# Death by Documentation:

## The penalty for corporate non-compliance

**David Zigmond**



Our organisational efforts to assure fail-safety, uniformity and probity can easily – in excess – turn destructive beyond anyone's wish or anticipation. This tale tells how such 'mission creep' happens and how it is sustained.

*The more laws the less justice*

– German proverb

**Background**

In the last twenty years the ethos of our Welfare services has changed exponentially: from colleagueial supportive trust to managerial litigious mistrust. In medical practice the erstwhile medical authorities mostly acted as supportive administrators to doctors' more autonomous judgements and activities. Current management, by contrast, is increasingly about identifying 'outliers' and fault, and then exercising control or elimination.

These changes are inimical to small General Practices and their unrivalled opportunities for high quality personal and family doctoring. To serve modern regulatory requirements GPs are now – almost entirely – corralled and managed in increasingly large and depersonalised practices.

The coerced demise of a long-established and previously well regarded exemplary small practice illustrates this process, and the price we pay.

**February 2014**

'That wasn't too bad, was it? I rather liked them. I think they liked us, here, too. They certainly listened…' Sara, the Practice Manager, closes the front door behind the two exiting Care Quality Commission (CQC) Inspectors. Her sigh is soft, tired and appreciative.

I agree: for this first inspection we had been probed, questioned and examined with the best kind of professional intelligence: dialogic and sharp, yet always with a view to a greater whole – with good sense and sensibility.

They dextrously sampled and witnessed the ethos of my small practice: engaging with patients and my staff, often sitting watchfully and unobtrusively to see our interactions. After that they perused and enquired about some procedural records.

Seeming satisfied with these, the Inspectors' attention shifted to personal infrastructure: how did I manage and sustain all this? What were my definite priorities? What would I then compromise? What did this cost me, personally?

Yes, I agreed with their questions' implications: to keep long-term, good quality personal healthcare is hard: it depends on well-nourished and well-perfused headspace and heartspace. So I described our endless choreography between the personal and institutional. And how, when it is impossible to do both, it must be the personal that takes precedence: institutional requirements are then relegated or sometimes avoided altogether. I gave examples: judgements to bypass detailed data collection boxes, or contextually clumsy prescribed care-pathways.

The Inspectors pressed me for my explanations of such judgements, my discernments. I drew a parallel with what they were doing with us, now: they could not sample or know *everything* by exhaustive procedure. So the skill is wise and pragmatic selection and compromise: from the accessible parts they would apply their imaginative intelligence to extrapolate a likely and meaningful whole, and then they would apply their best judgement. Yes, the Inspectors agreed, there is no

certainty in such human complexity; the skill is to construct and offer our best informed and shrewdest judgements. This is not easy – it required nuance and delicacy: too direct an approach may destroy or disperse what we are trying to see. We are here like naturalist-observers: often we must be stealthy, still and part of the landscape – that way far more will come to us.

The two Inspectors resonated with this and talked around my metaphor. 'Yes', the older concluded. 'Our approach has to be skilfully and subtly different on each occasion – we can then see much more of the important things that are going on, good and bad … If we don't do that our better judgement will be blind.'

As Sara closes the front door, she turns to me and smiles.

'Well, whatever their report I think they got a good sense of us', I say.

*

The CQC report, publicly displayed for the next two years, glowed with positive acknowledgements.

*

**February 2016**

A Clinical Commissioning Group (CCG) meeting. The atmosphere is wearied and listless, acquiescent though fractious. The GPs forming its nucleus are obligated to attend by the Health and Social Care Act: theoretically they have an executive role

but they feel more like political prisoners. This paradox is important – it illustrates how our institutions have massively misconceived the vocational psychology of healthcare: why and how we may wish to offer often difficult care for others. The result? An ever-increasing human and community waste and misunderstanding. Now we cannot contain, sometimes even survive, the effects of this. For years I have publicly and recurrently warned of this. I do so again today. I meet the usual kind of diplomatic avoidance and mollification.

As the meeting limps dutifully to a close, Dr C, a veteran colleague, approaches me inquisitively.

'Have you been CQCd yet?' I am struck by how the noun of this institution has been turned into a verb, to which I now serve as a passive recipient.

'No', I say simply, but I know he has a message as well as a question.

'Well, you should be careful. They can be very nasty…'

'Oh, I think I'll be alright. I found them helpful, intelligent and sensible last time…' I am thankful but cheerfully disregard him.

Dr C's look is of irony laced faintly with pity. He gives a twitch of a shrug and turns away.

*

**July 2016**

Sara spends much longer with the Inspectors than we expected and leaves them looking apprehensive.

'They're very different to those we had last time. They don't really want to discuss anything – just check documents and endless certificates. Some of them – the more obscure ones – I couldn't find…' A contrite hand rises to console her mouth.

It is now my turn. The Inspectors enter my room. After necessary greetings and seatings, a rhetorical question:

'Your Presentation?'

'I'm sorry … what's that?'

'It's the preliminary part of what you should have prepared for this CQC inspection. We informed you of this in a detailed email. Don't you read them all?'

'No, I don't. Certainly not all. Not if I want to stay alive in this job…'

'What does that mean?' their uneasy incomprehension already glares with disapproval.

'Well, it's an enormous problem. Everybody knows it, but we can't tackle it. The ever-increasing electronic traffic numbs our brains, dumbs our speech and often displaces off-screen reality. Email encephalopathy is an enervating institutional

disease. If I want to save my time, my Mojo and my sanity then I must be selective … Anyway, I think my semi-deliberate lack of preparedness is better now for us all.'

They are both busy note-keeping, their questioning frowns seem mirrored. One of them asks: 'How can not preparing something be *better*?'

'Well, I can explain. In my experience "presentations" easily become feints of PR: careful conjurings, editings and polishings. Slick packages. Choreographed distractions and distortions to get the other person to see what we want them to see, and conceal or opacify all else. An inspection is wonderful host territory for all this. No, I don't want to perpetuate this "spin culture": I think it has replaced, often dangerously, more natural and authentic dialogue in our NHS. I don't want to do that here, or anywhere.

'So, let's talk: a *conversation*. That way you'll get a more real view of our struggling, flawed but wholesome little world here and my role in it: what I do well and happily; what I do not; the compromises I make; the rewards I get; how I hold it – and myself – together … I want to be candid: warts and all…'

I pause, to see if they are receptive. There is a jerk of the scribbling pen – a green flag to continue.

I go on to talk of the complex challenges – and gratifications – of providing bespoke, personal continuity of good medical care in our inner city. My human results reflect what I believe is mostly good work: extremely high patient satisfaction rates since records began, no serious complaints (ie requiring a formal hearing), stable and

enduring staff expressing affectionate loyalty, low staff sickness rates and no substantial accidents…

'How do you achieve that, then?' asks an Inspector.

'By assuring my priorities: personal contact and understanding – *relationships*. If they're good, the rest usually follows: morale, cooperation, attentive intelligence … But what we have to secure first is headspace and heartspace: those are essential. Other things much less so.'

'What is less important?'

'Ah! That's where we come to what I'm *not* so good at: what I selectively relegate or discard.'

'What are those things?'

'Oh, mostly formalities to demonstrate corporate compliance: contextually unuseful and irrelevant data-inputting, some health and safety meetings or trivial regulations, sticking rigidly to Care Pathways when I deem them counter-productive. All that tick-box stuff…' My hand flips away.

'Give us an example.'

'Well, I haven't had a staff-minuted meeting about a Muster Station in case of fire. The premises are small, with four rooms, one straight corridor, a front door and a

rear emergency door. It is quite clear what we should do: go to the exit away from the fire.'

'But there are more serious omissions. For example you have no evidence of Child Protection Training…'

I sigh with encumbered irritation. 'Well, I went for an afternoon course.'

'Well, where is your Certificate?'

'Probably stuffed in a bag somewhere. I'm sorry. Look, that course was so useless for me it wasn't worth certifying. I was in a hot room with about a hundred practitioners of very varied grades and experience. For three hours we were lectured and instructed by a specialist nurse and social worker. They said, basically: "Children are neglected and abused more than we realised. Obviously this is serious and often stealthily concealed. This happens more with struggling, conflicted or unstable families – but certainly not only. Be vigilant. Contact us."

'I know this well. I've been working thoughtfully with families for years. I *don't* need to take half a day away from my work to be crop-sprayed in this way. What I *do* need – and what has now vanished – is easy access to an experienced colleague who personally advises and sees things through, both with me and the patients…'

The silence has grown leaden and glowering.

One of the Inspectors, Dr S, a neatly suited and formally mannered man in his mid-fifties, clears his throat. 'We have found other areas of concern. In Mental Health. Your under-diagnosis of Depression and Dementia. This may indicate your lack of providing a good service to certain patients.'

'Oh, I don't think so. Look, when someone contacts me anguished with, say, a broken love-bond, an inassimilable bereavement, a humiliating impasse at work, or a haunting from old traumas, I am not going to spend that delicate time with them filling in a formulaic – often clumsy – depression or risk-factor analysis. If I do that I may gain points with the compliance system, but at the risk of losing the patient. So, to avoid all that, I code such people differently: "Emotional Problem", "Work Stress", "Family/Marital Problem", etc. In carefully using those kinds of discernments I believe I am then freer to provide better care. Inconveniently for our current systems, that involves trusting the practitioner with those many deviations … But we do have to *trust* to make those decisions.'

'So, you don't see a place for the recommended diagnoses, templates and pathways?' The Inspector's voice is dry.

'Well, only sometimes. It's complicated, of course. My skills must have the professional autonomy to decide about *this* patient, *now*: is organisational compliance here likely to be helpful, unnecessary, or even deleterious?'

'And your approach to dementia: is it similar?'

'Oh, yes! And for similar reasons…'

'Being?'

'Complexity and context. Failing cognition is only rarely decisively treatable by doctors. Yes, we can help with certain risk factors. We certainly should offer our most informed guided support and advice. But 'Dementia' becomes mostly a relational and social problem: does the declining person have robust, and intelligently affectionate care-taking from significant others? Who are they? Do *they* need guided support? and so on … It's the same for all of us, when we decline with age…

'These problems increase with our ageing population. As a frontline GP I have to rapidly identify and weave these myriad and delicate threads to create a personally meaningful, useful and accessible whole. But I can only do that well when I can use my human and technical skills freely – when *I* am the choreographer. An institutional template often obstructs all this…'

'So, again, you choose to depart from established procedure?'

'Yes, sometimes. It's a tricky paradox. With these kinds of problems I can be a *better* doctor when I *avoid* doing what the institution might expect. I choose when and how to override institutional procedures…'

Dr S is looking at me with quizzical caution.

'But I am very thoughtful about how I do so', I quickly add, as an insulating caveat.

'I'm sure. But nevertheless you do feel you have the right to "cherry pick", when you choose?'

'Yes, that's true', I answer simply and softly, though I am already sensing a darker subtext to the question.

'Thank you. I have no more questions.' Dr S looks down at his notepad: his smile, to himself, seems consummate.

This meeting has been difficult but I want an amiable farewell: I chat as we are disbanding.

I ask Dr S 'Are you still in practice?'

'Oh no. Not for three years now.'

'Why did you retire?'

'Well, I'd accumulated a very good pension, so I could leave easily!', he beams. 'I'm just doing this [CQC inspections] now.'

'From practitioner to judge', I say: a serious banter.

'Yes, I'm doing a University Masters Degree in CQC Inspections', he answers, with enthusiasm.

'Ah', I respond simply, with rather less enthusiasm.

'And what keeps you going, in your fortieth year as a GP?', he enquires, as if he cannot imagine.

'It's like a happy second family here, this small practice. Through all our joys and sorrows we get to know one another: patients, receptionists, clinicians. And amidst this, with my human and technical skills, I can sometimes be really helpful. At other times we can, at least, be a personal comfort, support and witness to Life's inexorable sorrows. We all here want to come to work in the morning. Where else could I get such satisfactions?'

Dr S registers his own simple 'Oh' and shoots me a brief smile that is bemused but not hostile. He is now standing at the door, about to leave.

I offer my hand, to say farewell. His grasp seems reticent and ambivalent.

*

The *coup de grace* was coordinated with brilliant and shocking efficiency: a lightning strike worthy of *Blitzkrieg*.

It came three days later, on a Friday night at 6pm. My receptionist received a call from a Senior Officer at the CQC notifying me of their intention to close my Practice on the next working day, Monday morning. The charge is that my Practice was

found by Inspectors to be massively and irremediably unsafe and must be closed immediately. This would be done by an emergency legal procedure, through a Magistrates Court Order.

At the time – until a few hours before the set hearing – I was on a brief holiday, in France. I was uncontactable and oblivious of these rapid and shocking (for me) developments. Tired from a very long train journey I was unprepared and disorientated by such overwhelming and draconian measures.

I arrive flustered, hurried and alone to the Court. The CQC has assembled massive and well-armed forces to encounter my unsupported and unbriefed solitary enfeeblement: a solicitor, a barrister, a CQC Director, a CQC Compliance Officer and a Medical Expert (in what?). They all have hundreds of pages of meticulously prepared and filed 'evidence' against me. I cannot see how they could have assembled such thoroughly destructive documentation and slickly rehearsed choreography between them within three working days: there must have been much prior briefing and planning.

I immediately ask the Magistrates for an adjournment, but the barrister is adamant that this should not be granted: that my Practice is so extremely hazardous that the public need *immediate* protection, by its closure. Public safety must here, exceptionally, take precedence over natural justice. The Magistrates acknowledge they have never encountered this problem before and, bewilderedly, opt for safety. They rule in favour of the barrister: whatever complexities emerge, at least the public will now be protected.

This Court hearing will turn out to be extraordinarily long – eight hours. The Chair of the Magistrates will later describe what is (for them) unprecedented length and difficulty.

Throughout the long day there are Court adjournments for respite and procedure. Outside the courtroom I am expected to wait, seated, in a bare ante room which I must share with my CQC prosecutors, my assailants. This is awkward and they understandably create maximum physical distance, avoid looking in my direction and mutter very discreetly amongst themselves. In another context I would think they looked amiable. To loosen the tension a little I say: 'Look, we can see how difficult this is and I want to make it a bit easier, just for now. I can see you are all "just doing your job", following procedure. Yes, that's hard for me, but I shall argue my case and bear no personal animosity toward you. None of you know me, so I understand that – for you – it's a technical and institutional matter.'

I notice two of them look at me briefly, signal a tentative smile and say a quiet 'Thank you'. They seemed touchingly grateful for this: mercy from the condemned.

*

In this strangely cohabited space the 'other side' give me copies of the voluminous prosecution documents. I have time only to briefly peruse some of them: a thorough reading and response would take me days.

Very soon I can see the professional profile they have constructed: reckless or feckless, casually or deliberately unsafe, uninsighted, disobedient and unreformable

– in short a gross and intolerable liability to any public service. With ironic gloom I conjure cartoon scenarios. A uniformed senior policeman in front of TV cameras issuing a statement: '*We have been warned of the great danger this man poses. Members of the public should not approach him directly, but instead immediately contact the authorities'*. Or a shouting tabloid headline: *Dangerous Doc Exposed! Authorities find years of concealed danger to the public. How many have died?*

In my brief time for perusal I can merely identify some misattributions or inaccuracies. Maybe I will have the opportunity to designate them: many will go unchallenged.

But my more substantial legal vulnerability lies elsewhere: I have already frequently acknowledged deliberate and thoughtful non-compliance. I will never deny this.

My self-defence – however much I am allowed – will have to also address this. So, in the courtroom, I offer a few parries and corrections to (what I think are) documented errors. My main thrust, though, is an appeal to natural justice, as opposed to strict legality.

Yes, I argue, all can easily see areas of non-compliance. I have long argued that this, selectively, must be done if we are to provide our best *personal* care for others and (importantly) ourselves: that *over-regulation*, paradoxically, is destructive to much of our best healthcare. I have vigorously argued the reasons for this, often, in public, and in many publications.

The lawyers prompt my return to their combat arena of legalities – their many showcased items – but I am trying to break away, to view the bigger picture – the whole – the overall integrity of myself and my Practice.

Despite the lawyers' stymies, the Magistrates ensure some (if inadequate for me) time to do this. What is this bigger picture? Well, it's much longer, too. I attempt a brief, well-documented profile: thirty-nine years as a Principal GP; *never* a formal complaint needing a hearing; excellent long-lasting and warmly appreciated staff and close colleagueial relationships; never – until now – any litigation; never on-premises serious accidents; far-above average patient experience feedback, consistently and for many years; robust good health and humour; highly regarded and well-known academic and journalistic output; similarly acclaimed teaching … The Magistrates are attentive.

I continue. With all this – for decades, and no sign (yet) of personal decline – what is the *real life* evidence that I am a serious risk, professionally or environmentally? Wouldn't that now be long evident, and from many sources?

No, the barrister argues, you are flagrantly unsafe. All the regulation and requests for documentation are there to assure safety. Therefore, if you do not comply fully you become unsafe.

So, I reply, I am guilty (of unsafety) unless I submit to all your procedures and then get a certificate of compliance from you (the CQC) saying I am safe. Guilty unless proven innocent: innocent only by submission – a stark inversion of natural justice! Doesn't this – the self-referring system of proceduralism – eventually become a folly

of officious abstraction? Isn't that what is happening here? No, the barrister assures the Court: such devices are there for our communal protection.

I take a contiguous, but different, tack and then appeal to the Bench: my exceptionally good real-life record (ie not the one abstracted recently by the CQC) has been possible only *because* I have created the professional autonomy to decide on priorities with my Practice and patients. That is my skill and my ethos – to employ my good faith and judgement to make the best compromises. Our current error – as enacted by this CQC action – is to assume that every possible risk, problem and adverse situation can be prevented or solved by ever-increasing regulations of compliance, monitoring, management and penalties. The truth of this is very limited, but we (eg the CQC) are exerting this principle far beyond these limits. The resulting trespass is egregiously – though inadvertently – damaging of healthcarers' vocational ethos, spirit and healthy colleagueiality. Hence our evidence of another kind throughout the NHS: collapse of staff morale, health, career longevity, satisfaction, recruitment … Overstrict parents rarely produce what they, or anyone else, say they want.

This – increasingly for a decade – is what I have been trying to avoid. This is why – very selectively and conscientiously – I have openly chosen non-compliance. To serve as a good personal and family doctor I must sometimes compromise or discard my unworkably dense matrix of regulation.

Real-life General Practice – like so much of our lived (rather than abstracted) lives – is the art of the possible. Only rarely is it completable or perfectible. To suppose

otherwise will teach us painful lessons: that is what we are struggling with, here and far beyond.

I am relieved and grateful to the Magistrates for allowing me the time to say all this. Even more so that they seemed genuinely interested and supportive, despite their professionally neutral demeanour.

Not so, not surprisingly, the barrister. All this, he says, is beside the prosecution's argument and evidence: that I have been knowingly disregarding – flouting even – of clear regulations. Other argument, explanation or mitigation is irrelevant.

Within this narrow legal frame I can see he is right. I am guilty as charged. My heart sinks.

I am wanting to say: 'But the *whole* (evidence from life) is more than the sum of its *parts* (evidence from procedures). We must – whenever we can – pursue and grant precedence to the whole.' I look around the Court. After many hours I can see it is now wearied to a standstill. I do not think they can be further receptive to me. I decide to say nothing.

The Magistrates adjourn for their final, private conference.

*

Another thirty minutes. We are assembled for the summary and verdict.

The senior Magistrate delivers this: 'In my twenty-seven years on The Bench I have never encountered a case of such length, interest and complexity. Yet at the end of the day we are all subject to the law, and this Court's task is to administer the law, not to express opinions about any such laws or regulations.'

She turns to look at me directly: 'It is with reluctance, but necessarily for this reason, that we find for NHS England and against the doctor. To his credit the doctor has been open and honest – both verbally and in documents – about his failure of compliance to clear regulations, but this becomes indefensible in terms of his contract of employment. NHS England is thus legally entitled to immediately effect its remedial procedures.'

*

After eight hours we all leave slowly, sagging with fatigue.

I extend a friendly hand to each member of the hit-squad. They initially stiffen warily with surprise, but then loosen as they perceive my gesture is unusual, but not an ironic trick. I smile and say: 'You did a difficult job well for your employers. Of course, I don't agree with what you've done: for me, this may be the law, but it's not justice. I understand the principle, but see only, and much, damage from this decision. I have so many mixed feelings about all this, but not about you: not personally.'

For the first time each individual holds my gaze. They each smile with a sweet-sad sincerity and say a lingering and deliberate 'thank you'.

At the end of all this very long procedure we have – only now and briefly –found and recognised our common humanity.

I feel a tug of intense grief: it is mixed strangely with relief.

*

Notices are put up on the front door of my Practice informing of its closure of services and where patients may now go.

As I walk away from the front door Ronald approaches me. I knew him as a docile adolescent and he now approaches me as a thickset middle-aged man with a cumbersome gait and a habitual aura of trusting – but never really articulated – anxiety. This is evidently worse now.

'I've heard, doctor … Can't you be my doctor any more?'

'No. Not from now on. I'm really sorry. But I'm pleased I was able to offer a bit of help over the years…' I am trying to buoy us both up, offer us both something positive.

'But why is that? Don't you want to go on?' I think Ronald hopes that his question will bring a reversal. His eyes glisten with stemmed tears.

‘Oh, no. The Authorities have decided I’m not modern enough. I’m not really what they want. There’s all sorts of regulations I have to follow…’

‘Can’t you do that?’ His question sounds pleading.

‘Probably not. I’d exhaust myself and I wouldn’t be able to be the kind of doctor I believe in … how I’ve tried to be with you all those years.’

‘So they think they know, better than you, how to be my doctor, do they?’ His voice is earnest and slow: this sounds like a real question, without guile or rancour.

I respond in kind. ‘Yes, I think that’s right. You see, they pay the money, so they make the rules.’ I try to sound simple, neutral and benign. I exclude much else.

*

Later, outside the NHS City Gates, my severed professional head will be displayed on a spike. It will not need much comment or explanation to spread the necessary message. Corporations can function only with hegemony, and hegemony necessarily must have compliance, and when have we ever achieved mass compliance without publicly displayed, draconian penalties?

*

‘Oh dear! That’s terrible news … I’m *so* sorry. How did it happen?’

Dr E, a young doctor now senior in my CCG, sounds genuine in his shock, kindness and commiseration. He is an intelligently humane man but stressed, I think, by the diplomatic strain and responsibility of shepherding very difficult schemes of governance that he (privately) does not believe in. With delicate and opaque skill he has signalled this to me previously, while always ensuring protective ambiguity.

'I'm really sorry', his voice lowers further with the repetition and sadness. 'You know this is going to leave a massive gap for us. You're going to be greatly missed…'

'How so?' I am touched and a little perplexed: I have previously sensed his wish for me to be more silent, or even absent.

'Well, you're the one who always said the bold and challenging things other people want to, but never would. You're older and you've had this honest – some would say tactless – courage. But these things needed to be said … now there won't be anyone to say them…' His voice fades into a faint desolation.

'Why don't you, E?', I ask, trying to revive him.

E is silent for several seconds before side-stepping: 'Yes, but how are *you* David? Do you have enough support?' He is sounding brighter and stronger.

*

As I enter my exile I await a formal CQC report: a pillory, a publicly displayed penalty for non-compliance.

I am thinking that there are times in life when we must choose between personal integrity and survival. I am grateful that this – my most serious test – has been encountered so late in my career.

I am thinking, too, of the elemental questions of all relationships and welfare: what do other people want and need? How do we (think we) know? Who decides, and how?

-----0-----

*Some eyes need spectacles to see things clearly and distinctly: but let not those that wear them therefore say that nobody can see clearly without them.*

– John Locke, *An Essay Concerning Human Understanding* (1690)

*The young man knows the rules: the old man knows the exceptions.*

– Portuguese proverb

---

**Interested? Many articles exploring similar themes are available via David Zigmond's home page on www.marco-learningsystems.com**

David Zigmond would be pleased to receive your **FEEDBACK**