

Our unravelling humanity: do we need more regulations?

David Zigmond

© 2014

To its credit the government seems to now be understanding the importance of lost human connections. The response, though, is predictable: it is to add to Healthcare's already massive regulation. This may add rather more to our problems. How?

'Governments arise either out of the people or over the people'

– Thomas Paine (1791), *The Rights of Man*

For several years I have been one of several older doctors frustratedly outspoken in gloomy prophesy. We have shared alarm about what we witness: successive losses to personal continuity of care, and the growing complex consequences.

We have largely agreed about causes: often citing the inapt infliction of corporate managerialism, industrial streamlining and commercial commodification. These have converged to grievous losses of healthcare's best kinds of personal relationships, investments and understandings. This is reflected in doctors' motivation – now more externally structured by careers than personally generated by vocation.

To their credit the current Minister of State and his department seem to have seen that something is very wrong, and whatever that something is, it is related to our loss of personal care. Their recent response – to formulate a new raft of regulations – is less edifying.

Such well motivated initiatives may merely add to our nett problems. A good example is the partial reintroduction for patients of a named GP: this is restricted to the elderly and those with substantial chronic complaints. The hope is that this measure will significantly restore at least some relationships that offer personal containment and understanding.

But such things need far more (or less) than regulations. This is illustrated by my own subsequent predicament.

I am a long-established small practice GP: a perishing species. In this setting personal knowledge and understanding of each patient has developed in a way that is now increasingly rare. This is a more natural, often slow, growth of relationships. This happens best where central management is least. Such

human nexus also fares better where the scale is small, but stable over long periods. Such are the conditions that enable our best kinds of personal accessibility and contact – those that can then yield our better personal understandings for the chronically vulnerable, troubled or infirm. Of course, the practitioners' vocational attitudes and skills must first be there. But so, too, must the head-space and heart-space: to let these skills and abilities breathe and flourish.

Such smallness and stability has brought both professionals and patients good fortune in this practice: we have been more able to continue the best of this kind of care. Nevertheless my fight to preserve essential head and heart space has needed insistence and persistence. For some years this has become increasingly difficult. And here is the absurd paradox: such care is now rendered almost impossible by the burdensome new regulations – those that are meant to ensure that I am providing the kind of care that has been at the heart of better small practices for several decades. The weight of bureaucratic demands for compliance and data could now finally crush the care it is there to protect.

How can such an anomaly be true?

Let us look at one small part of this initiative and sample what happens.

The new regulations regarding named GPs is already generating its own intense gravitational field. It involves a complex system of templated registration, assessment, care plans and monitoring. The casual observer might think all this is sensible. They would probably assume that if a GP is very well acquainted with the patient and their problems, then merely formulating and documenting these details would not require significant extra work.

The reality for the participants is very different. An example: already there are problems with official letters. These have been sent to patients by NHS England to explain the new register and plan. The letters are prolix and bureaucratically phrased: they are incomprehensible and daunting to the kind

of patients who receive them. The result is much bewildered anxiety requiring timely reassurance and translation. Several elderly frail people needed even more of this: they thought that they were 'in trouble with the authorities'. Such misconstruction of menace may seem, at first, comically absurd. But there is a very serious point: it is the sort of thing that easily happens when we disrupt vernacular patterns, human eco-systems. For the mindset gap between the frail, lonely and slightly confused eighty-three-year-old widow and the gregarious and robust thirty-eight-year-old NHS England tankthinker is vast. I am now having to bridge that gap, for those directed to do my communicating for me!

The absurdity has another twist: I am a single-handed principal: with very few exceptions my vulnerable patients know very well who I am. The new regulations are, for my practice, superfluous, redundant and obstructive.

Such perversions of good institutional intent will follow when good intent is not matched by equally good discrimination. Such inapt compliance to Departmental diktats deprive me of the time and spirit to provide my most sensible and sensitive care. The waste and expense are egregious too, for these burdensomely completed templates will receive little attention from those who are not either data or compliance officers.

One criterion of a difficult situation is that it is much easier to get into, than to get out of. In the last two decades we have become very inventive at creating these for NHS Healthcare. This is yet another example.

Of course, most will rightly commend the Department of Health's identification of this human problem, and the need for some kind of action. But is more managerial diktat and regulation the best way to proceed? What are we understanding, or not?

Many of us have been warning for many years about the subtle yet radical human disconnections that will follow healthcare's emulation of manufacturing industries or commercial corporations. The destruction of human eco-systems in the 'drive for better outcomes' becomes almost routine.

Sometimes it seems justified. But sometimes the agenda is far worse: then the destruction is pursued because it is equated with – and then symbolically substitutes for – those ‘better outcomes’.

Such vicarious and hegemonic destruction is a dark Leitmotif in our more chilling history. In our more benign times such dynamics are still played out, though with far less terror and savagery. The destruction of personal medicine and its sacrifice to production-lined, target-driven systems is often an example of this. The destruction of the best personal doctoring in General Medicine, General Psychiatry and General Practice has generally served current systems and ideologies well, but patients poorly.

In recent years these reforming forces have directly affected me. The abolition of GP Personal Lists and the managerial and economic hostility to small practices have been very destructive of healing and containing bonds for the patient, and deeper, vocational satisfactions for the doctor. Large health centres with carouselled medical staff will rarely be able to find that human sense, for either patient or practitioner. For to belong we must often be-long: long enough to bond, understand and care.

*

Eventually it is not just the individuals and their skills that disappear but the milieu that nourished them, and then the habitat which is both essential, yet often irreplaceable. The culture of the traditional Family Doctor was one where patients and their families were often known and understood from many years of personal contacts. This is one of the more important examples of what we can call ‘human eco-systems’. Such fragile complexity cannot be simply decreed or regulated by governments. However, governments can be good stewards and custodians of such things. Although finer aspects of our Welfare cannot be manufactured, they can be nurtured and protected – or the reverse.

The tragedy of the Yangtze River Dolphin is far bigger than its current disappearance: it is that by first toxifying and then destroying its habitat it has lost its natural niche and can never return. Its extinction is absolute. Such extinction is never isolated: there are always collaterals.

If we are not very careful, personal and family doctoring will suffer a similar fate.

The-times-they-are-a-changing. Massively. Amidst all this how do we best guard and guide the humanity in our healthcare?

-----0-----

*'Nothing is as dangerous for the State as those who would
govern kingdoms by maxims found in books'*
– Cardinal Richelieu (1687), *Political Testament*

**Interested? Many articles exploring similar themes are available
via <http://davidzigmond.org.uk>**

David Zigmond would be pleased to receive your [**FEEDBACK**](#)