

Fallacies in Blunderland

Overschematic overmanagement: perverse healthcare

David Zigmond

© 2012

Introduction

For more than twenty years there have been various devices to create an internal market central to the NHS: Fiefdom-like Trusts, commercial-type commissioning, contractually defined 'purchasers' and 'providers' of healthcare are current examples. The resulting commodification and commercialisation of healthcare has become its own culture. What does all this look like at the frontline? The following authentic vignettes from contemporary General Practice provide a view. Only usual devices of disguise subtract from accuracy.

The first two tales are now commonplace and superficially trivial, but they already contain the possibilities of bureaucratic burden and distortion that make the shocking last two stories more understandable.

*

'It is a bad plan that admits of no modification.'

– Pubilius Syrus, *Moral Sayings* (1st century BC)

'Tis not the habit that maketh the monk.'

– Thomas Fuller, *Gnomologia* (1732)

*

1. Trivial tales: serious themes

A. The Loop

Dr T receives a letter from Mr O, an orthopaedic consultant. It is about Sheila, a healthy spirited woman of 40 who sustained a severe and displaced fracture of both bones of one ankle. She required surgery to realign the distorted bones, then plates and screws to secure them. All of this has gone well, but several weeks later her ankle remains painfully stiff. Sheila will need physiotherapy. Will Dr T please refer her?

This is not as innocent or straightforward as it may seem. A historical explanation:

Several years ago, before the fragmentation of our national service into parochial Trusts, such collateral work was usually done with speed, accuracy, ease, friendliness and very little, but essential and useful, documentation. Mr O would have spoken to his well-known Clinic Physiotherapist, Carol, and said, in effect: 'Carol, this is Sheila (and her problem) that you can help by doing "X". Let me know if there's any unusual difficulty. I'll see her again in six weeks'. Dr T may have been informed, but not involved.

Recent times and ideologies have moved to more complex procedures. Trusts now mistrustfully contend and vie, sell and buy. Mr O now has no such sensible and 'homely' arrangement with his physiotherapist (or anyone else). The commissioning health-economy mandates that fragmentation of services is introduced to generate extra revenue for his Trust. Thus Physiotherapy is now separately tariffed from Fracture Orthopaedics. Mr O must now write to Sheila's GP, Dr T, suggesting that Sheila be referred back to the hospital for Physiotherapy. Although Mr O is far better placed than Dr T to make this decision and to implement it, the new commissioning system disincentivises this. This is because the interposed administrative loop 'earns revenue' for his Trust, by 'selling' necessary physiotherapy services. This added complexity helps ensure the financial viability of the fiefdoms.

What does this mean? A short link is turned into a long loop: it is not just Dr T's professional time and attention that are distracted by this unproductive artifice – this must now involve clerks, IT coders, contract administrators, accountants, auditors. Such long threads lead to tangles, so Personnel and Contract Managers and Lawyers must be added.

The aggrandisement snowballs: physiotherapy must now present as more arcane and formidable. Mr O cannot simply make a colleagueial (if highly competent) request: such must be replaced by detailed referral forms, team referral meetings, documented referral thresholds and criteria, data collection and collation (however specious), the propagation of professional reports that illusion depth through length, and gravitas through the unnecessary elaboration of technical language.

Such seriousness must be suitably framed: Carol cannot simply and quickly decide – from her considerable experience – what to offer Sheila. Sheila must join a waiting list for a long, over-inclusive, formulaic assessment to be performed. This will be documented in assiduous and trivial detail, then sent to Dr T, though Dr T has no interest or use for this. He certainly has not asked for it. However, for the 'providers' of physiotherapy it bestows auras of completeness and complexity: devices of theatrical rhetoric and justification. A new, and now necessary, language of survival: Lebensraum.

Dr T has become an increasing though unwilling recipient of such overlaid and other-agenda communications. He now receives hundreds of e-mails every week whose purpose is not to communicate with him about what he needs to know and what may interest him, but rather to confer some kind of aura of immunity, impunity or importance around the sender.

Dr T, despite many years of diligent, competent practice, remains anxiously conscientious: he reads such letters, warding off an attrition of fatigued alienation and ... resentment. He hankers for a previous era of more straightforward communications from colleagues who wrote

pragmatically of what he wanted or needed to know: a culture where help came from personal connections, not a kind of commercialised totalitarianism. He sighs with unsentimental sadness and sagged purpose. He imagines restitution in early retirement.

B. Size 13 Moonboot

Mustafa is an athletic young man, very tall and with large feet. While playing in a football away-match he fractures a metatarsal bone in his foot. He is seen by the accident doctor at the home counties hospital (HCH) who says to him: 'It's a straightforward minor fracture: your body will slowly heal it, but you'll need a Moonboot for several weeks to get around. You've got very large feet: unfortunately we don't have any size 13 in stock. But you live close to the large London hospital (LLH): they are bound to have some. Just go along to their accident department and they will fit you up. It will be quite straightforward ...'

That was true until recent years. It is now very different.

Mustafa goes to the accident department of LLH. After a long wait he is curtly told that as this is not a fresh injury he will need a referral from his GP, Dr T. Mustafa sees Dr T, tired at the end of a morning infiltrated and obstructed by such bureaucratic formalities and ritualistic documentation. Dr T writes a clear request for the Moonboot and a routine follow up, with an equally clear and concise account of the background problem. Until the recent past this would have been responded to in kind.

Not now.

Mustafa reattends LLH accident department with Dr T's letter. A triage nurse peruses it briefly before consulting a Manager. She returns to deliver an accurate slow-spinner: Dr T is bowled-out with her first ball: 'Your doctor and HCH obviously don't understand the system. We can't just give you a Moonboot. You have to be formally referred to Orthopaedics, and then a proper assessment has to be made by a Specialist...'

Dr T had not really understood the concepts of a ‘purchaser/provider split’, ‘Commissioning’ and related notions to focus and facilitate healthcare. He is learning now as Mustafa’s agent, in these shuttlecock exchanges between Trusts: through these frustrations he is becoming familiar with the procedures, language and protocol.

What he has not learned – what he cannot see – is the value of all this to his patients, or his own efforts on their behalf. Amidst his many conversations – seeking to clarify the benefits of such systems – he talks with Dr Q.

2. Absurd but true: A corrupt cadenza – how the schematic becomes perverse

Dr Q is, like Dr T, a stalwart member of an older but dwindling species: a single-handed, vocationally-motivated, psychologically-minded family doctor. He is a quiet man of understated but sustained and sustaining warmth and laconic humour. Professionally close, in both geography and ethos, Drs Q and T meet for companionable support, ventilation and experienced guidance. Dr Q listens, and identifies with bemused and increasing frustration: he has experienced his own varieties of The Loop and Moonboot.

‘I’ve got one to appal and amuse you ... Yes, both! ... But I have to be careful who I tell ...’ says Dr Q, teasing gently with competition and conspiracy.

He talks of one of the many institutional directives attempting to raise the standards of practitioners and practices. Most such devices are now measured, scored and complexly linked to remuneration. He is describing one yoked to substantial (written) complaints from patients. Each practice must now show evidence of how it responds to the complainant, and then turns this to positive reflection, learning and changes in their procedure and organisation.

Dr Q slowly unravels his tangle of frustrations: ‘Of course, I agree with the better philosophy behind all this: listening, looking, thinking from

another's viewpoint; not being too busy, proud or fragile to reflect on, or share such variations.

'So far, so good – but from here it gets worse, for me anyway. You see, I've spent a working lifetime really interested in these complexities. Probably because of that I haven't had any substantial complaint for about twenty years. That's an achievement I'm happy with, but the absurdity is that my practice has lost substantial income through being unable to complete the exercise. For the last few years I have been financially penalised because no one has complained about me!

'Well, my Practice Manager, Muriel, has many abilities but I hadn't realised how she is also a Mistress of Dark Arts. She quietly conjured a miniature masterpiece: she forged a fictitious letter of complaint; invented a practice meeting to respond to this with discussion, reflection and action plans; provided minutes of the (non) meeting, and a summary report for the monitoring authorities. The result of all this? We invent a complaint, because we don't have one, write a long bogus report for an authority that doesn't read it, and then claim the same money as everybody else! Is that a good way to spend doctors' time or NHS money?' Dr Q expresses his rhetorical coda: 'Righteous fraud!', he laughs sharply, a kind of self-parodic cymbal-clash.

But now a cross-current of doubt, more hesitant. He clears his throat: 'That's not the way I normally behave, is it? ... I mean, what would you do?'

Dr T has not expected this earnest question. He shrugs self-consciously, while attempting awkwardly to combine expressions of fraternal collusion with innocent bewilderment. This is difficult: finding the right formula of words impossible. He shelters behind an enigmatic smile.

3. Absurd but tragic: When Care Pathways obliterate care

'I don't think I can do it any more, doctor. I think she needs to be looked after somewhere else ... I'm not as strong as I used to be ... I can't lift her,

especially if she falls. And now she's much more confused and gets upset in ways that I can't reason with her about ... It's so hard, doctor: I think it might kill me ...'

Dr T thinks he is not exaggerating: it might. Cyril is aged nearly ninety, Iris is ninety-four. They married seventy years ago, a wartime marriage. As a twenty-year-old signaller with the Royal Navy protecting the Atlantic Convoys, his hunger to marry Iris had been talismanic as well as romantic: he somehow believed that ritualising the strength of his love would protect him, help him survive. He had, and forty years later he had described to a young Dr T his then-unspoken war-time terror, and the transcendent power of his faith-in-love.

Iris had been a very attractive younger woman, but ravaged by primitive anxieties: severe early losses and cruelties had been semi-healed by Cyril's loving devotion, but her wounds were shaken open by a late miscarriage. The subsequent birth of a son assuaged but did not resolve. Dr T remembers reading the unusually neat fountain-penned notes of his predecessor, referring to her 'numerous functional complaints' and her 'polymorphous anxiety'. From the 1980s Dr T would help guide Iris through this hazily mapped, apparently endless, medical wilderness. His patience and imagination were his most important resources, but Cyril was his most important ally. For more than thirty years Dr T witnessed the finest manifestations of loving devotion, *Agape*: indefatigable support, humorous affection, practical containment. Cyril was happy in his role of loving protector: Dr T was appreciated for his professional support and guidance. A long period of eddied stability, until the onset of Iris's dementia.

*

As so often, the dementia was first signalled insidiously and ambiguously, in her ninetieth year. Unsighted by retinal degeneration and unwilling to wear her hearing aid, this frail and slight old lady became increasingly difficult to contact. Her confusion of place and persons was distressing.

Her shards of insight even more so: with angrily tearful eruption she would rage at her humiliated disintegration: Cyril tended her with quiet, soft tears of sorrow.

When Cyril developed his increasingly untreatable heart failure he knew that his tide, too, was running out. 'I just want to be able to look after her long enough, doctor ...' he had said with characteristic, stoic courtesy.

*

When Cyril – looking haggard, exhausted and afraid – talks with polite deference of his inability to cope and a premonition of his death, Dr T has no doubt about the need for urgent action. Iris needs immediate respite care. He calls Social Services.

*

Many years ago Dr T recalls a similarly abject and acutely disintegrating situation, and his similar request. He remembers his meeting and conversations with the Social Worker, Phyllis, a thoughtful, sensible middle-aged woman with maternal warmth and grand-maternal wisdom. Phyllis had been quick and seamless in her understanding and intelligent actions. Dr T had thought that such dextrous and humane holistic engagement had transformed a painfully tragic situation into one with a kind of elegant pathos. He had felt grateful, moved and proud to be associated with such unglamourised expertise.

*

Now, in 2012, it is very different. Dr T is phoning the duty-desk Social Worker, Vanessa. He is trying to convey, with intelligible rapidity, the nature of his problem with Iris and Cyril: a brief history and his urgent recommendations. This is turning out to be very difficult. Vanessa clearly has another agenda. Her voice sounds young to Dr T. She transmits it with manicured, polite cautiousness. She explains a protocol which must be

adhered to: preliminary screening questions must be completed. Existing Social Services' package? Home OT Assessment? Number of falls? Mental competence? Screening blood tests? Complete Medical and Psychiatric history? Most recent Social Services assessment? Yes, yes, yes ... and YES! Dr T attempts to tell Vanessa that a collegueial dialogue can get to the important points more accurately and quickly. But Vanessa is well briefed and disciplined: she sticks to her prescribed course. At the end of her formulaic collation, Vanessa (who has never met Iris and Cyril), informs Dr T (who has known them both well, for thirty years), that respite care can only be considered after she has been assessed and reported on by 'appropriate' specialist clinics: specifically and separately for her falls, her dementia, her mood instability and her age-related medical complaints. No, there cannot be exceptions. Dr T – almost incredulous, certainly incensed – asks to speak to Vanessa's manager.

There is a delay. When the manager, Marjorie, calls Dr T she seems to be listening diplomatically, but then, equally diplomatically, seems not to have heard or understood. Yes, No. She understands (?) but must support Vanessa in her correct responses: that is how these situations must be managed. Yes, she can understand Dr T's frustration: 'I'm sorry'.

Dr T does not accept defeat. He makes further phone calls. He will shake some senior sense from Social Services, but is told that the regional Director of Social Services is away for two days. He then phones Cyril, whose voice sounds weaker and more short of breath. Dr T asks him about this: Cyril is resigned, self-abnegating, (again) disarmingly accommodating. Dr T refers to administrative delays with respite care: he does not elaborate, but apologises and makes clear he is active in trying to make things happen. 'Yes ... Thank you for everything you're doing, doctor ... I'll manage somehow.'

But Doctor T does not feel good about this. It is Friday afternoon.

*

On Monday morning Dr T hears. The carer had gone in the previous day and had found both old people on the floor. Iris was moaning with hunger, confusion and soaked underwear, unable to raise herself. Cyril was beside her, but still and silent: grey-mottled and dead. He had probably been trying to lift her.

Iris was immediately taken into care by Social Services.

Dr T feels immersed in an ocean of sadness: for our human frailty, fallibility, folly, pride and evanescence. His surgery is due to start; he dries his eyes.

The whole is more than the sum of its parts.

Plans get you into things. But you got to work your way out.
– Will Rogers, *The Autobiography of Will Rogers* (1949)

-----0-----

Interested? Many articles exploring similar themes are available via <http://davidzigmond.org.uk>

David Zigmond would be pleased to receive your [**FEEDBACK**](#)