

# Healthcare's Hole in the Heart

Can we have value for money and not lose our  
humanity?

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Our lives lengthen, our population increases, our expectations multiply: inevitably our healthcare services need ever more resources, monitoring and coordination. *Efficiency* becomes crucial. Increasingly, management methods from competitive production industries have been adopted to meet these needs. Yet the results are often paradoxical and demotivating. Why is that?



*In a full heart there is room for everything, in an empty heart there is room for nothing.*

– Antonio Porchia, *Voces*, 1968

The NHS culture I will retire from has departed far from the one that tended and guided me several decades ago, at the beginning of my life as a doctor.

My working milieu has evolved a curiously unhappy amalgam: fatigued and demoralised, yet edgy and mistrustfully vigilant. This is manifest by a workforce subject to ever-increasing pressures by, and for, 'management': goals and targets, deadlines, directives, performance indicators, appraisals, inspections and audits. Such executive devices have, perversely, caused the loss of the very human satisfactions that make our difficult work worthwhile: personally invested relationships with both colleagues and patients, the flexibility and time spans that enable our most human types of *holism* – the ability to both perceive and mould how *this* particular diagnosis or intervention relates to *this* particular life and its relationships. The losses of such personal meaning and gratification in our NHS Workforce causes widespread destruction. This is reflected in many statistics: rates of sickness, career abandonment, intraorganisational litigation, earliest retirement, drug and alcohol abuse, suicide – all these have markedly increased.

Mostly undocumented, but very telling, is the growing discrepancy between the privately uttered and the publicly avowed: what is disclosed in quiet sequestered conversations is very different to the vaunted presentation in the conference room or official document. I am told that such fearful and hidden dissonance and loss of integrity premonitored the cynical and exhausted collapse of the Soviet Union.

All of these morbid signs have been generated, then accelerated, in the last two decades. This has happened usually because of serial service redesigns, hardly ever in spite of them. While ever more public funds and resources are ring-fenced for healthcare, the morale of its servants continues to plummet: at the heart of our Welfare we seem to have created a kind of human black hole.

Yet we have learned to revere our health service as a kind of Welfare Crown Jewel. Politicians of all hues understandably want quick and decisive reversals to any sign of degradation: the motivations are usually mixtures of public interest and anxiety about their job tenure. Their public statements are, therefore, designed to sound resolute, muscular and galvanic. 'Driving up standards' is a standard and safe mantra; 'Declaring all-out war on mediocrity' seems more desperate and courts the absurd. Both were recently broadcast by Cabinet Ministers.

Both of the phrases are worth some analysis: they are good examples of how we may exacerbate problems by simplistic judgements or plans.

First, 'the war on mediocrity'. What can this mean? The mediocre is an average, so how would we identify it as an opposition force? Then how do we eliminate it without another 'mediocrity' arising? The rhetoric has much bluster, but little sense. 'Driving up standards' may seem more cogent but induces many problems. We talk about 'driving' cattle, chemical processes or motor vehicles: it is a phrase that implies dominance and control, and thus complete submission of the driven. This brings us to the crux of a very important question, one central to the motivational psychology, and then management, of our Welfare Services: what is the best way to get other people to care for yet more other people?

Operationally, do we need more sticks and carrots? Why does this not work better? Is there something we are missing? Is it trust?

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Our best welfare is not like a manufactured chemical process; it is much more like a child, or at least a complex living tissue. In both of these survival, then sustainable growth, need a protected environment and nurture quite as much as any control. Expecting good Welfare to evolve and thrive in an oppressively controlled working environment is like expecting a happy and creative individual to emerge from a family that is determined by many inflexible rules – it rarely happens.

Yet this is what we have set up in our Welfare services. Our advanced industrial culture is now so accustomed to being able to design and manufacture objects that service our wishes, that we assume we can do the same with our complex human needs and interactions. Often we have been able to short-circuit complex natural processes. Sometimes this has been expediently successful, but cumulatively it has led to any 'family' ethos of Welfare being commandeered as a kind of factory process. What does this mean? Here are two scenarios, separated by forty years, to illustrate and explain.

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### **1972. Frank's Flower Bed. Mental Hospital. Outer London**

As a young psychiatrist I worked in a large and handsomely stalwart Victorian building set amidst extensive, landscaped and well-tended grounds. It had a staff canteen – a cheerfully clamorous space offering unpretentious, good-enough, home-cooked food and the opportunity for easy and informal colleagueial contact. Several times there I opportunistically lunched and talked with Frank, the Hospital Administrator. Frank was about thirty years older than me, with an unintrusively warm and avuncular manner. He liked, when possible, to talk to staff members and (those that wanted to) patients.

I remember occasionally continuing our conversations beyond the canteen, sauntering along the paths connecting the many lawns, flower beds, massed Rhododendrons and Azaleas. Tending these were small groups of patients to whom – the longer-term ones – Frank signalled a friendly recognition. Frank and I were interested in one another's roles and perspectives. He told me how he had started working at this hospital as an eighteen-year-old wages clerk. He had slowly 'worked his way up'.

Frank was interested my young, questioning, 'freshman's' view of his long-served job and ancient institution. I described my experience of working in this large, sequestered working community as like being in a village, in which he was the Mayor. He smiled with cautious pride. 'Yes', he said, 'I suppose it

is that kind of community. Well, I hope it's mostly a welcoming village for you to work in, and that I'm a worthy Mayor'.

My last image of Frank was unusual and it remains sharp in my memory. At the front of the hospital was a rather grand porticoed entrance. This itself was symmetrically flanked by a few parking spaces for staff beyond which there was a small, lawned roundabout with a central flower bed. Having finished work late one midsummer evening I saw an incongruous crouched figure, indistinct in the fading light. It was Frank planting a flowering shrub. My understanding lagged behind my greeting.

'Oh! Frank ... What are you doing?' I asked with friendly perplexity.

Frank firmed and patted the last of the anchoring soil and looked up.

'I thought this would bring a bit of life and colour to this rather neglected flower bed' he explained, glancing briefly with affection at the shrub.

'When it blossoms you'll see it from your office window.' I wanted him to receive some of his own beneficence.

'Yes ...', he looked around 'a lot of people will see it ...'. He paused and exhaled a soft, low sigh of satisfied completion and anticipation. 'I hope a lot of people will still see it well after I'm gone, too...'

His smile seemed poignant and intimate: an inexplicit intimation of our universal mortality.

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I had always liked Frank's unegotistical and humble personal pride in his work, which he enacted with such unassuming but steadfast public service: that was why I liked to walk and talk with him. Even at the time of this affecting yet brief encounter and dialogue, I realised it captured something subtle and precious with a poetic economy. Frank's tender planting was a

small act from a large heart and mind: an investment that could take root and enhance not only his life, but others' and other times. As far as I know, Frank's working life was long, stable and otherwise unremarkable. He received little public recognition.

He was called an Administrator.

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**2015. Brenda's Business Support. Frontline General Practice. Inner London.**

It is now four years into the Health and Social Care Act. This legislation was introduced stealthily, amidst much confusion: it was implemented (just) with assurances that it would free GPs from the growing bureaucratic mire and so empower them to make speedy and accurate decisions for the patients and localities that they supposedly know well. This last notion is a serious misconception, as GPs have largely lost their special vantage point for personal and vernacular knowledge. More broadly this is contributing to an unleashing of the Law of Unintended Consequences whose effects are far more durable than the political and rhetorical slogans that spawned them. GPs are now discovering just how complex are decisions of public healthcare policy and administration, and how different (however connected) these are to the skills of doctor-patient encounters. Frustrations about the demands of the massive new tasks are very substantial. Even worse is the way that doctors are further depleted of their already dwindling head and heart-space: the intellectual and emotional opportunities for personally invested and gratifying work with patients. Instead, their vocational energies are officiously abducted into conduits to serve a public utility. These initiatives – turning all professional activity, interchange and mental life into publicly managed commodities – have inadvertently displaced, and then destroyed, the powerful yet subtle personal nuances that are the vitalising human heart of our personal healthcare.

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Alarms are being raised about this, but no-one seems to be able to stem the rising tide of bureaucratic directives and incentives – the floodwater drowning us with such a massive volume of depersonalised stress and exhaustion.

Over many years I have issued dozens of invitations to managers and politicians to sit in with me, in a Surgery session. We could then share, *In Vivo*, experiences and notions directly from the front-line. My invitations have never been taken up. Often the declination has been explained by other ‘more essential’ meetings and commitments. Even if veracious, there is another never articulated truth: ‘We cannot deal with real experiences; we can only process abstracted representations of these.’ This is the thin end of an important wedge: one often signalling the nemesis of all those taking responsibility for others.

Ignoring such signs and alarms seems perilous to me. I repeatedly try to raise this at our professional (Clinical Commissioning Group) meetings: each time I am told that the Agenda is already full of essential administrative matters, and that these meetings, in any case, are an incorrect forum for my concerns. I ask where and when can we publicly discuss such crucial and perverse discrepancies? I receive no answer. Yet I am receiving some dark encouragement: for at other times colleagues seek me out in private spaces to express their hidden frustration, resentment and fear: the broken life energies behind the bad statistics.

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In an effort to assure open discussion I continue my efforts to contact a manager. They, surely, can ensure that this is put on an Agenda. This is proving tricky. If emails are answered it is with officially phrased dissemblance or procrastination. More often they lie unattended in a cyberdump. Personal conversations are required. I telephone the relevant manager but cannot get through: I leave messages with Assistants and an Ansafone. I persist.

On my last attempt I am put through to a voice that sounds to me clipped, correct and uninterested in involving herself in anything she cannot authoritatively answer. However, she responds confidently to my questions of designation: she is a Business Support Manager and her name is Brenda. I ask what her role entails and her reply seems stiff with bureaucratise: 'corporate strategy', 'integration of multidisciplinary planning', 'interface communication between Trusts in Commissioning implementations'... Her voice has the sing-song cadence of an official on autopilot. My attention soon drifts away.

I am thinking how distant are the worlds that Brenda and I inhabit. The Welfare work I have been doing for many years is very different from what she calls a 'business'. And who is she 'supporting'? I can imagine her 'supporting' some commissioning or auditing initiative ... I cannot imagine her supporting me.

'How can I help you?' Brenda cuts across my disengaged reverie with a brusquely managerial tone.

I briefly explain what I want to put on our meeting's Agenda: the collapse of NHS staff morale and rise of staff sickness and career abandonment.

Her voice cools further to a crystalline formality. 'I'm not, strictly speaking, the right manager for you to speak to. I'll pass your message on. Somebody will get back to you.'

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Three weeks later. Nobody has.

Who *does* Brenda support?

While I am pondering these questions my mind is crossed by another, tragicomic, notion: how I would rather be a junior shrub in Frank's flower-bed than a senior doctor in Brenda's business-supported NHS

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*It is not because other people are dead that our affection for them grows faint, it is because we ourselves are dying.*

– Marcel Proust, *Remembrance of Things Past*, 1913-27