Industrialised healthcare:

how do we replant our human sense?

A response to a King's Fund report

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In 2014 the King's Fund published *Reforming the NHS from within. Beyond hierarchy, inspection and markets*. This is a bold study showing how recent reforms have helped neither the economics nor the efficiency of the system. Here, four years later, is a response written to Professor Chris Ham, the author and longstanding Chief Executive of the King's Fund: it builds on the King's Fund's arguments to consider further the psychological and social damage caused by the reforms.

Tractored out. Dorothea Lange, 1938

Tractors replace not only mules but people. They cultivate to the very door of the houses of those whom they replace.

Dorothea Lange and Paul S Taylor

An American Exodus. A record of human erosion, 1939

Dear Professor Ham

Industrialised healthcare: how do we replant our human sense?

> *Just as modern mass production requires the standardisation of commodities, so the social process requires standardisation of man, and this standardisation is called equality.*
>
> Erich Fromm (1956) *The Art of Loving*

Thank you for recently giving me your King's Fund report *Reforming the NHS from within. Beyond hierarchy, inspection and markets* (2014). Despite its being published four years ago, and its long gestation period prior to that, I believe that its analysis and suggestions are now even more accurate and apposite – emergent events are a growing endorsement of your clearly written doubts and cautions.

Yet despite my strong agreement with your report's main arguments, I wish to offer some further caveats and variations of emphasis. This mixture of complexity and clear public importance has urged this long-considered (and lengthy) response.

I have not here adopted your sequence or convention of form, but instead opted for rubric questions, selected points and anchoring illustrations in real (though disguised) case histories. I hope, therefore, that what I jettison in formality and referenced detail is at least compensated for in substance and readability.

1. A personal preamble

My variations of view from, and elaborations of, your report can find helpful explanation in our relative vantage points. These we both occupied for several decades – you as a veteran academic researcher, health systems analyst and advisor; myself as frontline NHS GP and psychiatrist, holding the same posts for

forty years. So, I assume, your analysis draws much from data, statistics and official reports; mine from experience – my struggle to understand and make helpful, longer-term, sense of individuals' lives, and then the service I must work in. In this way your report's view draws from a cool collation of the objective; mine comes from myriad inter-subjective and often heated narratives over a very long period, in which, only periodically, could I lift my gaze to take in the bigger picture of our service and its changing culture.

Thus the material for views is different, yet clearly related. One richer in impersonal and abstracted data, the other drawing more from long, direct personal experience. That there is such convergence is reassuring for each view's cogency, yet worrying for the indication of that consistency: our NHS has enormous, yet misconceived, problems.

2. Fifty years of doctoring: a very broad and brief view

I was asked recently what I thought were the main changes I had witnessed in the NHS since the end of the 1960s. 'Everything to do with machines and technology has got better, most things to do with human relationships and understanding is worse', I answered quickly. This was a brief conversation, so there was much more I did not say: for example, that variation is less, so management, reliability and safety are greater … but that these efficiencies are often paid for by a loss of much that was valued by both NHS staff and patients.

Yet, on reflection, even such considerations merely elaborate and anchor my initial briefer statement: that in its machine-like operations the NHS may appear to function better; in its human experiences and matrices it does not.

3. The NHS as a faulty machine

But is it true that the NHS-as-a-machine has *really* become more efficient over the decades? Proof, or even clear inference, may be impossible to establish incontrovertibly. Yet what your report does assert clearly and thoroughly is that successive reforms dating from the Thatcher era have rarely yielded the promised benefits or economies.

Your report identifies three main approaches driving and guiding these reforms:

1.   Targets and performance management
2.   Inspection and regulation
3.   Competition and choice

Much of your report carefully analyses and explains how these externally imposed and managed ways of operating have added very substantially to complexity and thus cost of the services, with usually no evident longer-term benefit – yet sometimes with perverse consequences.

It is the perverse consequences I particularly wish to consider in this response.

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Several years ago I made a similar cultural and organisational analysis of the NHS's troubles. The three driving forces I define are certainly similar to the above, but the differences and elaborations constitute, I think, useful additions to your scheme. They are:

A. *The 4Cs*: Competition, commerced commissioning and commodification.

B. *REMIC* = remote management, inspection and compliance. Good analogies here are the largely robotic factory or air traffic control centre.

C. *Gigantism* = the mandate, whenever possible, to merged and ever-larger units (eg hospitals and GP surgeries).

Gigantism is the one principle I highlight that receives relatively little attention in your report: as you will see, I think Gigantism is particularly damaging to pastoral healthcare.

At various points in your report you express the view that highly managed and externally imposed changes are not as effective as more nuanced, maybe slower, changes that are encouraged to evolve from within healthcare professions and their organisations.

My assertion exceeds this: it is that our current excess of such external management is not just ineffective: it is damaging and destroying the internal motivations, capacities and spirit of healthcarers – the very elements that make otherwise healthy evolution possible.

4. **Bad humanity is bad economics**

The King's Fund, as I understand it, spends much time and resources collecting and patterning data about how our public funds are used in our healthcare, and whether these are the best options. So your reports tend to evaluations of efficiency and economics.

I have come to these concerns primarily from elsewhere – as a practitioner, not a researcher, who has seen the incremental depletion of my profession's morale: their spirit, creative intellect, healthy pride and secure attachment in their work. As your organisation knows well, the measurable indices of these depletions – shown in sickness, breakdown, burnout, premature retirement, litigation, parlous recruitment – all indicate how serious this is.[1] At the time of writing (July 2018) the new Secretary of State for Health had signalled his alarm at the evidence of endemic bullying within the NHS.

So your report shows how our current systems give us poor efficiency and economics: my emphasis builds on these to consider how these are both cause and effect of our poor humanity. And then, how and why are we doing this?

5. **Different approaches to our health needs**

Your report draws attention to the serious problem of relative (to comparable nations) underfunding. I certainly do not dispute this, but wish to place this problem in the context of another: we are often misusing the funds we have by increasingly adopting an inappropriate model. This needs some definitions and explanation.

Curative treatments (CT) are those encounters where procedural technology has a very high rate of complete problem elimination. Generally leading-edge advances may be transiently controversial, but established practice is not. Examples: Polio vaccine, Appendicectomy, Cataract surgery, Hip replacement.

Pastoral healthcare (PHC) is what healthcarers can do when we cannot decisively 'fix' with procedures and technology, a problem of health or distress. Yet with knowledge, interest and skill we can offer guidance and support of a kind that may induce various kinds of healing, comfort or re-view in the sufferer. This approach (PHC) accounts for: almost all of mental health and a very large part of General Practice, care of stress-related, very chronic , terminal and ageing conditions – altogether probably the larger part of healthcare activity, though not technical resources.

The distinguishing characteristics of curative treatments and pastoral healthcare are clarified in this figure:

	Curative Treatment	Pastoral Healthcare
Aim	'Fixing' a problem	Comfort, adaptation, skilled guidance, encouragement, subjective compensation
Key word	Treatment	Care
Completability of task	Often. 'Cure'	Less often. 'Good enough'
Art or Science	Predominantly science	Usually complex amalgam of art and science
Type of knowledge	Generic = what is generally true for this group	Idiomorphic = what is true for *this* individual *now*
Deduction or personal imagination?	Mostly deduction	Personal imagination indispensable
Personal knowledge and understanding	Relatively unimportant	Usually crucial
Role of objective diagnosis	Central and mandatory	Often peripheral and relatively disregarded
Human and personal meaning	Unimportant	Central

	Curative Treatment	Pastoral Healthcare
Insistence on procedure?	Often essential for safety and efficiency	May be destructive to engagement and efficacy
Helped by Gigantism?	Mostly yes	Generally no
Standardisation?	Generally yes	Generally no
Subjective or objective?	Mostly objective	Objectively processed inter-subjectivity
Measurable?	Generally easier	Difficult
Role of personal relationship	Peripheral	Central
Doctor-patient interaction	Didactic	Dialogue, dialectic
Relationships of resources to patient	External (eg conduction of drugs, sutures, stents, prostheses, advice, energy beams, etc)	Internal (eg induction of patients' capacities for immunity, growth, repair, trust, courage, hope, transcendence, etc)
Underlying philosophy	Biological determinism, atomism	Existentialism, humanism, holism
Controllability by REMIC	Easier	Very difficult, can be harmful
	Curative Treatment	**Pastoral Healthcare**

Figure: Curative Treatment and Pastoral Healthcare

You may see an equivalence of clusters in this Figure and Figure 1 in your paper. For example, Curative treatments may often be well-processed by Command-and-control approaches; Pastoral healthcare needs Systems thinking.

6. **The complex triumphs of curative treatments**

> *Nothing vast enters the lives of mortals without a curse*
> – Sophocles , 496-406 BC

In the last hundred years the accelerated development of biomedical science – and then its predicated and standardised treatments and prevention programmes

– has been historically spectacular. For example, the elimination of numerous lethal contagious infections, the eradicative treatments of many cancers and the prosthetic replacement of our failing parts are all – for the first time ever – what we have come to expect. The lives of thousands of millions have been assured and their likely fates changed. Inevitably our thinking, and then our culture, change too.

One of these changes in healthcare has been the pre-eminence now usually assumed for the biomechanical model and its basis in a particular kind of evidence. After all, our curative treatments have been so extensive and successful we can apply its methods across *all* the problems and dilemmas encountered by healthcarers, surely? Many would assert, partly correctly, that medicine advances by replacing the caprices of pastoral healthcare with the certainties of curative treatments.

This is a complex and partial truth, yet it has been eagerly and entirely adopted by most healthcare reforms in the last three decades, so replacing better PHC with what amount to scientifically attired nostrums: these have the appearance – but not the effect – of genuine curative treatments. The results are specious – formidable-looking but often hollow in effect. There are many examples amidst mental health diagnoses, procedures and care-pathways. We then come to overinvest in systems rich in data, technical discourse and managed procedures – and so, inversely, impoverished of personal understanding and engagements. And then the inevitable happens: if we overinvest in the treatment model, we then neglect or even deracinate pastoral healthcare. This accounts for much of our service's restive and demoralised inefficiency – particularly, as already exampled, in mental health.[2]

7. In healthcare, the more we can fix, the more we cannot

Seek simplicity, but always mistrust it
– Alfred North Whitehead, 1861-1947

This epithet about healthcare may sound self-nullifying, but it is not: it expresses a growing and inescapable dilemma in our individual and social lives that continues to expand as we avoid considering it. It is a conundrum, now pivotal.

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In the last century we have eliminated or contained a galaxy of previously lethal or crippling diseases. We have 'fixed' them and most of us live much longer.

But the price we pay for this success is often high in several ways. Our later deaths mean longer declines, which means an accumulation of inexorable degenerations which doctors will be less and less able to fix. As curative treatments expand, so too does our need – later in life, maybe – for pastoral healthcare. Eventually our skilled humanity is almost all we have to offer one another.

There is another – I think tragically human – aspect to this conundrum, and it is this: *if we are not struggling to survive, we must search for meaning*. In medical terms we can see society enacting this over the decades: in my parents' youth GPs' work was more dramatically about survival: a toddler dying of diphtheria, an elderly man blinded by cataracts, a teenager lamed by Polio, a young mother

doomed by kidney failure … all – doctors and patients – were more powerless amidst harsher fates. Doctors tried to fix, but usually could not.

GPs now can do much more with curative treatments, either directly or by referral. Yes, there are some contemporary examples similar to the above, but they are much less common. So what has filled the gap? Partly our longer, degenerative declines mentioned above; but, quite as much, we are now increasingly troubled – symptomatised and sickened – by our search for meaning and our problems of living. So the GP is now most unlikely to see Rickets – the failure to build an aligned physical skeleton; but most GPs' work is now spent dealing largely with the polymorphic varieties of individuals' difficulties in forming viable *mental* skeletons – secure, stable and satisfying senses of self-amongst-others. Hence our inexorable rise in afflictions of BAMI (behaviour, appetite, mood and impulse), and the stress-related physical syndromes. Few of these are readily fixable, so are poorly served by curative treatments. Yet, in our CT-templated service, that is what, increasingly, we presume to apply. Even more paradoxically our pastoral healthcare, which is best suited to addressing such problems, has been largely extinguished. So we have – by creating an 'illness vacuum' – simultaneously created new forms of health problems, while systematically driving out the very ways that we might personally contain, guide and heal such problems.

The troubled and ineffective medicalisations of psychiatry, and latterly clinical psychology, are prime examples of the misapplication of the CT model amidst the death-by-attrition of PHC. A simple index of this? Few psychiatric patients now know the name of the psychiatrist they last saw. A regime that has yielded

us this has clearly sacrificed personal continuity of care to a managed relay of procedures. Few veteran practitioners would sanction such displacements: in their time they have learned better. What does this portend?

Such misappropriation of therapeutic space is bound to be inefficient, and so it is. And again, bad humanity is bad economics.

8. **So what is the best place for the *modus operandi* of regulation, command-and-control, REMIC and so forth?**

> *Not all that counts can be counted; and all that can be counted counts*
> – Albert Einstein

Generally speaking, these dovetail with the distinction between CT and PHC: curative treatments are often compatibly and efficiently managed in this way; the opposite is true of pastoral healthcare. Here are some examples:

1. **CT. A coronary artery surgical operating theatre** needs clear, precise and rarely variable rules, protocols, regulations and systems of checks and inspections to ensure safety and efficacy. Generally, experts can effectively cascade authoritative instructions to the many workers as to what should be done and when. Variations of personal meaning, motivation or experience in such curative treatment procedures are almost entirely irrelevant. Continuity of procedure here is vital; continuity of persons peripheral. If the tight management is courteous, accurate and viable it will arouse little contention.

2. **PHC. Mildred**[3] is in her early eighties, very active and without serious illness. She has known Dr R, her GP, for fifteen years. Last year her loving husband Ralph died suddenly, from a stroke. Since then Mildred has suffered numerous apparently unrelated minor complaints which Dr R dutifully treats while gently alluding to her grief: Mildred nods in agreement as she swallows and glances at the door with moistening eyes – she politely parries further discussion and then Dr R's suggestion of counselling.

Dr R has long been struck by Mildred's stoic and introvertedly melancholic demeanour. Years ago she told Dr R that, when she was a teenager, her mother had died in a mental hospital. Yet Mildred, as so often subsequently, had not wanted her painful memory touched directly. So it was when her only child, Stephen, was killed ten years ago, age forty, in an industrial accident. And, Dr R supposes, this is how it is now, in her grief for Ralph.

Mildred takes Dr R's tablets, but not his suggestions for other support or ventilation. Dr R's resonant sadness is tinged with frustration at his self-perceived impotence. 'I only wish there was more I could do for you, Mildred', he says. 'Oh no, doctor. You do me far more good than you can imagine … When shall I see you again?', replies Mildred, dabbing her eyes, as she gathers her coat and bag to depart.

Mildred, it seems, wants her plight understood, yet not talked about explicitly. Dr R now understands this better than ever before. And then Dr R thinks: aren't we all like this, sometimes, in our intimate relationships?

Now Mildred (Example 2, above) represents a very common type of human problem in General Practice and psychiatry: a person whose persistent distress is not substantially helped by quasi-medical diagnoses and treatments. If we are to understand Mildred we must enter a personal hinterland of encoded signals and meanings that lie behind and beyond any standardised procedures, questions and 'evidence'. This – a more bespoke approach – puts meaning and experience at the centre of interactions: none of these can be standardised, mass-produced or micromanaged. We cannot even measure such meaning or experience directly, but are we foolish enough to deny their existence?

Not quite, but almost. In healthcare – and throughout welfare – our reforms have come with increasing rhetorical demands for *measurable* evidence, objective data

and outcomes; for schemata that can be standardised and mass-produced; and for documentation to be always computer-code and data-compatible.

The price we sacrifice for these conventions and protocols? We sacrifice human context and subtext – first the thinking, then the language, and finally the skills or the will to navigate these. The overreach, and then hegemony, of CT simulations into these vast areas has led to the creation of a healthcare culture that is now so technology-rich but humanity-poor.

<p style="text-align:center">*</p>

And what can we expect for the Mildreds of the future? It is now most unlikely that, say, in ten years' time a GP, or any healthcarer, would imagine or understand the encoded context or subtext as Dr R was able to do with Mildred. Without such personal continuity of care how could they link her polysymptoms to the unspeakable deaths of Ralph, Stephen and her incarcerated mother? How could the GP then offer that tacitly understood ritualistic healing contact that delicately offered Mildred 'far more good than you can imagine'?

So what will Mildred get instead? A psychotropic drug? More investigations? Referral elsewhere (unattended)? These managed regimes will be more procedural and more expensive. I cannot see how they will satisfy either patient or doctor.

9. What about Gigantism?

I section this separately as I think this is an important part of our problems; yet receives little attention in your report.

Gigantism, the expedient scaling-up or merging of organisations – in the interests of economy-savings, logistical and management simplification and pooling of expertise – is often vital to successful manufacturing and retail businesses. In healthcare the benefits are very uneven: curative treatments are frequently helped by devices of Gigantism; pastoral healthcare rarely so. Indeed, in almost all PHC activities Gigantism is likely to be inimical.

With high technology CT interventions Gigantism is almost always – overall – beneficial: intensive care, coronary care, stroke units, neurosurgery are almost all better when aggregated into few but larger operations. The pooling of sophisticated expertise and equipment far exceeds considerations of relationships or easy access for visitors, etc.

For example, if a man, Mr AC, develops an acute coronary syndrome and needs an urgent catheter-lab assessment with view to possible insertion of arterial stents, the benefits of the large, pooled-resource specialist centre are indisputable. This highly technical work cannot be undertaken on an occasional basis in a small, local general hospital.

But it is a common misconception to then deduce that such Gigantism should determine *all* our hospital provision; that we should then close down all small

local hospitals in the interests of safety and economy. Consider the following example:

Alfonso and Beatrice are both in their eighties, increasingly frail and struggling with proud pathos to remain both independent and together. Alfonso's diagnoses include moderate heart failure and emphysema, diabetes, macular degeneration and osteoarthritis of his lower limbs and spine. But their greater problem comes from a later development: his Parkinson's disease with dementia.

Alfonso now frequently gets ill beyond Beatrice's capacity to cope, even with good help from the GP and Home Treatment Teams: he freezes, he falls, he gets states of agitated deliria from increasingly frequent chest or urinary infections. The home-systems are not enough; hospital care is needed.

Each time Alfonso is admitted to hospital it is to an enormous airport-like conurbation. Here, each time, he is taken to a different ward under a different team where no one recognises him. Not only that, but the hospital is so large, and the staffing rotas so complex, that the clinical staff rarely know one another well.

In this enormous kaleidoscopic complex Alfonso is processed according to litigation-proof protocol. All plausible investigations are done 'just to be sure'. This includes a brain scan (why?!): Alfonso does not understand this entrapment and flails with agitation. A liaison psychiatrist is added urgently to the growing cauldron of polyspecialists.

Further protocol adds to this cauldron; according to his systematised problems he is referred to the following specialist teams: Geriatrics, Diabetology, Urology, Respiratory Medicine, Falls Clinic, Cardiology, Neurology/Motor Disorders, Dementia/ Psychogeriatrics, Liaison Psychiatry and Rehabilitation. Each of these specialists makes a fresh, templated assessment as per NHT Trust protocol. The records achieve impressive but almost unreadable bulk, while the actual, face to face, intercolleagueial dialogue becomes almost non-existent. No one takes overall responsibility or provides personal continuity of

care.[4] Meanwhile, the electronic records burgeon to such vast virtual bulk that they become less and less humanly navigable or assimilable … only a lawyer might persist in reading them thoroughly.

Beatrice, meanwhile, is too frail to visit Alfonso easily as the hospital is fifteen miles away. When she does manage the tiring journey, it is to a ward where it is not clear who really knows and understands Alfonso and his (and her) needs. Ten-teamed care is difficult to have a rapport with.

The situation does not improve after Alfonso is ambulanced home. Their erstwhile familiar and friendly small GP surgery has been replaced by a much larger Health Centre where everything seems more remote. Alfonso and Beatrice were informed by an unsigned letter that as 'vulnerable elderly' patients they would have an allocated named doctor. Yet they have never seen this person despite Beatrice's efforts: 'each time we go it's somebody different'.

Fortunately Beatrice's cognition and memory remain excellent. Less fortunately she cannot name a single doctor from Alfonso's ten-teamed hospital stay or her rapidly-carouseled, much-expanded and modernised Health Centre.

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In 1970 I worked a s House Physician in a small (by contemporary standards) general hospital, then about a hundred years old. My consultant was Dr A, a general physician who had his own 'firm', ward, nursing and support staff. We cared for many elderly patients who – like Alfonso – had multiple convergent complaints. We provided a complete service – 'general medicine' – which would only call in a tertiary specialist (eg a neurologist, cardiologist, etc) with particularly inscrutable or refractory problems. Dr A and his firm thus dealt with the vaster bulk of problems without such resource. The result? Everyone could know everyone else much better; lines of communication and decision making were shorter and clearer; care was more personally and humanly responsive and intelligent. Contemporary slogans of 'patient-centeredness', 'interprofessional integration' or 'personal

continuity of care' did not need galvanising by external experts and initiatives – they grew quietly and naturally from the family-like functioning of Dr A's firm and the personally colleagueial relationships that existed throughout this smaller hospital and beyond … to the smaller (again) local General Practices who (again) often knew their patients well.[4]

This portrayal of Alfonso, Beatrice and Dr A's erstwhile general medicine merits this long descriptive analysis because such problems now constitute the greater fraction of our acute hospital admissions: such admissions are mostly for older and frailer persons with convergent degenerative conditions, who need nursing care, recalibration of medication, drips and antibiotics, physiotherapy and reassessment of home services. Most of these do not need complex and expensive scans, an ICU or resuscitation. Many will want visits from similarly old family or friends nearby. Almost all will respond better to care by people, and in places, that can become familiar enough for personal understanding and trust to develop more easily.

Our better organisational responses to these needs are better found in smaller, more local and personal, hospitals and General Practices, surely? Yet our developments have been, almost entirely, in the opposite direction – to fewer and much larger organisations. 'Families' become factories; procedures burgeon unviably and human connections get lost; we see more parts but less often the whole.

The costs continue to rise and we sigh amidst our bustling and bewilderment.

10. IT: can we have too much of a good thing?

It is often assumed that wherever IT can circumvent human activity in a task we should use it: that we will reduce human staffing costs, variation, delay and error. A good thing, surely?

Your report seemed to endorse this view, I thought uncritically. My experience has indicated several limitations to IT use that may be subtle yet are obstructive, even destructive, to our aims – particularly in pastoral healthcare. For example, consider three 'simple' tasks that used to be part of a receptionist's role in traditional and smaller GP surgeries:

- Personally greeting patients, asking simple questions about why have they come. An appointment? For advice? For other information?

- Answering the phone, usually followed by similar questions to the personal greeting (above).

- Taking requests for repeat prescriptions and then liaising with the GP or pharmacist.

On the surface all these tasks can seemingly be unproblematically automated now. Screen interactions can greet and process patients and answer their simple queries. The sophisticated ansafone greets, guides and books patients. Efficient data systems can check and endorse repeat prescriptions. Who will object to this automation to economic streamlining? Administrators, managers and doctors have all (mostly) gone with the flow. 'It's progress', we say.

But this expedience then short-circuits some of the more subtle – yet powerful –
aspects of our roles, inherent in personal context and subtext. Often, for example,
it is very important to people who are lonely, afraid or vulnerable how they are
addressed and greeted. The receptionist's voice or manner, for example, may
determine whether a person will decide to see a doctor or not, or what kind of a
conversation they will then have.

Throughout my long tenure in a small practice I respected and safeguarded my
receptionists' roles as social antennae and buttresses in my contact with patients.
Their good sense, warm hearts and kindness helped greatly both my
understanding (diagnosis, even) and my therapeutic influence.[5]

These beneficent exchanges occurred through the reception hatch, on the phone
and when talking about doctors' prescriptions: the overt business was the
gateway, the metacommunication may lead to a related path that is often quite as
important.

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Zealous IT applications to clinical record keeping and requisite compliance
templates often bring similar sacrifices. While the benefits are readily evident
(readability, access, transmission, standardisation) the losses are major but subtle,
so often lost to us now. What does this mean?

Well, we lose sight of those losses in a similar way to the example above: subtlety
often means we may eventually perceive the effect, but are not aware of how and

when it happened. So computers, in their requirements for codes, data, categories and keywords, will mould or restrict the thinking and language[6] of the operator-practitioner … and also the behaviour. 'The doctor was looking at all this stuff on the computer … no, they didn't seem interested in me, just what was on their screen…' I have heard this kind of description of IT-era consultations hundreds of times: it is destroying the human heart and imagination of pastoral healthcare.

11. Should we protect doctors from 'trivial' requests and consultations?

The more you see of someone, the more of someone you see

Here is a commonly expressed notion, iterated in your report: doctors are lengthily and expensively trained; we should expect them, therefore, to deal only with important or complex problems. Other 'trivial' or procedural problems can be swiftly despatched elsewhere.

This scheme sounds clear and pragmatic, but is based on two unreliable assumptions: (i) that human behaviour is always rational, and (ii) that everything is as it seems. Erstwhile practitioners of greater emotional literacy knew how important it is sometimes to be free of these assumptions. Here is an example:

> **Ali** seems to want to see Dr F especially, rather than one of the other carouselled doctors sooner. He comes to her with what seem, to her, minor and transient problems: mild hay fever, a small patch of eczema, an occasional fluttering sensation of an eyelid. He appears to her a preoccupied man with a melancholic, somehow pleading, gaze. Why does he want to see her, in particular? She delicately invites him to say more. He declines but, remarkably, reaches to shake her hand as he leaves.

A year later he comes and tells Dr F a tragic and perilous domestic tale. Sabita, his much-loved wife, no longer loves him. For two years she has progressively distanced herself and he suspects that she has another love. Ali is tangled with intense feelings: lacerated love, powerless rage, lonely fear and reclusive shame. He is now – for the first time ever – drinking heavily and ruminating suicide. All of this is concealed, even from Sabita. No one knows.

'But I can tell you, doctor, I know I can … you've been very kind to me.'

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Two years later Ali is slowly building a new life for himself, without Sabita. He is sad, but thoughtful, appreciative and realistic about the decades and opportunities that lie ahead. This has not been easy and Dr F has needed other colleagues to help retrieve Ali's resilience, hope and motivation. Yet throughout this Ali has seen Dr F as his primary harbour and anchor-point.

'If I hadn't come to you that time I don't know what would have happened to me … I don't think I'd still be here', he says to her at his last appointment.

Dr F is wondering, too, what would have happened to Ali had she submitted to the expedience of the carousel?

Such are the kinds of serious problems that may ferment beneath the 'trivial'. Clearly, the human skills that are required to identify and guide such nascent problems are different from those demanded by curative treatments. The importance of this distinction was much better recognised, say, forty years ago. Then, the kind of pastoral healthcare enacted by Dr F with Ali had been recently explored, crystallised and galvanised by the work of Michael Balint. For two

decades these interests and skills burgeoned to raise the recruitment in General Practice, until the 1980s.[7]

But since then this kind of care has become increasingly unfeasible because it must have roots in ready access to personal continuity of care from doctors who have the head-space and heart-space to provide this. Generally this means vocationally-minded practitioners working in smaller units with good staff stability.[8] Yet the 4Cs, REMIC and Gigantism all pull our culture in another direction. Our reforms have rendered such care almost extinct.

So pastoral healthcare perishes; doctors' morale plummets; mental health services buckle as pundits talk of 'prevention'.

12. Transformation? Hm. What about evolution?

I want linger briefly over your word 'transformation'. It is used several times in your report to connote something bold and undeniably good.

But I am nervous: I have heard it used repeatedly by politicians and senior executives for three decades. Each reform is heralded by a phalanx of similar hypnotic-rhetorical words and slogans vaunting a new regime: among these *transformation* is a key word – *this time it will be different* – is the metamessage.

Well, I suppose, it was a bit different each time, but rarely in the way wanted and planned. The Health and Social Care Act (2012) is an egregious example. Historical parallels are many, usually depressing, often chilling.

The parliamentary mandate for the formation of the NHS in 1948 *was* a rare and true transformation in a sense that you (I think) now intend: an initiative of blessed boldness that few now dispute. Recent reforms – other kinds of transformations – have had very different yields.

In my first two decades working in the NHS (say 1969-1989) I saw improvements of a more gentle, stable and sustainable kind. This was a relatively uncorporatised world *before* such hierarchies, inspections and markets (the triad of your report's subtitle). Innate capacities and vocations were recognised, gently encouraged, guided … and (mostly) trusted.

I call that *evolution*, not transformation. Then I become more trusting.

13. **What we may do: an action-pointed summary**

In this penultimate section I want to list briefly the kind of things that we can do to reclaim some of our better human sense, understanding and connection, so assuming our better pastoral healthcare and – inseparably – the well-motivated good health of our practitioners. For necessary brevity I here hardly expand on these suggestions – I have done so extensively elsewhere.[9]

Are these changes 'transformational'? I think of them more as ecological or conservationist: reclaiming, enabling and protecting the more natural human eco-systems that can grow in sustainable ways – yet are so prone to destruction by industrial-type processes. So, like much environmentalism, these suggestions are about the retrieval, and then stewardship, of what we are losing with such heedless scramble for 'efficiency'.

Herewith:

A. **Abolish the entire marketisation of NHS Healthcare** and its apparatus of purchaser-provider splits, autarkic Trusts, financially-based commissioning, payment by results, financial penalties for comparative underperformance etc.

    The evidence of benefit is sparse. The evidence of inefficiency, waste, corruption, perversion and human inimicality is vast.

B. **REMIC (remote management, inspection and compliance) needs substantial disarmament**

    Ditto to A. Having 'police presence' is very different to living in a police state. Forensic-type inspections should be reserved for practices/institutions where there is real evidence of hazard or failure. Generally pre-emptive quality-control works poorly throughout Welfare, yet the economic and human costs are very high.

C. **Stop the closure of small, popular general practices**

    These often provide the best pastoral healthcare from an ethos of vocational practice. Most outlying curative treatment requirements can be provided via a hub-and-spoke model.

    Encourage and foster such practices rather than regulating them out of existence.

D. **Bring back General Physicians**

General Physicians used to service the bulk of hospital medical requirements, calling in tertiary specialists only with very doubtful or refractory cases. Despite the endless advances in medical care this is still largely workable and advantageous: it clarifies and simplifies clinical responsibility, anchors personal continuity of care both for patients and their attendant GPs, and makes clinical work both more integrated and personally satisfying.

E. **Abolish Geriatrics**

Most people who go into hospital are old and likely to have multiple age-related conditions. So why have a separate specialty? Almost all, in the first instance, should be cared for by General Physicians aided – of course – in matters of rehabilitation, social care and tertiary specialist knowledge.

F. **Bring back Consultant-led Firms** with their dedicated staff and wards.

This almost always helps (small) group cohesion, affiliation, identity and belonging by restoring family-type dynamics: older practitioners feel they have 'children' to care for, younger practitioners feel they have 'parents' to guide, protect and care for them. Personal continuity of care becomes much more possible and gratifying.

G. **Bring back smaller, more local, lower-tech hospitals**

Most hospital admissions are for older people needing lower-tech care, more locally, when the at-home services have failed. They can be looked after by

general-physician teams on familiar wards with far easier integration, personal continuity of care, work satisfaction and economy.

Giant, distant high-tech hospitals would exist for major surgical and higher-tech medical problems.

H. Bring back Nursing Schools

The abolition of Nursing Schools deprived hospitals of senses of belonging, affiliation, loyalty, familiarity and community. The loss of *esprit de corps* has profound effects on recruitment, retention … and nursing care.

Giant, generic universities can still be used for certain types of academic instruction – which could be pooled with other Nursing Schools – but the role of universities would be thus relegated and restricted.

Smaller, provincial hospitals could be Nursing School-annexed to larger ones.

I. Break up Medical Schools into more but smaller units

This has similarities to H, above. The ever-larger size of medical schools has led to afflictions of Gigantism and nobody-knows-anybody syndromes. This is a bad way to start.

Restoring smaller scales can mitigate or reverse many of these problems. As with nursing schools, some specialist knowledge and activities can be pooled and shared.

14. A coda: a belated riposte for Karl Marx

You began your report with a quote by Karl Marx: I wish to finish by replying to this. It is obviously too late for KM but, I hope, not for the rest of us:

> *KM: 1845* *Philosophers have only interpreted the world in various ways; the point is to change it.*

> *DZ: 2018* *I think I understand your impatience with inaction; a lot of us struggle with this. But what happens when our urge to change far exceeds our understanding?*
>
> *For seventy years successive Officers of State in Soviet Russia quoted you often: they* knew *what-had-to-be-done, yet seemed not to know what they did not know about human nature. And so then they did not care. And then they lost the philosophy you are so dismissive of. In human terms the cost was massive.*

But it seems this is a difficult lesson. It is a hundred and seventy-three years since Marx wrote this, and a hundred years since the Russian Revolution. Yet still we struggle with the same seductive folly of accelerating change, while leaving understanding further and further behind.

The Soviet system did not understand the individual's need for autonomy, initiative and privacy. The current NHS regime – of neoliberal industrialisation – seems not to understand communities' need for individual vocation, meaning and relationships.

The Soviet system became doomed by this blindness; hopefully our NHS can broaden its vision before similar catastrophe.

*

Thank you, again, for your excellent report: you have given me much to think about. I hope this response returns something in kind.

With best wishes

David Zigmond

Notes and references

1. To salvage some brevity I have not listed references for these kinds of assertions. Many of the references are well-known to you and already in your paper. Most data since 2014 reiterates the tendency of earlier quoted data. Footnote 4 (below) is a noteworthy exception.

    Throughout this response I have used sources such as: NHS Digital, Office for National Statistics, Social Care Information Centre, British Medical Association and the King's Fund. Also newspapers, *The Guardian* and *The Daily Telegraph*.

2. Problems of staff recruitment, burnout, sickness, premature retirement, intra-organisational litigation, etc are very similar in Mental Health, Primary Care and Social Work.

3. All examples in this essay are from frontline NHS practice: they are real, though disguised.

4. Pereira-Gray DJ et al (2018). 'Continuity of care with doctors – a matter of life and death? A systematic review of continuity of care and mortality', *BMJ Open,* 28 June. This is an important and thorough metanalysis published four years after the King's Fund report. It shows that continuity of care is crucial, not just for patient satisfaction and reduction of morbidity and hospital admissions, but also overall mortality. This study thus strengthens significantly my arguments against the 4Cs and Gigantism which are usually inimical to such continuity.

5. This is exampled and exemplified in *All is Therapy; All is Diagnosis. Unmapped and perishing latitudes of healthcare* (2013). This is Article 44 on my Home Page.

6. Our IT-dependent era has certainly changed our professional use of language. The kind of qualitative research and literacy imagination amongst doctors, and published by Tavistock Publications in the 1970s, say, has no contemporary equivalent I know of.

7. The equally rapid rise and decline of influence of the 'Balint Movement' in General Practice can tell us much about our healthcare predicaments. I explore this more fully in 'From Balint to Square-bashing. Fifty years of General Practice', *British Journal of General Practice*, 2016. 66(648): 372-373. Also Article 66 on my Home Page.

8. Pereira-Gray's type of research (see 4, above) could be very helpfully extended to how continuity of personal care may be related to other variables, eg the size of GP surgeries and hospitals etc, and whether the institutions are subject to short-term commissioned contracts etc.

9. I have written more fully about the following suggestions for several years, for newspapers, journals, planners and other professionals. Many of the writings can be found on my Home Page.

The Road West, US 54 in Southern New Mexico, Dorothea Lange, 1938