How and why have we so misbegotten our NHS staff?

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In Covid-stunned UK our NHS workers are currently lionised and eulogised. But this is very different to most of their experiences in recent years. What does this tell us about our working culture? And what can we do about it? This analysis is of culture, and its social and motivational psychology.

If you give me six lines written by the hand of the most honest of men, I will find something in them with which to hang him.

– Cardinal Richelieu, 1585-1642

We are pathetically eager to believe that if human affairs are managed right, nothing unpleasant need happen to anyone.

– Max Hastings, 1945-

At the time of writing (May 2020) much of the world is anxiously stymied by Covid-19: our assumptions of contemporary living simultaneously and shockingly unravelled and impassed.

In the UK, at the centre of our crucial battle of Humans *v* Aliens, our NHS is now lionised and eulogised in heroic terms. Like religious icons or Soviet State art, its practitioners have become our saviours and our martyrs. This warm mist of adoration has – until it passes – obscured a serious problem that has grown increasingly erosive of our NHS for several years: the destabilising demoralisation of much of our workforce.

This Covid-crisis has, as emergencies do, galvanised a new cooperative and colleagueial motivation in many of our professionals as they are – for now – again trusted to do their best to stem the alien tide. But as our enduring serious problems are temporarily out of sight we should beware: they remain, like perilous rocks, just beneath the water's surface. While we currently have the respite of dramatic distraction, we certainly do not have reprieve or resolution of our systemic troubles. They will surely return.

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So what are these rocks-beneath-the-surface that can sink this enormous, and enormously important, social vessel – our NHS? It is crucial that we ask this question in anticipation

(hopefully) of a post-Covid national recovery as we will otherwise then return an exhausted, even more vulnerable, NHS to these enduring and gathering imperilments.

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Our healthcare headlines and news items in recent pre-Covid times were frequently about a service labouring under a regime riven by accusations and disputes about finances, territory and responsibility. While still, often, providing satisfactory technology-dependent treatments well enough, the services for many years have been clearly struggling and malfunctioning in less hi-tech areas, particularly general practice, mental health and community services. This is reflected in a wide range of statistical indicators both for staff and patients in these domains. Staffing levels are often shown to be unsafe and unsustainable due to poor recruitment, sickness, intra-institutional litigation, career abandonment and earliest retirement. Remaining staff then struggle even more to provide even essential access and services to patients. Any more nuanced personal continuity of care becomes impossible, further demoralising and endangering depleted, wearied staff and vulnerable patients.

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Arguments and quasi-explanations are often translated into discourses about money. The services' spokespersons say, 'we don't have enough', and the government says 'you *do* have enough, but you're not using it efficiently: you need better management'. Variations of this exchange have been going on for thirty years, since the neoliberal revolution.

The nature and evolution of this philosophy – neoliberalism – is worth clarifying, as that will help us understand our current predicament. Neoliberal reform of the NHS began in the heyday of the Thatcher government, which said effectively: 'Welfare services are slack, inefficient and have too much unmanaged variation. This is what happens if professionals

make their own decisions and define their own tasks. We need then to replace autonomous vocation by commissioned and expertly designed corporation; and those corporations need then to be motivated, tested, challenged and stretched by the rigours of a competitive market.'

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Neoliberalism tends to view human activity and motivation in a machine-like way: humans can, therefore, be designed, tweaked and boosted to provide ever-improved performance or 'output' to meet the user's requirements. This approach is akin to a carpenter who procures his material and then designs, cuts, shapes and joins it precisely to his requirements. The wood itself is now a lifeless commodity whose only use is the carpenter's plans.

Let us contrast this to the more organic, holistic activities of a gardener. Here we may have a vision or plan, but we cannot precisely command and manufacture these. We must instead understand the viability and growth requirements of the various plants and their complex relationships with other life-forms, their eco systems. Then we must plant, protect, tend and nourish with care and deliberation.

Our pre-neoliberal NHS had these organic, holistic principles of better human sense guiding its management although this was never (as far as I know) referred to explicitly. The service was certainly not perfect, but in the main it had high work satisfaction, happily convivial work relationships and enduring robustness and sustainability. The tragedy of our neoliberal reforms is that rather than building on these organic, holistic, time-honoured tenets of human groups, they demolish them in the spurious belief that a commercial-industrial type model would work much better. In a way these reforms have been more like a revolution; and revolutions, like wars, almost always yield something very different to what was planned.

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To establish decisive control these neoliberal reforms have invested heavily in three main institutional strategies. They are:

- **The 4Cs**: competition, commissioning, commercialisation and commodification – a *marketised* system.
- **REMIC**: remote management, inspection and compliance – a surveillant and *policed* system.
- **Gigantism**: scaling up and standardising wherever possible – a system of *industrial capacity and efficiency*.

Together these three reforming vanguards have certainly revolutionised our NHS working culture from one of convivial cooperation to that of industrially commanded compliance: from family to factory. This radical transition may make sense in the abstracted spaces of government and management committees, but it makes much less sense at the practitioner and patient level – for here our actions and experiences are very much the products of the bonds, meanings, trust and resonance that develop from shared personal access and knowledge. Underlying our technically designated tasks, these are what confer human gratification for doctor and patient alike. For any of this to happen, the practitioner must be assured of headspace and heartspace but, tragically, our three revolutionary vanguards have been developed to short-circuit and exclude such invaluable human vagary. The revolutionary rhetoric is usually pitched around mooted (and mistaken) gains in efficiency, safety and value-for-money.

And what is the reality, now, of our neoliberally industrialised NHS? The evidence, from many sources, is that, most often, the 4Cs, REMIC and Gigantism have fragmented, dispirited and demotivated the previously more fraternal vast NHS professional network. By introducing a competitively siloed mentality, unprecedently complex bureaucracy and procedures, and then attempting to control all thought and activity through micromanaged

surveillance and compliance regimes, our service has become, all too often, *less* safe, humane or efficient. After all, how well can an abandoned, depleted workforce achieve any of these things? And even if the staff remain in post how well can they work if they feel unfulfilled, devalued, mistrustful, mistrusted and without fulfilled fraternal bonds – both with other workers, and with their patients.

The neoliberal agenda – with its control-levers of contracts, goals and targets, compliance instructions, rewards and penalties, sticks and carrots – has abrogated a central human principle of how we may best care with and for one another. Good welfare comes little from money, institutional fealty or compliance; it comes far more from finding and tending shared experience, meaning and thus relationship. Welfare practitioners motivated and gratified in this way are hardly ever 'poor performers'; conversely if practitioners are unhappily frustrated in these ways they are most unlikely to proffer the kind care we, they, or anyone would want.

This is what, in our zeal to 'modernise', we have so heedlessly sacrificed.

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There is, currently, a rising swell of frustrated contention among practitioners alleging (with copious and substantial evidence) numerous examples of mismanagement by licensing, employing or disciplining authorities. At their most 'benign' such allegations may be about out-of-touch incompetence; the rest sound shaded with the opaquely dissembled, the corrupt and the malfeasant. Constructive dismissals, gagging orders, officious skewering by small print regulations, procedural obfuscation, traducement of whistle-blowers … all have become familiar back-drop reports to our unhappily neoliberalised NHS.

Such fractious and pathogenic contentions were extremely rare in my first twenty years of practice: the fact of their current frequency surely tells us much about our discordant misdirection.

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In the last year there have been several legal challenges to these kinds of alleged miscarriages of institutional procedure and probity. Publicity and supported contention has been provided by, for example, The Centre for Welfare Reform, Doctors Association UK, our NHS our concern, and Doctors for the NHS. Recently I was invited by the latter two organisations to petition against what, again, sounds like a collection of egregiously perverse misapplications of institutional procedure: they will challenge the specious procedures with *correct* procedure.

I will support these challenges but wish to go much further. Where is that?

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The more laws, the less justice

– German proverb

We have here, I believe, a much greater problem than whether correct procedure has been followed. Cardinal Richelieu well understood this: how he could control and terrorise whoever he chose with his skilful (ab)use of the law. Legality is a frail buttress against a miscreant or bad culture: the law's ethical integrity is only as good as its practitioners. And so, it seems to me, a profoundly misdirected (at least) culture that is so often procedurally corralling, silencing or eliminating its welfare practitioners is likely to be well armoured against legal challenge.

The Stasi, with Germanic thoroughness, had many legal and policing devices and staff to deal with the dissidents and the inconvenients of the GDR. I don't know how many (if any) legal challenges there were to the GDR's hegemony, but even if they were successful what chance did any have of substantially changing the underlying totalitarian culture? As far as I'm aware, it was the collapse of this totalitarian system that neutralised the draconian powers of the Stasi and GDR courts, not any formalities of legal process.

A worrying part of this problem is that, with few exceptions, officials exercising and abusing such draconian powers appear to sincerely believe in the ideology that exonerates their actions. Officials in police states are usually otherwise unremarkable citizens who wish to side both with power and the right side of the law, whatever that happens to be. There are many reasons for this: retaining occupational status, security and livelihood are obvious. But protecting a good self-image is another; cognitive-dissonance threatens this – we can keep that at bay, by denial, rationalisation and doctored data. This is what happens when mistaken paths become culture.

So it is that totalitarian systems, by nature, have few ready portals for challenge. And in this culture-medium our neoliberalised NHS has produced a fascinating variation of totalitarianism: we have – amazingly – managed to fuse the paralysed, paranoid, dispirited repression of the Soviet Bloc with the venal, opportunistic, heartless and intimidating cunning of the worst of USA capitalism. This is like a monstrous child misbegot by two struggling yet coupling parents.

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I was talking of this with a senior manager, SM, of a large multinational organisation. He laughed with a kind of ironic, pitying recognition and then said, 'Look, this is just how it is in our large corporations: that's how they operate. You shouldn't be surprised, and you certainly shouldn't take it personally… If *I* publicly challenged the ethos or strategy of my

company I would be side-lined or eliminated very quickly. That would happen usually with great skill and stealth. How do they do it? Well, you'd best ask our HR or Legal Department – they're very good at it!'

He smiled warmly, with a brief flash of strong white teeth. I felt a chill run through me.

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I thought later about what SM had said. He was certainly right about large commercial corporations. It would be equally true in any dictatorship and any totalitarian organisation. And it is what we are struggling with now, in our NHS.

Yet this is a relatively recent development. Almost all older practitioners remember a very different service which – for all its unevenness and lesser capacity – somehow remained free of these traps. The kind of fractious and unhappy discord now so evident, was almost unheard of then … and the NHS was able to offer an overall quality of service, then, that served as a worldwide beacon and model.

So if – as I believe – our NHS is more helpfully viewed as a living organism, rather than a machine – then we can ask: what does it need in terms of protection, modelling, nourishment, living space, ambient relationships, motivational understanding, caring recognition…? If we can replant our best answers to these questions, we shall be much freer of many of our nefarious and tribulated tangles.

Hopefully legal and procedural challenges might, at least, help us focus on this larger task.

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Notes and further reading

This article has not made use of references. The interested reader is, instead, referred to the websites of Doctors Association UK (www.dauk.org), The Centre for Welfare Reform (centreforwelfarereform.org), our concern our NHS (www.ournhsourconcern.org), and Doctors for the NHS (www.doctorsforthenhs.org.uk). Many of their publications provide much background data, evidence and examples in support of the arguments developed here. Reiterated referencing would be unreadably burdensome and space-demanding.

This author has written and campaigned about these issues for several years. Many writings are found on his Archive Home Page (davidzigmond.org.uk). A preliminary list for the reader is:

- *Death by Documentation. The penalty for corporate non-compliance*. Article 74. Section L.
- *An instructive mausoleum. Contention with NHS England and the Care Quality Commission*. Section G.
- *The Perils of Industrialised Healthcare*. A discussion paper from The Centre for Welfare Reform. Section N.

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).