

The Proof of the Pudding is in the Eating

Actual and virtual realities: how our inspection culture unhinges

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What's really going on? How do we know? Who do we listen to: the participants or officially designated inspectors? This response to a contended official report – that rapidly closed down a small and very popular GP surgery – portrays our difficulties.

Introduction

The whole is more than the sum of its parts is an adage that carries ancient truth – yet only sometimes. For some tasks *Atomism* – breaking the whole into its parts – may work best: fixing broken machines or acutely ill humans are examples. For other endeavours *Holism* – approaching an object or system as a whole is far more rewarding – healing or encouraging individuals, families, groups or ecosystems that are not broken are examples.

What happens if we insistently misplace Atomism? This long letter in response to an official report outlines the unwise damage.

Care Quality Commission Report. 22.9.16

Thank you for sending this report. I have read it carefully. It makes very clear how far I have now departed – in many ways deliberately – from the governing culture. For my healthy survival I must retire.

However, certain things continue: my committed interest amidst substantial caveats regarding our troubled health service. Eventually – when my turn comes – I shall want competent, humane, personally invested care. Hence this careful yet expressive reply.

This response is centred around a stark and telling discrepancy: the report constructs a picture of my practice utterly different from that coming from all other historic and personal sources. I return to this repeatedly as a ‘home theme’: as in much complex music, it anchors the wide-ranging text – a Leitmotif.

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You can prove almost anything with the evidence of a small enough segment of time. How often, in any search for truth, the answer of the minute is positive, the answer of the hour qualified, the answers of the year contradictory.

– Edwin Way Teal, *Circle of Seasons* (1953)

First, a basic and important agreement: I certainly support the *aim* of the CQC and much other management: to assure (or, at least, facilitate) competence, reliability, humanity, safety and probity. Who would disagree? The problems arise with implementation: *how* best to encourage these things in other people.

For many years I have thought that our approach to these problems is increasingly mistaken; managerially officious and then paradoxically inefficient. Insistence on hegemony has replaced our (mostly) cooperative yet vigilant encouragement (holism) with forensic and divisive mistrust (atomism). Like over-controlling parents, we may say 'we only want the best for the family'. Like such parents we are finding that early compliance may be possible: what comes later is usually very different.

History shows us how this happens to political and religious movements, too. The motivating spirit (holism) is readily institutionalised, and then loses its benignity (atomism).

For many years I have seen all this gathering as our NHS management tightens its ratchet. This CQC report is just one of many examples. Late in a long and otherwise successful career I found I could only work meaningfully by exercising thoughtfully selective non-compliance: this 'civic disobedience' has eventually become, also, my conscientious objection to my profession being so mistrusted, deskilled, muted and herded.

Such unrest is now widespread.

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To return to my home them: **there is a massive difference between the long-term 'real life' record with my patients, close colleagues and staff (= exceptionally good) and recent management-designed reports of expected corporate compliance (= very poor).** This discrepancy is surely important and instructive, yet receives no recognition in either this report or a contemporaneous and allied report by NHS England. Why the silence about this crucial anomaly?

Further questions: How can the long experience of my cohort of patients, staff and close colleagues (holism) be so utterly different from the more abstract and formulaic view of those that manage us (atomism)? If both are 'real', what is the meaning and place of these different realities? The answers are not easy, but disregarding the questions soon brings us more harm than help. First, we need some definitions.

i) My 'real life' GP record: actual reality

Water is H₂O, hydrogen two parts, oxygen one, but there is a third thing that makes it water and nobody knows what that is – DH Lawrence, 1886-1930

For thirty-nine years I served as Principal GP in the same small practice. I have been blessed and rewarded with an exceptional record:

- *Never* a serious complaint (eg needing a formal hearing), forensic or substantial Coroner's investigation, a need to contact a defence organisation or lawyer, any serious dispute with a close colleague.

- *Remarkably good and consistent* feedback and loyalty from patients (clear since records began: the most recent IPSOS/MORI poll (July 2016) showed my practice was the clear favourite locally, across several parameters) and staff/colleagues. Almost all stay with me for years and usually depart with mutual affection for non-work reasons.
- *Good Mojo and engagement*, for the personal and clinical aspects of my work. This was maintained throughout my very long career as a GP and decades of highly regarded teaching and publications. I sustained this by finding something of human meaning and technical interest in every one of my many thousands of consultations, until my last morning at work.

This marathon record has been fuelled by a spirit of *vocation* (a life-form we are starving), not compliance to *corporation* (a commodified world growing obese from overfeeding).

The NHS could not buy or engineer these kind of results, even with massive resources.

ii) The CQC Report: virtual reality

In order to assess competence, reliability, humanity, safety and probity the CQC depended on a) reports of patient experience and b) the Practice's corporate compliance documents.

The Report does not comment on the very clear discrepancy between a) and b): patients clearly recorded very high levels of satisfaction with the service, but the

contiguously documented corporate compliance is judged severely deficient.

Notably the Report ascribes about 10% of its space to a) (very favourable) and 90% to b) (alarming poor).

Why?

My strong belief is that **substantial and good real-life results are achieved not just in spite of my selective corporate non-compliance but because of it.** This 'disobedience' is how I secure headspace and heartspace essential for the quality of my work.

Behind the CQC's modus operandi is a flawed assumption: that increasing regulation, surveillance and monitoring – whenever possible by employees completing a standardised computer template – will somehow prevent 'bad' things from happening and be a driver for the 'good' things.

So, computer documentation becomes the currency of compliance, and compliance becomes equated with safety and competence. Conversely, the lack of such compliance then becomes the indictment and definition of unsafety and incompetence. These are specious confluences that together are formed into a hermetic system that can then be given executive power: a virtual reality that replaces the actual reality. Hence we become guilty unless our documented compliance 'demonstrates evidence' of our innocence.

Although sometimes this approach may be effective, often it is not. Such a behaviourist and manipulative approach to our complexly intercrossed human

work does not engage well with our motivation, attention or relationships. Indeed, evidence is increasing that our now-prevalent type of surveillance managerialism is destructive of these deeper aspects: we become overwhelmed, deskilled and disheartened. There is now alarm at the bolus of consequences: NHS staff's plummeting recruitment and morale; increased sickness, stress, career abandonment and early retirement.

This cruel paradox is probably lethal to the kind of care the CQC wishes to champion: **in our unnuanced drive for 'efficiency', our unwise processes sicken or lose the people who must provide it.**

The description of my real-life record as a GP is very relevant here: in its current misguided form the NHS cannot now recruit or retain committed GPs, and could not purchase or engineer the kind of marathon and reliable quality of service I have provided with good (but different) evidence – even with massive resources.

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So, by devising such an elaborate system of compliance requirements and monitoring, our managing authorities mistakenly believe they are surveying and controlling 'care' and 'quality'. But this is soon shown to be specious: before long we are left holding merely the empty husks of compliance – box-ticking to pass muster, for the Inspection...

Hence it is that **compliance, paradoxically, can become increasingly dislocated from care quality.** Hence this bewildering chasm: my patients clearly demonstrated

my care and quality while our managing authority (the CQC) can nullify this by a decontextualised detailing of my lack of compliance to *its* requirements.

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This is the reductionist folly that comes from flawed but decreed conflations. To match it, should we shorten and redesignate the CQC to the CC: the *Compliance Commission*? That accuracy might bring realism: the greater care and quality are often elsewhere.

So it is that spurious conflations escalate beyond human sense.

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I wish now to consider the way my Provider (GP) Registration was cancelled by Emergency Magistrates Order on 5.7.16. Some key facts I wish to document and contend are:

- The CQC phoned my surgery at 6 pm on Friday 2.7.16 to tell them of the Court hearing on Monday 5.7.16. As I was then in France on holiday I did not get the (answerphone) message until 12.30 am on the morning of the hearing.
- **I thus had no time to prepare, and faced the Court alone, with no legal representation.**

- In contrast, the CQC had *five* representatives who, judging by the teamwork and bulk of documentation, were meticulously prepared for the legal *coup de grace*.
- Seeing this doomed disadvantage (for myself) I asked the Magistrates for an adjournment, so that natural justice might prevail.
- The CQC barrister raised an alarm and an opposing request: my practice was deemed such an immediate and massive risk to the public that it must be legally closed without delay, in the public interest.
- The Magistrates acknowledged both the exceptional nature of this request and their lack of experience of its like.
- After a hearing of *eight hours* – during which I openly declared and explained my selective non-compliance – the Magistrates eventually judged that this admission was a breach of my contract and *could* pose a risk (the actual risk is putative and unproveable).

Comment and questions: I had never heard of a practice being closed in this way, and am still dissolving my incredulity many weeks later. How could the exceptionally good and long record from all human sources be so abruptly discounted, devalued and destroyed by such formal, legal and management procedures? How have we so hegemonised the virtual over the actual? And why – only two years ago – did a very differently tenored CQC inspection produce such an emphatically positive report? (In this period the Practice has, if anything, improved due to the recruitment of two excellent staff members.)

Such draconian legal process – bypassing the need for legal representation – is very rare in the UK: reserved for heinous public risk such as murder or terrorism.

How could my practice be so bracketed?

How do we explain such an institutional reaction? Is it a response to my longstanding and public critique of our managerially top-heavy NHS, with all its troubles? Has such argument and publication turned me into an 'enemy' to be taken out?

However motivated, where is the natural justice? If absent, is that malfeasant? These questions require attention, though separate from your report.

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I want now to consider particular statements in the CQC Report. To keep this letter within more readable form and length I have not attempted to challenge, in order, every contestable statement. Instead, I have chosen broader themes from which I take examples.

Before this itemisation I want to record this broad numerical profile of your report: I counted 130 adverse judgements against just 24 comments of mere acceptability. Again, how do we reconcile such an unsatisfactory picture with so much, and very different, evidence?

The following selection and format attempts fair representation and clarity. Quotes from the CQC report are slightly inset and italicised: my response is in standard Roman type.

1. Are services safe?

I think my record is my best answer. (To reiterate: in thirty-nine years as a GP Principal I have *never* had a serious complaint (ie requiring a formal hearing), had reason to contact a defence organisation, had forensic questioning by a Coroner, or had a colleague who works with me have serious concerns.)

Your indictments, though, are many:

'Lack of emergency equipment...'

This has some truth. For example I had no oxygen or a defibrillator. My view has been that I do not offer care for acute severe illnesses: they require an immediate ambulance and hospital (which is very close). We cannot safely provide care for – say – respiratory failure *and* run a busy clinic. (Oxygen, however, would have been provided if the CQC was insistent: this, in my view, is more likely a symbolic concession than one of real use.)

'Staff did not adequately assess consent and capacity...'

This was never an actual problem. In this small practice both relevant patients and staff are likely to be well acquainted: lines of communication are short and good; access to the usual doctor extremely easy; apposite and accurate responses far more

likely. These things are far harder in larger, less personally acquainted practices. Such advantages of a small, stable practice are also reflected in the lack of litigation and complaints. In my view, your report should address this substantial mitigation.

'Staff not clear about reporting near misses and concerns ... lack of documented evidence ... risk of harm because documents were not in place ... insufficient attention to safeguarding children and vulnerable adults. Staff did not recognise or respond if they suspected if abuse had occurred.'

'There were cobwebs in most areas of the practice ... dust around the frame of the door ... etc.'

Comment and suggestion: This is an 1830s building with very high ceilings: the higher cobwebs are inevitable. The lower surfaces are clean in human contact areas. My room does not need to be like an operating theatre: my relevant risk activities are minor – occasional injections and aspirations. If my surgery is a risk, then so is most of District Nursing: corollary – these services should be closed and all patients referred to hospital.

'Incidents which should have been considered under the practice's significant event process. One involving the unexpected death of a patient ... and one involving a patient who had collapsed in the waiting area. There was no evidence that these incidents had been analysed or that there was any learning used to improve systems and processes or prevent the same thing happening again.'

This last paragraph merits a short analysis. Unfortunately the Inspectors missed some crucial facts. This, I think was due to a) time constraints on their large agenda and b) their interrogatory (rather than dialogic) form of interview. The facts are:

- The first patient was an elderly man long known to me with progressive Parkinson's Disease. He had a fatal collapse in the street while walking to the surgery. We had, earlier, had a poignant conversation about his intimations of his death.
- The second patient had a pseudoseizure in the waiting area. The nature of this was quickly recognised. She has severe, complex domestic problems and is getting help. We responded with comfort and reassurance.

We certainly discuss such events, but not usually formally. The particular learning and action points in these examples are moot.

Overall this CQC report reflects, again and again, my 'home theme': the indictments are very different from my marathon record, which indicates great safety. The problem, I think, is that our practice philosophy has always depended on a combination of intelligently vigilant informality and trust. This looser, more dialogic style is clearly very different from the prescriptive, formalised and omnidocumented management that is now expected from all practices, regardless of their size or history.

So, I treat my staff as I wish to be treated: I encourage autonomous intelligent judgement and trustworthy care in a culture that responds quickly to any failings. In

doing this there is far more good faith and sense than is likely to arise from the kind of documentation the CQC now insists on, but we have not found helpful. Yes, our documented compliance for your requirements may be poor, but **where is the real-life evidence of our failure or hazard?**

I understand that my approach owes its validity to factors that are now rare: that my practice is small, I have been there a long time and I have had long and wide experience, including psychiatry and psychotherapy. These make it much easier to have frequent, easy access and rapport with my well-known staff and patients in a highly efficient yet informal manner: with staff, we talk and discuss as we go along – we do not email one another and find that our need for structured, agendaed, minuted meetings is much less. I can see (and have heard) how difficult, or impossible, all this is in large practices.

However, my small practice brings an anomaly to the system that is inassimilable by the CQC: excellent results yet poor formal compliance.

I think I can see the CQC's quandary here: how to endorse exceptions that would be risky in larger (= most) practices. They cannot be expected to develop a similar vantage of personal observation, communication and thus formulation. In this much commoner type of practice, therefore, procedural governance and compliance becomes that much more necessary – because the alternative subtle personal care and vigilance is so much harder to implement.

Such variations pose questions to the CQC that are inevitably difficult. However, is it not best to recognise that different kinds of practices need different kinds of

guidance and regulation ... and then judgement? The alternative – our current course – is one where we surely create more problems: by attempting our current ‘one size fits all’ type of official diktats and procedures. (An analogy: in a family with many children, what would happen if we attempted always to treat them all the same?)

2. Are services effective?

The CQC’s judgements are similar to the previous section, citing my non-compliance and imputing high risk:

‘Inadequate for providing effective services ... not delivered in line with professional standards and guidelines ... for prescribing benzodiazepines or assessment of depression ... little evidence of quality improvement initiative ... minimal engagement with other providers of health and social care ... There was limited recognition of the benefit of an appraisal process for staff from the GP principal...’

There is far more of contention here than I can respond to in this space. Here are a few bullet points:

- Again, how is staff and patient feedback so consistently and enduringly excellent?
- Over many years I have arranged many meetings with Community Mental Health Team staff, our Community Matron, Palliative Care Nurses and Psychology (IAPTS) services. These are never agendaed or minuted but have

yielded much operationally and educationally. It is true I have rarely met Health Visitors, but this is certainly not policy. I would when necessary or opportune.

- In particular I have had regular meetings with senior practitioners and executives of psychology and psychiatry services, due to our many mutual (often nationwide) problems. The intent has been good, but results difficult to achieve. More parochially, for some years, I met weekly with our practice counsellors – we all valued our richly informal education and support.
- I have a veteran and intense interest in mental health and social care that has led to my radical critique (and positive suggestions) regarding our current troubled system. My many publications document aspects of my view and suggestions. I am asked to speak about these by institutions and at conferences. Conversely, there are many who wish me *not* to speak... Your report implies (I think) a lackadaisical disengagement – I don't think anyone who has ever worked with me would support this view.
- My practice quality for psychological and pastoral healthcare is excellent: hence the expressed loyalty, appreciation and documented feedback from patients and kindred practitioners. The problem, again, is that such qualities are not finding compatibility with the kind of documentary compliance now dictated by the CQC. I have explained this elsewhere.
- No, I did not persist with Staff Appraisals: I found them too blunt and cumbersome to have any real use in my practice. My views on GP Appraisals are similar and have been published widely.

However, I am certainly interested in my staff's general welfare and, more specifically, in their best working motivation, attention and engagement. I am guided by this general principle: if someone likes coming to work and wants to do their job well, they usually need very little formal appraisal, external motivation and discipline. These are principles largely lost to our profession now: I try to retrieve them, at least for my staff.

- Benzodiazepine prescribing. Yes, there certainly is a problem here, but it is far larger and more complex than the report implies. It needs far more than this bullet point. Please see the **Appendix** for further details.

3. Are services responsive to people's needs?

Again, some facts are correct, but the imputed judgement is not:

'No website (for practice information) ... no access to a female clinician ... not suited to those with mobility problems ... nurse only does two clinics weekly...'

- Correct, there is no website (though there is a practice leaflet that is also available online). What we have may be better: a friendly, interested receptionist who answers the phone quickly and will answer questions conversationally.
- We had a brief period without a female clinician, though one had been appointed shortly before the Inspection. The reasons for the hiatus were fortuitous; certainly not an indicator of practice neglect or policy.

- For nearly thirty years our practice has occupied a designated rented space in an 1830s church. This unusual workspace is much loved by both patients and staff, with no complaints from them, but regular concerns being raised by inspectors and remote managers. Obviously the premises have not been purpose-built and certain compromises are inevitable, yet often overcome. For example, two patients with electric wheelchairs were regularly seen in suitably private parts of the Church elsewhere: all were very happy with this arrangement. We had no history of on-premises accidents or evidence of increased infections.
- Although not ideal, ordinary wheelchairs could be manoeuvred in the surgery premises – though it was cumbersome. Staff would always help.
- Such difficulties were always explained to patients, with information about other very local practices which had full disability compliance in their premises. ‘Oh no, doctor: it doesn’t matter so much ... we’d much rather stay here’ was, almost always, the reply.

‘Nurse only does two clinics weekly.’

These two clinics were well spread and mostly very adequate for this small practice. Access has been good and satisfaction rates very high. Exceptional or emergency procedures or dressings are performed at other clearly designated local centres (eg Quay Health Solutions, Guys Hospital Urgent Care Centre). Your observation is accurate, but not any assumption of a substantial problem.

4. Are services well led?

Your report compiles another parlous and pitiful picture:

[The Practice] did not have a clear vision and strategy ... no clear leadership structure ... did not hold governance meetings ... no evidence of (staff) performance reviews ... no action had been taken on the basis of patient feedback.

All this may be superficially accurate, but has little functional meaning because all other evidence indicates good modus operandi: that my Practice's staff relationships and performance is otherwise excellent, efficient, stable and happy. Why else would staff stay so loyally and with so few complaints or mistakes?

Analogy: well-functioning families do not need more structured 'meetings'. My small Practice – like such a family – achieved an enormous amount of very high quality work for a very long time. We did not need any outside expert or authority to tell us how to achieve this: again, this is like a healthy family. By contrast, of course we attended closely to patient feedback.

There is a parallel here with my recent GP Appraisal: I was deemed 'inadequate' for my feebly offered Professional Development Plan, my lack of a learning diary or plans, and so forth. But this is not the way I have ever lived my life, either personally or professionally.

Nevertheless, my apparently unschematised and unsupervised personal resources have achieved a great deal over a very long period: a brief search on the internet gives some indication of my capacities for self-generation and self-discipline. How is anyone helped by my mandatory submission to some augmentation programme

devised by people who are remote and unknown to me and, almost certainly, have not matched my record? What does submission to such compliance regulation mean? Who is this for?

I think the kind of structured and monitored governance now vaunted and commanded by the CQC (and other, similar bodies) has a very limited place: it should remain confined to practitioners and institutions that are clearly troubled, struggling or failing. For all others (the vast majority) such projects of direct and massive control are, at best, a frustrating and irrelevant diversion and waste. Beyond that the damage can be much greater: my own small practice – so well regarded before the relatively recent ratcheted regime of standardised regulations and inspections – was terminated with a severity previously enjoined only by criminal law. In between is the much commoner damage: the various forms of broken spirits and cynical demotivation I referred to earlier.

I understood these principles well: that is why my practice has sustained its happy stability and quality for so long. In contrast, perversely, our governing authorities (including the CQC) are disregarding these principles: that is why, in recent years, the ratcheting of these kinds of governance has led to such fractious unhappiness throughout our profession.

How can we expect good care from wearied, craven, demoralised doctors?

5. Responding to and meeting people's needs

This section of the report starts:

'There was no evidence that the needs of the local population had been reviewed and that the practice had made any effort to engage with the NHS England Area Team and Clinical Commissioning Group (CCG) to secure improvements to services where these were identified.'

It is very difficult to see how or why this notion has been constructed. There is massive evidence to show my vigorous interest and initiatives in these matters for many years: I invited other health professional to meetings about problematic patients, similar meetings with managers about organisational problems and was a vocal attendee of CCG meetings, offering both radical critique (I have many disagreements with our 'architecture') as well as many practical suggestions.

For many years I have been invested in inviting, nourishing and provoking discussion within and between healthcare groups: from my immediate colleagues, to professional groups (CCG, BMA, other NHS Trusts), to the media and publications. A view of my website home page indicates the scope of my efforts, and their duration.

There is a conspicuous example among these misconstructions that is particularly serious: my anomalous Benzodiazepine prescribing. This had been identified as a potential, though poorly understood, problem for many years. I believe the anomaly may also reflect much wider problems than my own practice. For several years I made suggestions to my authorities (then the Primary Care Trust) as to steps we might take to clarify and resolve (if we could) this problem. I did this repeatedly and clearly, though verbally: these positive suggestions were never responded to meaningfully or purposefully. Why?

After many years of avoidant non-response from NHS authorities I eventually hear from them. But not by way of an offer to dialogue or for further understanding: instead I receive a forensic inspection-without-dialogue – this yields a quick judgement (against me) but no understanding of the complex problem (for anyone). Result: the deviant has been eliminated and the ambient data may look tidier. But what is the human cost?

This is a very large and complex problem. Neither your brief, summary judgement nor a recent NHS Case Report engage sufficiently with the complexity and context – these need much more analysis. To further this I have attached an Appendix (this is taken from my response to the *Case Report of NHS England August 2016*).

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Adieu

A fairer and wiser CQC regime would have said something like this about my Practice:

“This is a small and old fashioned type of Practice that is now very rare. Much of our regulation now is designed to safeguard much commoner and much larger Practices than yours. In some respects your formal compliance to these new regulations is consequently deemed as poor, but this is clearly offset by your wider and longstanding record of outstanding popularity, safety and good practice. This is an anomaly but a positive one: we would like to support your last few years of practice. During this time we would like to understand better the working principles behind

your exceptional record, and then discuss how we might apply these to the managed welfare of future Practices.'

This was the tone of my previous CQC Inspection in 2014, though only partially explicit: it was guided by conference rather than deference. This latest CQC Report has taken a very different, severely uncompromising, line.

This has finished my much-loved practice, but certainly not discussion about what this means.

Appendix

Abstracted from *NHS England Case Report August 2016: my response*

i *A long, wide and bullet-pointed view of Benzodiazepines (BZPs)*

- BZPs were preceded, from the 1930s, by Bromides and Barbiturates. The latter persisted into the 1960s: they were certainly potent as hypnotic sedatives but were easily overdosed – often accidentally – and then rapidly lethal.
- In the mid-1960s the BZPs were introduced. They were less crudely potent than Barbiturates and very much safer – their lethality was much more remote and seemed only to occur when mixed with large quantities of other drugs, alcohol or from secondary accident.
- Fifty years later this remains the general view: BZPs are considerably less toxic and hazardous than most related antidepressants and antipsychotics.
- **BZPs are certainly much safer – even in excess – than excess alcohol**, which is often used by patients instead, to self-medicate. Paradoxically, alcohol has no requirement for professional regulation or supervision at all.
- BZPs can form habituation and dependency patterns **especially in individuals or situations when skilled guided support and containment is not provided**. This happened a lot in the 1970s and 1980s: careless and uninterested doctors would prescribe large quantities of BZPs as a ploy to keep the tranquillised patient uncomplaining and away (from the doctor). BZP habituation and dependency then become rife: addiction less so.
- BZPs consequently got a reputation as bad as their bad prescribing doctors. This was (in my view) a false conflation: the doctors were far more antitherapeutic than the tablets.

- The cautions and caveats that were so pertinent to the 1970s and 1980s persist now as a kind of ‘keloid scar’ ie an overgrowth of reparative tissue.
- Many practitioners and researchers are now challenging this professional orthodoxy of draconian avoidance of BZPs: they maintain that **within a matrix of good pastoral care BZPs are often the safest medication options.**

ii *A brief personal view and philosophy of BZPs*

- As with all psychotropics I aim always to prescribe as a second option, after more natural/healing options (eg the innumerable kinds of bespoke guided support and containment = ‘psychotherapeutic influence’).
- When I am dealing with severe damage, disturbance or decompensation I try to employ the alliance of mental health or addiction services, etc. I welcome this synergy. Often, though, it does not work out: resources have become thin, delayed, cancelled or of poor quality contact. Then I have little or no help in coping alone.
- **In this respect my BZP prescribing pattern also reflects overflow from problems elsewhere. This is like tarmacked front gardens causing flooding elsewhere, in the lower parts of a town.**
- With all such patients I do my best to provide guided support and containment within the limited time and resources I have. Monitoring, of course, accompanies this.
- I rarely think of any psychoactive drug as my preferred and first option, but they may be the device that helps achieve a tolerable survival: sometimes they are a bridge to other influences (eg by making socialisation or Counselling possible).

- I am thus never cavalier, reckless or feckless in either my prescribing or personally engaged follow up.
- My prescription of BZPs therefore represents my best judgement as to how to contain, palliate and engage with individuals who are raw with often inchoate damage and pain. If I could achieve these without any, or with much safer, medication I would do so. **Certainly, I consider the way I attentively prescribe BZPs is much safer than their lonely and unaccompanied retreat into alcohol and street drugs – this is a common response to poor engagement with our services yet, paradoxically, often lies outside official statistics of Service Providers.**
- Because I have developed a reputation for offering this kind of help, many patients have sought this from me. I always try to engage the other relevant agencies, but often their contact is not helpful: this is a complex issue meriting separate investigation.
- As indicated in i), above, there are frustratingly few kinds of clear ‘right’ and ‘wrong’ when entering this kind of BAMI territory: we, mostly, act with our best faith, judgement and heart and with very limited science. None of us here can act with the reliable precision, predictability and outcomes of – say – the ophthalmic surgeon.
- In this marshland no-one does as well as we would like. Those services more rigid in their protocols may prescribe less but often lose rapport with their patients, and then their attendance ... and then what?

I have often taken the other course: my aim is to keep the patient engaged: as long as I can do that all sorts of other developments and influences may be

possible. This is not so if they are lost. BZPs here are, often, I think, a very acceptable compromise to achieve that.

- Such processes may be very long. But I am a long-serving GP with substantial psychiatric experience and much patience for such things. My results are often eventually good, but not easily achieved: like reeling in a large strong fish, timing and patience are essential to avoid the line snapping. This involves skills now perishing throughout pastoral healthcare, particularly with BAMI: there are many snapped lines and distressed, disengaged individuals.
- In brief: **BZPs are most likely to do harm by dependency when the patient is not engaged adequately with some kind of skilled, guided support and containment.** I strive always to provide this. The results can then be very different.

iii *My prescribing anomaly: institutional responses*

- For about a decade my otherwise unremarkable prescribing has shown me to be a regular outlier in one area: I prescribe significantly above average BZPs.
- My attitude to this has always been keenly Socratic: I want to understand it better. I certainly have never attempted to parry, avoid or obfuscate any issue – I recurrently tried to *invite* discussion.
- Although I thought I could, possibly and in part, account for my high BZP prescribing (by considering the material in the above section), I acknowledged that there may be more that needs exploration and clarification. Without this clarity we cannot reach a sound judgement: unfortunately this is where we have stalled (see below).

- I suggested, therefore, the help of two kinds of expert:
 - *Statistical/IT* – to verify that this is a ‘real’ problem, not one due to a technical glitch, duplicate entries, errant coding etc. If these were excluded, then we could identify particular patients.
 - *Clinical* – with either an Addiction or General Psychiatry Consultant, to review each of these patients jointly, in person, in one or two designated clinics. This would get us beyond data to much fuller personal and clinical understandings, with their many predicaments. This might also offer some new and opportune therapeutic leverage with the identified patients.
- **I made this suggestion, repeatedly, for several years. It was never taken up.** I was given no explanation for this parrying.
- (On 12.7.16 the Medical Director of NHS England south London verbally apologised for this oversight, but this cannot now retrieve this opportunity for understanding and influence.)
- In the last couple of years I managed, coincidentally, to introduce some of these patients to senior specialist colleagues (two Consultant Psychiatrists, a Clinical Manager, a Medical Director, a Chief Executive Officer – and Clinician – of my local Mental Health Trust): they were all helpful in attitude, but helpless in effect. Haplessly they explained how they had not the staff or the facilities (eg Day Centres) to deal with people with these kinds of diffuse disturbance, damage and distress.

Yet there are many of them. How should I respond?
- For many years I attempted to raise awareness and debate about these matters by writing, speaking up at meetings and lobbying anyone who

might have any influence. (I evoked much collusive commiseration, but little change.)

- How did NHS management respond? The next I heard was this investigation ... and now this response.
- Maybe now – after this long and elliptical trajectory – something positive will evolve.

*

A process cannot be understood by stopping it. Understanding most move with the flow of the process, must join it and flow with it.

– Frank Herbert (1920-86) *First Law of Mentat*

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