Abolishing the NHS Internal Market?

Too big to talk about?

David Zigmond

Our healthcare culture is now largely controlled by notions of commerce, ubiquitous surveillance and micromanagement. The inevitable depersonalisation is increasingly disliked by both healthcarers and patients. Nevertheless we seem unable to reverse these. What is happening? How do we respond?

Men reform a *thing by removing the reality from it, and then do not know what to do with the unreality that is left*.

– GK Chesterton (1928) *Generally Speaking*

A few months ago the Care Quality Commission (CQC) did an inspection of my small, long-established inner city General Practice and closed it down within a week. This was done through an emergency Order at a Magistrates Court: a procedure enabled by recent legislation to protect the public from exceptionally hazardous practitioners or institutions. The CQC had 'found' such egregiously bad practice, they said, and this was worsened by my attitude which, to them, seemed uncontrite: the three Magistrates had no experience of such matters so ceded the decision to the CQC 'as protection of the public must be our priority'.[1]

More recently the CQC recently published their Inspection Report documenting and anchoring their earlier 'findings': the justification for the subsequent court action and the closure of my practice. They described deficiencies across a number of axes of care, organisation and safety.[2] The reader of this report would easily and clearly conclude that I must be reckless or feckless, insouciant or incompetent, unreflective and unreformable – an intolerable burden or hazard to any human or public service.

So, the CQC and the Court must be correct in such guardian decisions, surely?

Well, it is not so simple. A wider view reveals much that is very different: this was mostly disregarded by both the Court and the report. Yet this fuller view is crucial to any deeper understanding of this wasteful debacle and to assure better future judgement. Here, as corrective contrast, is some of it:

In stark contrast, an earlier CQC Inspection just two years earlier reached very *positive* conclusions and published a correspondingly glowing report. In these two years my practice maintained all that was good and made some slight improvements (due to two high quality recruits to the staff). Nothing had worsened.

Evidence from all, and many, other sources – over a long period – led to a picture that, again, is very favourable and different from this last CQC report. For example:

- Exceptionally high patient satisfaction, affection and loyalty. (A contemporaneous IPSOS/MORI poll in July 2016 showed my practice to be the clear favourite locally.)
- Similarly good relationships with practice staff and close colleagues. This is reflected in high morale, staffing stability and little absence through sickness.
- *Never* a serious complaint or untoward event requiring a formal hearing, litigation or professional representation.
- Many decades of highly regarded academic publications and teaching. Parallel cheerful enthusiasm for the core of my work (ie not compliance documentation or similar).

How can all this – evolved and clearly evident for more than thirty-nine years – come from a severely failing or unsafe practice?

How can we account for this enormous discrepancy, between the *actual* reality (historical records and people's experience, all indicating stable and good practice) and *virtual* reality (a formally itemised snapshot of poor documentation of compliance to recent regulations, that is then deemed to indicate 'bad practice').

Can good practice be thriving amidst bad indices? What are we to believe?

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There is another influence that may contaminate judgement, more or less consciously. For many years I have been speaking and writing about the dangers of our increasing insistence on managing healthcare as if it can be standardised, monitored and controlled as it can – so efficiently – in competitive manufacturing industries. My arguments have been vigorous, though always courteous. Several months prior to the CQC inspection my anthology *If You Want Good Personal Healthcare see a Vet*[3] was published to broaden my readership.

The feedback for this writing has been mostly very positive, voluminous and broadly represented – though NHS Executive and management cadres have been notably silent. It is unlikely the CQC would acknowledge how these challenges may be disliked by them and then affect their judgement.

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This story is not merely about a necessary resolution between a recalcitrant employee and his employers: the example being considered is but a microcosm of much wider difficulties. We will find much else that lies behind – crucial societal trends – for example – to account for this kind of disjunction. Yet the underlying causative forces have become so 'normal' as to become largely unnoticed, and then unconscious. Our awareness is then confined mostly to the breakdowns. What is all this and where does it come from?

To understand this one small story – and the larger problems it represents – requires a broad view of our changing social matrix and the assumptions that inevitably follow.

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Men are more like the time they live in than they are like their fathers

– Ali Ibn-Ali-Talib (7th century), *Sentences*

Here is one seminal explanation for our difficulties: our emergent technologies and the adaptive changes that follow in our mindsets and relationships. Crucially, and increasingly, we are living with devices that we expect to yield us immediate and accurate *remote control* and monitoring of other distant devices and events; we come, involuntarily, to depend on myriad objects whose manufacture, operation and safety is determined in worlds we are largely ignorant of and oblivious to. So then we need many experts to oversee, monitor, regulate and police all this for our security. Our world has become much more immediate and convenient in some ways, yet at the price of insidious remoteness, control and abstraction in others.

To design and manage this cybernated and industrialised world we come to depend upon the rigid and precise roles and regulations of the *factory*. This ensures the safe reliability of the many manufactured objects that are now essential to mediate our lives. These growing assumptions eventually accrete to a cultural *Weltanschauung*: an instrumental world that quickly conforms to our designs and commands. This presents us with some ineluctable, though subtle, problems which can surely

ensnare us when we assume this approach to control our human (as opposed to object) relationships: if we are not very careful, our factory-like procedures will – when applied to our fellow humans – destroy what we are trying to see or care for. In our welfare services this is, clearly, an outcome that is not just paradoxical, but absurd and sometimes tragic.

This explains how we produce such a flagrant yet unacknowledged discrepancy as we find in this CQC report: we have eclipsed the living reality of the whole (= my 'good' practice) by a template of procedural parts (= my 'bad' practice). There are other, broader, examples: how NHS healthcare workers feel so uncared for themselves is particularly topical and serious. Our instrumentalism produces much collateral damage.

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The family is the test of freedom; because the family is the only thing that the free man makes for himself and by himself

– GK Chesterton (1923), *Fancies Versus Fads*

But we can, with care, restore human sense in our institutions: for we have another, much older, way of affiliating our important relational activities, and that is the well-functioning *family*. Here there are, by contrast, far fewer rigid rules, roles and demands. Moreover these are freer to evolve more naturally – with time, context and other influences. In families important changes often occur with an inexplicit reciprocity. All of this depends on trust, flexibility, good will and a knowledge and understanding of the other that is largely instinctive, sometimes unconscious and

thus seldom documented. By such natural processes well-functioning families can offer innumerable kinds of kaleidoscopic guided support and containment to individual members throughout their interdependent lifecycles. Like many natural processes this is delicate and often mysterious. Families that try to jettison such trust and vagaries – for example, by having one member in control, or by a draconian regime of rules – usually become internally (sometimes externally) destructive.

So well-functioning families develop their own ethos, communications and understandings. These cannot be planned or prescribed from the outside – although, very significantly, State agencies may attempt to do this with very troubled families.

If a family needs to 'hold a meeting' it often signals the serious breakdown of more natural understandings and adaptations.

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Broadly we can conceive of these two approaches – *family* and *factory* – being used to describe or influence any large group. Within our healthcare both have their most apposite places: for example, surgery and vaccinations benefit most (but never entirely) from a factory approach needing precise definition of rigid rules and roles to exercise *control*; in contrast, mental health and primary care need far more imaginative flexibility of these to enable *personal understanding* – any therapeutic change that occurs here is much less due to the kind of direct control essential to the factory.

Blendings are often essential: very young children need certain regulations around them for safety and survival, but simultaneously they need much loving understanding. As we become older, the regulation within a family should dissolve as our autonomy grows. So, as we become adults, our families should (ideally) morph towards an equal and trusting reciprocity with very little regulation.

Well-functioning families manage their safety and growth requirements with this kind of sense. They hardly ever need external authorities to provide mandatory regulation, action algorithms or regular inspections. Generally we trust families to create their own way, unless they show clear evidence of failing to do so.

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These notions were the cornerstone of the good practice I was taught, and the NHS I inhabited, for the first thirty years of my work. The culture was mostly a cooperative affiliation based on trust and flexible understanding – a family. This meant that our cooperative good faith and intelligent competence were generally accepted by colleagues, managers and government alike. Such family-type synergy took root, and then thrived, throughout my decades of service as GP Principal. In particular, my small practice developed and prioritised our sense of each staff member and how they might best function with this kind of autonomous colleagueiality. Unless there was good evidence otherwise we presumed people could do their job. Yes, sometimes others would step in with help, correction, suggestion or reparation or – very occasionally – reprimand. Overall, we were guided by friendly, impartial vigilance: never the kind of continual mistrustful micromanagement that has become, now, mandatory.

So, as in well-functioning families, our members – staff and patients – were kept safe and found the kind of more natural support and autonomy that led to satisfaction. But there is a growing conundrum here because such good results – as in healthy families – were not achieved through the kind of mandatory proceduralism and documentation that has now become so prolific and uncompromising. Indeed such imperative documentation would have *impeded* the growth of our personal good faith and sense – as it would in families.

Such family metaphor guided the ethos of my Practice. This relied on centring our best human sense and sensibility: in recent years I found that to do that I had to circumvent – even abjure – much of the rising tide of obstructive and cumbersome compliance documentation. Intelligent autonomy – so essential to our best personal doctoring – cannot thrive when automatically and comprehensively subsumed to corporate compliance. It will perish.

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As far as the laws of mathematics refer to reality, they are not certain; and as far as they are certain, they do not refer to reality

– Albert Einstein (1871-1955)

My stand against this obstructive overgrowth of corporate compliance was very deliberate. I saw it as being responsible for the cardinal and flagrant discrepancy that was, later, so remarkably ignored in the CQC report. Amidst such obfuscation we must cleave to this notion: that real-life experience and safety may be very different

from our documented procedures of compliance to prescribed indices of safety and quality. At best – and only sometimes – such procedures and documents may offer correlation, but that is very different from an equation. In reality, most often, our documented compliances now serve as shibboleths to placate the authorities.

It is called 'playing the game'.

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Seek simplicity, but always mistrust it

– Alfred North Whitehead (1861-1947)

The appeal of reductionism is probably nowhere stronger than when dealing with human complexity, and here, paradoxically, reductionism is probably nowhere more specious and unreliable. Our subsumption of sophisticated quality of care to documented compliance is an excellent example of this trap.

Eventually this tightening dilemma made inescapable demands: I chose not to compromise the best human sense and sensibility I could bring to my personal doctoring: I would not 'play the game'.

My resistance to the instructions to do so protected – for a while – my professional core and personal integrity, but eventually it would cost me my job.

At seventy years old I am grateful I had, previously, so much time.

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The axe forgets; the tree remembers

– African proverb

References

1: Zigmond, David (2016). 'Death by Documentation. The penalty for corporate noncompliance. *Journal of Holistic Healthcare*. Vol 13, Issue 3, Winter

2: *Care Quality Commission Report*, September 2016

3: Zigmond, David (2015) *If You Want Good Quality Healthcare – See a Vet. Industrialised humanity – why and how should we care for one another.* New Gnosis Publications

Published by The Centre for Welfare Reform, March 2017

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