How and why have we so hazardously misconceived our NHS staff?

'If you give me six lines written by the hand of the most honest of men, I will find something in them with which to hang him.' (Cardinal Richelieu, 1585–1642)

'We are pathetically eager to believe that if human affairs are managed right, nothing unpleasant need happen to anyone.' (Sir Max Hastings, 1945-)

Much of the world is anxiously stymied by COVID-19. Our assumptions of contemporary living simultaneously and shockingly unravelled and impassed. 'Unprecedented' is a common contemporary adjective. In the UK, our NHS was, early on, lionised and eulogised in heroic terms. Like religious icons or Soviet State art, its practitioners were referred to as saviours and martyrs. But this is very different from most of their experiences in recent years. At its start, this COVID crisis has, as emergencies do, galvanised a new cooperative and collegial motivation in many of our professionals as they have been — albeit transiently — again trusted to do their best to stem the alien tide. But although our enduring serious problems are temporarily out of sight we should beware: they remain, like perilous rocks, just beneath the water's surface. The warm mist of adoration has — until it mostly passes — obscured a serious problem that has grown increasingly erosive to our NHS for several years: the destabilising demoralisation of much of our workforce. What has happened to our working culture? And what can we do about it? It is crucial that we ask this question in anticipation (hopefully) of a post-COVID national recovery as we will otherwise then return an exhausted, even more vulnerable, NHS to these enduring and gathering imperilments.

WHAT HAS HAPPENED TO OUR WORKING CULTURE?

Our healthcare headlines and news items in recent pre-COVID times were frequently about a service labouring under a regime riven by accusations and disputes about finances, territory, and responsibility. While still, often, providing satisfactory technology-dependent treatments well enough, the services for many years have been clearly struggling and malfunctioning in less hi-tech areas, particularly in general practice, mental health, and community services. This is reflected in a wide range of statistical indicators both for staff and patients. Staffing levels are often shown to be unsafe and unsustainable due to poor recruitment, sickness, intra-institutional litigation, career abandonment, and earliest retirement. Remaining staff struggle to provide access and services to patients, and personal continuity of care becomes impossible, further demoralising and endangering wearied staff and vulnerable patients. Arguments and quasi-explanations are often translated into discourses about money. The services' spokespersons say, *'we don't have enough'*, the government says *'you do have enough, but you're not using it efficiently: you need better management.'* Variations of this exchange have been going on for 30 years, since the neoliberal revolution. The nature and evolution of neoliberalism is worth clarifying since it will help us understand our current predicament. Neoliberal reform of the NHS began in the heyday of the Thatcher government, which said effectively: *'Welfare services are slack, inefficient, and have too much unmanaged variation. This is what happens if professionals make their own decisions and define their own tasks. We need to replace autonomous vocation by commissioned and expertly designed corporation; and those corporations need to be motivated, tested, challenged, and stretched by the rigours of a competitive market.'*

NEOLIBERALISM

Neoliberalism tends to view human activity and motivation in a machine-like way: humans can, therefore, be designed, tweaked, and boosted to provide ever-improved performance or 'output' to meet the user's requirements. This approach is akin to a carpenter who procures his material and then designs, cuts, shapes, and joins it precisely to his requirements. The wood itself is now a lifeless commodity whose only use is the carpenter's plans. But let us contrast this to the more organic, holistic activities of a gardener. Here we may have a vision or plan, but we cannot precisely command and manufacture the output. We must instead understand the viability and growth requirements of the various plants and their complex relationships with their ecosystems. Then we must plant, protect, tend, and nourish with care and deliberation.

David Zigmond

Our pre-neoliberal NHS had these organic, holistic principles of better human sense guiding its management, although this was never referred to explicitly. The service was not perfect, but in the main it had high work satisfaction, happily convivial work relationships, and enduring robustness and sustainability. The tragedy of our neoliberal reforms is that rather than building on these organic, holistic tenets of human groups, they demolish them in the spurious belief that a commercial-industrial type model would work better. In a way, these reforms have been more like a revolution; and revolutions, like wars, almost always yield something very different to what was planned.

To establish decisive control these neoliberal reforms have invested heavily in three main institutional strategies:

The 4Cs: competition, commissioning, commercialisation, and commodification — a marketised system.
REMIC: remote management, inspection, and compliance — a surveillant and policed system.
Gigantism: scaling up and standardising wherever possible — a system of industrial capacity and efficiency.

"Our neoliberalised NHS has produced a fascinating variation of totalitarianism: we have managed to fuse the ... paranoid ... repression of the Soviet Bloc with the venal ... intimidating cunning of the worst of US capitalism."

Together these three reforming vanguards have certainly revolutionised our NHS working culture from one of convivial cooperation to that of industrially- commanded compliance. From family to factory. This radical transition may make sense in the abstracted spaces of government and management committees, but it makes much less sense at the practitioner and patient level — here our actions and experiences are very much the products of the bonds, meanings, trust, and resonance that develop from shared personal access and knowledge. Underlying our technically designated tasks, these are what confer human gratification for doctor and patient alike. For any of this to happen, the practitioner must be assured of headspace and heartspace but, tragically, our three revolutionary vanguards have been developed to short-circuit and exclude such humanity. The revolutionary rhetoric is usually pitched around mooted (and mistaken) gains in efficiency, safety, and value-for-money. *'The more laws, the less justice.'* (German proverb).

And what is the reality, now, of our neoliberally industrialised NHS? The evidence is that, most often, the 4Cs, REMIC, and Gigantism have fragmented, dispirited, and demotivated the previously more fraternal NHS professional network. By introducing a competitively siloed mentality, unprecedently complex bureaucracy and procedures, and then attempting to control all thought and activity through micromanaged surveillance and compliance regimes, our service has become, all too often, less safe, humane, or efficient. After all, how well can an abandoned, depleted workforce achieve any of these things? And even if the staff remain in post how well can they work if they feel unfulfilled, devalued, mistrustful, mistrusted, and without fulfilled fraternal bonds — both with other workers and with their patients?

STICKS AND CARROTS

The neoliberal agenda — with its control-levers of contracts, goals and targets, compliance instructions, rewards and penalties, sticks and carrots — has abrogated a central human principle of how we may best care with and for one another. Good welfare comes little from money, institutional fealty, or compliance; it comes more from finding and tending shared experience, meaning, and relationship. Welfare practitioners motivated and gratified in this way are hardly ever 'poor performers'; conversely, if practitioners are unhappily frustrated in these ways they are unlikely to proffer the kind of care we, they, or anyone would want. This is what, in our zeal to 'modernise', we have so heedlessly sacrificed.

There is, currently, a rising swell of frustrated contention among practitioners alleging (with copious and substantial evidence) numerous examples of mismanagement by licensing, employing, or disciplining authorities. At their most 'benign' such allegations may be about out-of-touch incompetence; the rest sound tarnished with the corrupt and the malfeasant. Constructive dismissals, gagging orders, officious skewering by smallprint regulations, procedural obfuscation, persecution of whistle-blowers. All have become a familiar backdrop to reports of our unhappily neoliberalised NHS. Such fractious and pathogenic contentions were extremely rare in my first 20 years of practice: their current frequency surely tells us much about our discordant misdirection. The last couple of years have seen several legal challenges to some egregious and perverse misapplications of institutional procedurey.[a]

A PROFOUNDLY MISDIRECTED CULTURE

But we have here a much greater problem than whether correct procedure has been followed. Cardinal Richelieu well understood this: he could control and terrorise whoever he chose with his skilful (ab)use of the law. Legality is a frail buttress against a bad culture: the law's ethical integrity is only as good as its practitioners. A profoundly misdirected culture that is so often procedurally corralling, silencing, or eliminating its welfare practitioners is likely to be well armoured against legal challenge. The Stasi, with Germanic thoroughness, had many legal and policing devices and staff to deal with the dissidents and the inconvenients of the old German Democratic Republic. What chance would legal challenges have of changing the underlying totalitarian culture? It was the collapse of this totalitarian system that neutralised the draconian powers of the Stasi, not any formalities of legal process.

A worrying part of this problem is that officials exercising and abusing such draconian powers generally sincerely believe in the ideology that exonerates their actions. Officials in police states are usually otherwise unremarkable citizens who wish to side both with power and the right side of the law, whatever that happens to be. There are many reasons for this: retaining occupational status, security, and livelihood are obvious. But protecting a good self-image is another; cognitive-dissonance threatens this — we can keep that at bay, by denial, rationalisation, and doctored data. This is what happens when mistaken paths become culture. Thus totalitarian systems have few ready portals for challenge. And in this culture-medium our neoliberalised NHS has produced a fascinating variation of totalitarianism: we have managed to fuse the paralysed, paranoid, dispirited repression of the Soviet Bloc with the venal, opportunistic, heartless, and intimidating cunning of the worst of US capitalism. This is like a monstrous child misbegot by two struggling yet coupling parents.

I was talking of this with a senior manager of a large multinational organisation. He laughed with a kind of ironic, pitying recognition and then said, *'This is just how it is in our large corporations: that's how they operate. You shouldn't be surprised, and you certainly shouldn't take it personally … If I publicly challenged the ethos or strategy of my company I would be sidelined or eliminated very quickly. That would happen usually with great skill and stealth. How do they do it? Well, you'd best ask our HR or Legal Department — they're very good at it!'*

He smiled warmly, with a brief flash of strong white teeth. He was certainly right about large commercial corporations. It would be equally true in any dictatorship and any totalitarian organisation. And it is what we are struggling with now, in our NHS.

Yet this is a relatively recent development. Almost all older practitioners remember a very different service which — for all its unevenness and lesser capacity — somehow remained free of these traps. The discord now so evident was almost unheard of then, and the NHS was able to offer an overall quality of service that served as a worldwide beacon and model.

So if our NHS is more helpfully viewed as a living organism, rather than a machine, we can ask: what does it need in terms of protection, modelling, nourishment, living space, ambient relationships, motivational understanding, and caring recognition? If we can replant our best answers to these questions, we shall be much freer of many of our tangles. Hopefully legal and procedural challenges might, at least, help us focus on this larger task.

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Further reading

[a]For background data, evidence and examples, see: Doctors Association: www.dauk.org; The Centre for Welfare Reform: www.centreforwelfarereform.org; Our NHS our concern: www.ournhsourconcern.org; Doctors for the NHS: www.doctorsforthenhs.org.uk

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