Collateral damage: the policed industrialisation of healthcare. A personal and professional recent history

You may recall the sudden and draconian closure of my small, long-established and very popular inner London General Practice by NHS England and the Care Quality Commission (CQC) in 2016. Realising that this drama was but one episode amidst much wider troubles throughout welfare services, I have, in the period since, thought, talked and investigated widely around our health service. In this process I have attempted to engage these authorities in a dialogue which gets beyond the procedural, the managerial and the legalistic. I have failed to do this, and so the following constitutes a kind of valedictory history of this complexity, both personal and organisational. I attach, also, a 'virtual' dialogue – the kind I imagine and wish we might have started. I hope both may be of interest and help to you, and that the considerable length is at least matched by quality of thought, narrative and argument.

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2016-7

The practice closure was followed by a brief flurry of public interest carried by the media and on the internet.[1] The CQC maintained that my documented compliance to regulations was so egregiously bad that my practice must be immediately closed, for public protection, by exceptional legal order, obstructing my request for legal representation and thus postponement.[2] I maintained that this charge of extreme hazard was specious: that this small practice was, rather, a clear example of how the rolling-out of ever-more rigid regulation often rolled over and crushed much of

greater value, often heedless of what is crushed. Our regulation is then more harmful than helpful. In my own particular case, I argued from another, and more vernacular, kind of evidence: that of an excellent long record – of patient and close-colleagueial relationships, accompanied by the remarkable absence of complaints and critical incidents – notably these were clearly recognised in a previous and positively glowing CQC report just two years earlier (with only improvements in the meantime). All these offered, I believed, far more realistic indicators of competence, safety, compassion and probity than this incumbent regime: a mandate of box-ticking for all 'performers', to demonstrate documented compliance to prophylactic regulation.[3] Very significantly, I had been writing about the destructive aspects of such formulaic 'solutions' for several years prior to the CQC's existence.

I have never argued that such CQC measures are always wrong, rather that they are certainly not always right, and that evasion of this complexity can be very damaging. It is like any medical screening, diagnosis or treatment: real harm can be done to exceptions, anomalies or outliers. As in medical practice it is important to know when this is happening. So all such activities need our intelligent restraint and humility – and sometimes eccentric objection – as much as assertion: we need to know when to desist, deflect or stop.[3]

At the time of my practice's closure I was increasingly troubled by authorities' heedlessness of this first Hippocratic principle: *First, do no harm*. I had witnessed how widespread and serial reforms – our 'treatments' of the NHS itself – were often actually making our NHS sicker, both personally and organisationally. This seemed to me particularly true of ever-more extensive and ratcheted appraisal and inspection regimes: these were – overall – wearying, stressing and burning-out many

otherwise good-enough (or significantly better) professionals.[4] Increasingly we are flogging a dying horse.

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In my last years of practice, I had written and published these views to stimulate thought and raise alarms. I attempted the equivalent in professional meetings, often to be stymied by management's prescribed and blocking agendas. Attempts to engage managing authorities in courteous, thoughtful dialogue seemed doomed to circumvention After nearly forty years in General Practice I now considered many of the burgeoning regulations were often unsustainable, contextually non-sensical and even – most crucially – destructive to more important tasks. This experience seemed true across the generations of practitioners.

What to do? I hoped that a kind of well-mannered Ghandist 'non-cooperation' might galvanise management's broader and better sense. My belief that this was possible drew equally, probably, from hubris and naivety.

Events then quickly demonstrated how my mission may be correct, but clearly my method was bound to fail.

I am aware of an interesting and instructive parallel here: the divergence of mission and method – isn't that central to my analysis of what has gone so seriously wrong with our ratcheting reforms? Clearly this is easier to critique than avoid.[5]

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2018

So, many months on, what do we find in the profession and patient population I left with such mixed sorrow, regret and relief?

In this period I have attempted to assemble and understand the prevailing bigger picture, realising that my own experience is just a small, if dramatic, part. To do this I needed to conduct a kind of informal field-research: hundreds of personal conversations with practitioners, patients and managers, together with material in the public domain.[6]

The more parochial picture from my own erstwhile patients and close colleagues is grim. Patients report the replacement services offering poor access to ever-changing doctors who seem stressed, rushed and thus officious: personal continuity of care seems to have almost disappeared. Practitioners glumly report their complementary role and respondent frustration.[9]

The larger picture that emerges seems unmistakably one that I was long warning about and campaigning against. Any satisfaction I could savour about being correctly foresighted is short-lived and massively eclipsed by the consequences: what pleasure is there in seeing my erstwhile much-loved, yet (inevitably) flawed, profession become so craven, fragmented, stressed, dispirited and mistrustful … thus compromising even further a difficult and demanding job? The damage done to patient-doctor access, relationships and quality of care is then inevitable. As you will see in the later and attached dialogue, how this happens, and then what it leads to, takes many forms.

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An underlying and anchoring principle is this: *our healthiest welfare services grow and survive best from matrices of trust, encouragement, human connection and meaning. Conversely, attempts to manage or engineer such services – predominantly by forensically-spirited checks and punishments, grounded in command-and-control human systems – will manage, mostly, only short-term compliance. Healthy growth becomes increasingly impossible.*

The longer-term penalties of failing to heed this are the perverse consequences we now struggle with.

Exceptions? Yes, of course. But what are the hazards of disregarding this seminal truth?

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We have a tragedy of errors here. A historical similarity – far more massive and shocking – may nevertheless serve as a kind of explanation.

> In the 1960s the USA government believed they could win the Vietnam War – both militarily and hearts-and-minds – by eliminating the 'bad' Vietcong[7]. The USA then guided their campaign by assumed metrics and algorithms: if they could kill ten Vietcong to every one of the Allied (USA and South Vietnam) Forces, then they would surely win the war.
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> What followed is, retrospectively, horrifically stupid. The USA adopted the strategy of killing as many Vietcong as possible. But Vietcong were often hard to identify definitely, so then anyone

who was *possibly* a Vietcong was killed: that way the figures would be assured and the war would be won.

But the war did not go well for the USA, despite their vaunting very successful death-yields: Vietcong fresh recruitment kept exceeding the deaths, and with that recruitment came hearts and minds. The indiscriminate slaughter – to ensure a predominance of Vietcong deaths – almost certainly resolved the surviving lives to opposition. The greater the American 'success', the more they were bound to fail.

Eventually, in the 1970s, the USA realised it had become a victim to its own follied misassumptions: taking out 'bad' people could not have made anyone 'good', or any better. Stumbling towards peace would require much more understanding of what makes for our better trust, cohesion and any kind of peaceful, viable cooperation. The next decades would unearth and demonstrate just how counterproductive their coerced 'solution' had been.

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Of course, it is important to distinguish between napalmed villages and, say, the closure of small, popular general practices. But there are instructive parallels.

The common central folly is the hubris of control without the kind of engagement that brings understanding. Such regimes – predicated on design-command-control mindsets – have a natural history: they initially seem to have decisive clarity and resolve which launches into early success. But then, like a motor engine without adequate coolant or lubricant, they will eventually slow and then seize through increasing internal friction. Such a situation is hardly likely to be helped by trying to drive the motor harder. Yet this is the equivalent of what we are now doing in our welfare services: '*We must have more rules, regulations, goals, checks and punishments,*

whatever the cost'. This – as we are witnessing – becomes doomed to a kind of institutional self-damage.

So, curiously, this is the common fate not just of the most terrible dictatorships of the last century, but also our more benignly intended attempts at current welfare reform – those whose rapidity and rhetoric leaves behind our more subtle engagements and understanding.

True-spirited democracy is slower, more cumbersome and messy, initially at least. But it has enough coolant and lubricant to keep its engine running.

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Our increasingly troubled remote management inspection and compliance regime (REMIC) finds another and more contemporary instructive parallel with our civilian policing. Stop-and-search is sometimes truly necessary, but its inordinate use will surely add to our problems. So the balance is always difficult, and directive formulae from HQ have often made matters worse. To cause least damage to the wider interests of our community we must constantly relearn the values and skills that come from contextual knowledge and intelligent discrimination.

Isn't this capricious – fallible and risky? Yes, but less so than our overzealous yet doomed initiatives to eliminate all such risk with universal formulae.

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In my first decades in practice I had many conversations with colleagues and managers about these matters. Questions of individual, group and governmental responsibility were much discussed, but little dictated or boundaried by officialdom. So the profession was trusted with much more judgement and responsibility, and so accountability. Curiously, I found that old fashioned world to be much less hierarchical and authoritarian than now – as a young junior I often talked with people at many different levels in ways that have since perished from loss of time, autonomy, trust, language and culture. Through these previous, less formal and formulaic times, much more seemed to get done without the kind of authoritarian mistrust that has now taken hold.[8] Of course there were faults and imperfections, but few veteran practitioners perceive that their working life is now safer or more efficient. Almost all would say it is less pleasurable.

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As I became an older practitioner the culture utterly changed. Certainly, we are now replete with all the correct words and phrases that seem to empower, encourage and democratise: *patient-choice and transparency, coordination, consultation, three hundred and sixty degree feedback, integration, dialogue, compassion, dignity, open-consultation, advocacy, going forward, …* Yet these words were rarely heard three decades ago despite, or because of, the fact that such experiences then emerged more readily, implicitly and naturally: we did not need to constantly talk about these things, or manage them. It seems that as we have driven out the natural growth of these qualities with our industrialised welfare, so we have vainly attempted to compensate for their loss by a kind of sanctifying, then propagandising, language.

It is no coincidence that the term *NHS Trust* was introduced at the time when the actual and natural trust of our services was being destroyed by marketisation. We are left with many legal Trusts, but little human trust.

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These are the kind of topics I tried to talk with my latter-day managers and administrators about. Almost always I was met with avoidance, obfuscation and obstruction.

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After my retirement I thought this pattern might change as I would no longer be an organisational anomaly or operational threat to executive officers or organisations. This has not happened. For example, my very carefully phrased missives inviting exploration and debate have usually drawn no reply. The two replies I did receive were epitomes of procedurally-anchored and defensive justification, steering well clear of my invitations to a different kind of dialogue.[10]

So why do I persist? Well, my motivation extends far beyond my obstinacy or vanity: it is about my reluctance to relinquish an ethos that I learned, practised, cherished and taught over five decades. It is about the kind of world I continue to want to live in, and the kind I do not, and the one I am leaving behind.

Ghandi said *'Be the change in the world you wish to see.'* Well, my preferences have always tended to philosophy rather than procedure, to understanding more than

data, and to dialogue exceeding declaration. So if I want such dialogue I must build bridges and then keep them open.

In view of the effective lack of response from the relevant authorities I have created a 'virtual' dialogue with NHS England and the CQC: what I believe a candid and courteous initial ten-minute conversation would sound like – were we to risk such an unprocedural interchange. It is in the attachment *Life After Death*.

If you wish to join in a real life (before death) dialogue I will certainly respond.

The more laws the less justice

– German proverb

Attachment

Life After Death. A posthumous dispute (Article 108)

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Notes and references

1. My own account of these events was written in the week after the CQC inspection, and several months before the official report was published. It is titled *Death by Documentation. The penalty for corporate non-compliance*. This, together with later relevant accounts, and my limited replies from the CQC, are found in Section G of my Home Page. Newspaper articles were carried in *The Guardian* and *The Observer*, among others.

2. This is documented in relevant NHS England records, IPSOS MORI polls, etc. In recent years these have been internet-accessible.
3. I expanded the evidence and arguments for this in, for example, Articles 77 and 89 on Section G, Home Page.
4. The innumerable private accounts of these are supported by consistent and convergent statistical data from a wide range of collators and researchers, eg The Kings Fund, Office for National Statistics, Health and Social Care Information Centre, NHS Digital and the British Medical Association. The data is drawn from both experiential questionnaires and relevant events, eg sickness, emigration, recruitment, career abandonment.
5. I am certainly respectful of the complexity of your task, though still maintain the conviction of my critique. The fact that I may err in similar ways does not detract from the validity of importance of the argument, but it does demonstrate how tricky it is to navigate.
6. These interviews were as untendtious as I could make them, both in selection and style. With very few exceptions people described what I have generalised here. The exceptions all held official posts they were anxious to defend.
7. Amidst the immense scholarship and journalism of the Vietnam War the meticulously-made documentary films *The Vietnam War* by Ken Burns and Lynn Novick are the most intelligently clear introduction I know.
8. A narrative account of the changes in the ethos of NHS management in the last forty years can be found in *Healthcare's Hole in the Heart. Can we have value for money and not lose our humanity?*, Article 60 on my Home Page.
9. The sudden cessation of personal GP services to patients caused much immediate agitated anxiety, distress and physical hazard. This occurred despite the stalwart efforts of NHS administration staff making emergency recruitment arrangements. On at least two occasions emergency services had to be called to help contain distressed and angry protests.

   Two years later, several patients still contact me for more bespoke guidance and skilled support: they tell me the replacement services cannot or do not respond to their needs. This says a little about me, much more about the residual services.

   Erstwhile colleagues endorse and elaborate their perspective of this picture, while anxiously guarding their patch and avoiding conspicuity.

10. The official replies can be found in Section G of my Home Page.