Debate & Analysis

Industrialised medicine:

a step too far?

INTRODUCTION

In a system hard-pressed to cut costs and make efficiency savings, healthcare professionals are being urged to be more 'productive'. The King's Fund NHS productivity challenge aspires *'to close the funding gap through improved productivity'* and *'ensure the greatest value for every pound spent'*.[1] This is essentially the language and ethos of the production line. Indeed the Health Secretary recently hinted that a future rise in nurses' pay might be linked to productivity.[2] But the growing crisis in nurse recruitment and retention is surely evidence enough that an industrialised work culture, even if it did temporarily stoke industrial-style productivity and efficiency, must soon enough become unsustainable. And so we are left wondering what the term 'product' refers to in the context of health care and what the metrics of such 'productivity'-related pay might look like; and altogether whether the NHS, to quote Oscar Wilde, has become an organisation that *'knows the price of everything and the value of nothing'*.

UNINTENDED CONSEQUENCES OF EVIDENCE-BASED MEDICINE

As the burden of long-term disease soars in an ageing population,[3] the quest for industrial-style efficiency might seem like a reasonable response. In which case, faced as it is with relentless demand,[4] is medicine destined to change from *'a craft concerned with the uniqueness of each encounter with an ill person, to a mass manufacturing industry preoccupied with the throughput of the sick'*?[5] On such production lines where standardisation and assured quality would be mandatory, unpredictable human factors introducing variation, error, and bias would have to be minimised. Seen in this context, even though the guidelines and population goals of evidence-based medicine (EBM) can undoubtedly raise standards,[6] there is yet a danger that EBM plays into the industrialising agenda. The randomised controlled trials (RCTs) at the core of EBM provide at best only statistical generalisations about experimental outcomes generated in particular patients groups, and in atypical settings where the human elements (non-specific therapeutic factors, natural remission, and individual differences) have been more or less rigorously cancelled out. In practice, of course these individual differences matter a great deal, and when our clinical decisions ignore them we risk depersonalising ourselves and our patients. As an unintended consequence, the patient's mind, mood, and predicament may fade from the medical view, along with the added value of the therapeutic alliance and the benefits of engaged self-care.

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In acute disease with a single biological cause and a definitive, effective treatment, there is everything to be said for the biomedical model. These, after all, are the customary criteria and conditions for most drug trials. In such circumstances RCTs, conveyor belt medicine, and well-defined standardised guidelines can indeed improve outcomes and efficiency. However, on an average day in primary care, not many patients conform to strict diagnostic and treatment guidelines: distressed people mired in insoluble predicaments; people with social problems who have nowhere else to turn; people who find it difficult to cope day-to-day with long-term mental or physical conditions; infirm older patients with multiple morbidities; and conditions where lifestyle is a key factor. Managing these encounters calls for personal knowledge, insightful and holistic biopsychosocial diagnoses, and, quite possibly, masterful inactivity leading to reduced resource utilisation.[7] Yet, inevitably, as patient numbers and their complexity and expectations escalate,[8] the temptation to write a prescription rather than offer a listening ear or have an eye for what lies behind the symptom grows stronger. Perversely, then, in an over-stretched system with a large multimorbidity burden, industrial-style high-throughput biomedicine may all too easily encourage overinvestigation, overreferral, overdiagnosis, and overtreatment: the results would be an inefficient use of resources and a greater potential for harm.[9]

THE VALUE OF SOCIAL CAPITAL AND FLEXIBLE GUIDELINES

On the other hand, good relationships and patient-centred care benefit doctors as well as patients.[10] These human effects augment every kind of healthcare intervention but they operate on a larger scale too, for no organisation becomes great just by pushing out ever more 'product'. The greatest asset in any people-facing enterprise is its staff, yet the NHS is more that just the accumulation of their individual effort. The extraordinary social capital that this huge organisation produces is far more than the sum of its parts and it cannot be directed by guidelines and targets alone. Here, mission and vision must be more than management-speak, for people generally come into healthcare work because they want to make a difference. If the resources required to do good enough work are lacking, then these values will be stifled, and the enthusiasm and sense of purpose that empowers teams and encourages them to go the extra mile will be lost.

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As the NHS adapts to the changing needs of an ageing population, multidisciplinary teams will need to feel that every level of the system supports strong trusting and respectful relationships. Consequently, if EBM is to reflect the totality of treatment effects in patients with long-term disease or comorbidities, it cannot be based simply on measuring condition-specific indicators while ignoring quality of care and wellbeing outcomes. Worryingly, there is evidence that a substantial number of doctors will follow a guideline even though they believe this is likely to harm the patient.[11] Perhaps they see non-adherence will invite litigation or a GMC complaint; perhaps they think that they are mere 'cogs in the machine'. If by diminishing independence and autonomy industrialisation strips away passion and enthusiasm, then disillusionment and a sense of ineffectiveness will follow. Our profession should pause to reflect on this direction of travel. In this regard, the need for better, more practical clinical guidelines has been recognised,[12] for it is not impossible to incorporate patient-reported outcomes and measures of quality of life into healthcare research,[13] nor to strengthen patient involvement in research design. More flexible guidelines representing a better balance between disease-specific indicators and patient-centred outcomes would return a necessary degree of clinician autonomy, and a revival of respect for professional knowledge and patient preference could enhance our profession's self-respect, and help restore the public's trust in our motives and methods.

CONCLUSION

The NHS must move beyond the kind of accounting that measures 'productivity' and 'efficiency' only by counting numbers treated, mortality, and costs. Rooted as it is in a visionary commitment to the public good, to social justice, and a recognition of human interdependence, its metaphorical spreadsheets must also account for the value added by staff enthusiasm and compassion, dedication, the patient's wellbeing, enablement, and satisfaction. Only by recognising and supporting the qualities that humanise health care, and by celebrating organisations that strive to nurture them, will our NHS achieve genuine efficiency and productivity.

Mark Lown,
GP and Clinical Lecturer, University of Southampton, Southampton.

David Peters,
Clinical Director, University of Westminster Polyclinic and Centre for Resilience, University of Westminster, London

Funding
None.

Provenance
Freely submitted; not externally peer reviewed.

Competing interests
The authors have declared no competing interests.

DOI: https://doi.org/10.3399/bjgp18X699701

ADDRESS FOR CORRESPONDENCE

Mark Lown
Primary Care and Population Sciences, Aldermoor Health Centre, Aldermoor Close, Southampton SO16 5ST, UK.

Email: m.lown@soton.ac.uk

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