Boadicea and The Machine

The price of survival
as a frontline medical practitioner

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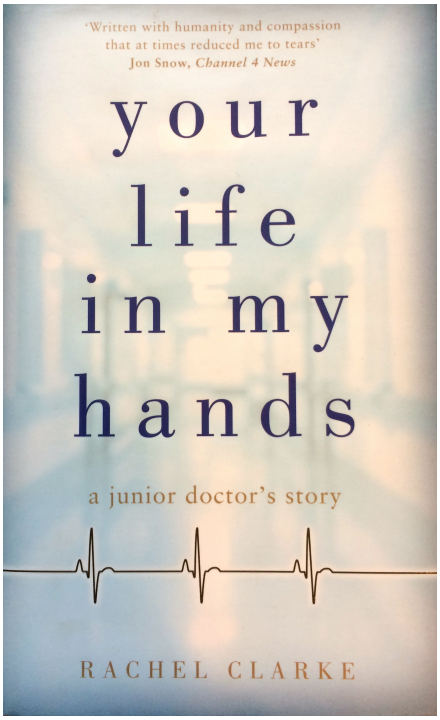

NHS doctors describe increasing stress, pressure, demoralisation and alienation. What is this like to work in? Why is this happening? A recent book, *Your Life In My Hands: A Junior Doctor's Story*, offers vivid description and challenging analysis.

… if, as a doctor, my duty of candour – of being honest and open with my patients about mistakes or failings of care – means anything at all, then it behoves me and all of us who work in the NHS to speak out, uncowed, about this reality. How else can we stand up and look our patients in the eye?

This quote, from the latter half of Dr Rachel Clarke's *Your Life In My Hands** could well serve as a kind of trailer for much that comes before. It is typical of this book's confronting courage, challenging conviction, rightness and righteousness. Her voice is certainly personal, yet it draws on the common experience of multitudes.

Clarke's descriptions and analysis of her work as an NHS junior hospital doctor are refined and crystallised by her previous decade's work: she was a documentary film maker. So her language is clear, direct, colourful and sometimes theatrical as she vividly depicts two kindred aspects of her work as a hospital doctor: the practice of medicine, and its frustration by political and economic forces, as she understands these.

The book's subtitle – *A Junior Doctor's Story* – is true of her account of her experiences and struggles with the political and economic forces she finds so inimical and destructive. This subtitle is technically less apt when she writes – mostly lovingly – of her clinical encounters: for here we have *many* stories – making a kind of collage of vignettes. These two aspects – the personal-clinical and the political-polemical – occupy opposite poles in her affections yet are here woven together with deftful art: the many switches between them are stimulating rather than confusing. Nevertheless, it is worthwhile here to separate the two strands to better understand and evaluate this arresting and important book.

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Clarke's tour of frontline hospital medicine is strikingly vivid and evocative – her previous career, making films, bears ectopic fruit in her cinematic-like scenarios and editings. We witness the maelstrom of cardiac-arrest, the ticking time-bomb of a leaking aortic aneurysm, the pathos of the end of a young life eviscerated by malignancy, the bated breath in neurosurgical theatre as the instruments converge to clip a giant, pulsating basilar artery aneurysm. She writes with candour of her dilemmas and struggles with breaking bad news to the grief-struck and fear-ridden, and what she must then contain and heal in herself.

These rich scenes come from her experiences in hospitals, amidst her colleagues and managers … and ultimately the largely unseen, but unmistakably felt, people who manage them – the control-tower managers and politicians. Clarke here portrays an uncaring NHS work culture in which she is attempting to deliver a wide range of complex, often exquisitely sensitive forms of care. She describes this unhealthy and unviable conflict – between the personal and the institutional – and then the high price paid by those professionals who must bear it: disabling stress and dispiritedness, then staff sickness and breakdown, then staff shortages that bring further stress to the brave but dwindling practitioners on the frontline. Her experiences of responses from NHS HQ are redolent of a movie of the Eastern Front in World War II where inadequately armed Soviet troops were commanded to advance against overwhelming forces or be shot from behind by their own side – the NKVD. Obey or be executed. In a similar vein Clarke examples the impossible demands conveyed by goals and targets, directives without support, the displacement of vocational ideals by fatalistic cynicism. These tales are always concerning and convincing, often deeply affecting. In this book they reach a kind of climax with the recent unhappy and fractious surrender by doctors to a new contract

'negotiated' with (or rather *by*) the government. Clarke sees the government's resulting hegemony here not as necessary good sense but as unsustainable and corrupt folly – a pyrrhic victory for slick bullying. So the doctors surrendered: out-spun and out-armed by government forces well practised in media and committee-combat.

Her survivor's spirit and articulate intelligence are carried with pithy strength in the quality of her writing. The content, too, is of sufficient importance to merit extended quotes:

- *Talking to patients and their relatives is inevitably left until last. The humanity of a conversation has become a luxury your conditions of work deny. Doctors are turned into hardened machines, patients are left in the dark.*
- *I am afraid we may have reached the point at which the NHS's greatest asset – its staff – has become terminally exhausted. The goodwill and kindness without which the NHS will not survive are being inexorably squeezed out by underfunding, understaffing and the evermore unrealistic demands placed upon a floundering workforce.*

On the perversely high costs of austerity she says:

- *It was entirely possible in this gridlocked world that, thanks to insufficient funds to fit a stairlift in one elderly patient's home, somewhere on the other side of the county another patient could be left lying on the floor, post-cardiac-arrest, because the ambulance they urgently needed was pointlessly pinned down on a hospital forecourt. And if the limiting factor was funds, I reasoned, then no amount of paramedics, nurses, doctors or hospital managers could prevent this from happening.*

And of the dangers of professional alienation and loneliness:

- *… medical school had largely taught us distance: how to separate from, not connect with, our patients.*

- *… the old days had at least had proper teams of doctors, a traditional 'firm', led by a consultant who kept the same set of juniors for six months or more.* [But we have become] *mere shift workers, numbers on a spreadsheet who slotted in and out of days and nights on the roster almost as interchangeably as the patients. No one knew us, let alone formed meaningful relationships with us … I feared that, if my hours and workload continued as they were, I might fail to cling onto the one thing that had driven me into medicine in the first place: my compassion. That or I might just crack up.*

And of the resulting discompassion:

- *… it does not necessarily follow that the individuals whose acts or omissions caused cruelty or harm are to blame for their behaviour. Sometimes, in spite of their best efforts, doctors and nurses are as trapped within a failing system as the patients whose care is being compromised.*

And consequently:

- *In today's culture of increasing complicity and compromise – where the standard of care is too often curtailed by inadequate numbers of staff – it is small wonder our doctors and nurses are quitting the NHS …*

In addition:

- [If we] *break down the human relationships that sustain and nurture a medical workforce,* [we] *risk creating doctors who first lose their compassion, and then become too brittle to remain at work…*

And the relationship of relationships to our era of austerity:

- *Treasury expenditure must be rigorously justified. Perhaps concepts as fluffy as wonder and goodwill are – just like kindness – entirely superfluous. After all, none can be counted. We cannot price up any of them. Yet the truth is, though these values cannot be bought and sold, they inspire the staff who drive the NHS more than any profit motive…*

So, her cardinal question:

- *… do we wish to cut NHS services to fit the current budget, or to provide the budget to fit the healthcare we want?*

And a plea for a different kind of dialogue:

- *Transparency, if it means anything at all in the NHS, begins with candour about the costs of a world-class health service. If we want the best, we cannot avoid paying for it.*

Clarke's love of her work is clear and fiercely expressed. So, too, is her condemnation of those who, she perceives, obstruct or obfuscate what she regards as good and humane medical care. She identifies lack of funding, and the avoidance of debate about this, as seminal to our great mass of problems. Her cogent and articulate arguments will gather much support: few will disagree.

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So far, so very good. But Clarke's analysis does not go much further. From hereon her arguments become Manichean: healthcarers are good people who want only to do what is good *v* politicians are curmudgeonly, mendacious people who want to deprive others of that goodness and then conceal the deprivation. The population want – *deserve* – our best care, but governing forces are unsympathetic or obstructive. Here we have easily identified heroes and villains, victims and persecutors.

But such portrayals, so immediately alluring, eventually will offer us much more gratuitous expedience than creative understanding.

Rachel Clarke's account of our problems certainly makes a major contribution to our knowledge of what we must tackle. But we must explore far beyond her analysis to construct our wisest responses.

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We must first acknowledge how our government, like our commerce and manufacturing industries, reflects our natures, our wishes, our culture. The best and the worst of us. Whenever I have had more personal contact with politicians or senior managers I have (mostly) been struck by how kindred are their nature and predicaments to mine: they, too, work very hard for what they consider the greater good; they attempt to do this amidst almost continual conflicting interests and sabotaging forces; most describe some initial kind of vocational motivation that they know to be as valuable as it is vulnerable. But to do any good they must first *survive* in a political jungle that quickly destroys perceived weakness and is therefore often fickle, treacherous, unforgiving and unstable – they retrench to an old adage of Rab Butler: 'Politics is the art of the possible'. So politicians and senior managers do what they can in very difficult conditions and with limited resources: compromises have to be made yet are often concealed. Many become defensive and secretive when they know they are failing; they feel trapped by much larger systems and circumstances. Their strategy is to survive until better times.

Is this not disturbingly similar to the now well-documented plight and behaviour of healthcare staff at Mid-Staffs?

History has innumerable examples to show us how bad systems can bring out the worst in all of us. In trying to understand or improve our current healthcare problems this is probably a more helpful generalisation than searching for heroes and villains.

Rachel Clarke is probably correct in pointing out examples of politicians' forked-tongued, sham-sincere mendacity. Yet we can all find more uncomfortable examples closer to home. Who does not know someone (ourselves?) who will angrily denounce the government for its lack of funding for public Welfare, yet talk with smug satisfaction about their canny recruitment of an Eastern European builder whose 'great value' comes from cash payments, whose meagreness may be further reduced by bluff and haggling. These same people will often find clever sleights of procedure, sophistry or language to avoid paying taxes, or reward highly paid professionals to do this for them.

Yet we know that we cannot have adequate Welfare without adequate taxes. Any avoidance of this truth adds to our problems, not our solutions. Even so, many people (us?) talk with easy collusion of two eternal bogeymen: the *Government*, which deprives our community of rightful Welfare, and *The Tax Man* – a kind of horizoned, governmental Black Rider who intends to expose and extort what is ours for the baleful government. We, the good citizens, remain innocent victims. We should have what we want and choose.

Most of our social relationships cannot bear this kind of searching personal analysis (I have tried it). Clearly our destructive lack of realism goes far beyond Rachel Clarke's targeted politicians.

Here is a small but significant remedy: we should all avoid talking of Tax *Burdens* and speak instead of our Tax *Contributions*.

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The book's depiction of *inadequate funding* being central to our systemic problems poses similar conundrums of partial truth. Few will argue that the funding is adequate – apart from the government that wishes to conceal this from a tax-averse electorate whose support it needs to survive.

But the broader truth is demonstrably more complex. For parallel to inadequate funding lies our continually burgeoning devices to drive up *efficiency* and *value-for-money*: our ever-increasing schemes, systems, management reforms, competitive tenderings by marketised Trusts, sticks and carrots, formalised appraisals and inspections, scaling-up for economy, standardisation and measurement of every conceivable activity, the elimination of outliers … This incomplete list indicates the lengths we have gone to to make our healthcare more like a manufacturing industry. It is a perverse fruit of our culture of consumerism: cumulatively it is poisonous.

In my view it is this, more than lack of money *per se*, that lies behind the unhappy world Clarke depicts so well. For the widespread conflicted misery comes more from human alienation than 'simple' poverty. My own medical career started at the end of the 1960s: our working hours were generally longer and our resources much less. Yet work satisfaction was much greater, vocational spirit higher and contentious distress much less.

So what are we missing? I think this is best described and explained by an analogy.

Before our recent decades of cumulative reforms our healthcare was like a healthy *family*: most encounters were cooperative, attuned, respectful, and intelligently caring. Boundaries and understandings were flexible and negotiable. Trust was assumed and only exceptionally transgressed. The most creative, satisfying and healing work sprung from all this: regulations were rarely invoked; talk of contracts was rarer still.

But some families fail, some very seriously. So our serial reformers have dismantled the vagaries of the family and instead mandated the (fictional) security and certainty of the *factory*. The two are mostly polar opposites: far from the healthy family's flexible synergy and cooperation, factories depend on a rigidly hierarchical system of rules, roles and relationships that enact a primary division: *executive intelligence* (EI), which designs, funds, instructs, monitors and inspects (designers, production and financial managers, inspectors etc) and whose decisions cascade down to *compliance healthdroids* (CH) who are employed to obey precisely what is in their contracts, as designated by EI. As with factory workers CH are not expected to exercise their own experience, intelligence, judgement or ethos – indeed, these are discouraged as they are now provided and prescribed exclusively by EI. Likewise, the experience and relationships of CH are of little interest to EI, much as they would be to Factory executives or their shareholders. CH are expected merely to show up on time and do what they are told.

So what then gets lost, in this cascaded system of executive intelligentsia and compliance healthdroids? Well medicine loses its art, its heart, its soul, its spirit, its

wit, its intelligence, its philosophy … and its vocational home. I was fortunate to have been welcomed into a good vocational home for so many years. I am greatly saddened that Dr Rachel Clarke and so many of her peers have, instead, been passed a poisoned chalice rather than a rich inheritance. I fear for the future, yet such ill omens may lessen if we heed her book of such candour and courage.

Boadicea has led a charge with a battle cry: *More funding!* Yet we want and need more than that. How do we respond?

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My Life in Your Hands. A Junior Doctor's Story
Rachel Clarke (2017), Metro Books, London

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