Dear Mr Hunt

The future of NHS Primary Care: the sickening of its human base

I am a long-serving NHS inner London GP. For many years I have been witness, party and victim to the complex and inadvertent loss of our best relationship-centred activities in healthcare.

As I approach retirement I feel much sadness about the future of my cherished vocation. Beyond that I have a fear of the kind of engagements I will have with healthcarers when my decline makes me vulnerable.

On the positive side I know of your serious concerns and awareness about these issues. I am reassured that you are continuing as Secretary of State in the new government. I am wanting to believe that personal continuity of care in the NHS is being taken more seriously in government, even extending to Cabinet appointments!

I have extended some of these thoughts in an attached article. It is illustrated by an account of a conversation I recently had with an NHS manager. Obviously I would like you to read it.

Thank you for your time, and your evidently good influences in this ceaselessly difficult but essential work.

Yours sincerely

Dr David Zigmond (GP)

Burgeoning need: collapsing staff morale – the management conundrums of the NHS

David Zigmond

Collapsing staff morale within NHS pastoral healthcare is possibly the largest threat to the integrity, even survival, of our service. There is a tragic irony: much of this is due to the reforms that try to assure efficiency. How has this happened? What is the way out?

Recently both the Health Secretary and Prime Minister have stressed the importance of access to Primary Care and how the government will improve this by recruiting more GPs. This initiative sounds initially reassuring but is stymied at the outset – by wider problems that have been avoided in publicly targeted statements: we have a massive and growing problem with morale throughout NHS pastoral healthcare.

The evidence for this is compelling: poor staff recruitment and retention, rates of sickness, breakdown, burnout and early retirement. Simply 'training and recruiting more GPs' may merely lead to an unstable bank and then further loss of damaged and dispirited professionals: another tranche of expensive waste. To avoid this we need to better understand our leaching professional malaise. This personal account and dialogue, from a veteran frontline NHS doctor, serves also as a wider explanation.

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In the last twenty years I have seen my profession lose its vocational spirit and identity: heart and soul; art, intellect and wit. I do not believe these losses are primarily rooted in pay or funding, or even the volume of work, though clearly these are most easily cited by an unhappy workforce. Thirty years ago doctors usually worked longer hours and the remuneration was often less. What has got lost is more subtle: it is about personal identification and gratification: the *relationships* we have with our patients and colleagues: our work as human, rather than technical, experience. The problem is the nature of our work, rather than its volume.

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Thirty years ago I was a young GP working in the same small inner London practice I have managed – with great difficulty – to conserve. In those earlier years GPs had relatively low interprofessional status, often long and unremunerated working hours, yet much better motivation and morale. Doctors then mostly liked their work through long, stable careers, and then were reluctant to retire. Such personal–professional gratification reflected a culture that both allowed for, and gently encouraged, investment in

relationships – both between doctors and patients, and within colleagueial networks. These relationships developed and functioned relatively 'naturally' and informally, with a minimal amount of governmental or managerial control. Healthcare relationships were thus much like a massive extended family.

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But families are very variable: certainly not all function well or even legally. And even in the 'best' families there is sometimes dissonance and unhappiness. They might also not be the best human groupings for efficiency or production. So surely, some thought, with a modern health service, can we not get better and more homogenous outcomes by emulating manufacturing industries, competitive commerce or even military hierarchies? To do this we needed to transform the culture: from family to factory.

This is what we have done in the last two decades.

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This very deliberate cultural transformation has been propelled along two axes: the *corrective* or *forensic*, and the *industrial.* These two are sometimes distinct, sometimes compounded. What are they?

The *corrective* and *forensic* imperatives are varieties of quality control. Their function is to identify, remedy or eliminate substandard, hazardous or corrupt practice (colloquially: 'duffers', 'slackers' or 'rotters' = DSRs).

The *industrial* influences are those attempting to streamline and standardise activities so that they may be reliably managed and economically proceduralised. These are essential to mass production.

The implementation of these measures has taken enormous human and economic resources. The results are very mixed.

First, the positives. The individual DSR prevalence is probably much lower: evidently and substantially flawed practitioners are nettled much sooner. Critical diagnoses and treatments are delivered more speedily. There is more apparent transparency and accountability.

All good, surely? Yes, but only up a point. Beyond that, more of something 'good' can be worse. This is often due to an 'undertow': powerful, countervailant forces not readily visible, yet decisive.

It is this undertow that increasingly subtracts from our conventional current, what we intend. Such undertows account for many paradoxes, and then the perverse and unintended consequences in our highly managed system. We can find many examples. There is a general tendency: that our increasingly dense and numerous appraisals, inspections, compulsory trainings, care pathways and performance indicators might reform or motivate some DSRs but they also tire, deskill and demotivate many more who do not need such structure or guidance. So it is that in our efforts to guard against worst practice we inadvertently devitalise, even kill off, our best spirit and practice. The net losses are seriously impairing our healthcare.

Such losses are usually due to programmes of displacements. In the healthcare world before ratcheted management it was largely left to professionals and their peers to self-motivate. Certainly there were DSRs, but they were individual anomalies in largely sensible and benign institutions. Mid Staffs and its like show us how we have replaced this significant problem with something far more egregious: we now have entire institutions perverting care and concealing calumnies in order to favour their survival-slot in the larger Darwinian system. It is less likely to be the individual now that is a DSR: it is the bluffing but cowering institution itself. The individual has become a compliant or collusive cog: when coaxed to speak candidly these cogged individuals describe depersonalised, deskilled, dispirited obedience to strict, formulaic authority. Descriptions of affecting attachments or creative identifications in their work milieu – its heart and humanity – are remarkable by their absence.

Yet our initiatives to industrialise healthcare have at times had extraordinary success. The elimination of Poliomyelitis was achieved by millions of identical procedures that needed almost no attention to personal meaning, history or context. This kind of massive achievement is due almost entirely to brilliant technology and tight management.

But elsewhere it is those jettisoned personal factors that provide most of the motivation, spirit and comfort essential to palliation and healing – not just to those who are sick, but also those who provide any continuity of care. Healthcare is often difficult and tiring work: to keep our minds sharp we must have intellectual freedom. But to keep our hearts engaged we need attachments and relationships that can grow in depth and value, both to us and the other. Our contemporary healthcare's neglect and abandonment of this principle has led to the unimagined damage we must now repair.

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After much persistence I have managed a conversation with an NHS manager, NM, about how our well-intentioned managerial systems can so easily, though inadvertently, destroy our essential human substrate. I am giving him real-life examples of how we obliviously displace essences of our best imaginative personal care by default: a thraldom to ever-increasing administrative devices: the diagnoses, boundaried specialisms, Care Pathways, algorithms – the fare and decrees of Trust Protocols and Best Practice.

NM is an intelligent man, but his loss of philosophical curiosity seems to me a microcosm of what I want to talk to him about. This loss is from pressure and attrition: from the endless, anxiety-auraed demands of his job and the massive system that expects compliant results but not challenging questions. He is having difficulty assimilating ideas alien to our corporatocracy: that the larger part of what I do lies outside such devices so ready to designate, manage, command-and-control.

'So what is this larger reality? What is it that you *do*?' NM slows: his interest sounds genuine. I venture a complex answer.

'In a working day I see many different kinds of people with even more different kinds of problems. Some of these are relatively simple, they can be dealt with at face value, by our formulaic devices. But many more cannot: with these the presenting problem is encoding or masking or displacing another that might be more important. Then I have to have the time, skill and interest to decipher this and its human meaning – its subtext and context.'

'So what are the skills you've developed to do that?' NM's curiosity is growing.

'Very often, when someone sits down with me, I have less than fifteen minutes to grasp a whirling kaleidoscope of loosely related notions and then offer my most useful, though always incomplete, synthesis of understanding and suggestion …'

'Meaning?' I am already losing NM in gathering abstractions.

'Well, I quickly have to grasp the nature and mind of the person, sometimes a couple or family. I need to imaginatively surmise what kind of language, understandings and imagery they use. Then I am in a better position to understand what we are saying to one another, and what this means to *them*: the discrepancies are often crucial. This then often extends to my thinking about what they are *not* saying: this can be more important than what they *are* saying. And here is fragile territory: whether to approach the unexpressed, and if so how directly?

'Then, within a few minutes, I have to generate other syntheses: to say or do something that both addresses their personal experience, understanding and my constructed meaning – of diagnoses and therapeutics. Then there are the time-strata to stage manage: is my influence just for now, or am I also thinking of tomorrow, next week, month, year … or beyond? Often, too, my formulation and intervention must include others in the person's life –

sometimes they are non-existent: the ghosts of the departed or the promise of the unborn.

'Each time I encounter someone I am attempting this: to craft and choreograph such complex and bespoke empirical responses …' I pause.

'That sounds quite a package … you must be asking a lot of questions', NM says.

'Yes and no. First, my response must be not a package: I must keep it open, so that I can easily add, retrieve or change things – that's the opposite of a package. And then, although I must keep my mind open to many possibilities, a lot of these are necessarily implicit or imaginative. Personal knowledge is only partly about stated fact; much more is about inferred meaning. So I may enquire widely but not ask many questions …'

'How can that be?' NM is perplexed by the apparently irrational.

'Think about a skilled artist or cartoonist. Often with a few discrete and imaginative lines they can capture far more than a much more detailed and methodical depiction. Excess detail gets us to see less, not more.'

'How is that related to holism?' NM is now casting imaginative lines: he knows my ethos.

'Holism is not about massing and then schematising lots of facts. It is riskier than that. It pursues unobvious connections and the possible meaning and influences between facts. Holism is often about the spaces between things: the interstices rather than the atoms. As with the artist, the skill is knowing when to leave things out.'

'Do all the recent NHS changes make that harder for you?' NM is focused and serious.

'Oh, yes! Our increasing systems and management tend to an ever-greater acquisition of data that we can then only deal with by atomisation: everything becomes reduced to parts and procedures – the opposite of holism: "the Whole is more than the sum of its parts".'

'And then?'

'Well, all sorts of things get lost. Relationships get lost: we don't perceive them or have them … they become supplanted by prescribed tasks.'

'Why is that important?'

'Partly it's because much of my therapeutic leverage comes from understanding, enacting and influencing relationships. But, equally important, it's that pursuit of holism that keeps my Mojo going. Holism, like play, grows things: it's creative. Atomism and proceduralism chops things up into they unliving: as it increases it deadens the mind and spirit.' My voice fades.

'What about the new initiatives for Integrated Care?' NM's voice is brighter: he is trying to revivify and integrate me.

'Well intentioned, but doomed …'

'Why?' NM's monosyllabic question is firm and stern.

'Because already – so soon – "Integrated Care" and "Holism" have been commandeered by managerial proceduralism. They become prescribed and protocoled by Trusts. They become add-ons to all the other – increasingly unsustainable – "must-do" lists: more boxes to tick. Yet essentially Holism is a philosophy, an ethos, a metaphorical effusion and engagement of the heart: if we attempt to directly manage or commodify such things we destroy them. They must evolve *In Vivo* but are often extinguished *In Vitro*. Not understanding that is our tragic folly.'

‘Are you saying we need less management?’ NM’s question is direct and level.

‘Yes, but more discriminating and trusting …’

‘Meaning?’

‘Meaning we must re-establish a culture where experienced practitioners are themselves trusted to make intelligent discriminations: to decide – in our endlessly imperfectible work – what, in each situation, is the wisest, most creative, humane and sustainable compromise.’

‘Isn’t that risky? Won’t mistakes get made?’

‘Of course, But probably not so much as our current risk-averse corporatocracy, which has left us with so little head and heart-space, and so much demoralised exhaustion.’

‘So you want to radically rescind and redesign our redesign. Where would you start? What would you do?’ NM seems warily and furtively frisonned by possibility.

‘Oh, I have many ideas, but they need many more conversations.’

I welcome them, with many others.

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