Our Ill-faring Welfare

The hinterland of our headlines

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Much of our healthcare malaise can be seen as symptoms of oblivious damage: our drive for technical efficiency has often destroyed valuable human ecosystems. These healthcare follies are microcosms of broader damage unleashed by unbalanced 'progress'. Holism can offer some useful insights and thus guide restitution. The problems are massive: this article profiles them.

Journalist*: 'What do you think of Western Civilization Mr Ghandi?'*
Mahatma Ghandi*: 'Western Civilisation? I think it would be a good idea'*

As we delve, as we look, we find yet more examples of bad care, of neglect and cruelty behind the official façade. Clearly our communal life is increasingly haunted by some curious and unsettling paradoxes. To start: as we pour ever more human and economic resources into our welfare services, so its employees have become increasing disheartened, dissatisfied and stressed.* So we ratchet up our mass-management, micro-management and derivative blizzards of healthcare algorithms, directives, targets, goals, deadlines and information-swarms[1]; employees respond with lost concentration, heart and sight of their charges of care. So often, even when the administrative parameters look good and there are no horror-headlines, both the carers and the cared-for do not feel cared for.[1]

Such ill-faring welfare is not confined to healthcare: these paradoxes are stymying elsewhere, too. If you listen you will hear similar weary and dispirited voices from those working at all levels and varieties of education, social services, probation and civil service.*

All our Welfare** seems maladied by a mounting alienation from ethos and vocation. This is a kind of shadow to our media-slick, corporatised culture, outwardly so shiny with righteous rhetoric and instant sound-bites, yet inwardly rotting with human disconnection – another variety of paradox. We declaim increasingly about 'transparency', 'accountability', 'consultation', 'forward planning' (what is backward-planning? Official History?), 'the patient always considered first', 'compassionate, integrated care' … the reader has heard many more. I sometimes think there is a desperation to these (usually, I think) sincerely buttressing words: as if theatrically exhaled into an inflatable, but now punctured, life-raft. We continue to sink.

Yet it is not any kind of hot air – the exhaled exhortations from 'strong management or leadership' – that will prevent deflation: we need a puncture repair and possibly an internal sealant. What and where is the puncture? The leak and loss is personal and interpersonal: it is about the loss of human

connections, meanings and understandings; it is about the sidelining – sometimes destruction – of our more natural affections and communities[21]. [21] Over my working lifetime I have seen this human disconnection acrete and accelerate with most of our successive grand schemes and redesigns.[2,3] 'Efficiency' is the mission, but the consequent losses to our conduits and containers of human connection soon nullify the possible gains. If people do not feel *individually* heard, understood or valued, no amount of management can bring good Welfare. When heedless of this our services soon devitalise to fearful, surly and thus inefficient hives of officious compliance.[3] This accounts for much of the syndrome we have now.

How and why does this happen? Because we live increasingly in a factory manufactured world and then assume that we can similarly industrialise human welfare; that we can use similar methods of objective monitoring, measurement, management and mass-production in complex human activities as we can – and with increasing success – in, say, car production.[4] Such attempts to depersonalise the personal may look good to planners and academics, but are often experienced quite differently by practitioners and their charges. The missed but seminal point is that Welfare delivery is very different from the industrial manufacture of objects. This difference is about the primacy and unobvious complexity of human relationships: in much Welfare these are quite as important as the designated task – sometimes more so: then the journey becomes more important than the destination. Our Welfare calamities convey an important lesson: if we over-apply industrial-type thinking and schematisation to how – communally – we care for one another what we end up with is more like an unhappy family than an efficient factory.[5] We must not conflate car production into care production.

The paradoxes and conundrae thicken as we explore. Here is a sample: unless we are very careful, and make delicate and imaginative compromises, our management can destroy the heart of what is being managed; objectification of persons easily bestows alienation; generic and personal understandings are often discrepant in handling human distress and dilemmas: thus what may make sense to a plan may not be what makes sense to a person. Ignoring this inconvenience is a humanly (and thus economically) expensive trap. This is

particularly so with Mental Health Services, which have become increasingly heedless of how 'objective' (it is not) measurement will quickly displace individual meaning: for example, the attempt to quantitatively, 'objectively' measure a person's disturbance or distress by standardised questionnaires or interview formats yields not merely specious science but devitalised intercourse.[6] Attempts to standardise the ways we engage with human struggle or offer healing contact – the naturally idiomorphic and idiolectic – almost always incur the loss of individual meaning.[7] We professionals may here bestow on ourselves misbegotten and premature pride for our evolved plans, for though our assiduously packaged codes and data may be impressively ordered, it may be like a hollow and grandiose military parade: for the packages, increasingly, contain administratively abstract – not humanly meaningful – realities. Our institutional lives have become massively littered by such excessive packaging: often the vital contents can no longer be discerned. So here is another frequent inverse relationship: the denser and vaster the informatics and technical language, the sparser the personal contact and understanding.[7,8]

Such complexities and our compounding institutional responses now enervate our welfare services: employees share frustrated recognition by weary shrugs, fatalistic sighs and tacit smiles.* The more grotesquely tragic examples bring flurries of media and political attention: beacons of agitated hope.[1] Gradually though, and more worryingly, we cease to notice the less egregious examples: they become culture, like landscape.[9]

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Our difficulties now have massive momentum and are hard to turn around.

Humankind is much blessed by its capacity for clever invention, expedience and production, but we curse ourselves equally with our lack of wisdom: in not knowing when to stop. Poisoned air and impassable streets from our traffic; young children dextrous with electronic gadgetry yet unable to be patient with natural complexity; our factory-fast access to nourishment and then our obesity pandemic; our dizzying explosion of human choices at the

cost of other life-forms we must coexist with … There are myriad examples of how blessings from a pioneering few then evolve, then coagulate, as collective folly.

The attempt to comprehensively and objectively systematise, and then commodify and industrialise, *all* healthcare is such a collective folly. Yet originally, restricted to its legitimate territory, such systematics started as a blessing; but the further we stray from this home territory, the more problems we have – clients, practitioners, managers, all.

Our collective curse: our folly.[4]

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As with most follies we have been enticed by specious expedience and its inevitable partial-sightedness. So the formidable task of healthier and sustainable restitution will require our full(er)-sightedness: *holism*. Yet holism is not an easy trick or procedure. Holism is a philosophy, an ethos, a variety of spiritual imagination, a way of being.[10] It cannot be captured, manufactured or managed by yet more of our habitual prescriptive procedures and rigid checklists.[6] Yet this is the usual response of institutions attempting to be 'more holistic'. 'Being holistic' is a subtle and slippery task: how do we subsume our more quickly and easily defined expertise of parts to an overarching wisdom of difficult-to-define wholes?

There cannot be, must not be, definitive answers – another essential, but frustrating, paradox and conundrum. Holism may be an aim but we cannot count the goals. So there is a need for innumerable offerings: some of these are really valuable but only some of the time![11]

From this spirit of elusive complexity here is an assorted medley of maxims and suggestions. Although written from a healthcare perspective, application to other welfare areas is mostly pertinent:

- In Welfare *adequate* management may prevent some worst practice, but cannot itself assure best practice. *Excessive* management will destroy the morale, habitat and creativity of best practice. Management, like good parenting, often requires lightness, flexibility and imaginative intelligence.[4]

- In complex Welfare, the larger the scheme, plan or institution, the larger the risk of incomprehension and unresponsiveness to individual vicissitude and variation.[9] Bigger is often not better, nor is more of something 'good'. Smaller, less machine-like institutions often gain in human connection and identification what they lose in economics of scale[5].

- The purchaser-provider split (PPS) in complex Welfare provision arose two decades ago from a then burgeoning – now collapsing – monetarist ideology. Almost all older practitioners have witnessed progressive and successive staff alienation, demotivation and demoralisation and a bureaucratically boundaried fragmentation of services. Many consequent casualties of care are now investigatively documented; even more are not. PPS, from its monetarist ideology, conceives of motivation in healthcare in largely economic terms – and then, managerially, as costed and prescribed carrots and sticks. We are now seeing how this humanly impoverished view of healthcare motivation then yields humanly impoverished results.[1] PPS has a very limited (if any) long-term benefit to offer healthcare. It should be largely (if not fully) dismantled.[12]

- Healthcare is a humanity guided by science. That humanity is an art and an ethos: these are higher forms of human growth and to achieve them requires patient and imaginative attention to milieux and to unobvious connections. Such comes quite as much from energies of *Agape* and *Physis* as our more logically defined lists and plans, goals and targets.[13] The relationship of these two attitudes to healthcare is like that of the spirit and the body: we need a good relationship with both and this requires a wide (and never complete) repertoire of language and understanding.[14]

- To spawn and sustain a more holistic and humanistic healthcare thus requires communications that are encouraged to be rich and broad. In the last two decades the trend has been quite clearly in the opposite direction:

to signalling of a restricted technical vocabulary of officially designated codes or words which are then quickly and precisely conveyed as electronic bolae to other practitioners and administrators.[15] These data-dense packages are mostly devoid of human thought, imagination, interaction, meaning or even editing. This has evolved consequent to the current necessity for all healthcare activity to be compliant with computer-coding, data collation and statistics-for-all.[16] If payment-by-results extends into areas of greater human complexity there will – perversely – be an ever more restricted language to deal with them.[8]

- This frog-marching of human language into compounds of officially managed technical terms and data distillation has consequences far beyond taste of aesthetics. For there is an ineluctable relationship between language, thought and relationships.[17] For example, the doctor who is encouraged only to use the word 'depression' when encountering the vast galaxy of human dispiritedness is then unlikely to use words connoting ennui, shame contrition, alienation, guilt, futility, impotence, loneliness, despair, resentment …[18] If the words are not used, the thoughts do not come and subtly powerful conversations are not had. This extinction of valuably vernacular thought and interchange is made more thorough and rapid if the doctor, early on in his encounters with the lost-Mojoed sufferer, attempts to 'objectively' rate the problem and issues them with a standard questionnaire. The institutional need for generic data and statistics quickly overwhelms and silences the more vulnerable, yet often more fertile, forms of interchange.[19,20] This has happened, on a massive scale. Signalling can also be colonisation and hegemony: we must beware.

- The problems behind our ill-faring welfare are so wide, various and deep as to now be *cultural*. Some turn to blame: Practitioners, training and regulatory bodies, Big Pharma, Capitalism, Politicians (choose), planners and managers, public demand, increasing litigation… Whatever our particular interest, fear or anger we can plausibly project them into our ill-faring welfare: all have useful truth – in part.

- Ultimately we are faced with the vast and tangled complexities and paradoxes of human nature and our more limited capacities and resources

to deal with them. Any successes we have will always be amidst such limitation and failure.

- It is the same in our individual lives, too. The more we can know and accept our limitations and contradictions – the more we can see our multivalent yet evanescent place in the whole – the more imaginative and fertile we can be in our contact with others. All our projects die, yet all leave some kind of ghosts.
- Such is holism: we can never finish, but should always start; a doomed project, but a good ghost.

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'*If I am not for myself, who will be for me?*
If I am only for myself, what am I?
If not now, when?'

– Rabbi Hillel (1st century BC-1st century AD)

'*Be the change in the world that you wish to see'*

Mahatma Ghandi (1869-1948)

Notes and References

This article is itself a kind of personal holistic project. I have attempted to synthesise and thus transcend several previously published articles. The intention is to weave together older ideas to engage new territory. It can, though, be read apart, without other reference. To keep the length manageable I have not cited evidence or supporting stories: these are available in the earlier writings. Some interested readers may find a greater Gestalt by exploring the 'foundation' articles. I have therefore listed these numerous references: they are most conveniently accessed via my Home Page.

1. *Institutional atrocities: The malign vacuum from industrialised healthcare* (2013)
2. *No Country for Old Men: The Rise of Managerialism and the New Cultural Vacuum* (2009)

3. *Psychiatry: Love's Labour's Lost. The pursuit of The Plan and the eclipse of the personal* (2010)
4. *Five Executive Follies: How commodification imperils compassion in personal healthcare* (2011)
5. *From Family to Factory: The dying ethos of personal healthcare* (2012)
6. *How to help Harry - Friend or Foe? The scientific and the scientistic in the fog of the frontline* (2012)
7. *Idiomorphism: the Lost Continent. How diagnosis displaces personal understanding* (2011)
8. *Missed and Miscommunications: Personal disconnections in Psychological Healthcare. A letter for embattled colleagues.* (2013)
9. *Beyond Orwell: Healthcare's hollow governance* (2013)
10. *Continuity of Care: Of course, but whose? A Sleight of Slogans* (2012)
11. *Babel or Bible? Order, Chaos and Creativity in Psychotherapy* (1986)
12. *NHS Savings? Abolish the Internal Market* (2013)
13. *Physis: healing, growth and the hub of personal continuity of care* (2013)
14. *Three Types of Encounter in the Healing Arts: Dialogue, Dialectic and Didacticism* (1987)
15. *Language is not just data: it is a custodian of our humanity* (2013)
16. *Words and Numbers: Servants or Masters? Caveats for holistic healthcare Part 1* (2012)
17. *No Country for Old Men: The Rise of Managerialism and the New Cultural Vacuum* (2009)
18. *If you want good personal healthcare, see a Vet. Caveats for holistic healthcare Part II* (2012)
19. *Sense and Sensibility: The danger of Specialisms to holistic, psychological care* (2011)
20. *Edward: shot in his own interest. Technototalitarianism and the fragility of the therapeutic dance* (2005)
21. *All is Therapy; All is Diagnosis. Unmapped and perishing latitudes of healthcare* (2013)

* These assertions are based on my hundreds of enquiring conversations with Welfare workers over many years. I do what I can to keep an open heart and an open mind. The statements represent views and experiences massively prevalent. They correlate, too, with employment statistics

showing clearly increasing rates of sickness, early retirement and career exit.

The reverse, positive, equivalents are much rarer – they can provide a refreshing and welcome contrast to a dispiriting trend.

** 'Welfare' with a capital 'W' in this article refers to the national schemes and responsibilities we have for health, education and rehabilitation. This is in contrast to the vernacular and organic 'welfare' that evolves between people without other (State) intervention.

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