The Perils of Industrialised Healthcare:

Some reflections on 'chaos' and 'nostalgia'

David Zigmond

The words we use to define, describe or dismiss events or people are often instructively ambiguous. Exploring that ambiguity can enlarge our view of much else. Here we consider the many difficulties generating the current imperilment of personalised general practice. An analysis of how two words – 'chaos' and 'nostalgia' – may be used differently illustrates the reach of such concealed issues.

A few months ago, deep into the Covid era, Peter Toon reviewed my discussion paper *The Perils of Industrialised Healthcare* (BJGP Life 1/7/21) and provided a long, essayed and probingly thoughtful analysis. Peter Toon's style here is consistent with his long career as an academic: the language and tenor of the writing is kept precise, judicious and impartial, so any affinity (if there) with *The Peril*'s strongly held views is not directly expressed: it can only be inferred. Despite such correctness, that review nevertheless ventured its own *metanalysis* where Toon adds something of his own thoughts and observations to the already wide-ranging *Perils of Industrialised Healthcare*.

Mostly I concur with Toon's embelishments and caveats; yet the few exceptions are themselves worth revisiting with further dissection and discussion. In particular, the different understandings and use of language (between Toon and myself) are, I think, good examples of very common miscomprehensions and then, alas, the unsustainable systems that have been built on these. Although the material Toon refers to is now several years old, its relevance to our current and future NHS is probably now even greater: Covid has merely amplified many of our long and deeply-rooted predicaments.

Two examples are extracted to illustrate these kinds of problems and their significance.

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1. Whose chaos?

> *Much of the social history of the Western World, over the past three decades, has been a history of replacing what worked with what sounds good … There are no solutions; only trade-offs.*
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> – Thomas Sowell, 1930-

Drawing from a 2016 *Guardian* report on the sudden and exceptional closure of my small erstwhile GP practice, Toon suggested it was: 'a rather *chaotic*, old-fashioned but caring practice loved by its patients, not unlike the one I took over from a single-handed GP in 1987.' (my italics).

Toon is certainly correct to surmise that the CQC *assumed* the presence of hazardous chaos. They believed this was signalled by my (very mindful and discriminating) lack of institutional compliance: lack of compliance is largely how they defined risk. This is an unreliable and specious equation, important to identify and understand.

Let us here consider the real-life evidence. This was very much at variance with their assumptions of hazardous chaos: for a very long period I was getting very much more right than wrong. The discrepancy is worth examining, so here is some of the evidence:

> For decades the practice had exceptionally high patient-popularity (latterly evidenced in independent surveys) together with staff loyalty, stability and popularity. These contributed to an excellent safety record – never (for thirty years) a serious complaint leading to any formal investigation, hearing or litigation; never an untoward accident or death requiring a

> Coroner's Court attendance. It is worth considering: how many practices now could manage this kind of unproblematic and popular stability?

In any case, is not such a record the most reliable and substantial evidence of an orderly (ie well-functioning) organisation? Where, here, in real life, is the hazard and the chaos?

But NHS managing and inspecting authorities had a very different 'evidence base' (a term they favour): their 'evidence' has become, increasingly, that kind of dense and demanding formulaic regulation and metrics that is, all too often, cast adrift from real healthcare competence and compassion. So much so that these core activities and qualities become seriously displaced and eroded. I could see this happening and thus chose, and took responsibility for, disregarding what I considered was the contextually inapposite or even oppositional.

That's a bit of a mouthful, so what does it mean? Well, for example, neither my long-term receptionists nor I performed Criminal Records Checks on each other (… but I knew them, their work and their families well, for many years); we did not have a Surveyor's report certifying the functioning and safety of the single fire door (… this small surgery had a very visible, fully signed and accessible well-functioning fire door – the inspectors refused to see this but instead insisted on the correct prior documentation); we did not adhere to *their* recommended cancer follow-up protocols (… this was a small practice where such patients were usually personally well-known to us. There were no cases of involuntary [for the patient] failures of follow-up. Our system worked well. The inspectors did not want to know how our own modus operandi actually worked [and it did, very well], only whether it conformed to their model); neither I nor my staff could be

bothered with professional development plans (… yet the practice's staff morale, motivation, loyalty, and feedback of patient care had long been exceptionally positive).

So, to return to the beginning, what kind of chaos are we dealing with here? The CQC, for all its vaunted good intentions and densely formulated schemes and inspections, has generated for more contention and, sometimes, egregious error and oversight than this small, stable, now obsoletely-eccentric practice.

And which is more dangerous?

This contrast – between the blind-sided collateral damage from juggernauting large-scale reforms, and the time-tested benefits of small, stable units – does not necessarily reflect (initially, at least) on the intent or integrity of the reformers. But it does reflect the often clumsily cumbersome and unviable nature of much of their method; and a seriously flawed method most often betrays its mission.

We are now seeing the price of such heedless bureaucratic over-reach: our seriously demoralised, debilitated and depleted workforce.

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2. Nostalgia or learning from history?

That men do not learn very much from the lessons of history is the most important of all the lessons history has to teach.

– Aldous Huxley (1894-1963)

Toon later has trouble with my historical view: 'Some of Zigmond's anti-gigantism ideas sound *frankly nostalgic*: return to smaller medical schools, hospital firms, single-handed practices. One cannot go back, and the reality of those structures was perhaps more mixed than he suggests…' (my italics).

It seems that I have been unclear to at least one reader, so let me clarify here the misunderstandings I think are implied by the mantle of 'nostalgia':

- I do not believe I am nostalgic in the 'rose-tinted-spectacles' sense: my endeavour is, rather, to discern and understand what worked better in the past, why and how we have lost such things, and how we might judiciously reinstate them.
- Alongside this I have always accepted that the older, pre-1990s NHS, say, was 'more mixed' than now – that there were some dismal yet tolerated failures of fair distribution and acceptable practice. Yet in our drive to serial reforms for a more managed and guaranteed homogeneity we have also destroyed much of our best practice, particularly that which involves personal understanding and thus relationships and continuity. This is the view of the vast majority of practitioners from that era.
- In general we can say that in our NHS anything to do with technology has become much better, but anything involving relationships is most often subverted, imperilled or disappeared. Our capacities to treat have accelerated ahead; our capacities to personally heal and care have become destitute.

- This discrepancy has been particularly damaging to primary and mental healthcare – the cornerstones of pastoral healthcare. The evident levels of dissatisfaction and distress there are particularly rife.

- All pastoral healthcare must depend on people getting to know one another personally – both patients and practitioners. This becomes more and more difficult as organisations grow larger: our tendency to Gigantism has pitched our pastoral healthcare services into a culture of no-one-knows-anyone-but-just-do-as-you're-told.

- Erstwhile smaller units were far less prone to this: small GP practices with personal lists, smaller local hospitals, consultant-led firms, smaller (and then more) medical schools are some examples of how we could look after, and look out for, one another better. Where we *belong* we can more easily find personal satisfaction and identifications. (Yes, smaller units have other problems – mostly logistical – yet most other Northern European nations manage these trade-offs rather better than us.)

- Aldous Huxley's maxim has, almost always, been depressingly true yet need not be. The last century has much to teach us.

  In the 1920s the USSR's farm collectivisation programme extinguished the resilient working independent spirit and energy of the Kulaks. The result of this politically driven coercive Gigantism was social deracination and misery, starvation and death for millions.

  In the 1930s USA opportunistic farming burgeoned on the mid-Western steppes, encouraged by quick profits and enabled by newly invented disc-ploughs, agrichemicals and powerful tractors. All this exhausted the previously fertile earth to form a vast Dust Bowl – unviable and

unfarmable. The casualties were in scores of thousands rather than the USSR's millions. This was the price paid for high tech opportunism thrusting forward without ecological sense – the heedless disrespect for the fragile yet crucial forces that both boundary and bind the existence of all living things.

Both were national tragedies, but the USSR's was much greater. Why? Well, the USA, under the new Roosevelt administration, swiftly identified, acknowledged, understood and rectified those errors. In Stalin's USSR there was no such humbled wisdom, only tyrannical edicts, fearful denial, concealment and abject submission. Such is the price we may pay for intransigent ideology.

2020s NHS is not, of course, dust-bowled 1930s USA or collectivised-starved 1920s USSR – we are not shot, cachectic or asphyxiated en masse (yet). Yet these historical follies can be instructive for our own: Gigantism often leads to alienated, roboticised dearth of relationships; over-dependence on technology may design good seeds but the crops will fail if the soil is exhausted and depleted. So the government may train many more doctors for our NHS but they cannot thrive and we will not keep them if the deeper personal and professional satisfactions and relationships are no longer there in their work.

If we learn from history we may yet steer this to our advantage.

- There are, currently, some well-researched beacons of hope from those whose projects can reverse some of our destructive industrialisations: 'rewilding' some of our abused terrains, replacing some of our vast

monoculture open farmland with more varied, smaller hedge-boundaried fields so contributing to 'sustainable agriculture'.

Peter Toon's statement: 'One cannot go back …' is, thank goodness, only sometimes true.

Is that caveat – my caveat to his truism – nostalgic, captious … or (sometimes) true?

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