

Further NHS Reforms: inevitable and unintended consequences

As the debate becomes more fraught, I want to add my voice to the fray. I have been a frontline Medical Practitioner for more than forty years, and have seen recurrent waves of reform and their very mixed results. The least disputable advances are in the realms of technology and technical competence: drugs and procedures have become more accurate and effective, practitioners mostly apposite in their delivery. Likewise, a few decades ago we all knew of doctors widely reputed as rude, curt, alcoholic, incompetent and shabby – sometimes simultaneously. In those times, with moderate luck, they would retire, without formal challenge, on a full NHS Pension. That kind of collusive incompetence is now most unlikely. These changes represent real progress.

But the institutional reconfigurations and the management devices applied to achieve these have inadvertently destroyed much of the best, in order to extirpate the worst. I experienced this ‘best’ in my first twenty-five years, working in NHS General Practice and Psychiatry. I was mentored by Practitioners who were vocational in their ethos and holistic in their view of their specialty. Although my administrative duties and salary were referable to one tiny sector of the NHS, my professional efforts and communications roamed with easy and pragmatic conviviality amongst colleagues from other disciplines and institutions. Despite some ‘bad’ practitioners, I felt mostly a welcoming and fraternal support: a kind of ‘therapeutic family’. I was not then much interested in branded politics, but I wondered if this was one of the few good and viable examples of a kind of ‘Confederate Socialism’: a world of collegial exchanges that was benignly intentioned, inclusively respectful and often mutually educational and supportive. ‘Medicine is a humanity guided by science’: not a phrase I heard explicitly from my early mentors, but they would have readily agreed.

For the last two decades this network of interpersonal communication, support and understanding has been increasingly eroded and dismantled by various ideas to increase ‘efficiency’. The galvanising panoply has included: The Internal Market; Commissioning; NHS Trusts; the widening of schematic

medicalisation of complex human distress; mandating goals and targets, performance-related pay and league tables; proliferation of ever more and sharply defined specialties, then acceleration of specialist training ... and now GP Commissioning. The danger with each and all of these is that Medical Practice is propelled away from any basis as a humanely networked welfare activity, and towards an entrepreneurial kind of 'civic engineering' whose currency is commodification. Thus, increasingly, we attempt to 'manage' people and their distress without the commensurate growth of personal contact, meaning and understanding.

Notions and methods from commerce and manufacturing industries may make some useful contributions to Healthcare, but they are seriously limited. Beyond these limits they can do real damage. NHS doctors' pay and working hours are now more generous than twenty years ago; in contrast, their morale, work-satisfaction and sense of creative and compassionate engagement (with colleagues, as well as patients) are not. In a recent large meeting of senior colleagues, we were being briefed and instructed, yet again, by another executive imperative, about a complex and subtle area of care. I protested, saying I felt like an eight-year-old working in a car factory. The identification was explosive and rapturous – especially, I thought, from older colleagues schooled in the earlier culture. The comic relief was evident and welcome. The underlying reservoir of alienation, resentment, mistrust, fear and anomie remains largely unarticulated, and little understood.

Doctors are probably the most privileged among the victims of our misindustrialisation of healthcare: certainly they are the best paid. Among other welfare and NHS Healthcare workers the pay is less, but the psychospiritual affliction much the same. The shocking stories of elderly, frail, dry-mouthed patients lying with abject helplessness in soiled sheets, while within yards of them nurses sit rapt in electronic engagement with abstracted NHS Foundation Trust data collation tasks, are harsh symptoms of a malign *Zeitgeist*: the consequences of depersonalising the personal. This is what happens when we overinvest in the biomechanical, when we industrialise the procedural, but fail to see or value or understand the complexity of human needs and attachments.

The biomechanical is necessary but not sufficient in healthcare. Competition, commercialisation and commodification – the 3Cs – may contribute peripherally and in minor ways. But we must heal as well as treat; compassionately engage as well as manage. For these we need practitioners and networks fuelled and nourished by the energy and art of the interpersonal: by humanism and holism. For all its flaws (many otherwise remediable), the old NHS of ‘Confederate Socialism’ encouraged this in me and for me, and those around me, for twenty-five years.

I am asked: what would I now do to rehumanise our healthcare? To start, I suggest a phased, radical retreat, then reclamation. Practical examples: to abolish any kind of Internal Market, Commissioning, and thus the likes of NHS Foundation Trusts; to restore Hospital Nursing Schools, the centrality of General Physicians, and personal patient lists to General Practitioners. But the cultural tides propelling our problematic recent changes are wide and strong: the easiest course is confluence, to be swept along. Creative counterculture will always be harder.

Amidst these conundrae, as my own career nears its end, I mourn the loss of Love’s Labour. I fear, too, for my future: when I become old and helpless, what kind of personal care and understanding will I receive?

Dr David Zigmond
Principal GP, Bermondsey, London

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Published as a BMJ Blog, 30 May 2012

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