinical practice, I've worked with a large number of expert professionals from domains within and outside medicine. In previous lectures in this series I have shared the platform with a magician, a puppeteer, a robotic surgeon, a classical music improviser and pioneers of early keyhole surgery. In these lectures we've explored themes such as close-up performance with a small audience; team working under high-stakes conditions; the changing role of touch; improvisation as a characteristic of mastery; and the intersection of people with technology.

Many unexpected insights have come from areas of expert performance in domains apparently unrelated to medicine. One of these is fine dining. For me this started several years ago with a collaboration with the team from *The Fat Duck*, a three Michelin-starred restaurant established by Heston Blumenthal. I was initially put in touch with the restaurant team by Professor Barry Smith, Director of the Institute of Philosophy at the School of Advanced Study in London. He's also founding director of the Centre for the Study of the Senses, where his research into multisensory perception focuses on taste, smell and flavour.

In 2014 I had the opportunity to invite a team from *The Fat Duck* to Imperial College London, the university where I work. There my colleagues and I presented a simulation of surgical encounter, starting with the initial assessment of a patient with abdominal pain and progressing to an exploratory procedure in the operating theatre. We invited members of the restaurant team to take part in the surgical simulation (including being first assistant in the operative procedure itself), then discussed possible areas of overlap between these apparently unrelated forms of expert practice. From the outset it became clear that there were similarities between our areas of work

that had not occurred to any of us before. These included working in a close-knit professional team, a commitment to excellence and an awareness of the impact of the work on those it was designed for (whether patients or diners).

My Imperial colleagues and I then visited *The Fat Duck* in Bray, outside London. There we observed the workings of the kitchen, where - as we expected - we found striking parallels with the world of surgery, and especially with the operating theatre. Highly skilled professionals work under pressure to prepare dishes with great precision and consistency, handling sharp tools and coordinating their movements in a restricted space within a clear yet supportive and mutually respectful hierarchical structure. The sense of teamworking, shared goals and a dedication to the highest standards resonated strongly with surgical practice.

Even more striking, however, were resonances between pre and postoperative clinical care and the restaurant's front-of-house staff. Talking to the Fat Duck team (led by Dimitri Bellos) it became clear that each diner's experience was placed at centre stage, and the members of the restaurant team gave their undivided attention to how their guests were responding. This led to a project we called 'Let me take care of you', funded by the Arts & Humanities Research Council. This project's starting point was that everyone has experienced a meal in a restaurant and a visit to the doctor or hospital. Its aim was to compare the experience of care in clinical and restaurant settings, inviting participants to participate in simulations of both and discuss their impressions with professionals and with one another. This led to numerous suggestions for cross-fertilisation of ideas between the two arenas of care.

In 2017 I was introduced to Jozef Youssef. Soon after we met, he alerted me to the culinary concept of 'mise-en-place', the meticulous and systematic organisation of workplace, ingredients and processes on which every kitchen depends. I learned that this principle is part of every culinary student's training from the very beginning. Working with a nursing scientist from Bern in Switzerland (Claudia Schlegel), we explored how the concept of mise-en-place is evident throughout the worlds of medicine and science too, even though the term itself may be unfamiliar to many clinicians.

At an exploratory event at *Kitchen Theory*, Jozef demonstrated this principle in a restaurant setting before our team (including a domiciliary wound care nurse from Switzerland and a molecular biologist from Imperial College London) presented examples and drew parallels with their own experiences. After further exploration we recognised that the principle of mise en place played a central role in many different kinds of expert practice, from wood carving to lute-making and from operative surgery to laboratory science.

This provided the starting point for an ongoing collaboration which explores how underlying principles of care can be explored and transferred between apparently unrelated domains of expert practice. When medicine and dining are both viewed as instances of performance, unexpected similarities come into view.

Since then, Jozef Youssef and I have developed a number of collaborative explorations, looking at the wider picture of care in our respective settings and asking how each perspective might inform and illuminate the other. These will form the basis of the conversation in the latter part of this lecture.

Elements of Care

Resonances with previous Gresham lectures in this series are clear. The concept of medicine as performance highlights aspects of the clinical experience and of clinician-patient relationships which are often overlooked. These include the need for clinicians to shift their attentional focus from themselves to the patients they treat; the need to move imperceptibly in out of someone's personal space; and the ability to 'read' patients or diners, responding to them as guests in a system of care. For example, awareness of personal space is crucial in both settings.

This term was popularised by Edward Hall in his 1969 book *The Hidden Dimension,* where he outlined the notion of what came to be termed 'proxemics'. Hall was inspired by Heini Hediger, a pioneering 'zoo biologist'. Hediger recognised that animals function within small bubbles of territory which they take with them when they move. His ideas revolutionised zoo design, inviting professional and publics to think of animals as 'owners of territorial property' rather than captives. Hediger's observations of animal behaviour shaped his ideas about interaction distances between members of the same or different species. He described different degrees of distance - flight distance, critical distance, personal distance and social distance.

Hall then applied this to people, focusing especially on personal and social distance. He elaborated categories - which he termed 'intimate', 'personal', 'social' and 'public' distance - each with an exclusion zone, an area where people don't want others to be. The extent of this zone varies with the context and it can be reconfigured according to the circumstances. Anyone who has been jostled in a crowd instinctively understands this - and the current need for social distancing to reduce the risk from coronavirus infection is throwing this into sharper focus.

In the decades since Hall's book was published, the neuroscientist Michael Graziano has shown a neurophysiological basis for these ideas. He has identified multisensory neurones for tracking the location of objects, even in the dark. He has demonstrated how an invisible 'second skin' strongly emphasises nearby space while weakly representing far space. Every body part has its own bubble, with its own 'radar system' for recognising where other people and inanimate objects may be.

This has implications for professionals who work in close proximity with others. Entering someone's personal space is like going into their house. When you become a guest in someone's domain you must be respectful and conform to their ways of doing things. You wait to be invited rather than barging in. You respect how that person expects you to behave, and you fit in with how things are done on their territory. You take off your overcoat and perhaps your shoes. It's the same with touching strangers' bodies. You have to become comfortable with being with people at close quarters before they will be comfortable with you. You have to 'read' people's signals of personal space.

This is easier to recognise when it goes wrong than when it goes right. It's especially evident in a restaurant setting. A successful waiter will be invisible. The more expert the service, the less (as a diner) you notice it. But inept service is hard to miss. A waiter who looms over you, encroaching on your personal space without your agreement, creates a lasting impression of discomfort and unease. Something similar happens with an inexpert clinician. Their insecurity transmits itself to you. An expert does the opposite, effortlessly passing through the body's defences.

Expert front-of-house staff are consummate artists here. They can enter and leave personal space imperceptibly, appearing and disappearing with grace and elegance. They bypass Graziano's radar, slipping in under the exclusion zone. Clinicians have to do something similar. They have to create a sense of ease and confidence with each patient they engage with. Like waiters, they have to remain aware of differences in height and posture, and the anxieties associated with a visit to the doctor. It is all too easy for someone standing to generate a sense of discomfort in someone else who is sitting (at a restaurant table, say) or lying (in a hospital bed).

An expert performance will take these elements into account, ensuring that the experience of each person - whether a patient, an audience member or a restaurant guest - remains prime. Such an experience cannot be taken for granted. High levels of knowledge and skill 'behind the scenes' are indispensable, of course - whether in the kitchen, the practice room or the operating theatre. But if we (whether as patients or diners) are to feel valued, cherished and cared for by those whose profession is to look after us, we must experience care in its deepest sense. The role of an expert performer is to 'curate' each person's experience and ensure it is as good as it can possibly be. That's what this lecture will explore.

Notes from a chef: Jozef Youssef

As a chef it is always intriguing to see how food and the culinary arts are used in scientific, artistic and conceptual collaborations. In most cases the emphasis is on the food itself rather than the experience of those producing and consuming it. Working with Professor Kneebone on exploring the parallels between medicine and gastronomy is fascinating, as it allows us to reflect on the processes, practical elements and experiences in both fields. There are obvious examples between the kitchen in service and an operating theatre; the importance of hygiene, safety, hierarchy, non-verbal communication, timing, teamwork and so on. What was less obvious to me initially, was the similarities between what the terms care and hospitality represent in both fields. As a chef my profession falls under an industry termed 'hospitality', and to see that this was in some manner applicable to the world of medicine was eye opening. But this is probably less of a surprise when you consider the origin of the term; the word hospitality derives from the Latin *hospes*; meaning "host", "guest", or "stranger". By metonymy the Latin word 'Hospital' means a guest-chamber, guest's lodging, an inn, thus hospes/hostis is the root for the English words host, hospitality, hospice, hostel and hotel.

Good hospitality in fine dining is an art. A great meal, in the world's finest of restaurants in a picturesque setting, can all be destroyed by poor service. So service seems to me like a good place to start when designing such experiences. Based on research with Oxford University experimental psychologist Professor Charles Spence, my team at Kitchen Theory and I take a 'user centred design' approach towards developing our dining experiences. We start by asking; what is the guest's journey with us and how do we want them to feel throughout? We break this down into what we call a 'run of show', starting from when the guest makes a reservation, through to arrival/welcoming, the dinning/food experience itself, and of course the departure/farewell. At each point we look at how we can add value to their experience, mostly by enriching the sensory environment.

Will the aroma of lavender calm and relax our guests upon arrival? How about the music in the background? And let's not forget a glass of good champagne to ease them into the experience! After doing this for many years, one of the most powerful elements we have found in shaping our guest's experience is in the language we use, both when engaging with the guests as well as in how we describe our dishes. We found that simply memorising each guest's name and addressing them by their name, had the effect that they learn our names too, and a much closer relationship is developed. For our team, establishing that relationship is the essence of good hosting and giving our guests a remarkable experience. It would seem this may also be true in the world of medicine!

Conclusion

This lecture, like the others in this Gresham series, has explored an underlying principle that links two apparently unconnected areas of expert practice - in this case *care*, as expressed within medicine and fine dining. We have found that it is easy to focus at first on the differences between domains of practice. However, by shifting our focal point to the lived experience of whoever such work is *for,* we have shed unexpected light and uncovered intriguing parallels.

We believe that such collaborations can deepen each participant's understanding of their own area of expertise as well as gaining insights into the worlds of others. Further Gresham Lectures in this series will continue to develop this concept and explore its potential impact on experts and learners alike.

References

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Acknowledgements

Professor Barry Smith, Institute of Philosophy, University of London
Jonny Lake, Dimitri Bellos and the staff of *The Fat Duck* restaurant
Dr Claudia Schlegel and colleagues from the Bern Institute
Royal College of Music - Imperial Centre for Performance Science
Dr Sharon Weldon and Dr Terhi Korkiakangas
Arts & Humanities Research Council
Economic and Social Science Research Council