

Dear Professor Bailey and fellow Academicians

Plummeting morale of junior doctors: one branch of our blighted tree of Welfare

I am encouraged that your Academy – with its wide range of experience and knowledge – will investigate the mounting risks posed by our demoralised junior doctors.

I write as an older NHS GP and Psychiatrist, in practice for several decades. My years as a junior doctor were in an era much freer of management: our hard work often entailed longer hours than now, but mostly we were happier and more fulfilled. All those years ago I could not have foreseen such intense dissatisfaction that has evolved, so equally, in both those fresh to the profession and those leaving it. My older colleagues can, at least, retire with exasperated relief at the earliest opportunity as long valued careers turn sour; younger colleagues have a more difficult quandary: nascent careers are already becoming an unappealing burden.

But such transgenerational malaise is not confined to doctors: something very similar has happened throughout our welfare services; to nurses, psychologists, social and probation workers, school and university teachers... Our common discontents have emerged from a new kind of driven and institutional mistrust. These have incubated in the newer possibilities of management technology: constant electronic prompting, surveillance, documentation and box-ticking of compliance – all have replaced more holistic, skilled professional judgement and discrimination. Computers first made such things possible; they are now massively dominant. The result? Trusted personal vocational satisfactions have been driven out by management rote and edict. Our previous family-like colleagueial networks have become displaced by factory-like algorithmic management. Our culture has become *technototalitarian*.

So, such massive and rapid systemisation has segued to unintentional but destructive consequences: we have extinguished the larger part of our human

connections and influences – those exchanges that make our often onerous and difficult work personally gratifying and thus sustainable. The result is that younger practitioners now feel unmentored and orphaned, while older practitioners feel devalued and childless.

Our intent and follies in factory-modelling NHS healthcare are similar to the 1960s and 70s revolution in city housing. Tower blocks then vaunted rapid remedies of economy and logic, but only at the price of sacrificed communities – we are still living with the distressed wake. Forty years later, as we were demolishing those blocks of specious modernism, we realised that the few surviving Victorian streets and houses had become often cherished homes and appreciating assets.

The lesson here is that economies of systems and scale can easily become catastrophic for human bonds and relationships. The USSR's Farm Collectivisation Programme ninety years ago remains a horrific example of the destructive possibilities of such prescribed reform.

The forced injection of the 3Cs – Competition, Commissioning and Commodification – into our NHS has unleashed and compounded a new kind of alienation and technototalitarianism few anticipated: colleagues have been divided, boundaried and often set against one another. Inevitably we have lost much of our wider vocational sense. Previously friendly fraternalism binding our professions has given way to a new kind of parochial distrust or indifference.

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This is the humanity-eviscerated employment-world my generation is retiring from and which our younger doctors have been recruited to.

As the roots of our dissatisfaction often seem obscure, they are easily misattributed. Arguments about working hours or money – as so often – are usually, also, about much else: it is harder to talk about our deprivations of

personal engagement and identifications – yet it is only these that can sustain our work’s sense of meaning, satisfaction and affiliation.

Clearly our healthcare’s human needs – and how we so easily overlook or misunderstand them – require a different kind of thought and vocabulary.

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So, we need to invite very different kinds of discourse if we are to retrieve, and then protect, our healthcare’s perishing humanity. But apart from these kinds of verbal exchanges what can we *do* to encourage and replant these values, this endangered culture?

We can start by thoughtfully revisiting the past and understanding better what previously worked well: we can then restore much that was carelessly abandoned.

So here is a preliminary list of historically enlightened suggestions with some cursory explanation. Suggestion 1 has fuller text as it introduces common notions that follow. Likewise suggestion 9 introduces a much avoided but crucial bolus of themes about Culture as briefly as I am able.

1. **Bring back hospital General Physicians.** Such practitioners can (and used to) deal very competently with most medical outpatient and inpatient problems. They would refer to tertiary specialists only rare or unusually refractory problems. The benefits are:
 - Greater personal continuity of care (PCC) especially for patients with multiple co-morbidities. As we live longer this is, increasingly, the patient profile presented to hospitals. By restoring General Physicians, many patients and their families could then, again, get to know the people that care for them – and vice versa.
 - In this way PCC brings much greater personal satisfaction to practitioners and patients than our current trend to ever-more specialised multi-team hit and run systems. PCC makes possible more

holistic views and engagements and our ability to see things through. Yet these are the larger part of both our healing influence and our clinical wisdom. If we jeopardise such things, the losses are serious because our better judgements and encounters are essential, not just for people but also for our health economy – the humanly resonant is almost always more efficient.

- Such anchorage of most non-surgical conditions with General Physicians would then reduce the number of specialisms trainees must be rotated to. This reduction can then increase the duration of each placement – thus helping mentoring, colleagueial bonding, learning about and then providing PCC. Everyone’s sense of belonging is increased.

The following suggestions often confer kindred benefits:

2. **Enable Consultants to have designated wards.** Nursing and medical staff would get to know one another and the patients for whom they have joint care. Such reclaimed bonding and familiarity brings much improvement in morale, efficiency and economy.
3. **Re-establish Consultant-led Firms.** The current culture of multi-disciplinary team (MDT) management very often loses personal identification and responsibility in care. PCC all too often becomes dispersed to an amorphous anonymity: no one is then interested in an overall picture and seeing things through. Named consultant-led Firms could restore this.
4. **Review the role of Nurse Practitioners and similar.** Such practitioners should not be employed with the intent of devolving PCC away from doctors, leaving doctors as mere expert and executive technicians. Both doctors and patients used to draw great benefit from PCC – it used to be a cornerstone of practice. The loss of these kinds of bonds is responsible for many of our increasing NHS problems of morale and efficiency.

5. Break up medical schools into smaller colleges.

Amalgamation of medical schools has resulted in institutions too massive for good personal acquaintance, bonding, mentoring, tuition, identification or sense of belonging.

Return to smaller, but more, schools would reverse this. Arrangements could be made for exchanging or pooling some specialist facilities.

6. Mental Health Services should mostly revert to Consultant-led Firms.

They would work similarly to General Physicians (see 1, above) and would delegate mostly within their own Firm. The Consultant (or deputy) remains the primary contact-point or anchor. The hub-principle of clinical encounters should be PCC, not administrative, diagnostic or algorithms that automatically direct specialist Care Pathways.

The rationale for this is similar to General Physicians offering and enabling PCC.

7. Re-establish residential Nursing Schools. Since these were disbanded there has been a grievous loss of nursing morale, cohesion, identification, loyalty and retention.

Universities could be used for sporadic tuition, but not as a home base, the Alma Mater.

(This Nursing School rehabilitation might not be easily implemented in smaller towns: other arrangements (eg secondment) would be developed there.)

8. Bring back personal lists for GPs. The abolition of personal lists was undertaken for reasons of administrative expedience. Patients were henceforth allocated to a *place*, not linked to a *person*. There was little understanding of the human value and significance of the time-honoured lists that encouraged personal bonds and identifications between doctors

and patients. GPs and patients consequently now have much reduced personal knowledge and understanding: they rarely know one another. PCC is hazardously lost.

9. Dismantle the dominance of computerisation and quantified informatics

Doctors' time and attention is spent increasingly with computers – filling in details on formatted templates, recording and collating data and indicating compliance to Trust protocols. If they are not busy assembling these extensive electronic documents, they are likely to be spending considerable time receiving, and then attempting to decipher and then check, a large number of equally labyrinthine missives. The wearying and stultifying length and detail of this traffic has largely accrued to defend against litigation or inter-organisational procedural difficulty.

This vast sediment of cyberclerical work is now a key feature of our healthcare's technototalitarianism. The demands of this endless blizzard of data, compliance-boxes, reports and briefings leaves practitioners with less and less *personal head-space* and *heart-space* – the essential starting point for our complex bonds and understanding with patients and colleagues. When we lose these we are left with doctors who see only the computer screen, not the human face; 'patient data' is clear, but not the patient's life.

We must live with a tragi-comic paradox; we now have so much signalling that we can no longer communicate.

This managerially determined cyberworld of healthcare is generally experienced as not just unsatisfying, but as deadening to the intellect, heart, art and fraternalism of practice. Certainly older practitioners have struggled more to adjust to all this, but younger practitioners eventually find it equally enervating and demoralising. Few doctors signed up wanting to do this kind of job.

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These problems – of the place of machines among humans – have provoked consternation and debate since the start of The Industrial Revolution. But the recent computerisation throughout our lives has led to an unprecedented acceleration of our predicaments: what is the place of individual or community experience or meaning amidst ubiquitous managing cybersystems? To assure our humanity do we need increasing defensive vigilance and sometimes contention?

Clearly, the depersonalising and intrusive effects of computerisation are, to some extent, inevitable if we are to reap the benefits. Equally evident is how universal this problem has become: worldwide we can see similar trouble arising in both private and occupational lives. So, while this is, almost certainly, a large factor in the demoralisation of junior doctors, this is part of a much wider problem.

Ubiquity tends to become culture: 'it's just how things *are*'. And it is all but certain that computers are here to stay. These two factors – culture and inexorability – have led to two types of paralysis: either to denial of the problem's existence, or to fatalism about the problem's modifiability – again, 'it's just how things are'.

My view is different: it is that we can ameliorate much of the damage I have described, though this is an endless and difficult challenge. We require much more, and unceasing, human discrimination and intelligence in how and when we use computers, systems and procedures: it is our *mindfulness* that again needs to be in charge. This letter is one small contribution.

- How we conduct this struggle – of mindfulness against technototalitarianism – is one of the most important of our era. The junior doctors' dissatisfaction is just one symptom of a much greater cultural malaise we must better understand and attend to.

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This very long letter grew from my intention for a much shorter one. As I wrote, a wide web of rich themes emerged and expanded. Such is the complexity of these problems: I hope, at least, I have conveyed my ideas in a form that is clear and may be useful: obviously, there is much else to be considered.

If you, or any members of your committee, wish to discuss any of the points I have made I will be very pleased to hear from you.

With best wishes for this most worthwhile project.

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