Should All Doctors be Resuscitators?

Unfactored costs of prescribed risk-management

Rhetoric is easier than reality

David Zigmond

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Being prepared for unlikely risk or adversity may sound like good counsel. But only so far: beyond that other things are damaged. This speculative analysis is of a recent safeguarding inspection. It demonstrates how apparently sensible procedures may, when extended, distort and implicate far more than we usually imagine or intend. What happens? How do we understand?

Maps could wield an immense influence, sometimes becoming more real to people than the reality they claimed to represent.

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– Maps and the 20th century: Drawing the Line

British Library (February 2017)

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At a recent (CQC) Inspection of my medical practice it was discovered that my statutory training in resuscitation was a year overdue. My response probably struck them as nonchalant – I was oblivious and not very concerned. I began to explain: I regarded other aspects of my practice as deserving much greater attention and precedence – surely most of us could see how perilously stressed our services are. To survive we must prioritise: that is the nature of professional judgement and responsibility… But the Inspectors quickly and skilfully invalidated any self-justifying deferral: *they* would decide what was important.

There followed well-briefed and rehearsed related allegations: my lack of on-premises oxygen and a defibrillator. Yes, I readily acknowledged, that was the case. But, again, these seemed to me much less of a likely risk than many others. A common example: my lack of time or accessible support facilities for those distressed or hazarded by complex emotional or incurably degenerative conditions – the much more likely and difficult bulk of my work. I tried, tenaciously, to expand on this but the Inspectors now cut me off with peremptory severity, like a gamekeeper firing a warning shot toward a poacher. My attempted debouchment had, for them, I think, passed from unprofessional impertinence to more serious sedition.

Clearly, they did not consider my doubts to be territory for legitimate dialogue. Later I would pay a much harsher penalty for this candid breach of corporate convention.

So, the CQC briskly exercised its legitimate authority; any discussion was forestalled and some interesting and important notions pre-emptively muted. Had the guillotine not fallen, I would have offered these mitigations and alternatives:

- Emergency resuscitation is hardly ever required from GPs. The harsh reality is also mundane: life-threatening collapses occur most often on 'home territory', where people live their lives eg in domestic or residential properties, day centres, pubs, betting shops, shopping malls, etc. Such collapses are, therefore, rare in GP surgeries. (In thirty-nine years I have encountered only recoverable faints in my surgery, never a fatal [or near fatal] cardiorespiratory collapse.)

- We cannot, of course, insist on full CPR (cardiopulmonary resuscitation) training and equipment around all citizens at all times on their home territory – the area of their highest risk. Why, then, do we insist on it elsewhere – with GPs: a zone of much lower risk? Like many protective and pre-emptive gestures our acts often have more symbolic significance than likely effect – more on this later.

- My inner city practice is less than a mile from the nearest large hospital, which is well-staffed and equipped for dealing with those who are acutely and critically ill.

- If someone is severely breathless and needing oxygen, then they need far more care than can be provided in a distracted, multi-tasking GP surgery. Such patients need an ambulance (whose staff are both well-equipped and frequently experienced with such episodes) and probably hospital.

- This deflection of evident acute and severe illness is practical and safe for a practice such as mine (inner city, very close to a large acute hospital): this becomes less tenable for remote and rural practices.

- The provision of oxygen on GP premises could, paradoxically, *add to risk*: it might 'encourage' patients to attend the GP when severely breathless or with likely cardiovascular chest pain, when their care would be far more rapidly and reliably delivered elsewhere (ie hospital A&E or Urgent Care Centre).

- GPs can be expected to do their best across a very wide range, but not everything all the time. Critical or resuscitary medicine, so rarely encountered by them, will usually be beyond their confident competence: their role is, rather, preventative, anticipatory and directive.

All such notions are certainly plausible, yet controvertible: I did not expect easy agreement with these briefed Inspectors. But I thought they might respond with some cautious openness – that we could discuss, cooperatively, our need to fashion the best compromises amidst such competing realities.

Not at all. I was promptly halted and chided as some kind of heretic or blasphemer, not as a conscientious practitioner attempting to discuss inescapably contentious

issues. Many years ago my colleagueial conversations about such matters had been very different.

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Why does management now resort to the draconian when faced with such inevitable human complexities of healthcare? What is this growing compulsion to *manage* every aspect of human interaction, behaviour and fate? How do our modern notions of 'governance' and 'duty of care' become so densely rhetorical as to lose wider and wiser sense?

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Our understanding of all this cannot be easy, for we are simultaneously actors, carriers and often victims of a *culture* – and culture is difficult to observe from within. Yet we can surely see that in the last two decades we have been party to, part of, an astonishing tide of – first – new technological and – then – human change: our culture.

First, our technology: mechanisation, cybernetics, robotics, informatics, algorithmics … electronically managed mass production, surveillance and standardisation … immediate and remote signalling and control… And then something very important, though insidious happens – our technology comes to model our mindsets and our expectations of human relationships. This follows wherever such technology is prevalent: we come to respond like our ambient machines and so become unreceptive to delay, uncertainty, ambiguity, non-compliance, inaccessibility. In our

corporations we increasingly expect to cut out all such vagary and then *manage* others by signals for remote control: we lose interest and then the patient skills in mutually evolved and interchanged *understandings* – the silent prodding of the computer keyboard replaces the personally projected human voice, expressive face or attuned ear in our contact with others. So, as our world becomes more cybernated we risk losing more natural forms of personal knowledge, encounter and acceptance.

Yet our immeasurable and nuanced humanity remains universal and undiminished: we must all learn to live with inevitabilities and predicaments that cannot be simply banished or vanished by some purchasable or manageable procedure, instruction or commodity. To make our lives bearable we must carefully *grow* things between us – relationships. These cannot be manufactured or directly controlled.

But we now have a growing and ineluctable problem, for the technologisation of our lives often both leaches and breaches the more natural basis of our relationships. This accounts for many of our growing, bewildered and refractory types of misunderstanding, and then unhappiness.

Take the clustering of our public welfare into factory-like Corporations: we expect that their structure will provide the kind of command-and-control systems that serve us so well with our machines. Like industrial designers, we now employ 'Commissioners' who, on our behalf, will design 'contracts' of care: remote control devices to ensure human compliance and reliability – the kind of responses we now automatically expect when we finger-tap instructions to our mouse or keyboard. This, almost everywhere now, has become our virtual bridge to, and representation of, the real world.

Yet we have so much evidence that the more we try to directly control relationships, the more they somehow elude us. The result is usually very different to what we intend.

So, this *modus vivendi*, seemingly so sensible, is actually doomed by an ineradicable discrepancy: our fellows and our lives are much more recalcitrant than the ubiquitous machines we have so cleverly designed to serve almost every aspect of our lives. Attempts to simply command-and-control our fellows can easily go very wrong, sometimes disastrously so. Clearly this distinction – of human *v* machine – is very important. Indeed, many of our mounting follies are due to not taking heed. Hence our confused, then scapegoating, anger at our systems' inevitable failures; our healthcare culture's now depressed, craven obedience shrilled by occasional 'necessary' eliminations or righteous whistleblowing; our rising tide of blame and litigation… Not surprisingly we have a restive system of healthcarers who themselves are increasingly made sick by working milieux they experience as depersonalising and care-lessly controlling.

How can any of us heal, comfort or grow amidst all this?

These problems are now so extensive there are few areas of respite or even insight. Managers, politicians and other health authorities are likely to feel just as bewildered, powerless and frustrated as the rest of us – for we have created a universally immured system: *Technolototalitarianism*.[1] Like all bad relationships this is easier to get into than to get out of. And like all culture, noone is to blame, but we are all responsible.

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So how do we respond to this: our vast pall of enervated alienation and confused tension?

Often we do more of what we know best, what we are most confident with. Regulators increase regulations, managers manage more. Then, if we can link our efforts to stealth and strategy, so much the better. Even more, if we can harness our coping strategies to a mission statement, an epithet, that connotes hope, nobility or even heroism – then the effect may be uplifting, even galvanising. Like erstwhile ECT for collapsed spirits, the placebo effect can be massive – though often transient – for the whole group.

And what has more dramatic rhetoric than the timeless, yet always frissoned, archetype: *Doctors Save Lives!* ? If we can return to *that*, then all doubt, uncertainty, division and conflict seem – for a while – to become insignificant.

Over many years I have probably offset and procrastinated many deaths. But the nature of almost all such GP 'life-saving' is rather quiet fare: passable for a low-ratings TV documentary, but not for a high-ratings drama.

Yet although GPs are most unlikely ever to successfully deliver such seemingly-miraculous, always charismatic, death-defying resuscitation of a cardiac arrest, their demonstrated capacity to do so may have great emblematic power: 'our staff are always ready, no matter what' is the implicit message both from, and to, a workforce

that is – in humbling reality – struggling to keep itself together enough to perform its far more certain and demonstrable, yet undramatic, tasks of care to those more assuredly alive.

The symbolic power of this is valuable currency and the CQC becomes an influential trader.

Is such speculative unmasking unfamiliar and contentious to our authorities? Probably. But our best response is to grasp this nettle rather than walking wide to avoid its sting. With such human convolutions difficult dialogue is almost always better, eventually, than officious control.

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Prescribed risk-management programmes can easily become cuckoos in the nest of Welfare: hungry tyrannies that devour far more than they can provide. If we carry on as we are it will soon be our profession that will need resuscitation.

And who will be able to deal with *that*?

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Death is not the biggest fear we have; our biggest fear is taking the risk to be alive –
the risk to be alive and express what we really are.
– Dan Miguel Ruiz (1952–)

Reference

1. Zigmond, D. 'Edward: Shot in his own interest. Technototalitarianism and the fragility of the therapeutic dance' *Journal of Holistic Healthcare.* Vol 2. Issue 4. November 2005

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