

Institutional atrocities:

The malign vacuum from industrialised healthcare

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Flagrant neglect or abuse in our care of the vulnerable within our advanced Welfare State seems shockingly perverse. How and why does this happen? This article argues that excessive industrialisation and schematisation are speciously alluring, but then alienating. Restitution of any culture of more compassionate care is like an organic process: it must develop from milieux that have receptive space for attachment, affections, and containment.

So, from the tide of depersonalised healthcare we have netted a flagrant and demonic example of maleficent neglect at Mid Staffs and, now alarmed, subject it to forensic analysis. Understandably we want to know: how could this happen? Who is responsible? Who can we blame? Government? Inspectors? Policymakers? Regulators? Practitioners? Administrative Managers? Clinical Managers? Almost immediately we have rhetorical cries for justice and resolution: More trainings/inspections/management! Professional eliminations! Clear and strong leadership! Show-trials for public pillory!

All of these responses have relevance or truth yet seem, to me, to miss some deeper understandings about how advancing technology is changing not just our thinking, but also our configurations of human connection. Like our banking and economic systems, our problems extend far before and beyond our crises, or our judgements of villainy or technical incompetence. These events are grotesque aspects of Zeitgeist: we are all in this together. We are all easily, unwittingly, victims or perpetrators; we have much to understand.

In my exploration I have come to some different, though contiguous, ideas. At their centre is this: that healthcare has become too beholden to the objective, technical, systemic and informatic; that the unmindful excesses of these have driven out interpersonal understanding, attachment and, thus, instinctive and gratifying caring. We have ignored – at great cost – an omnipresent paradox in our care of others: that is, impersonal treatments and formulations (science) tend to countervailance with personal engagements and holistic understandings (art). Our contemporary healthcare thus requires a vigilant balance: to offer our best skill, effectiveness and humanity, we must be able to combine these opposing principles – to weave and titrate them – differently with each encounter.

Four decades ago I was mentored by doctors who, generally, had a canny awareness of the importance of such complex balances. Successive generations have lost this sentience in our cultural rush and thrall to the impersonally managed, measured and procedural. In our increasingly push-buttoned world we are increasingly uncomprehending or intolerant of anything else.

I recently watched a BBC *Newsnight* programme: graphic descriptions of cowered, helpless people dying of dehydration on soiled sheets exemplified our problems. The fractious lobbyists and pundits exchanged recriminations and accusations and never-again contritions. Several talked of inadequate or incorrect training, assuming that it is training that prevents a gravitational drift to blatant inhumanity. My view is different. Such omissions of care and connection are not a matter for adding specialist *training*, but of retaining or reclaiming our common *humanity*. How have we lost this, and on such a massive scale? How do we repair this, and in a way that will be sustainable?

In answering these questions it is important that we first acknowledge the blessings from our accelerated industrialisation of healthcare, for these have certainly brought us dramatic benefits alongside the insidious losses we are exploring here. The benefits are greatest for complaints that are primarily physically localised, and then are speedily and decisively resolved by procedural expertise. Clear examples are timely interventions in cardiovascular disease and some cancers. The way we systemise deliveries of such blessed interventions can be thought of as being like a *factory*.

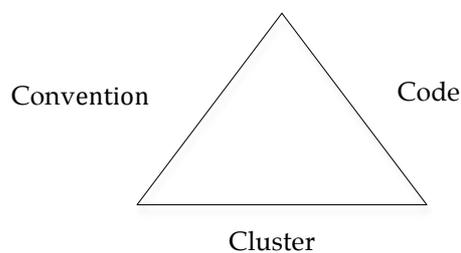


Figure 1: Generic ordering of structural illnesses

Easy to measure and subject to 'factory' processes.

Impersonal

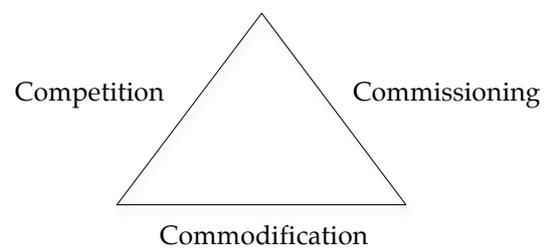


Figure 2: The current boost of industrialised healthcare

Designed to optimise management, measurement and 'factory' efficiencies

Impersonal

Yet the modelling of healthcare solely on this illness/procedural intervention paradigm is hazardous: when our suffering or its causes are not easily despatched, we need a culture that encourages something very different – attachments, affections and containments that develop *between* people. This enables personally anchored understanding and care: these offer not only comfort, but also the subtle inductions of *healing within* the person: of immunity, growth and repair. These activities cannot be schematic, but they are vital and vitalising. Notably attachments, affections and containments are at the heart of any healthy kind of *family*.

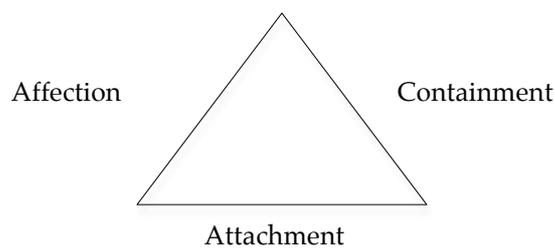


Figure 3: Interpersonal healing inductions

The 'family' ethos of well-fared welfare

Difficult to measure

Personal

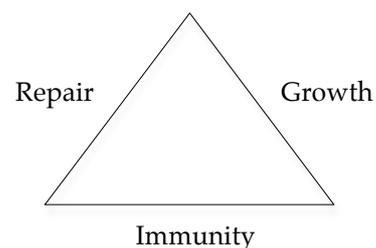


Figure 4: Intrapersonal healing inductions

The 'family' effects of well-fared welfare

Difficult to measure

Personal

While factory and family healthcare paradigms both have irreplaceable functions, their coexistence is not straightforward: for our best benefit can come only from ceaseless and careful choreography between them. Failure to understand, respect and achieve this delicate balance leads not just to ineffectiveness, but then to inhumanity or hazard. This is our current nemesis: our healthcare has become factory-rich but family-poor; informatics and scanner-sighted, but humankind-blind.

We have erred through our indiscriminate and thus excessive use of systematics: objectification, coding, planning and atomisation into managerially proliferated and boundaried specialisms. This may be a good way to run a robotic factory; it is definitely not a good way to raise a (healthcare) family.

Many will regard the Mid Staffs' debacle as criminal; I think it is more true, and more instructive, to think of it as *cultural* – Mid Staffs is thus a severe symptom, a warning sign, of our collective and collected errors. It is, of course, a severe event, but also one of many and now everyday examples of our healthcare anomie and human disconnection. This has happened both despite, and because of, our ever-increasing welter of commissioners, statutory bodies, dividing and divisive specialisms and competing autarkic Trusts – all these have led to a kind of healthcare that may look good as an architectural model, but is not good to live in. The worse the economy, the more impressive the economists.

I used to work in a much more heterogeneous NHS: the worse was worse, and the better much better. What was that 'better'? For the professionals working hours were longer, but morale was higher. Official Regulation was less, but vocational conscientiousness greater. Physical treatments were simpler and cruder, but personal care more sustained and sensitive. Electronic signalling non-existent, but conversational dialogue much easier. The pay was less, but the human reward was more. Didactic training facilities were meagre, but educational discourse richer. Most of my older mentors passed on loving care for their work, now my younger colleagues attempt to control others by formalistic Personal Development Plans.

And what of the patients? In the earlier, less technocratic NHS the better Clinicians understood the importance of attachment, affection and containment in *healing*: we assured time, flexibility and imaginative space for these. We knew that such subtle interactions were often our best offerings of care for those conditions not easily cured – probably the larger part of our healthcare (yes!): our ageing, our mental distress, our tangled, troubled reactions to Life's vicissitudes. For these our best efforts are more imaginatively pastoral than procedurally technical. Here the professional's integrity and judgement need *personal* enlightenment and nourishment, yet these are now often driven out by further *technical* management and training. The stark inhumanity at Mid Staffs is what happens if we do not understand and then neglect this delicate ethos of human connection; it is not about the kind of competencies that can be quickly and easily trained and regulated.

The realisation of this may be an awakening, to reopen our eyes, hearts and minds.

This schematic desiccation of human connection in NHS healthcare is thus seminal to many of our serious and widespread problems. Over the decades I have observed this previously humanity-rich but imperfect organisation become more and more machine-like. People in the NHS I now work in, have a steadily declining personal knowledge or understanding of one another. In this ex-human vacuum the computer now sits, like a glowering, increasingly obese and enthroned Emperor, appropriating the impersonal hub and frontline of administrative and informatic continuity.

What does this lead to? Anomie and depersonalisation. Few people can now name their GP, Hospital Consultant, or even the name of the specialist Clinic they attend – mostly the computer will bid and book them, and mostly they will comply. GPs are increasingly working in large conglomerate practices where they offer little personal continuity of care, do not know families, neighbourhoods or even the names of their own receptionists. The receptionists, in turn, are disconnected from their (many) doctors and increasingly from the patients – ‘reception’ is now often done by a computer screen, leaving the receptionist ‘free’ to tend the computer with other tasks. Those other tasks often involve some kind of electronic data-collation, which will be necessary for the doctor to have on the screen, when he is having a procedural (non) contact with a patient he will never really get to know, and does not look at (because he is instead looking at the computer screen) ... Get it?

In hospitals this anomic haze is even worse. In my local airport-like hospital I have seen consultants doing Ward-Rounds with rota-directed junior doctors they have never met before, attended by Nurses who do not know their own colleagues, the patients or any other ward staff. This consultant, clustered with strangers, then attempts quickly to evaluate a complex (for we are) human/technical problem in a patient he is seeing for a first and (often) only time. Such a symphony of fragmented depersonalisations has been orchestrated by successive layers of ‘improvements’ to logistics and

efficiencies of healthcare's training, standardisation, procurement and delivery. Examples? Amalgamation of Medical Schools, the dispersal of Hospital Nursing Schools to Universities, standardised modular trainings (rather than apprenticeship-type education), the encouragement of subcontracting, the abolition of GP personal lists, autarkic powers of NHS Trusts, payment by results, the fragmentation of Psychological and Psychiatric Care into complex speciality-based streams, the European Working Time Directive, and, of course, the 3'Cs' (Commissioning, Competition and Commodification) ... all of these exemplified initiatives – plotted and hatched by experts – have added to the remote-control complexity of our healthcare machine and the human inaccessibility for its operators and operatees.

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Authentic caring is not a commodity to be traded or a skill-set to be instructed. It is an ethos, a metaphorical effusion of the heart. It is a benign, often relayed, human transmission that tends to mirror, then amplify, the incoming signal. It is a similar, but opposite, process to the contagious relay of cruelty, bullying or intimidation. For caring we need holistic imagination – to perceive or conceive *more* than is explicit or apparent. In contrast, cruelty requires us to see in a person or situation *less* than is clearly there. Cruelty is a kind of reductionism. Yet our current systems of management will urge us to the simplistic, formulaic and formalistic. Trust-employed healthdroids are now paid to look only at one prescribed part of complex problems, and in the Trust's officially prescribed manner. This is usually influenced significantly by the Trust's interests of autarky or economy.

Caring for others also depends on our own morale: whether *we* feel cared for, embraced by human connection and value. This, of course, will depend much upon our milieu: as health carers how do we perceive our working and employing culture? What kind of 'factory' or 'family' do these represent for us, and in what kind of ratios?

The quality of how we care about our care of others depends on ensuring receptive and imaginative mental space and time to make possible personal *attachments*. From these may develop *affections*: the investment of bonds with discernable feelings – for now we become significant, then important, for one another. This establishment of affectionate attachments then makes possible another and essential aspect of compassionate care: *containment* – we bring comfort, calm and often understanding to others when we receive, hold and share what they can no longer bear alone. Again, this is often a relay effect: the sufferer is helped to contain their suffering by feeling contained by the helper, who can do this much more readily if he himself feels an equivalent caring containment in his environment. Caring containment is thus passed on in successive relationships, like Russian Dolls, one within the other. It is important, so reiterated, that the opposite experiences and effects – of indifference, fear, cruelty etc – are passed on in a similar way. Thence come our dysfunctional or hostile families and institutions. Was Mid Staffs such an example of discontinuance?

So, caring and containment can be best assured where attachment and affection can develop. As we have seen, this is unlikely in an NHS in which the ethos of the ‘factory’ has largely driven out the ‘family’. Consider, for example, an undramatic and very common scenario: the process of a hip replacement in 1983 and again in the more industrialised / schematised 2013.

1983. A technical task: personal continuity

Ali is 65-years-old and already crippled and housebound by his hip arthritis. He goes to see Mr O, an orthopaedic surgeon. Mr O hears Ali's story and complaint: Ali tells Mr O of how his life has been diminished and disempowered by his infirmity. Mr O recommends a standard hip replacement and sees Ali several times before and soon after the successful procedure, and then for longer-term follow up. The two men develop a low-key but cordial and discernable affection. Ali expresses his gratitude for a much restored life and feels encouraged by Mr O's interest and advice early in his recovery: he talks of him warmly as 'my surgeon' – this is affectionate, not presumptuous or possessive. Mr O is grateful, too. It is good for him to see the human effects of his technical intervention, to hear from Ali about a life restored. Mr O's work is often difficult and stressful: such human contacts nourish and sustain him,

too. One of his young and idealistic students once tried to interest him in a conversation about Holistic Medicine. Mr O had replied that he'd never really understood what the term means; he was 'just a surgeon'. For Ali he was more: Mr O knew this, but did not speak of it.

2013. A technical task: a production line

Ali is Ali's son: he, too, has succumbed to a similar disability at a similar age. Ali attends the same hospital as his father had, but its inner workings are now very different and Mr O has long retired. There seems to Ali no equivalent or replacement for his father's surgeon, for he sees someone different each time he goes to the hospital. He does not know if the stranger he is talking to is a Nurse, a Doctor or a Physiotherapist and he does not feel he should ask. Nor does he remember the names of the different Clinics, but takes the appointment letter with him to ensure his accurate destination. He is seen by different practitioners for orthopaedic assessment, preoperative assessment, surgical admission, surgery, surgical recovery, and post-surgical follow up. He does not know the name of any of his attending Clinicians or who replaced his hip. Ali thinks his technical care was 'probably alright', but confusing. He was afraid in hospital, but told no one. He found recovery painful, lonely and difficult: he had no quietly affectionate professional relationships to encourage him, and no smile of gratitude to bestow. 'Job done', true enough, but no human connection or deeper satisfactions for Ali or the anonymous 'Teams'. And the innominate, unknown hip surgeon – Mr or Ms O2 – what sustains them? What gives their tiring job human value and meaning?

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Vernacular maxims: no statistics

After more than four decades as a frontline NHS Doctor I have mounting sadness and fear for the human and philosophical impoverishment of my profession. If I live long enough I, too, will have a serious role as a patient. The Mid Staffs exposure may shock many: for me it is merely another shard of disheartenment. Every working day I encounter similar, if lesser, systemic human disconnections. I look back over the rolling eras of errors, and management ideologies, and the hundreds of colleagueial conversations I had trying to make sense of them. In all of these I am searching for general caveats

and motivational principles – the kind that might better guide institutions to enable, rather than stifle, imaginatively compassionate healthcare. Like the work itself, my compilation is flawed, never complete, and must always be revised:

- If we like our work and find it interesting, we will do it well and willingly.
- Such liking and interest often involves the gratification of seeing our work’s longer-term evolution and personal effects. Deeper satisfactions, too, are often personal and holistic: conversely, fragmented, short-term work offers little of these.
- Encouragement to draw on our experience to make intelligent creative decisions is likely to engage and develop our best qualities. Submitting to endless committee-designated diktats does not.
- We thus prefer flexible and collaborative working arrangements rather than those that are rigid, competitive and divisive.
- If we get know people well, we will be well-motivated to care for them. The more you see of someone, the more of someone you see.
- If we do not know people it is far easier not to care, or even to collude with harm: History has innumerable examples prior to Mid Staffs.
- People who feel attached, interested and positively personally engaged need relatively little disciplinary or motivational management.
- In contrast, it is very difficult to get good work from people who do not enjoy their work, feel attached or positively, personally engaged: these are primary deficits, and no amount of regulation, management, training or financial incentive will rectify them.

Figure 5: Imaginatively compassionate healthcare – some guiding caveats and principles

If large organisations, like individuals, can have breakdowns of spiritual and emotional integrity, then the NHS is set for an epidemic. This is largely due to our disinvestment of natural and positive attachments. Mid Staffs is but one early, now publicly flaunted, casualty.

The whole is more than, and different from, the sum of its parts.

Healthcare is a humanity guided by science.

That humanity is an art and an ethos.

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