

# **Industrialised Humanity**

## **How may we best care for one another?**

**A dialogue between Dr David Zigmond  
and John Burton from the Centre for Welfare Reform**

**David Zigmond and the Centre for Welfare Reform**

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Massive advances in our technology – particularly IT – have made possible new forms of ‘evidence-based’ corporate management and industrialisation. These have frequently been linked to marketisation.

But such ‘advances’ are paralleled by growing distress and demoralisation throughout our welfare services. Why? What can we do about it?



JB: David, by way of introduction can you first give us a short summary of your professional lifetime's work and interest? ... not too much detail – that can emerge later.

DZ: Yes. Well, briefly, I did my medical training in the 1960s and have spent nearly fifty years as a frontline NHS doctor. Forty of those years have been spent working between two enduring posts: a small inner city General Practice, and in a large general hospital working as a psychiatrist and psychotherapist.

JB: What led you to choose those specialties?

DZ: Well I suppose my choices reflect my lifetime's search for human meaning; so these are both the least technically specialist of the specialties. They are both, to my mind, very much concerned with human connection and personal meaning – where deeper understanding of people is crucial. As a doctor I have always been as committed to understanding these things as much as the 'safer', apparently objective – so depersonalised – scientific approaches. Unfortunately, I think that those interests – the social and personal – have become increasingly squeezed out by systems that ...

JB: Whoa! Too much, too fast! That's a big subject and we'll return to it. Can we get back to *you*? You've taught and written a lot and for several decades. Who has that been for, and what has it been about?

DZ: Well, my teaching has been for a wide range of healthcarers and psychotherapists. That, and my writing, have been largely about the *subtext* of our afflictions and care: the often hidden personal, psychological and social aspects of our experiences and transactions. It's a vast hinterland, yet essentially unmeasurable – so now becomes increasingly neglected as we try to subject everything to measurement. Despite this I think that it often comprises the larger part of whether we are 'helpful' or not. It's the *art* of medicine, rather than its *science*. It's care, rather than treatment...

JB: You've condensed all that into an aphorism somewhere...

DZ: Yes: *Healthcare is a humanity guided by science. That humanity is an art and an ethos.*

JB: So ... let's get back to *your* relationship to all this. Taking a long view of your medical career – a span of fifty years – how would you now summarise the changes you have lived through?

DZ: OK, one sentence. Anything to do with machines or technology has got better, while most things to do with personal connection or understanding have got worse.

JB: Meaning?

DZ: Well, our science has clearly advanced, so many more physical illnesses are 'fixed' or cured: these are often the ones that need relatively little personal understanding or connection. We can call this curative healthcare. It's mostly science.

But there is a larger area of affliction that presents to healthcareers that cannot be so decisively and quickly fixed.

JB: What are they?

DZ: We cannot easily fix those disturbances of body and mind that largely reflect our complex, and often conflicted, human natures, histories and predicaments. Or our eventual decline or demise. So doctors can't usually fix these conditions, but we *can* – through both personal and medical knowledge – offer skilled guidance and palliation: we can help people's capacities for immunity, growth, repair and endurance. We do that through growing relationships and the personal understanding that follows. That's palliation or healing – an *art* more than science. All this I call *pastoral healthcare*, and generally this kind of care, rather than cure, depends more on *personal continuity* of relationships ... This is especially important in General Practice and Psychiatry. But here we have a serious and growing problem because recent decades of serial reforms have made it increasingly difficult to deliver pastoral healthcare, so it's got *worse*.

JB: Why has that happened?

DZ: Largely because we have insistently rolled out systems that destroy its essential basis: personal continuity of care! Practitioners and patients know one another less and less.

JB: And why has *that* happened?

DZ: Well, it's complex – a kind of *Zeitgeist* of our industrialised way of life.

JB: I'm confused. Can you explain?

DZ: Well, consider the objects we use, the food we eat, and how the experiences we have are mostly mass-produced and packaged in remote factories. Commodification follows. Commercialisation opportunistically enters as a siren, the dominant force. This, increasingly, is our world ... remotely sourced, generated and controlled.

JB: So what gets lost?

DZ: In medical practice all the aspects of care that can't be industrialised or commodified: so most of pastoral healthcare.

JB: Because?

DZ: Because such care depends on personal relationships, understandings and affections. The *art* of medicine – comfort and healing – cannot be manufactured by design, it has to arise and grow naturally, from interaction. So there's an important paradox here: we can't *make* these things happen, but we can certainly make them *not* happen...

JB: By?

DZ: By industrialising them! Yes, I know: I keep circling around the same themes. But here is reflected a tragic folly that ensnares us: *because* industrialisation has mostly been so successful in curative healthcare we've expanded that approach aggressively throughout healthcare, so that pastoral healthcare gets pushed out and now battles to survive...

JB: That reminds me of some wildlife film footage I saw of the stronger baby bird getting fed more, and then pushing its weakened, starving sibling out of the nest...

DZ: Yes! I'm sure that many veteran GPs and psychiatrists now would identify with the condemned chick.

JB: In recent years you've written prolifically about your analysis of *how* this happens: the methods of governance and management. As I recall, you refer particularly to the 4Cs, REMIC and Gigantism. Can you tell us about them?

DZ: Well for clarity it's best to take each separately. But what they all have in common is a tendency to industrial expedience, and thus depersonalisation. In my view each of these, in pursuit of efficiency, will often sacrifice important forms of connection, discourse and understanding. And that leads to much of our malaise right throughout welfare services – a kind of institutional heart failure...

JB: Many of us will recognise that as important, so I'll want to return to it later. But for now I want us to return to what they are. What about the 4Cs?

DZ: The 4Cs refer to competition, commissioning, commercialisation and computerisation. Each of these is essential to the neoliberal ethos of marketising whatever we can, so that even our many forms of care for one another are conceived and implemented as if they are industrially manufactured consumer objects...

JB: Well, successive governments have said that such methods add to choice, transparency, incentivisation and efficiency. So what's wrong with that?

DZ: Well, after thirty years of such reforms we can see that the consequences are very different from the claims.

JB: Can you be more specific?

DZ: Yes, OK. So specifically, and in order:

- *Choice* in much of healthcare is very different from purchasing, say, a microwave oven or a car. Complexity – from vulnerability or impairment, for example – frequently makes guidance, advocacy, even surrogacy, unavoidable. 'Choice' can then easily become a corrupt masquerade.
- '*Transparency*' may be the official policy but has very often become an expedient sham. Marketised services soon learn how to 'game' the system. At its worst, much nepotism remains cleverly concealed. Even at its best,



legality and decency drift far apart. Stealthy misfeasance has probably *increased*.

- Doctors are not, mostly, primarily *incentivised* by money. Until recently our motivation mostly came from somewhere else: vocation. Yes, we want a secure middle class lifestyle, but beyond that the quality and attention of care we offer is not dependent on the amount of money exchanged. Attempts to replace vocation by corporation has mostly yielded the kind of disheartened and mistrustful alienation we now witness throughout welfare services.
- *Efficiency savings?* In view of the above losses it is easy to see how these do not materialise in any enduring form. Trying to enforce certain efficiencies has actually made us *less* efficient. Our service's difficulties now far exceed mere funding problems.

JB: You've obviously thought about this in some detail. What about REMIC?

DZ: OK. I'll try and be briefer. REMIC is remote management, inspection and compliance. It's the idea that, especially with IT systems, we can design and deliver all important healthcare by continually instructing, controlling and monitoring all its employees – we can think of REMIC as a kind of control-tower.

JB: You've written about this for some years. I remember especially your terms *Technototalitarianism* and *From Family to Factory*.

DZ: Yes, I'm trying to describe and explain how we are depleting more open systems of trust, personal understandings and judgements by submitting to hermetic systems that are mistrustful and cannot then assimilate personal understanding. So we replace flexible judgement by executised protocol.

JB: But you don't think *all* REMIC is harmful, surely?

DZ: No. I certainly am not advocating complete abandonment of all accountability, regulations and checks. It's a question of intelligent judgement and balance...

JB: What does that mean?

DZ: Perhaps I can answer that best by my analogy to families. The best functioning, most healthy, families certainly have some structure – 'rules' – but not too much. Over-regulated families are likely to produce all kinds of developmental and relational disorders in their offspring – from the cravenly stunted to the defiantly destructive: there are innumerable forms of these. And the parents can always self-justify: 'but we only wanted what was *good* for them!'.  
  
With our welfare services now, what kind of 'family' are we now raising?

JB: Well, certainly a very troubled and a very large one – which brings us to Gigantism. What is that?

DZ: Gigantism is the 'natural' tendency of systems and organisations to scale up and standardise. Almost all manufacturing and retail industries will do this for gains of convenience, logistics, economics, efficiency and power. Mostly it works there. The governing and mistaken notion now is that we can roll this out, with similar confidence, throughout healthcare.

JB: When is that mistaken? What are the problems?

DZ: Well, Gigantism isn't *always* mistaken. For example, it works very well with activities that really are successfully, so uncontentiously, based on agreed procedure: eye surgery, cardiac surgery, renal dialysis or vaccination programmes, for example. There's little dispute there.

But it works much less well in pastoral healthcare – general practice, chronic (thus incurable) disease and mental health – because that kind of care generally works much better, and more happily, when people can get to know one another and develop bonds of trust, personal knowledge and affection. Gigantism makes these things increasingly impossible. Generally the bigger the scale, the more automatic the system, the less anyone knows anyone...

JB: Here is a question a lot of people would ask: aren't all these problems just due to inadequate funding?

DZ: Well it's true that compared with similar nations we spend less of our GNP on healthcare – so in that way we are underfunded. And it's also true that successive governments have turned increasingly to the 4Cs, REMIC and

Gigantism to make 'economy savings'. But even this is misjudged because an over-industrialised welfare service destroys its best human sense and sensibility – our personal relationships. It cannot then work efficiently. So, perversely, unless we are very careful, our efficiency drives can make us *less* efficient ... I know I've said this here already, but it's a crucial point.

Yes, more money can help many of our problems, but *only* if we intelligently deindustrialise much of our culture and institutions.

JB: David, you have very direct personal experience of these organisational problems because of your failure, or refusal, to comply with all the increasing regulations that the authorities insist must be obeyed for the greater good. So you were closed down, with dramatic suddenness and force, by the CQC (Care Quality Commission). What happened?

DZ: Well, it's a long story\*. I'm not sure that in the time we have ...

JB: Give it a go...!

DZ: OK. For thirty years I ran a small inner city GP practice. I loved it and I was rewarded by remarkably appreciative and affectionate trust and loyalty from staff and patients. Objectively this was indicated by exceptionally good results in independent polls, staffing stability and the complete absence of necessary inquiries into formal complaints or adverse events...

JB: Well, you must have got *something* very wrong to get closed down as you did!

DZ: Oh yes! Because I was a small, stable practice I found that the increasing amount of regulation was becoming increasingly (often absurdly) irrelevant and obstructive to our core work. Bureaucracy was suffocating our ability to do clinical work ... To survive we had to be selective...

JB: Can you give us some examples?

DZ: Oh ... Doing criminal records checks on staff who'd worked well with us for fifteen years (and they failing to check me); not doing regular fire drills with detailed documentation (the premises had only four, contiguous rooms with very clear exits); not completing professional development plans for myself or my staff (when and why should the well-functioning have to do such things?) ... The list is very long...

JB: But a previous CQC report – two years earlier – knew all this, yet wrote an exceptionally positive report...

DZ: Yes, that's an important anomaly. You see, the earlier inspectors *did* use intelligent judgement, rather than just checking for complete compliance to an ever-larger regulatory grid. They could see that regulatory requirements sometimes should vary with context: a small, stable practice where staff stability and personal knowledge are very good is very different to a massive airport-like practice where such anchorage barely exists.

JB: And the last inspectors?

DZ: They would not even discuss these matters and considered my challenge an impertinence. I think my closure was both a punishment and a warning to others: *we decide and we are in control!*

JB: At CfWR we have heard many similar stories, though few with such drama. If we carry on like this what will happen?

DZ: For healthcare the omens are grim; unless we make some wise revisions.

Currently our healthcarers – doctors and nurses – show increasing malaise with each successive industrialising reform. Even if we can recruit, we are having widespread difficulty retaining staff: they are dropping out, burning out or being taken out. Sickness, breakdown, career abandonment, early retirement and litigious redundancy are all dysfunctional exits from our sickening service culture: all are increasing. And then the cost of shoring-up the ailing and crumbling remainers is immense: importing locum or foreign staff – often via commercial agencies – is much more expensive than retaining a well-rooted and happier workforce. It cannot be sustained, humanly or economically.

What then? We may ‘rescue’ the NHS logo only, while outsourcing all real services to bidding competitive businesses. It will become yet more expensive. So what will be free at the point of delivery will become much more limited, rigidly prescribed and corporately delivered. Personal continuity of care – and thus pastoral healthcare – will die.

Consultations will resemble *Kwikfit* more than the best of an NHS we have cherished.

JB: Grim indeed! So what can we do instead?

DZ: I'm aware of our limited time now, so I really will have to be brief. To do that I'll give you a list of suggestions, but without explanations. I hope you'll be able to see how much each can help restore human scale, connection, belonging, trust, morale, and personal knowledge:

1. Abolish the entire market within the NHS. This includes all purchaser-provider splits, autarkic Foundation Trusts and financially-based commissioning.
2. Radically revise and edit REMIC mechanisms; restore much lost professional autonomy, trust, responsibility and accountable judgement. Abolish the forensic 'you're-guilty-unless-and-until-we-proclaim-you-innocent' culture.
3. Halt our relentless and ubiquitous Gigantism. Selectively encourage the regrowth of smaller and more local hospitals and family doctor practices.
4. Restore personal lists to GPs: patients to register with a named practitioner, not a place.
5. Encourage GP partnerships, rather than commercial conglomerates of agencies and locums.
6. In hospitals bring back:

- Consultant-led firms with (when possible) their own designated ward and staff.
  - Supervising Matrons. Nursing Schools (rather than university courses).
  - General Physicians (reducing the number of tertiary specialists).
  - Smaller, more local hospitals for the many elderly admissions that do not require expensive scans, intensive care etc.
7. Reduce the size of Medical Schools, but increase their number.
  8. Bring back General Psychiatrists. (Like General Physicians they can reverse much fragmentation of care from relays of evermore specialist teams – personal continuity of care can then be restored...)

I can see we're out of time now, so I'd better stop there.

JB: Yes, we do have to stop, but I can see you're far from finished! David, although you've been describing a long, broad view from healthcare, it's important to acknowledge how what you have identified is often and equally true right across our welfare services – at all levels of education, social and probation work, legal aid, residential care and rehabilitation... At CfWR we have enormous correspondence about this every day. So, thank you.

DZ: Well it's even better to contribute to a different kind of greater whole. So many thanks to you, too.

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## Note

\* The interested reader is referred to David Zigmond's Home Page. Articles 73 and 74 describe the inspection and emergency court hearing. Section G clusters subsequent correspondence.

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**Interested? Many articles exploring similar themes are available via David Zigmond's home page on [www.marco-learningssystem.com](http://www.marco-learningssystem.com). Many of his videos are also on YouTube.**

David Zigmond would be pleased to receive your **FEEDBACK**



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The interviewer for CfWR was John Burton. The discussion was in February 2018.



David Zigmond



John Burton