

FROM FAMILY TO FACTORY

THE DYING ETHOS OF PERSONAL HEALTHCARE

For more than 40 years I have worked as a frontline NHS doctor, mostly as a psychiatrist and GP. With other newswatchers, I join the surges of angry moral revulsion when hearing of the latest exposure of gross neglect of care, or even darker cruelty.

Yet my outrage, sadly, is not shocked: I have long considered such events almost inevitable. For in our eagerness to exploit the efficiencies of industrialisation we have carelessly sacrificed the caring human heart of healthcare. We see 'treatments', but people become invisible. This is – at least sometimes – the price we pay when we create a culture that excessively objectifies and commodifies the complexly human.

I remember a different ethos. At the start of my work in the NHS – before our hermetic rhetoric of measurement, quantification, computer-coding and managed goals and targets – I thought of my working milieu as a (mostly) good-humoured, well-functioning family. Complex tasks were shared across disciplines with welcoming courtesy and cooperation. Roles and experience were sensibly recognised and respected, but rarely rigidly enforced. Likewise inter-professional boundaries: we usually accurately understood others' competence and responsibility and adjusted our activities and encounters accordingly. There was often considerable overlap of skills and practice: this would now be regarded as 'untidy' and inefficient, but actually was usually to everyone's benefit – we could provide a more seamless service: it was easy to refer patients across to colleagues whose work and language we understood, and who were often personally known to us. Although one practitioner might be best suited to a particular task, others could expediently temporise and substitute themselves when necessary: like well-functioning families, where good-faith prevails, this would be guided by open dialogue – by sense and sensibility. The result? Patients rarely got lost within or between systems: personal attachment and knowledge guided a sense of continual care. Practitioners, too, enjoyed this broad conviviality. We can see these principles operating in well-functioning families: the healthy resilience both

of the entire group, and its individual members, depends on an ever-changing mixture of structure and flexibility.

In human families there are essential jobs to be done: the 'infrastructure' for the security and welfare of all. But beyond that families exist to play, provide nourishment, pleasure and meaning for one another – and then create new life that transcends and may surprise them all. These life-affirmations all had their equivalents in my first two decades of NHS work. I felt part of a large 'organic' network of care – colleagues then seemed like relatives of many kinds, who also ranged in familiarity, seniority, wisdom and power. There were other subtle fruits from this family-like network of care: we knew and understood real families far better than we do now. I remember many helpful conversations with 'family doctors', helping us understand the struggles, yearnings and sorrows of the ailing within their patients' families. Within this family-sensitive, vast, sprawling NHS 'family' I had myriad and mostly good contacts with my healthcare 'siblings'. I appreciated then – more now – that I was part of one of the best, and most workable, kinds of 'Confederate Socialism'.

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It was not to last. For the last two decades we have seen a progressive dismantling of this family ethos. Successive think-tanks, management consultants, specialist committees and then briefed-politicians have adopted the mindset of the engineer, the industrialist and the market-economist. Healthcare is now forged as a kind of Civic Engineering or, even, a project for Venture Capitalists. Some forms of healthcare submit well to these approaches: the elimination of Poliomyelitis and the spur to advanced pharmaceuticals are respective examples of clear successes. The treatment of certain well-defined physical illnesses – for example, a the surgical remedy of the blocked coronary artery or opaque eye lens – are now routine 'products' of these approaches.

But we must beware of losing our balance: for our new managed healthcare culture is now evolving more like an insect colony than a human family: roles

set rigid, repetitive, prescribed, and dictated. Skills become narrow and executed without either consciousness or view of the whole. Care is reduced to a complex system of interlocking, algorithmically proceduralised tasks: an Airfix Kit of (non) human engagement.

In contrast, a healthy human family is like a garden: growth is facilitated, protected, tended – never coerced. Relationships are nourished and encouraged as ends in themselves, not for any external ‘product’ (though often this may be spawned). How different this is to our insect-colony-like healthcare factories where all human conduct is mandated and managed by the group’s circuit-board. Relationships and communications are subsumed to a strict division of labour – rarely are they ends in themselves. Individual variation is likely to be perceived as subversion. The group’s totalitarian function commands all.

Clearly the ethos and activities of the family and the factory both have essential – yet very different – places in our complex lives. This extends to our healthcare. An important task needs to be discerned: the necessity for wise and flexible judgment as to how to balance these opposing principles in all our important human projects. Failures are common. For example, attempting to ‘manage’ family life by uncompromising parental authority will not work for long: eventually myriad forms of unhappiness, subversion and defiance will obliquely countermand.

Yet, as we have seen, our factory-industrial approach has procured us massive benefits, otherwise unreachable. But, when overused, this approach can alienate, erode and destroy important human bonds and understandings. In healthcare we must be vigilant, for these conundra and complexities demand our endless capacity for fresh and creative compromises.

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Our factory-type healthcare will deal poorly with those many human ailments that need different kinds of *personal* engagement for their relief and transcendence. These require healing encounters that mobilise the sufferer’s

internal resources for immunity, growth and repair. These are subtle and delicate activities and – importantly – cannot develop in a *factory* culture, whose structure and function both depend on rigidity (like a vehicle chassis). They can only emerge and thrive in a *family*-type milieu where structure and function and strength are linked to flexibility and elasticity (like a tyre). The general principle for healthcare is that while factory-type management may be best for *conduction* of less psychologically demanding tasks ('Science'), it is much less suited to socially and psychologically complex situations, where subtle, imaginative *induction* is required ('Art').

We need these kinds of inductions for any successful attempt to understand personal experience and meaning. For these there are no adequate plans or maps – for while personal experience and distress may contain universal themes, they are always – in some ways – unique. The factory cannot recognise such important discriminations and thus can only hinder us. Yes, our ideas of faulty biomechanics are essential in many of our healthcare encounters but we will often need, also, other approaches of flexibility and imagination. We need some understanding of *this* person's life, experience, struggles and relationships: holism and semiotics – this is that as well as this. In a culture that is less industrially rigid and driven, the power and meaning of personal attachments will extend far beyond procedures. This is what happens in 'good' families.

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The price of short-circuiting all this is high: it is what we have now. I am told there is much academic, systematic research into such matters. In my realm – a veteran frontline doctor – what do I experience? I now inhabit a world much richer in precise, high-technology interventions and informatics, and much safer from evident rogue or incompetent practitioners. Yet it is a world more humanly impoverished: of human connection, knowledge, understanding, affection or enduring personal concern. I now attend many meetings with harassed, dead-eyed, fatigued, dispirited doctors. They say: 'I do what I have to', and talk of earliest-date retirement – despite being better remunerated than ever before. Our meetings are pressure-cookers of abstracted

management: Agendae, Goals and Targets, budgets, performance indicators, Care Pathways Exception Reporting, Integrated Care – a new lexicon of depersonalised management. It is many years since I sat together with colleagues to better personally understand and develop our frequent and inevitably flawed, fragile and evanescent human work. The factory has driven out the family: I am frustrated and sorrowful. I still have some cohorts: displaced older members of a now-homeless vocational family. We commiserate.

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What of patients ('service users!'): what do I hear? Those most satisfied – I fear transiently – are those plucked with timely and efficient specialist intervention from cardiovascular or malignant catastrophe: the life-saving coronary artery stent or hemicolecotomy. Well-managed factory-healthcare does well here: these beneficial matchings must be acknowledged and continued.

But I hear many more stories of another kind: of vulnerable, fearful people (all of us, sometimes?) feeling personally insignificant, unknown and unanchored in a large, complex, indecipherable system. There is a new kind of anomie in our healthcare: I hear it routinely from intelligent, conscientious, alert people – that they do not know the name of their GP ('The Surgery is so big and busy: I see somebody different each time.'). Likewise the elderly or mentally anguished ('No, I can't remember the name of the clinic or the doctor: there are so many ... They said they'll send me another appointment. Yes, I'll do what I'm told ...'). From older patients I hear laments for the loss of smaller, friendlier practices and the hospital general physician who saw them through many travails ('Dr X and his staff knew me and my family: I didn't have to explain ... I felt understood and cared for ...'). Wanting to continue my ethos of family doctor, I frequently extend my interest and the interview, to develop better personal understanding. Younger patients are surprised – positively and appreciatively ('No one before has shown the interest to speak with me like this.'). As a family doctor this was easy: it is much more difficult as a 'primary-care service provider'.

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The ennui and fractious demoralisation of our NHS has become a constant back-drone in our national life. Periodically we can expect interruptions: startled shrieks from many more sickening healthcare atrocities. These will usually occur within forests of managing regulations and procedures. In the shocked tumult, listen for the displacing, buttressing countercharge: 'Inadequate resources!'

I do not usually believe this. The impoverishment is of another kind.

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Healthcare is a humanity guided by science.

Further reading: notes

Being a busy single-handed practitioner I do not have time or facilities for systematic or quantitative research into the issues that so concern me. Others do, with my respectful gratitude.

My research remains qualitative, informal and vernacular: exploration is of people and situations known to me. For interested readers I have listed some relevant writings that explore some themes more fully. I attach brief notes for descriptive guidance. All are available via my Home Page on www.marco-learningssystem.com.

- *The Psychecology of Gladys Parlett* (1988)
An elderly woman suffers unarticulated grief and loneliness. Written in 1988, the professional responses forewarn our over-schematised services.
- *Five Executive Follies* (2011)
A lengthier and more systematic dissection of factory-type thinking and management.

- *Why Would Anyone Use An Unproven Therapy?* (2010)
The importance of the implicit and rarely-spoken in healthcare. The difficulties of researching these.
- *Eric: Another Case of Hypertrophic Obstructive Management ...* (2012)
What happens to vulnerable, inarticulate people in our complex system of industrialised specialisms?
- *Edward: Shot in His Own Interest ...* (2005)
The human connections throughout healthcare are often much richer, more complex and influential than we are encouraged to think.

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