

Our ailing profession

We need more than resilience and replenishment

David Zigmond

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The malaise among NHS healthcarers is akin to the patient dying from an internal haemorrhage: oral replenishments, or even transfusions, may be very inadequate.

A recent day conference parried this perspective.

I recently attended a brief conference designed to ventilate and motivate our dispirited and defecting doctors. Its brief title was businesslike in its optimism: *Restoring Health in the NHS*.

The recruitment was geared to the young: the growing loss of their ranks is causing increasing concern for, first, abandoned colleagues and, then, health planners and government.

In the morning about a hundred of us sat together. A young cheery consultant, Dr Y, outlined the now-familiar litany of unavoidable stresses for doctors: increased expectations from 'consumers', 'providers' and commissioners amidst unyielding or declining resources; increasingly complex, technical multi-tasking amidst ever-present, often opaque, human complexity; the frequent anxiety from inevitable yet serious fallibility; our often foolishly litigious culture; the perennial exposure to pain, loss, decline and handicap; long and antisocial hours; the eventual damage to our intimate relationships ...

But Dr Y was upbeat: we could prepare and brace ourselves for these ordeals – we could tend our *resilience*. Anchoring her suggestions in Selye's classic research into the physiology of stress, she offered sensible restorative and reparative advice in our needs for eating, sleeping, breathing, exercising, emoting, laughing, loving and meditating. She ended with a communal deep-breathing exercise.

Dr Y radiated sensible kindness: for a short time, following a long joint exhalation, we felt better.

Later in the morning an older consultant, Dr O, added human depth and mystery quoting surprising (for some) research: that palliative care practitioners are among the least stressed and most gratified doctors. Paradoxically, their doomed outcomes often offer the richest human meaning, mutuality and connectedness. Yes, we must tend our physiological selves, but these can only thrive in relationships – and relationships need communities...

An afternoon session clustered a smaller group of senior practitioners and managers round a large table. Our task was to consider how we might action some of the morning's notions – how to best retain and enliven those younger practitioners that succeed us.

Encouragingly most discussion and suggestions revolved around *relationships*: their inaccessibility, their fractious insecurity, their impermanence. We all agreed that our relationships could be, should be, better. We should offer – and expect – more kindness and patience, better listening and empathic imagination. We should be nicer to one another, try harder. *Replenish* one another.

Who would disagree?

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I had no disagreements, but many caveats. I asked to speak. 'Yes, of course we should be ever-more compassionate, open-hearted and open-minded with one another. When is this not so?

‘And yes, each of us – in our own small but always significant way – should take responsibility and contribute.

‘But there are much larger factors and forces that limit, stymie, even undo our efforts.

‘Young doctors’ claims to a lack of personally interested guided support from their seniors are both substantial and serious. But those seniors – us! – are ourselves mostly feeling alienated, dispirited, powerless and unheeded. And whether you are a junior trainee or head of a department, these experiences are now endemic. What kind of nurturing can be generated from such experiences? ...’

Dr N is a pragmatic no-nonsense chair. She wanted my brisk concision.

‘So what is your point, exactly?’

‘It is that our sentiments here and now – in this Conference – are all very commendable, but our working culture can quickly blow them away ... we are then left with our many benign platitudes...’

‘Where are you going with this?’

‘Well, in recent years each successive “progressive” reform has gone further in breaking up our erstwhile healthcare ‘family’ to replace it with commissioned clusters of ‘factories’. The 3Cs – competition, commissioning and commodification – are inherently antithetical to our development of personally invested relationships

and communities. And yet – as we have been recognising – it is our human bonds that generate our vocation, motivation and good morale. These things have to grow naturally: we can't just manufacture them, or trade in them as commodities.'

Dr N is looking down thoughtfully. I still have space to expound.

'Look, the latest reform – *The Health and Social Care Act* – has massively accelerated our already destabilising problems of divisive conflicts and anxieties, and the "haemorrhage" from our once robust and well-perfused human "vascular tree". Consider the history. The Act was pushed through six years ago, with stealth and guile, by a Health Secretary who knew well how few people understood it. His fate is now of a rather awkward and little-mentioned peripherality. Our fate is our cumulative professional loss of heart, art, humanity, identification and gratification. That's why we are sitting here, in this Conference.

'Yes, of course we all need to be "kinder to one another". But to do that really well we've got to abolish the entire Internal Market: its purchaser/provider splits, autarkic NHS Trusts, competitive tendering and commissioning ... It is these things that are destroying our professional fraternalism, our humanity ...'

Dr N is roused to stem this breach in my dam.

'That's enough. You are talking beyond the brief of this Conference. Many of us know all this and agree with you, but these are very large forces outside of our control. There really is no point in going on about it any more.'

I think I might just manage another thrust.

‘But if we believe it to be so important and true we must always say it, and go on saying it: like hammering in a nail. That may be tribulating and difficult for some, but only that kind of resolved tenacity will change things. *Not* talking about it – out of a kind of “decency” or tact – becomes a kind of surrender, or even collusion. We just add ourselves to the vast mass of totalitarian inertia ... Our system is paralysing and pitting us against one another.’

‘I really am going to stop you there.’ Dr N glowers with authority.

I demur and retreat. I respect and like Dr N: it would be easy to now say too much.

There is a brief lull. To my right a middle age GP, Dr G, is sitting. I have been aware of her silent attentiveness and her supportive nods. As Dr N begins her summing up Dr G turns toward me, shielding her mouth with her hand so that it is visible only to me. Her whisper is silent but slowly and clearly enunciated: ‘I agree with you.’ I nod: a fleeting, furtive, subversive alliance.

This brief, sequestered but richly complex interchange and its context – what does it augur for our healthcare culture?

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