Whatever happened to professional judgement and responsibility?

David Zigmond

The erosion of a gratifying sense of professionalism is now – belatedly – often cited as a major factor in the collapsing morale of NHS doctors. How has this happened?

In the decades of NHS history there have certainly been sporadic stress-symptoms amongst its healthcarers before, but never such gathering fractious unhappiness and demoralisation. Often this is now expressed in disputes about money, or working hours or contracts, but these surely also signify deeper frustrations: for older doctors remember much longer hours for less pay – yet they were happier.

Why? What have we lost?

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Much of our institutional dis-ease can be attributed to our serial reforms. These have mostly extinguished our erstwhile *family*-like professional relationships, affiliations and modus operandi. Instead, our reforms have replaced these with *factory*-modelled systems, procedures and regulations. Collectively these have precipitated a new kind of restive loneliness and anomie.

An important aspect of this disconnection is *deprofessionalisation* – the focus of this short analysis.

In medical practice being professional used to mean that an individual doctor carried responsibility for the competence, compassion and probity of their practice: themselves and, often, their staff. The individual practitioner was accountable for assuring high standards in these matters: it was usual to assume their presence, unless there were contrary indications. Their *absence*

had to be adduced by real-life events, not putative or theoretical risk. Any such real-life failures then became major and serious responsibilities for management. This old system thus usually allowed – depended upon – a basis of trust in the professionals' capacities for judgement and responsibility. Relative autonomy, dependent on good motivation and colleagueial vigilance, was the implied norm. Innocence was assumed, not – as now – guilt, which can only be removed by procedural compliance to an endorsing authority.

But such a trusting regime had its failures, just as families do. So our serial reforms were set up to prevent any failures and protect us all: systemising pre-emptive *risk-management*, displacing the reactive by the proactive, and turning our healthcare culture from family to factory. Through these we would transform our healthcare by increasingly emulating manufacturing industries.

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Let us consider how these operate.

Factories derive their efficiency, reliability and safety from two inseparable and essential principles: *strict compliance* to a *rigid hierarchy*. These work as a kind of relay. A manufactured object, for example, typically depends on the stages shown in the following figure:

The hierarchy here manufactures an object by, 1: defining *what* is to be made, 2: defining *how* it should be made, and then 3: *strict obedience* to the precise instructions from 2. Nothing less than complete and automatic compliance of the workers can assure reliability of the object.

This, increasingly, is how we attempt to design and deliver our healthcare.

So how does this translate, from manufacturing industries to healthcare?

On the surface, theoretically, quite well. In providing our (intended) reliably commodified healthcare we now have three similar stages to assure governance. These are shown in this second figure:

1. **Executive 'expert' committees** (policy makers, specialists, academics, management consultants etc) who design and prescribe schemes and action plans = *what* is to be done.

2. **The Control Tower** (managers and their extensive devices to signal and monitor) who implement these executive plans by issuing strict instructions, and ensuring compliance = *how* it is to be done.

3. **Healthcare workers**, whose job is to do precisely what they are told = *doing* it.

Figure 2. **NHS Governance: REMIC**

We can call this design-control-and-command system *REMIC* (remote management, inspection and compliance). It has evolved rapidly and massively since mandatory – so ubiquitous – computerisation. Synchronised *Gigantism* – the tendency to ever-larger institutions – greatly helps both industrialisation and REMIC. So, while IT is essential to REMIC, Gigantism expedites it. We must acknowledge how these 'modernising', industrialising influences have streamlined and improved those parts of healthcare that are truly mass producible. Equally, such modernising devices have helped eliminate some hazardous outliers – our DSRs (duffers, slackers and rotters).

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Elsewhere we are less fortunate, for as we develop REMIC and Gigantism, our managers, then practitioners, become increasingly detached from understanding relationships, human vagaries of context and meaning, and therefore what may be most possible and wisest in any particular and difficult

situation. For wisdom is often about knowing what to overlook: an antithesis to REMIC.

These increasing anomalies are a serious matter. This is because they deracinate not just the art and heart of medical practice, not just its professional judgements and responsibilities, but also the subtle but deep personal pride and gratification we may get from our work … *when* we are trusted and dignified to be both personally and professionally responsive and responsible. Generally this wiser trust sustained previous generations of doctors with much better morale and motivation than now.

But our excessive use of command-and-control systems has constituted a kind of confiscation of such professionalism. Such systems replace our human intelligence with artificial intelligence, our professional judgements with corporate algorithms. Yet the losses turn out to be much more than cognitive, they are also deeply relational and affective: for as such alienating proceduralism has massed, it has sapped our spirit and heart for the work.

So now our professional body suffers a kind of heart failure: we can extend this metaphor, too, to its understanding: procedural overload and inadequate human perfusion.

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