# More funding, training, and recruitment? Or just more *Verschlimmbesserung*?

There is growing darkness at the (imagined) light at the end of the COVID-19 tunnel.

As the earlier massive tide-surge of the pandemic seems — for now — to be receding we have many reports of its legacy of damage and cost to our health care: not just delays and interruptions of sometimes vital treatments, but also of increasing staff burn-out, drop-out, and opt-out. And many of those who remain seem like heroically motivated runners staggering towards the end of a gruelling marathon — painfully determined to continue, yet collapsing into the arms of supportive and restorative care in order to recover.

Thankfully, the effects of this as well as the vicious criticism of GPs has been recognised.[1,2] These are serious problems to be neglected at our peril. Part of the remedy? Adequate funding for greater training and recruitment of staff. In a post-COVID-19, post-austerity era this may sound encouraging, but it raises many other questions, some very quotidian, others more fundamental yet obscure. How much funding is 'adequate'? How will this be raised, distributed, and secured? If we recruit medical and nursing staff from other (often much poorer) countries — what are the ethical and practical (elsewhere) consequences of this?

## COMPUTERISATION AND THE NEW ECONOMICS

But there are much greater and deeper rooted problems that threaten our NHS workforce than this COVID-19-induced concussion: the insidious and cumulative demoralisation and depersonalisation of healthcarers who have lost a sense of vocational pride and satisfaction, and collegial trust and belonging in their work. This deep and widespread dissatisfaction among so many nurses and doctors far precedes the super-added — albeit far more dramatic — COVID-19-crisis. Perhaps because this erosion of spirit and morale has been more gradual and incremental, its substantial damage has received little sustained attention from governing and managing authorities. Despite many years of growing evidence — for example, falling recruitment, failing health, increased early retirement, and career abandonment among primary and mental healthcare workers — little attention has been paid to the human meaning of this. This inattention is highly selective and thus tells us much about the nature of our problems.

For the last 30 years there have been successive NHS reforms that may be seen as shifting attention, with increasing resources and precision, to money and metrics. The pioneering neoliberal agenda of the Thatcher era converged with the excited early development of digital technology: this enabled the mass-management and commodification of health care, and thence to marketised commissioning, monitored performance, and regulated compliance — together these are most compatible with corporate tendering and contractual negotiation. All this was much less possible in a previous world informed by mere ledger-books and managed by variable human good faith and judgement. The combination of computerisation and the new economics could then reform health care to become more and more like competitive commercialised manufacturing industries — like a giant web of siloed factories.

## BONDS OF CONVIVIAL TRUST

Before such serial reforms the NHS functioned more like a relatively informal network of families than a system of contracted factories. This analogy can tell us much about the pre-1990s NHS and its strengths and weaknesses. As with real-life families there was much variation: there were those that were dysfunctional, even hazardous; but most resembled happier families that functioned well with flexibly adapted bonds of convivial trust that grew from personal familiarity, shared experiences, and bespoke understandings. These bonds of personal identifications were shared between the healthcarers and their staff, and then with their patients

— a professional community caring for a wider community. This sense of belonging nurtured deeper senses of shared context, meaning, motivation, and purpose. This was exemplified by how we looked after and looked out for others: the bedrock of personal continuity of care — the Family Doctor.

It was such 'organic' growth of familiarity, community, and care that sustained the practitioners' deep work satisfactions and thus the mostly buoyant morale, excellent recruitment, and staffing endurance and stability of pre-1990s general practice. GPs liked their work: despite working hours being longer and the pay no better, they usually retired late with poignant reluctance and reciprocated affectionate gratitude.

## *VERSCHLIMMBESSERUNG*

There is a German word — *Verschlimmbesserung* — which means trying to fix things, but making them worse. This accurately describes much of the legacy of those serial reforms that did not see, heed, or understand the organic nature of health care's complex human ecosystems and thought short-circuiting

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these to inorganic industrialised systems would be more 'efficient' and cost-effective. This often draconian process — from Family to Factory — was often answered with protest, argument, and mounting evidence of its unpopularity, inefficiency, and damage. But such reforms, once rolled out, are very difficult to roll back.

The tragic portents of the consequently dispirited and sickening NHS workforce — wrought by its no-one-knows-anyone-but-just-do-as-you're-told culture — have been very evident well before the pummelling of COVID-19. But that ethos, in its zealed mission, blinded those who designed and managed it.

## NOW WE FACE THE POST-COVID-19 DENOUEMENT, WHAT WILL 'BUILDING BACK BETTER' MEAN?

It will be another extravagant folly to train and recruit a larger tranche of healthcarers if they do not want to stay with us, and for us, for a long working lifetime. And yet they are only likely to do this if their working milieu is one of greater belonging, trust, and satisfactions that can dovetail with personal vocation and identification … as so often happened before our serial reforms.

How can an industrialised system, particularly one yoked to corporate and commercial interests, ever fulfil these conditions?

**David Zigmond,**
Retired GP and psychiatrist, London. David has written and campaigned on problems within the NHS for several years: http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html

**Email: Zigmond@jackireason.co.uk**

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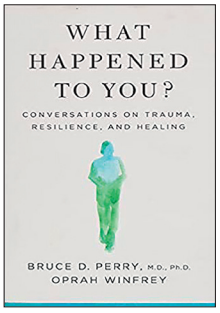
**What Happened to You? Conversations on Trauma, Resilience, and Healing**
**Bruce D Perry and Oprah Winfrey**
*Bluebird, 2021, HB, 304pp, £13.39, 978-1529068467*




## EXPERIENCES OF ADVERSITY

Dr Bruce Perry is a leading neuroscientist and child psychiatrist based in the US, who researches the impacts of childhood trauma on children and adults. He wrote the best-selling book *The Boy Who Was Raised as a Dog: and Other Stories from a Child Psychiatrist's Notebook — What Traumatized Children Can Teach Us About Loss, Love, and Healing*. Here he teams up with Oprah Winfrey and the book is presented as a conversation between the authors, which makes it feel accessible to take on the emotional and, at times, technical content. Dr Perry's science and evidence-based approach will engage doctors, while Oprah's curiosity and storytelling helps to lighten the subject matter.

The main purpose of the book is to shift conversations away from 'what is wrong with you?' to 'what happened to you?' By understanding people's pasts, we can understand why some behaviours develop in adulthood. Children who have grown up in emotionally or physically neglectful environments have to adapt to cope and get their needs met. These behaviours can become maladaptive in later life, and negatively affect adult relationships and wellbeing. The book helps the reader to make the connection between current thinking/feeling/behaving and experiences in the past. As GPs we see the impact of these maladaptive behaviours, for example, patients struggling with difficult relationships, low self-esteem, anxiety, depression, addiction, low health motivation … the list goes on.

Dr Perry explains the limitations of focusing on Adverse Childhood Experience (ACE) tools. These tools were designed for population-level research and they are valid and useful in this context only. He explains that defining an event as traumatic depends on many variables including the timing, the specific event, the experience, and the effects, rather than an incomplete tick sheet of 'adversities'. We shouldn't give individuals a 'score' on the ACE tool even if a high 'score' increases the risk of many conditions in adulthood at a population level. It is more helpful to focus on the individual's experiences of adversity. Dr Perry also shares his cynicism about labelling people, services, or even countries as 'trauma informed.' It is impossible to become truly trauma informed from a workshop alone!

This book also helped me think about racism and how implicit bias can develop. How being from a minority group within a majority group is a traumatising experience in itself. Feeling 'other' can have lasting effects. Dr Perry talks about how trauma can pass through generations, even if this isn't a genetic change. He gives the example of black Americans 'inheriting' a fear of dogs from when they were used aggressively to attack civil rights marchers. Their children would detect the fright and develop their own fear, which they too can pass on to their children.

There is an explanation of self-harm too. People with a sensitive dissociative response to stress, due to previous trauma, can experience an opioid release when they cut themselves. It can even become addictive for this reason. Most people have developed their own ways of dissociating from stress, for example, exercise, reading, eating, alcohol. Obviously some ways are healthier than others. There is a discussion about resilience: how this can develop and be nurtured in children through small manageable episodes of psychological challenge. There is plenty of hope, with an explanation of post-traumatic wisdom and how people can have the capacity to heal from huge trauma. So many of the concepts within this book are relevant to the patients we see every day and are presented sensitively and accessibly.

**Hannah Milton,**
Hannah is a GP, a mum, and a runner.

**Email: hannahmilton@doctors.org.uk**

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