

# **Beyond Orwell**

## Healthcare's hollow governance

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Our smallest difficulties with others are often rich in political complexity. What does this mean? Two apparently trivial examples from healthcare administration are explored.

'Totalitarianism spells simplification: an enormous reduction in the variety of aims, motives, interests, human types, and, above all, in the categories and units of power.'

– Eric Hoffer, *The Ordeal of Change* (1962)

'Men reform a thing by removing the reality from it, and then do not know what to do with the unreality that is left.'

– GK Chesterton, *Generally Speaking* (1928)

### **Prologue: Brave New World**

My formative years working in healthcare occupied a kind of pre-industrial world. The now ubiquitous and centre-staged rhetorics – to measure and manage – were then minor, quieter players. Like all industrialisations the transition has brought gains through losses: technical treatments are better, but personal care often worse.<sup>1</sup> The most parlous practitioners are now detected and removed earlier; but the pre-emptive management required to do this is often at the cost of our finer personal vocational identifications, devotions and initiatives: these often ail and then perish.<sup>2</sup> Healthcarers' technical errors may be less, but so too is vernacular human understanding. In forging such industry, we change the culture: a vocationally conscientious 'family' of practitioners has been steadily replaced by a 'factory' of centrally programmed and managed personnel: healthdroids.<sup>3</sup> A new term has been invoked to legitimise all this: *governance*.

The official intentions are sloganned into allures of healthcare improvements and entitlements to be delivered by ratchets of efficiency, equity and vigilant policing.<sup>4</sup> Increasingly these are procured and corralled by computer-compatible – thus electronically mediated and standardised – forms of surveillance and control.<sup>5</sup> While all this may work well with simpler tasks and scenarios, it elsewhere leads to perverse incentives and squandered resources.<sup>5</sup> Alarming, such surveillance and control then develops hermetic and ineluctable qualities: no-one claims ownership or the authority to intelligently divert or discriminate.<sup>6</sup> Matters of subtle and sensitive welfare become rapidly and automatically delegated to new kinds of cybernated servomechanisms.<sup>3,7</sup> The complex galaxy of human needs and meanings must

now submit to a culture of computer-templated compliance solely beholden to its own consistency and completion: a Frankenstein's Monster of non-humankindness, Technototalitarianism.<sup>8</sup> The following two apparently prosaic examples from General Practice are commonly endured though resented; rarely (as here) explicitly disclosed or discussed.

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**1. 'We've all got to do it. We've got to feed The Beast: that's the way we get the money.'**

Eddie's distress is raw and naked: it is stark and disturbing and needs no further evidence for Dr T to know that Eddie needs much compassionate containment and guidance. Eddie's wounded sensibilities far exceed his meagrely educated capacities for articulation. His tremulous tearfulness bespeaks awakened shock from the past. This has conflagrated a subterranean arsenal of long 'forgotten' childhood memories: a leaden legacy that, til now, has wordlessly crippled his life. The force of this awakening has blown aside his frail defences: Eddie is now unable to stem the erupting intensity. His sense of fear, shame, humiliation and sorrow has accelerated beyond his words. Now, with Dr T he struggles to have a personally disclosing conversation for the first time in his life: his vocabulary is sparsely stocked. The doctor knows he must pay careful attention to these highly-charged but inchoate utterances. He will need his imagination, too, if he is to make much personal and systematic sense of this cloistered, encoded and intense drama. If he has any success Dr T will need much other help in his efforts to help Eddie: he starts the necessary contacts.

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Eddie's first contact from the Psychology Service brings him bewilderment and alarm: he receives through the post a densely packed envelope. In it, amongst the legally required (but rarely requested) information documents and leaflets, there are many questionnaires. These firstly ask for wide-ranging personal and demographic details, and then there are those asking

for more precise disclosure of the nature of his 'complaint'; its history and the severity of his disability. None of these make any sense to Eddie, who has needed all his courage to trust his few and difficult words with Dr T. He left school at 13: he is semi-literate. His level of distraction and distress make impossible the process of self-objectification required to competently complete such forms. More inadvertent though meaningful complexity emerges, for exposure to the questionnaire has itself *worsened* Eddie's fear of inadequacy and rejection: the 'science' pre-requisites as essential for the therapy has itself become countertherapeutic (and can offer only a contaminated vagary of science).

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Dr T wants to procure psychological help for Eddie, yet he must also protect him from such procedural thickets he finds impassable. Dr T doubts that these complex routines will bring to Eddie any timely benefit. Yet to get this fragile man Diplomatic Immunity from the Psychology Department's Informatics Scanner is proving difficult. Dr T starts an escalade with their office staff and then Manager: their responses are polite but tethered – they have their instructions to instruct others. No, they are sorry they cannot accept exceptions. Next he tries a Senior Practitioner, SP, who baulks at what she considers Dr T's presumptive 'diagnosis' of Eddie. She attempts to explain to Dr T that 'psychological treatments' are now much more scientifically based and accurate: for Eddie to receive the benefits from these it is necessary for him to submit to these procedures – it is for his own good. Dr T wishes to demur and dissect, but SP instead wants him to submit to instruction, correction and compliance. He diplomatically disengages: he will try to recruit higher powers.

The Clinical Director, CD, another older practitioner, listens carefully to Dr T, who is relieved by CD's sanguine manner and open intelligence. His interest in people and their complexity seems still fresh and compassionate, but he now talks with a tired, stoic cynicism of the larger picture, of the vast, increasingly industrial NHS service to whose upper ranks he has been promoted.

CD is looking at a pencil which he taps on a note-pad, a discrete becalming rhythm, as if slowly Morse-Coding to unseen sympathisers. He raises his gaze to Dr T and smiles, a mixture of vicarious apology and conspiratorial sentience. His sigh is emphatic, a wished-for exhalation of greater difficulties.

*'Yes, you and I both know how obstructive and redundant all this is, but it's the way we've got to do it. The way the System works now requires us all to produce the right data and statistics for our managers and Commissioners. We've all got to do it: we've all got to feed The Beast, otherwise the money doesn't come through and we don't get fed ...'*

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## 2. **'Don't ask questions: just do it! That way they make it easy for you.'**

The week is a hard one for Dr T and his defence of any autonomous or vocational homeland: he is due for an Annual Appraisal, his ritualised submission to governance. This year it is with a much younger colleague, Dr YC.

Dr T's difficulties are mounting. For as successive appraisals have increased their demand for rigid format, formality and itemised detail, so has Dr T's difficulty in conforming to them. He is increasingly aware that the committee-consensused mindset and ethos come from a very different world of values and intent to his own. For decades he has been sustained by warmth and nourishment in his work, by a culture of unengineered and yet (mostly) mutually affectionate and respectful contacts with staff and patients. By assuming the primacy of such quiet attachments, other things have followed naturally: keeping curiosity and engagement fresh and alive; learning by his own enquiry, rather than others' protocol. His understanding of people, too, has been kept vernacular and fluid: he has avoided the crystalline solids, the public convenience-packs of devitalised psychiatric and social diagnoses. Essential to maintaining this engaged stamina is an enjoyment and wonder of our shared – yet often denied –

human complexity – of ambiguity, paradox and semiotics. For behind the evident almost everything is also about something else. What? When is that useful? Who decides? How?

Dr T likes such questions, not for any clear or definitive answers, but because the process of questioning suffuses his mind and work with interest, light and life. If people become personally interesting they are much more rewarding to care for. Such questions have thus helped him start each of his thousands of working days with alertness, imagination and curiosity: for alongside our commonalities each moment, each individual, each encounter is unique. Such is the *Art of Medicine*.

But the new culture of governance, and thus its many employees, are now increasingly if unmindfully countervailed to such philosophy and holism, such semiotics and humanism. The language and format has consolidated as a commonality of schedules, items, boundaries, lists, measurements and prescribed plans.

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Dr YC has a friendly manner and face. Her handshake is warm and reciprocal. Dr T is encouraged, but also wary of a brisk convergence in her movements and speech: she is a multi-tasking young woman and Dr T senses her bristle with delay.

Her survey of the voluminous obligatory documentation is more to identify anomalies and deficiencies than to pursue creative enquiry. She asks why Dr T has not filled out the section on his Professional Development Plan more fully and cogently. Dr T replies that he cannot: in more than forty years of exemplary medical practice and senior academic work, he has achieved a great deal, but has never had a private or public plan for any of it. His record has clearly been long, fertile and excellent, but never had governance. Dr YC draws in a breath and offers a brief mock-puzzled smile: 'Yes, I can see that – but it's not what is required now...'

Dr YC finds another failure: the selected Audit Project is not up to date: the Practice's documented and templated analysis of a defined area of prescribing is last year's. Dr T had not even been aware of his bureaucratic lapse. He is frustrated by being technically compromised about something that, beyond administrative formality, has little other value or meaning. What do they learn about him from such an Audit? That he can think clearly? Can collect, collate and analyse data? That he can organise his staff? That he is mindful about prescribing? Surely, Dr T is surrounded by evidence that he can do all of these things. He also knows that such ubiquitously harvested Audits are hardly read by anyone: they are perused and inspected, to see only if they pass muster. Usually they are then quickly cybertised for an oblivious eternity. Why, then, are thousands of Doctors, throughout the Land, having to spend time on projects that have no evident benefit or interest to anyone?

Dr T has a view: that such requirements of governance are rituals of hegemony, demonstrations of roles of dominance and submission, and Shibboleths of acquiescence. They indicate – in diplomatic code – who is in control and who will obey, who is the definer and who the defined, who decides language and meaning. It also implies the spectre of professional extinction for non-conformists. Like an electric-fence for cattle, it may itself have flimsy structure, but its sharp, hidden signals quieten and control vast populations.

Dr T thinks this cattling of professionals raises important matters of integrity: not just his own, for he has seen the effects throughout the Welfare Services. He tries to interest Dr YC, but her cordiality is timed-out and is evaporating to irritated fluster:

*'You may be right, but I have two children I must soon collect from school: I simply don't have time to talk about that kind of thing...'*

She looks at her watch with tensioned resolve, and then toward Dr T, as if throwing him a line:

*'Look ... a lot of us know that most of this is nonsense, but we've got to do it, so we do. My advice to you is: Make Things Easy For Yourself. Don't ask so many questions. Just do it! That way they make it easy for you...'*

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### **1984 in 2013: Epilogue in dystopia**

Dr YC's brief attempt to rehabilitate Dr T awaits fruition and formal process. While his fate and intent remain doubtful he has an impulse to look again at George Orwell's *1984*, a book he first read well before that date. Then the book was prophetic; now it occupies historic prophecy.

Dr T is unsure of the origin of his urge to return Back to The Future, but he thinks it is something to do with his encounters with CD and Dr YC. He thinks now of his early life, shadowed by relics and prophesies of totalitarian malignity. Bomb-wrecked, hollow buildings; shuddered, fresh fragments of tales of Samurai or Nazi atrocities; revered and mantle-pieced photographs of the keen-eyed, young deceased; silently or expletively despised images of the violently fallen, ogrous, totalitarian dictators – these picture his 1950's memories. That era gradually gave way to a quieter, more insidious, totalitarian menace: the Great Bear's Communism and the long Cold War. The fear and evidence of The Enemy at the Gate became less visible; the communal experience was less clear, more of an undertow. It was at this time that Dr T first read the, then, prophetic *1984*.

As Dr T revisits Orwell's world, he notices his disparate reactions of gratitude and gloom. The harsher, barer aspects of Winston Smith's Oceania are mercifully absent: the endless war, the dreary physical deprivations, the mortal hazards of exposed dissent, the ubiquitous transmitted images of the nation's Salvation and Nemesis, of Big Brother and Goldstein.

But he has also ominous awareness of less flagrant similarities. He thinks of Oceania's omnipresent television screens and loudspeakers endlessly streaming public information, statistics and diktats, of the screens that spy as



well as transmit. He thinks of Oceania's Doublethink: then thinks again of CD and Dr YC – how they must also fork their tongues to keep their jobs.

Dr T thinks of other subtle and geared-down similitudes. In the last decade he has seen his previously benignly-spirited, if sometimes heterogeneous, profession become drilled into a cowed, dispirited, orderly hive of healthroids – of obedient supplicants or prescriptive commissars. True: there is no Room 101, yet Dr T has seen colleagues' fear – how anxious they are to show evidence of conformity: how their professional behaviour and speech then becomes a self-conscious, imitative, stilted carapace. There may be no Party uniforms, yet such uniformity of thought, conduct and vocabulary have successfully completed their tasks: uniformed attire becomes unnecessary. Much of the conformity is anchored and assured by Technototalitarianism:<sup>7</sup> the now requisite pathways, algorithms, templates, key-words, codings and procedures. How and what to think or say is decided by unseen authorities. Thought and dialogue outside prescribed agendas, boxes or codes becomes increasingly irrelevant, uncomprehended and eventually subversive. Independence implies dissent; dissent is a precarious perch: there is unemployment beyond.

Dr T has glimpsed the faint, secreted, spectre of procrustean murders – the quiet expedience to remove any obstructions to the industrialisation of Welfare Services. He has seen the constructed and fatal undermining of well-respected and liked colleagues who failed to demonstrate timely enthusiastic alacrity for the new colonising Trusts and plans. It is The Plan that must endure: individuals can be airbrushed from the picture. For the survivors, disquiet is quiet, murmured and brief – survivors have gratitude for their jobs. That gratitude turns fragile and nervous.

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Dr T is talking to another senior survivor, Dr S. This sixty-year-old cohort may be assumed to be more secure and comfortable in this driven and industrialised culture, for he is a long-established advisor to government: a citizen in the citadel.

Dr T tells his old cohort first of his recent experiences and then of his tangled thoughts and feelings: he wants a thoughtful and experienced view from the other man, not quick and expedient commiseration or collusion. He is encouraged as Dr S seems intently attentive and sympathetic, nodding and softly ahaing. Dr T takes care, and whatever impartiality he can muster, to convey clearly his knotted frustrations.

He thus curbs his urge to overtalk and pauses, leaving a short, silent rest for his weltered thoughts. Dr S sits quietly too, as if in meditation, separating then gathering his thoughts. From this brief hiatus Dr S gazes and speaks. His directness has a soft, slow deliberation; he has clearly been incubating his thoughts well-prior to this encounter:

*'Yes, I am of a similar inclination and generation to you, so I am sympathetic but, alas, not effectively so as I am beleaguered and outflanked by factors beyond my control or – and this is both alarming and deeply depressing – anyone's. Sometimes we introduce administrative or regulatory devices, believing they are sensible and helpful, only to find later that they are difficult to stop, and that their overgrowth has become more of a problem than the one we are trying to solve in the first place.*

*'Sometimes the overgrowth spreads and roots rapidly: these devices, planted on the surface, leach into the subterranean to produce culture; both our consciousness and unconsciousness change – we cannot easily rescind such things. We now live in a world that expects speed, standardisation, convenience and clearly labelled packaging. We've set that up in healthcare, and it's initially certainly brought us some advantages, but now we can't stop ... so we continue to try to turn all healthcare problems into computer-compatible data, mass-produced processes and then a complex economic system that commodifies and trades in these. This speeding juggernaut is now difficult to brake: we now have hundreds of thousands of NHS staff whose salaries, status, homes – whose livelihoods, even identities – depend upon occupying a role in this healthcare emporium. And then the people who are likely to do best in all this are those most surrendered to the culture: those who most believe it...'*

'So it's just like Orwell's 1984', says Dr T, offering what he tritely thinks is a pithy summation.

*'Oh, no! This totalitarianism is much more refined – and probably durable – than our fictional 1984', Dr S quickly retorts, a slightly acerbic and ironic taint to a residually courteous manner. 'Our system doesn't need endless wars, flagrant scapegoats, monolithic and ever-present leaders or a life-threatening Secret Police: our system now largely runs itself: that's one definition of culture. There isn't really anyone in charge! Even at my level many of my colleagues seem – to me – unaware of how much they have bought into the package and thus speak the language. In my meetings with them I try to influence quietly: with patience, stealth and diplomacy. But I'm careful to stay in The Tent: if you're outside The Tent you have little influence, and you probably won't be heard...'*

Dr T protests against his own agreement with this: his interruption intends reason, but is soured by concealed, petulant grievance:

*'The problem with that is if you stay in The Tent long enough you lose your own voice and vision, and end up talking there like everyone else.'*

Dr S sidesteps the beginnings of this angry charge, like a seasoned and taciturn Matador:

*'Well, in my case I hope that is incorrect. But I have more than myself to hold onto: my wife and family ... my mortgage is not yet paid off, and I have two teenage children still to put through University...'*

Dr T is quiet again, but differently, now gently melted with fresh and protective contrition.

All is not what it seems. Citadel? Yes. Citizen? Yes, but also hostage.

Dr T imagines a conversation he would like to have with George Orwell.

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'Everything begins as mystique and ends as politics.'

– Graffito, Wall in Paris, Student Protest, 1968

### **Further reading**

1. Five Executive Follies: How commodification imperils compassion in personal healthcare
2. Further NHS Reforms: inevitable and unintended consequences. Letter to BMJ
3. From Family to Factory: The dying ethos of personal healthcare
4. How to help Harry – Friend or Foe? The scientific and the scientistic in the fog of the frontline
5. Fallacies in Blunderland. Overschematic overmanagement: perverse healthcare
6. Bureaucratyrannohypoxia. An open letter to Mental Health Services Director
7. Words and Numbers: Servants or Masters? Caveats for holistic healthcare Part 1
8. Edward: shot in his own interest. Technototalitarianism and the fragility of the therapeutic dance

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