The More Abbreviations, the Less Personal Care:

the depersonalised relegation of a corporatised NHS

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In our Welfare activities there is often an instructive and inverse relationship between the burgeoning of new institutional terms and language we use on the one hand, and the declining core of human interactions we are trying to guide and

safeguard on the other. The profuse new lexicon currently generated by reforms attempting to salvage NHS General Practice illustrates this. What is its significance?

In her article *Hidden Plans? The sinister links between the new GP contract and the NHS Long-Term Plan* (DFNHS, July 2019) Anna Athow raises a serious alarm: the many reforming processes and organisations she mentions and abbreviates may well be concealed preludes to large-scale privatisations – first corporatise, then privatise.

Surely, this possibility is egregious to most experienced practitioners who have long been exposed to some of the preliminaries. I am a recently retired veteran GP. In my work's last two decades I endured, with increasing difficulties, a vortex of successive and accelerating 'progressive' reforms. Each of these burgeoned and swirled with new terminology and abbreviations that became wearying beyond assimilation and dizzying beyond comprehension. Over many years I witnessed my peers, too, burrowing into a survival-mode of detached apathy. Anna Athow's article, despite its very serious message, might have a much smaller yet similar effect upon the current reader by necessarily referring to, and then using, such a confusing galaxy of recently vaunted reforming devices for NHS Primary Care. Here is a quick (not complete) list of staple terms: Integrated Care Service (ICS), Integrated Care Provider (ICP), Accountable Care Organisation (ACO), Accountable Care Service (ACS), Sustainable and Transformation Partnerships (STP), Primary Care Network (PCN), Direct Enhanced Service (DES)…

Had enough? This is a diorama of the increasingly abbreviated and corporatised world that GPs must now live and work in, and gives us clues as to why general practice is now so ailing, unhappy and struggling to staff its workforce.

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There is a relationship here between our use of language and how we conceive our Welfare services: the more we adopt corporatised technical language and its inevitable abbreviations and acronyms, the more we depersonalise the service in its actual human encounters. Here is an example: in the era Before Serial Reforms (BSR), which started in the late-Thatcher years, the better, yet common, General Practice had excellent morale, recruitment and staff stability. Because of this it could more easily provide the quintessence and *raison d'être* of General Practice – personal continuity of care. It could do this because it operated within both a human scale and a *modus operandi* of professional autonomy that together allowed and encouraged our better relationships and understandings. It was not (yet) corporatised and nor were the other services that GPs conferred with – District Nurses, Health Visitors, Social Workers, Counsellors, Probation Officers etc. Consequently we personally got to know kindred colleagues' names, voices, temperaments, modus operandi … and how best to *personally* contact them. Such professional colleagueiality and cooperation was, then, certainly more integrated than now so we could, often, with efficient rapidity, facilitate personal and bespoke care for patients we knew, together with colleagues we also knew. The idea of designating, let alone commissioning or commodifying, 'Integrated Care Services (ICS)', would have seemed (and been) pointless – it was a natural and indivisible part of how we operated. We did not need a graft or a prosthesis.

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But our Era of Serial Reforms (ESR), since 1990, has scaled-up, standardised-by-compliance, and then (supposedly) sharpened-by-commercialisation our NHS in a quest for yet greater efficiencies and thus savings. The erstwhile motivation and navigation of our Welfare services by personal vocation, relationships and understandings then became seen as capricious, unreliable and thus both unnecessary and unmanageable. So such time-honoured Art of Medicine – our human sense and sensibility – became first discouraged, then almost completely discarded. So corporation replaced vocation, the algorithm system replaced personally engaged judgement, and the e-mailed pro forma missive replaced the personally mindful letter.

'*No-one knows anyone but just do as you're told: The system knows best*' seems the guiding maxim of this commercialised and industrially policed ESR NHS.

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The results are clearly not what was planned. In mental health and General Practice our ever-more depersonalised NHS has now produced unprecedented demoralisation and thus parlous problems with maintaining the motivation, or even the physical presence, of its workforce.

Amidst these depletions how can we possibly provide the kind and quality of human engagements required to enact our more bespoke and holistic therapeutic influences? It is unnecessarily tragic that what used to emerge more naturally and easily from largely undesignated and uncontracted, but personally sentient, professional intelligence is now subordinated, sometimes suborned, to increasingly remote forms of commissioning, management and commerced commodification. In these, the destruction of our personal sense and understanding – essential ingredients of 'Integrated' or personal continuity of care – perishes. And what is the response of the governing authorities to their iatrogenic dilemma? So far it has been more of the same treatment: more aggregation and regulation, more centralised instruction and inspection, more reforming plans with their spawned managerial lexicon, duly abbreviated or acronymed. So it is that as we lose our valuable realities we become so prolific in generating new language in the desperate, but specious, attempts to retrieve what is banished and vanished.

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Anna Athow is correct that marketisation has certainly catalysed the cumulative toxic damage to our serially reformed NHS. Yet it is mistaken to assume that de-marketisation alone would return it to its erstwhile conviviality and viability. Removing markets does not necessarily guarantee our better fraternal trust, cooperation, skill and compassionate respect. Soviet Communism, too, managed its own kind of clumsy and depersonalising Gigantism, malfeasance and eventual paralysing and craven inefficiencies.

Yes, we need to remove the marketisation of our healthcare but we must also take equal care to selectively dismantle our other systems of policed industrialisation. We can then restore much that was smaller in scale, but larger in trust, personal connection, responsiveness and responsibility.

Humanity and vocation can grow in good communities; they can never be commanded or purchased into existence.

Further reading

- Athow, A (2019) 'Hidden Plans? The sinister links between the new NHS contract and the NHS Long-Term Plan', *Doctors for the NHS Newsletter*, July
- Zigmond, D (2019) 'Disintegration of General Practice: The Compound Cost of Serial Reforms', *Doctors for the NHS Newsletter*, July

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Interested? Further exploration of these themes, evidence and remedial suggestions can be found in *The Perils of Industrialised Healthcare* (2019), also published by The Centre for Welfare Reform. The author's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html) also has many articles of related interest.