How may disciplining authorities best be dialogic?

Should governance have limits in Welfare?

David Zigmond

Is the nature and quality of our healthcare a primary social and political responsibility? If so, its assurance – by governmental regulation, management and inspection – must always be good, surely?

Not so: more of something 'good' is not always better – it is often worse. This paradox is often refractory to dialogue. An essayed letter, to a senior officer of a healthcare executive body (the Care Quality Commission – CQC), samples this process and what can happen.

Dear Professor Gallagher

How may disciplinary authorities best be dialogic?

Democracy means government by discussion, but it is only effective if you can stop people talking.

– Clement Atlee, 1883-1967

A few weeks ago you wrote to invite me for a 'face-to-face meeting to discuss your letter[1] and related article[2] and to ensure complex problems that affect us all can be discussed as a matter of importance.'

This initiative was immediately welcomed by me: it broke a pattern of managerial response that, from my perspective, from the last two decades, has seemed ever-more rigidly procedural, systematically didactic and thus personally and contextually unresponsive. Indeed, for many years I publicly reflected, and often opposed, these trends and warned of the likely consequences: this continuing journalism now draws from nearly fifty years of frontline work as an NHS medical practitioner, forty years as a principal GP.

This letter reflects on our meeting.

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First, I would like to start on a more personal note and comment on the *process* of our discussion.

Our meeting did not disappoint me. I found your approach to be open-hearted and open-minded, though understandably tethered by caution: you need to protect the perceived integrity and mission of your organisation. I hope that I conveyed reciprocal respect for your difficult responsibilities – even amidst my dissent.

So even starting this more informal exchange has offered some unprecedented encouragement: previous attempts at correspondence had evoked only fortified parries and justification from the authorities.[3] Our dialogue, in contrast, managed to inhabit new joint territory: this certainly needed my determined tenacity and your discerning trust to get it started. Remarkably, our allotted time of one hour then overran to two and a quarter hours; until the end of office hours. Our conversation was then necessarily stopped, but clearly was not finished. On leaving, I shook your hand and said: 'Well, there's much more we can talk about…'. 'Indeed', you replied.

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This letter continues the implications of that brief parting exchange. It is intended to be a kind of temporary bridge to further discussion. So this first span documents, in mere outline, the skeleton of our exchange. I hope it may serve as both a milestone and a stepping stone: these are early days, and there are many positive paths we may create from here…

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I want now to turn to the *content* of our wide-ranging discussion.

To aid assimilation and clarity I have itemised what I discern are the main points. (I have devoted more space to my arguments than yours *not* because I think they should be preeminent, but because the thinking and policies of governing authorities are already widely propagated and certainly known by you – my arguments are less familiar and immediate: their complexity is then all too easily discounted and disregarded.)

Herewith:

1. The avowed *mission* of the CQC (and kindred Welfare governing authorities) is all but indisputable: the stewardship of safety, competence, compassion and probity (SCCP) in our Welfare is – arguably – our most serious social responsibility.
2. But this seminal responsibility, while unarguably clear in its *mission*, becomes much more contestable in its *method*. I have always attempted to draw this distinction: it is important always to honour the aims of the CQC (and related REMIC[4] – Remote Management, Inspection and Compliance – bodies) while sometimes vigorously decrying many of their more excessive or inapposite regulations and initiatives.
3. This conundrum charged and fuelled our discussion: you talked with sincere and clear deliberation about the importance of assuring SCCP in our healthcare, and the sometimes shocking and tragic consequences of not doing so. You talked of egregiously poor standards, often disguised, that your procedures then exposed – a recent example was a GP who had (probably) never meaningfully conducted a single examination in twenty years of post-partum checks. I acknowledged the serious nature of these stories, but also

wondered how such practitioners or institutions have become so alienated or corrupted.

4. This iceberg tip indicates massive problems beneath and, surely, such enormity requires equally-scaled forces of detection and correction? I acknowledged that this argument is an important foothold used to justify CQC (and other REMIC) policy, but have substantial caveats (see later).

5. Such CQC and REMIC arguments and evidence may be consistent, but there are often other, very different, kinds of evidence and perspective to guide our best efforts. This is the basis of what I intend as creative dissent, and what I now turn to.

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6. This knowledge of, and concern about, such other strata and perspectives has certainly been informed and energised by my own adverse experience: the drama there played out may have been exceptional, yet the difficulties and traps it illustrates are not – they are common. My experience can thus serve as a canary-in-the-mine indicator.

7. In our meeting we did not discuss my case in systematic detail, and I will not do so here, but will refer to it. Much such detail you are already familiar with.[5]

8. Despite this, I think we agreed that my case highlighted, at least, two remarkable paradoxes and anomalies:
    a. Two fairly close CQC inspections (in 2014 and 2016) reached starkly opposite conclusions: the first was warmly positive, the second shockingly negative – so much so that the practice was effectively

immediately closed in the interest of public safety, circumventing the almost invariable right to legal representation. (NB The practice in those two years had improved nursing services, but was otherwise much the same.)

b. All other real-life evidence supported the first report, and so was sharply opposed to the later report. For many years the practice was extremely popular with patients and staff, with easy accessibility and extremely low levels of complaint or adverse events.

9. What do we make of such discrepancy? The CQC has stated that the report's accuracy comes from the inspection procedures being fully followed, and that these procedures are 'robust'. But what does 'robust' mean in the context of such a complex and contested evaluation? Even in the most straightforward assessments we can only be clear about estimated probabilities. Robust is never certain.

10. Let us take a medical analogy. There are very few (if any) therapeutic or screening procedures that are *always* effective or accurate. Because (always) we are faced with the possibility of anomalies, variants and exceptions to our common experience and organising concepts. Cleverness in medical practice may be about which test or procedure to apply, but wisdom is often about when to parry or avoid these, and when to be guided by something else. In many ways cleverness and wisdom are equivalent to science and art in medicine: our greater wisdom, by seeing a bigger picture, helps us navigate anomalies, atypia and contradictions.

    Is not this capacity, for imaginative flexibility, important in the management of all human complexity? Including inspections?

11. Here is a related, additional anomalous paradox, yet on a much larger scale, so now generally true across our Welfare services: as compliance and inspection regimes become denser, tighter and more 'efficient', so professional staffing becomes an increasingly serious problem – earliest retirement, plummeting recruitment, sickness, burnout, career abandonment, litigation … This relationship – between the ratcheting of REMIC and an ailing workforce – is not fortuitous, but probably causal and is therefore very important.

    So the CQC may talk of thoroughness of inspection driving up a uniformity of high standards, but most practitioners and patients can attest to how impossible this is with a consequently disintegrating workforce.[6] The mission, the method and their effects are inevitably dehiscing.

    This conundrum is not, of course, confined to General Practice: similar problems are evident throughout mental health and social work services, probation and the entire spectrum of education.

12. So what can be so wrong about applying pressure to get things right?

    It is a question of proportionality, of balance, and of necessary compromise. More of something 'good' may not be better, it may be worse. Something 'good' in one context may be very problematic in another. What does this mean?

    Some common examples:

    - Eating is 'good'; we all need to eat. But eating too much … what then?
    - Discipline and structure in parenting are necessary. But when parents are inordinate in their demands, does anyone eventually get what they want?

- Most of us want police presence, at least sometimes. But who wants a police state? Yet in such regimes the population is told it is necessary and therefore good for them – without such a regime, their fate would be dire…

- A carburettor needs fuel to drive a vehicle, but it must mix the fuel with a very different substance – air – in precise but endlessly varying ratios. Failure to provide this accurate and varying response leads to unreliability, poor economy and running, and eventual immobilisation.

13. Many of the increasing problems we have in our Welfare services are due to excessive REMIC control. The analogies above – the overstrict parents, the police state and the flooded carburettor – are all helpful[7] in understanding many of those difficulties that persist despite such assiduous (REMIC) efforts for their relief.

14. Of course, stressed executive officers often tend to denial, and to defend what they are doing. Returning to the analogies above, this is like:

    - the over-controlling parent says: '*I'm only doing what's good for them…'*
    - the police-state minister says: *'we have to have this suspicion and control: don't you realise what would happen otherwise…?'*
    - the (incompetent) mechanic says: '*I can't see what the problem is … there's plenty of fuel'*.

15. A year previous to my CQC decommissioning I was (courteously) recusant with NHS England – a kind of forewarning to us all. I wrote them an analytically essayed response to their REMIC-styled management titled '*General Practice used to be the art of the possible: we are turning it into a tyranny of the unworkable'*.[8]

NHS England never replied. Meanwhile, the assertion in this title seems ever-more true (see point 11, above).

16. Shortly after our meeting I watched a documentary film about the industrial trawling of our seas. As this has become more 'efficient' it is producing all kinds of unsustainable damage and losses that we largely disregard in favour of the immediate 'catch'. For example, large ships trail – to very great depths – enormous, fine-meshed, but very strong nets that then trap enormous yields. But often only a smaller fraction comprises the desired catch. The rest die anyway and are usually dumped overboard.

    But such overfishing is worse still: it can dislocate or destroy habitats and ecosystems on which many more species depend…

17. Watching this hi tech ocean-depletion I immediately resonated with consequences from this short-termism. How this damage-for-the-catch is now being played out – by excessive REMIC and its agents of inspection – throughout Welfare.

    For example, in healthcare it is now very hard to get to see a GP. It is even harder to see one who is likely know you, or show an interest in the importance of doing so. It is increasingly unlikely you will see them again. Family doctoring and its personal continuity of care has become humanly fished-out. Pastoral healthcare is dying. [9]

18. My own particular story – of being giant-netted and then dumped-dead overboard is a kind of small-scale tragedy for me, my patients and my staff. No, my practice was not perfect (what is?), but it was excellent and much-liked in most major, real-life respects. In quieter, kinder, wiser times the

authorities would have worked with me, with friendly cooperation, to pursue the 'art of the possible', not deracinate with a 'tyranny of the unworkable'.

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19. What to do?

Although our meeting was long, we did not have time to do more than nod towards this most important question – the aim of many more possible conversations.

In the meantime, let me reiterate these essential footholds and questions on common ground:

- the *mission* of all REMIC and the CQC – of facilitating safety, competence, compassion and probity – is the essential and core task.
- the *method* of doing so is problematic: even with the best will and intent REMIC easily backfires. When are there better, more sustainable, alternatives?

My view is that the ratcheted inspections and micromanagement of REMIC need radical pruning and reconfiguration, though with some careful retention – even the best societies need some policed vigilance and enforceable codes.

So what, specifically, do I suggest as reformed structures and strictures for our best pursuit of SCCP in our troubled NHS? My answer is far too long for this already long letter, but I have outlined my suggestions in a recent missive for the King's Fund: *Industrialised healthcare: how do we replant our human sense*?[10]

I hope you will read it and we can continue our dialogue.

Meanwhile, thank you for your attention.

With best wishes

David Zigmond

We cannot solve our problems with the same thinking we used when we created them

– Albert Einstein (1979-1955)

Notes and references

1. *One Small Altercation: a Massive Residuum. How do large systems deal with outliers* (2017). Article 95. My Home Page.
2. *The Proof of the Pudding is in the Eating. Actual and Virtual realities: how our inspection culture unhinges* (2016). Article 77. My Home Page.
   *wrong, wrong, WRONG … OUT! How can we contain one size fits all policies? Three struggling letters (*2017). Article 89. My Home Page.
3. The previous two years of correspondence are introduced and recorded in Section G of my Home Page.
4. *REMIC – remote management, inspection and compliance*. This refers to our increasingly cybernated and proceduralised style of Welfare management. It is modelled on manufacturing and distribution industries, and controlled by computer algorithms. Welfare management thus comes to resemble an air traffic control centre.

   See, for example, *Collectivising the Personal: Seminal lessons from Bolshevism* (2017). Article 100 on my Home Page.

5. As in note 3, the events and context of my CQC-determined professional decommissioning are recorded in Section G on my Home Page.
6. This is well evidenced in research published by diverse bodies: The King's Fund, the BMA, the Royal College of General Practitioners, NHS Digital, Office for National Statistics, Social Care Information Centre. Institutional reports have also been collated and amplified by investigative newspaper reports, eg in *The Guardian* and *The Daily Telegraph*.
7. In my many exploratory conversations about these problems (with healthcarers and patients) I have offered these analogies. Responses have usually been enthusiastically resonant: 'Oh yes , … that's just how it is…' is typical.
8. Article 75. My Home Page.
9. *Industrialised healthcare: how do we replant our human sense? A response to a King's Fund report* (2018). Article 109 on my Home Page.

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