Whatever Happened to Medicine's Mojo?

Cultural and economic perspectives of the last hundred years

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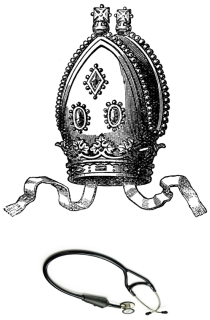

The scientific effectiveness of modern medicine is ever-more powerful. Why, then, are doctors in the NHS feeling so dispirited and discounted? Here, a brief outline of our healthcare's organisation over the last century provides some answers.

In October 2019 Archbishop John Sentamu talked to Doctors for the NHS (DFNHS) in a medieval banqueting hall close to York Minster, the centre of his diocese. He told us, I think, not only what he believed, but what he thought these seasoned doctors wanted to hear. His speech was rich in references and eulogies to a confluence of both Christian and humanistic values – compassion, kindness, belonging, personal understanding and connection … all induced by some kind of universal spirit. His manner was serious and warm, earnest yet lightened with humour. The audience responded with rapt reverence: certainly, he was here preaching to the converted – surely a moral boost, and a boosting of morale, from one who personified the good to the many holding out for something better.

This infusion was both welcome and timely; it was now the last session of the day and the previous speaker – a heroically resilient and remarkably tolerant-though-frustrated GP – had talked of a solid commitment leached by a growing despondence: she described the demoralised unravelling and staffing depopulation of her beloved profession. So the Archbishop's speech, mere presence and aura lifted our plummeting spirits.

But his rich and full engagement had now filled the time-slot: there would be no time for questions or discussion.

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As the meeting was formally closed and the microphone switched off there was the inevitable encircling huddle for contact around the Archbishop: gratitude, greeting, homage, flattery … I waited my turn.

A hiatus in the huddle. He turns toward me, with a slight tilt of the head and an extended hand to signal his attention. I introduce myself.

'Thankyou. Of course there's a lot of support for everything you say in a meeting like this and, I hope, both ways. Who here is going to disagree? But there's a major problem for us doctors. Believing these things is now easily stymied. You see, our system with its serial reforms makes it ever-more difficult to live by our beliefs, to *do* them … so eventually they ail and perish …'

He nods with, I think, thoughtful sorrow. 'I know … I hear … it's very hard. What do you think has happened?'

I am encouraged by his question. 'Well, you talk, quite rightly, a lot about care – the heart of your religious and our medical activity. Yet if you talk to any long-serving NHS doctor they will tell you that over their working lifetime, although everything scientific and technological is better, almost everything to do with personal contact, understanding and relationships is worse. So our *treatments* are much more effective, but our *care* has become so much poorer…'

I can see him thinking hard. I venture a question: 'Have you noticed the age of most of the doctors here?'

'I am not sure … why?' he wants to divine the nature of the question: is there an implicit statement? 'What are you getting at?', he says.

'Well, this is a pretty old group, isn't it? I think most of us are retired', I answer.

I see him looking around, confirming this and then, I think, trying to guess its significance for me.

I forestall his needing to ask. 'It's life-after-death!', I jest seriously, a transprofessional banter. He looks at me with amused bewilderment.

I continue, 'Well, these doctors want to keep the spirit – the better ethos – of Medicine alive well after they are no longer doing the work, when they are professionally deceased … very similar to much of your religious faith, I imagine. We want our better essences to survive us, in others.'

He nods vigorously, an emphatic agreement. 'What about the young doctors?', he asks.

'Well, here's a sad, and I think very significant, observation … the young doctors seem too stressed, fatigued and dispirited to invest in these "higher functions": they have enough to do just to do their contracted job, just to survive. I call that the "Zimbabwe Syndrome". I guess I don't have to explain that …'

He shakes his head with rueful recognition and asks, 'Why is that?'.

'Well, as you were making your speech my mind drifted to my profession's plight and then to the evolution of this country's last century of healthcare. I think we can helpfully understand our current problems by dividing the century into three periods.

It seems to me that each period had its own ideology, economics and modus operandi. As I can explain, the older doctors here spent their formative years in the second period and now flounder in the third. Younger doctors have no experience of the second and know only this last and third era – these periods are quite different in a way that's very important to understand…' I falter: I can see my unexplained abstractions have tumbled out faster than his comprehension has caught them.

He tries to orient himself, 'Yes, but what are …?'

Before the Archbishop's question is completed there is another hand on his shoulder, courteously guiding him to attention elsewhere. My severed dialogue has already far exceeded any others here.

'Thanks … I'd like to continue this: there's much more …', I say, casting a line to a possible future. I pictured myself in an old black-and-white film, standing on a station platform waving off a departing train.

'Indeed', he said as he was turned to the larger throng, 'yes, let's keep in touch'.

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So what are these three eras of healthcare – the distinguishing modi operandi, the ideologies, the economics – that may help us understand the story of the reform-driven malaise now blighting our services?

Herewith a very brief overview:

A century of healthcare: a brief cultural history

1. Pre-1948: Individual capitalism and charity. *Each man for himself*

Before the NHS in 1948 most doctors worked among wealthier populations where they could be paid. The poorer and much larger majority of people therefore had very little access to medical help. There were many singular exceptions provided by charities, religious organisations and remarkable proto-socialist doctors – but the overall trend was unmistakable: most doctors worked either for themselves or for small, profitable groups, operating like small independent shopkeepers.

This guild or small-shopkeeper culture may have incorporated some vocational spirit toward individual patients but remained, mostly, protectionist at a social level. That is why most doctors (or at least their representative BMA) fought so hard against the founding of the NHS. At the time it seemed unlikely that doctors would mostly settle with, and for, this revolutionary reconfiguration of their work: many experts then were pessimistic about the viability of this new NHS.

2. 1948-c1990: Social and vocational medicine. *We're all in this together*

Yet the medical diehards so obstructive to the launching of the NHS were emphatically proved wrong. In hindsight we can now see how remarkable was this unprecedented and rapid reform: within a few years the recruitment, morale and staffing stability of this new service provided comparatively equitable care that developed a quality that drew international acclaim and research, and mostly affectionate trust and esteem amongst our own practitioners and general population.

There were failures, of course: *DSRs* (duffers, slackers and rotters), both institutionally and professionally – but these were the exception. Most worked with a high degree of colleagueial cooperation, fraternal reciprocity and interprofessional trust. Practitioners and institutions were guided and motivated by an often-unspoken sense of social vocation. There was little (if any) reference to contracts and no inspections, commercialised competition or commissioning, or metricised appraisals.

This forty-year period may, from today's perspective, seem remarkably lax, unincentivized and unmanaged. In a way this is true. It is also true that demands and expectations were then lower. Even so, most veteran practitioners would say that this pre-1990 period was one of greater work efficiency due to its better personal relationships, trust and morale. And then the more seamless and synergistic relationships that could flourish between its operational groups.

We all had a clearer sense of belonging with, and belonging for.

A good-enough system, surely? So what happened?

3. **1990-present: corporate capitalism and micromanaged medicine**. *The system will decide*

In short, this last and current period can also be denoted by healthcare via the rising culture of neoliberalism, and systems of cybernetics. Or, in more ordinary language: markets will propel and decide, and computerised systems will micromanage.

Here was a new concoction – a potent mixture of culture, ideology and new technologies that, in effect, said: '*Welfare services cannot possibly provide their best by relying mostly on the personal motivations, skills, relationships and judgements of those who work in them. That is far too capricious and unreliable. We must, rather, incentivise by introducing competitive pseudomarkets. We can further ratchet-up quality and value-for-money by computerised micromanagement. This will instruct and monitor all employees and then, where necessary, sanction or eliminate. We can do this from outside the professions; the spectre of power will soon assure recruitment from within*.'

These reforms were first unleashed in the heyday of the Thatcher government, a regime with a quasi-religious belief in the liberation of markets, yet the astringent external governance of Welfare. Despite the increasingly evident destructive effects over these thirty years, each successive government has colluded with, elaborated or amplified these Thatcher-era initiatives.

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So what has been the fate of this post-Thatcher, CCMM (corporate capitalism and micromanaged medicine) era? It is mixed, but mostly not good. Most independent investigations conclude that the marketisation has brought inefficient bureaucracy, perverse incentives and 'gamings' as well as mistrustful – often hostile – fragmentation of services. There is little evidence of greater healthcare efficiencies or better motivation.

There has been similar research indictment of the policed regulation and inspection aspects of micromanagement. While the more egregious DSRs may be identified, we create a far greater problem among the rest by generating an alienating and unsustainable environment with an enormous burden and distraction of compliance tasks and bureaucracy. Most healthcarers find this not only unintelligently unhelpful but divisive, dispiriting and exhausting of their limited energies. The net effect, again, has been negative.

Such negative effects can be illustrated by a metaphor: our earlier NHS (era 2: social and vocational medicine) was handled more like a living tissue – with understanding, care, nurturance and protection it would mostly grow to produce a natural synergy and balance between its parts. In contrast, our current NHS (era 3: corporate capitalism and micromanaged medicine) is approached, rather, as an inanimate mechanical object – a motor engine, say – that must be designed, engineered and manipulated to surrender the performance we choose and command. Era 2, a time of greater work harmony and satisfaction, was *guided* by animate, organic perspectives. Era 3, our current period of commanding algorithms and policised monitoring and instruction, is, contrastingly, *driven* by considerations from the inanimate, the inorganic.

What has this led to, in human terms? Well, it has yielded us the personally 'homeless', rootless, lonely, fractious no-one-knows-anyone-but-do-as-you're-told culture. Here, now, data and metrics displace personal understandings and meanings; corporation eclipses vocation; nuanced judgement, initiative and colleagueial trust are all needlessly pushed aside by the blunt rigidity of (often commercialised) corporate contracts.

The personal warmth, spirit, élan vitale, reciprocal nourishment and mojo (choose) – the essentials to sustain our difficult work over long periods – is starved and dies. We have removed the metaphorical human heart of human warmth and inclusion, then replaced it with a mechanical heart that can only pump to order.

That is why we now have such serious problems with NHS practitioner morale and then staffing. Money may easily purchase short-term locums: it will rarely secure us veteran vocational practitioners.

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A recent cartoon in *The Oldie* is seminal here. Depicted are manacled rows of haggard, emaciated galley-slaves in rags. They look craven and exhausted as their lives depend upon them pulling endlessly on their oars. Above them towers their galley-master: corpulent, massively muscular, menacing and wearing a Roman tunic of office. His right hand brandishes a whip.\

'*Remember lads'*, he shouts above them, '*next week: staff appraisals!'*.

The cartoonist here, with profound simplicity, brilliantly captures so much of what has gone astray and away with our NHS, and more generally in our Welfare services.

This comedified wisdom has again and again seriously eluded our serial health-reformers and their political captains (or captives?)

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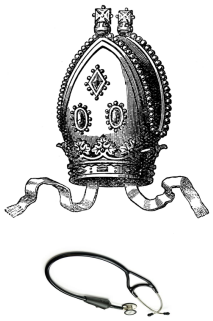
Note and further reading

1. Sources for this historical analysis and current description of our NHS are numerous and wide-ranging. For reasons of space I have not listed here the many audio, video or paper documents from times past, or the many more current evidence and research statistics from independent thinktanks, academics or government institutions.
2. Further and more systematic analysis of these NHS problems, together with some suggested remedies, can be found in Zigmond, D (2019) *The Perils of Industrialised Healthcare*, The Centre for Welfare Reform.



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Interested? Many articles exploring similar themes are available on David Zigmond's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html).