Life After Death?

A posthumous dispute

David Zigmond

The end of contractual employment usually terminates our legal responsibility. But what about our *moral* responsibility toward unattended compromises we know we are leaving? How well can ghosts speak for, and to, the living?

Here is a virtual dialogue with healthcare's governing authorities.

Background

In 2016, following a contentious inspection, my general practice was closed with exceptional rapidity. This was ensured and legitimised by overwhelming legal forces.[1] Yet for thirty years this unusual practice had been exceptionally and consistently popular with patients and staff and had shown a notable lack of dysfunction or hazard.[2] It was not problematic by other criteria, though it *was* conspicuously and outspokenly old-fashioned in cleaving to an erstwhile style and ethos of personal and family-doctoring.

Clearly there was an anomaly here that continues to deserve our fuller understanding. Among the many factors contributing to this anomalous judgement and execution are five that are widely observed to be problematic throughout our welfare services, yet epitomised in this single outlying practice[3]:

1. We have empowered increasing standardisation and regulation regimes that, by definition, cannot then intelligently respond to either variations of context or any other hierarchy of needs.
2. A tick-box culture results. This reduces all problems and remedies to terms of executive-commands and then employee-obedience (or the lack of these).
3. This now vast command-and-control regime requires considerable resources and management. This, in turn, necessitates the development of *REMIC* (remote management, inspection and compliance) – the increasingly algorithmic and automated ways of monitoring, assessing and controlling the workforce. We can think of REMIC functioning much like an air traffic control tower. REMIC is dependent on ubiquitous computerisation.

4. In particular, this has led to the increasing official disfavour of small practices, partly (probably) because of their greater difficulty with REMIC bureaucracy and compliance. Notably, the high popularity of many small practices has remained, both because of – and despite – this fact.
5. REMIC, like so many systems of automation and mass production, tends increasingly to become a hermetic system, accessible to and modifiable by only a small cadre of designated and privileged 'experts'. Intelligent and open dialogue becomes ever harder outside of this elite; compliance to managed procedure becomes preeminent, if not coercive.

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All this has become clearer with my experience. It has long proved almost impossible to engage the relevant authorities (in particular here, NHS England and the Care Quality Commission) in candid discussion. I hoped that retirement might reduce my spectred threat or perceived impertinence-rating: not so. Courteous and thoughtful letters inviting from them responses in kind have been answered (if at all) by formulaic and defensive types of wariness that are more informed and limited by imperious regulations and computer templates than any openly thoughtful minds.

So I have never managed the kind of open dialogue that I, and many others, desire and which, I believe, could help even more: the 'silent majority'. My pursuit, though, continues despite these obstructions.

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What to do? Here is one response: construct an imaginary dialogue without the unresponsive authorities – they can always join in later, in reality, if they choose. So here it is – a professionally posthumous and imaginary dialogue with the authorities, which I here collectively name *REMIC*. The dialogue is fictitious, but the problems are very real. I have been as impartial as I am able, to try to imagine how REMIC would respond were they to risk such an interchange.

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The dialogue

REMIC: Why are you still contacting us, after all this time?

DZ: Well, I've long wanted a broader conversation … Not just about my own case, but what it represents throughout Welfare services … Many people continue to contact me about it.

REMIC: Look, we're not here for such 'broader conversations'. We're getting on with an important job to help the public. We do that using established and transparent *procedures*. If you think we haven't followed those procedures correctly, then you have every right to an Appeal: that, again is a correct procedure. We note you haven't followed it.

DZ: Well, the reasons are pretty substantial…

REMIC: Meaning?

DZ: I was seventy years old at the time of my decommissioning. My practice income from real work was falling, while my regulatory and compliance

expenses kept rising.[4] Like many small practices I was doomed to extinction.

Most important, though, was that the way I was closed down made it almost impossible for me to ever reopen…

REMIC: Why is that?

DZ: Well, I was immediately stopped from working. So my patients had to be cared for elsewhere, and a final 'closure payment' was made to my practice. But my trusty reception staff etc would need solid security of future payments and jobs and I couldn't vouchsafe these during a lengthy appeal process … I couldn't continue to pay them for an indeterminate period for an unsure future. Being realistic, they would have to find other jobs. And, being equally realistic, I would never be able to replace them with people of equal calibre. Who would give up a good job to join a battling septuagenarian? I knew I was finished by this strike: I couldn't get back onto my feet again. I think REMIC calculated that…

REMIC: No, those are not our considerations. But, again, you *could* have appealed.

DZ: Well I *could*, but without hope of success, yet incurring much expense and stress. REMIC is a large corporation which simultaneously is the executive, the judiciary and the jury and has funds and lawyers aplenty. I am an outlying septuagenarian with no ready funds or lawyers, who has been very selectively non-compliant with – and therefore in breach of – REMIC-managed contractual regulations. How could an Appeal possibly succeed? … So I decided to continue to argue my cause, but to cut my losses before martyrdom.

REMIC: Beyond your own hurt and losses why do you think your cause is so important?

DZ: Well, I see the incremental effect that the machinery of REMIC has had on our healthcare culture. Look at us! We are a sickened and demoralised profession. If you want statistics there are many to show the extent of our dispirited trouble: poor recruitment, career abandonment, earliest retirement, retreat into 'portfolio careers', widely varied physical and mental illness, intra-institutional litigation, drug and alcohol abuse, marriage and family breakdown … and …

REMIC: OK, OK. And your point is?

DZ: That if we're not very careful REMIC overuse increasingly generates more problems than it can solve. In my working lifetime I've seen the collapse of my profession's heart, art, spirit, soul, intellect and wit. And other welfare services, with their own kinds of REMIC, report much the same[5]…

REMIC: That's quite a list! We can't be held responsible for all that, surely?

DZ: Well not personally, and not completely. But it's like any partially-sighted yet overdeveloped public system. It becomes dysfunctional because it becomes both hermetic and then difficult to change or steer. And then all participants are forced into one of three roles: perpetrator, victim or bystander. There is, however, a fourth position: *opponent*, but that has its own problems, as you can see. So direct opposition from employed practitioners is frightened into retreat and hiding.

REMIC: We've heard this from you before and think it's unfair. It's certainly not our intent…

DZ: OK, probably not to begin with. But all sorts of social and political campaigns have a horrible tendency to turn into something quite different.

And then avowed intention becomes very different from consequences. Shall I give you some historical examples?

REMIC: No! We don't need all that from you. What we're trying to do is quite straightforward. We're assuring *for the public* the quality of their health service: its compassion, competence, comfort, efficiency and safety. What can be wrong with that?

DZ: Only that you're conflating your *mission* with your *method*.

REMIC: What does that mean?

DZ: Well, few people are going to dispute your mission. Who would? But almost all experienced practitioners who are not defending a governing position have much more doubt about REMIC's methods. How can we possibly fulfil a mission if our method can't even get people to do, or stay in, the job? What kind of care can we offer others if we, ourselves, are dispirited, insecure, harried and harassed?

A year ago I wrote an essayed letter to NHS England titled *General Practice used to be the Art of the Possible, but we have turned it into a Tyranny of the Unworkable.*[6]

They never replied.

REMIC: One of our concerns about you is that you seem to be against *all* organisational rules, regulations, checks and disciplines. You don't seem to see the necessity for any of it … In our view that makes you look very risky.

DZ: Hm! I'm in the same boat as you, then: *that's not my intent, but those are the consequences*. I apologise for you misunderstanding me. Look, I'm not that kind of nihilistic anarchist. I believe all structures, strictures and penalties

have their place and value, but that such placement and value are complex matters needing endless thought, editing and navigation. We have to understand how something good in one context can be very harmful in another. Our structures must often be tempered by flexibility. We have to understand how some grand schemes spawn even larger, however unintended, problems…

REMIC: So how much institutional direction *do* you believe in? Will you submit to?

DZ: Well, I'm certainly not going to give you a figure! Let me answer with a metaphor. The health service used to mostly resemble a well-functioning *family*, which depended on appropriate trust, commonality, personal understanding, overlapping and interchangeable responsibilities and flexible judgements about these. But our reforms have attempted to disband the family and replace it with a network of *factories*, where all these 'family' qualities are replaced by rigid command-and-control procedures, protocols and instructions.

Sometimes parents will attempt to bring up their children in this way – they are overstructured, overstrict, intrusive and controlling. They say: 'we are only doing what is best for them, for the family.' The long-term results, though, are usually very different to what they say they intend…

REMIC: But all our procedures and disciplines *are* there for good reason. Overall they are there for everyone's safety and protection. Abandoning those responsibilities would lead to much greater problems, dangers and harm. Do you not see that?

DZ: OK. I agree that REMIC is not the *same* as, say, a military dictatorship! What I am saying is that, if we are not careful, there are *similarities* in process and outcome.

REMIC: But what about our public responsibilities?

DZ: Look, let me repeat an important point: I agree with your concern and your mission, though clearly and often, not your method.

Perhaps it will help *my* mission to make these distinctions:

- Creative dissent is different from destructive anarchy.
- Outliers to systems are not necessarily bad; they may be outstandingly good.
- In history, conscientious objectors have brought us Gandhi, Martin Luther King, Galileo. In contrast, the millions who automatically obeyed governing authorities brought us … what? I'm sure you can fill in the gap.

REMIC: Yes, yes. History, the herd, the compromised individual, the corrupted mission.

But what about our question about public responsibility?

DZ: Of course, but I think we've become paralysed with anxious confusion and lost sight of this: *in Welfare most workers want to do good work with good care. Generally, this is what they will do as long as they get good human contact, encouragement and satisfaction from their work milieu.* But the inverse is also true: *If welfare workers are frustrated in their human and vocational satisfactions, no amount of regulations, rules, trainings and inspections will remedy a failing service.* That is what we have now: a tendency to draconian and forensic management attempting to control – yet actually further damaging – an ailing service. Flogging a dying horse.

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And this brings me back to your first question: 'why am I still trying to discuss all this with REMIC authorities?'

In a way I am trying to heal my own grief, of both private and public kinds. Let me differentiate.

There is my private grief for the ending of my much-loved role, my practice, familiar and dear people and daily time-structures, my reciprocated significance for others … If we live long enough we all have to face such losses, so they are universal and inevitable as well as private. You may be sympathetic, but you cannot otherwise help me with this.

My other kind of grief may be publicly generated but must be privately borne. It is about the cultural loss of certain kinds of relationships and shared values. For the first half of my long career I was blessed by welfare work that – for the most part – could grow healthily in a wholesome and trusting (yet inevitably flawed) 'family'. The second half of this working life has seemed like an accelerating and enforced march to work in a series of mistrustful and depersonalised, REMIC-controlled 'factories'.

What I learned, how I practised, and how I taught were all anchored in this earlier vocational, fraternal ethos. My grief is about the systematic deracination and destruction of all this: it exceeds what I personally have lost; it is more about what I am leaving behind, in the public sphere, for others. So it is a transcendent and transpersonal grief.

This you *can*, certainly, help me with.

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REMIC: So we're not just the bad dictators, then?

DZ: Not so long as you invite discussion and debate. There's more hope for all of us then.

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And, reader, what would you wish to add to this debate?

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References and notes

All referenced articles are available via David Zigmond's Home Page, Sections D, G and L.

1. *Death by Documentation. The penalty for corporate non-compliance* and *Introduction*. Articles 73 & 74, Sections G and L.
2. *Obituary: St James Church Surgery 1987-2016: the demise of small General Practices. A personal celebration and lament*. Section D.
3. *Collectivising the Personal. Seminal lessons from Bolshevism*. Article 100, Section L.
4. At the time of my decommissioning my practice list size was only slightly below average, yet my hourly working pay could allow a rate only 10% above my receptionists. This has become a common predicament for the few small practices that manage to survive.
5. The Centre for Welfare Reform has documented many such problems across our Welfare services.
6. *General Practice used to be the art of the possible, but we have turned it into a tyranny of the unworkable. Reflections on our inspections regime*. Article 75, Sections G and L.

Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learningsystems.com. Many of his videos are also on YouTube.

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