Volume 25 • Number 4 • Winter 2018

Humanistic Management: an alternative way of organising

Journal of the Association for Management Education and Development

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Thanks to our friends at Triarchy Press for their continuing support.

Cover image: A Gaudi mosaic: photo by Christina Schwabenland

Rehumanising General Practice?

A cautionary tale

David Zigmond

Small General Practices used to be very common, and mostly popular. Yet, due to current healthcare policies, they are now increasingly rare and almost extinct. What are we losing? This is my story as a long-serving London-based GP: I write of recent experiences of being forced to close my much-loved practice in the teeth of what many perceive as non-humanistic management on the part of regulators.

Keywords

general practice, regulation, inspection, Care Quality Commission, non-humanistic management, clinician-patient relationships, resistance, dialogue, grief

Introduction

Industry regulators employ cadres of inspectors who visit organisations' premises to assess the quality of providers' work. This is an important job and necessarily confers considerable powers. A case in point across Welfare services (note 1) is the Care Quality Commission and its responsibility for assessing the state of GP doctors' practices. Regulators operate by defining a system of a 'best-practice' framework and then construct rules and processes as the basis for assumed objectivity in assessing and then applying a rating (note 2). Inspectors' work is often controversial, generates fear, and tempts those being assessed to lie low and game the system. A damning report can close an organisation. Such power can be maladroit or even abused – displaying a lack of humanity towards those who fall short. A high price can be paid for being honest with inspectors.

I write this cautionary tale as a GP who spoke his mind to inspecting authorities who were insistent on demonstrating command and control at all costs. As always, I attempt to do this in a manner that is courteous, principled and well-argued.

Context

I am a London-based, independently minded GP whose practice was closed down by the regulator, using what I experienced as a heavy hand to direct an industrial production model. By contrast, I, instead, inclined to a personal service that offered greater primacy to doctor-patient relationships. Inspectors found excessive variation against their standard framework. Yet this prohibition of variation often destroys a greater wholesome variety – the kind that may best respond to patients' diverse human circumstances and needs.

Colleagues and patients attest to my impeccable 30-year-old record as a GP, running a practice that was enduringly popular for what I could offer my patients. Much of this is due to my devotion to holistic perspectives of medical care and to my background in psychiatry. By contrast, inspectors perceived me as difficult, resistant, often recusant to current trends, and questioning of the views and imposed formulae of experts. Rather, regarded by many as old fashioned and gentlemanly, I have endeavoured consistently to express polite contention, and to remain open about what I regarded as my thoughtful and selective non-compliance.

This stance cost me my job.

I believe that there is much to learn from this case about how quality of performance can best be regulated, assured and improved other than by resorting to criminal-type litigation, as happened to me. In writing this piece, I hope that an understanding of my first-hand experience may help to make the case for much-needed reform, possibly influenced by aspects of humanistic management.

Background to my story

In 2016, following a sharply officious and uncompromisingly formulaic inspection by the Care Quality Commission, my small general practice was closed down by the regulator of GP practices unexpectedly with immediate effect (note 3).

Location and vocation – some grand entrances: St James Church, Bermondsey (Home to the author's NHS surgery for nearly three decades)

For thirty years, my unusual practice had operated out of a rented section of an active 1830 church in Bermondsey, south London, UK. It had been exceptionally and consistently popular with patients and staff. There was no history of alleged dysfunction or hazard. But my practice was traditional and had long been resisting the tide of larger, multi-partner – even corporatised – primary care health centres increasingly favoured by government (note 4). And the practice was conspicuously and outspokenly old-fashioned in cleaving to an erstwhile style and ethos of personal and family-doctoring.

My GP practice embodied my own character, including my deeply-held beliefs and values about clinician-patient relationships. In place of the recent imperatives to increasingly apply procedural and reductive approaches, I championed the medical profession's better traditional practice: a more personal and holistic approach to medical diagnosis and treatment. I thought that treating physical symptoms in 10-minute slots – slots that have resulted in GPs becoming, also, increasingly personally unfamiliar with patients and their lives – was akin to an automated factory production line. While some medical conditions would reliably respond to generic 'best-practice' solutions, many could not: this is because the patient's particular mental state and personal subtext are often quite as important as any generic considerations.

A case of non-humanistic management?

My practice had come to occupy an outlier status in the GP health sector. It no longer fitted the Care Quality Commission's increasingly formulaic mould; the regulator's requirements and inspection questions were designed to suit much larger practices in modern buildings – they thus followed the government's preference for large, multi-GP practices. Awkwardly and embarrassingly, my practice bucked the trend.

But why should this be such a problem? Why the rush? What was the risk to my patients? And why was the regulator's goal of closure pursued so ruthlessly?

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The end of one's contractual employment usually terminates all legal responsibility. But what about our moral responsibility toward unattended compromises we know we are leaving? Though my practice had been quickly killed off by the CQC, I wondered: how well can ghosts speak for and to the living? Doggedly, I chose to fight the CQC intellectually, challenging its organising principles and modus operandi. I wrote numerous articles and engaged in lengthy correspondence with CQC's leadership of its GP practices team. If not a thorn in the CQC's side, to them I became a campaigning and time-consuming nuisance.

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I reject much of the over-managed and routinized factory-type model with which so many doctors are now, increasingly, required to comply. I challenge the CQC's lack of careful understanding and engagement with my community of satisfied and loyal patients and staff. I am saddened by the CQC's lack of wisdom and interest in my employment situation where my long and distinguished career was approaching retirement within a few years. And I reject the CQC's draconian powers where, here, its zealously pursued bureaucratic, so unintelligent, tick-box enforcement model so harshly and thoroughly eclipsed wiser, good-practice improvement guidelines ("Are cobwebs visible in the ceiling space" Yes, Fail. "Is there a book recording dates when fire drills were conducted for the three staff?" No, Fail).

The author receiving his Positive Deviancy award from Dr William Tate

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For my energetic campaigning, I received the Positive Deviancy category award at an international annual leadership event held in London in November 2016.

Below, I tell more of my personal story.

My personal story

> *"Our factory-type healthcare will deal poorly with those many human ailments that need different kinds of personal engagement for their relief and transcendence. These require healing encounters that mobilise the sufferer's internal resources for immunity, growth and repair. These*

are subtle and delicate activities and – importantly – cannot develop in a factory culture, whose structure and function both depend on rigidity (like a vehicle chassis). They can only emerge and thrive in a family-type milieu where structure and function and strength are linked to flexibility and elasticity (like a tyre)."

[Zigmond, 2015, pp 463-470]

On Friday 8th July 2016, my practice staff received a phone call at 6pm from CQC informing me that I am summonsed to appear at Camberwell Green Magistrates' Court the following Monday morning, 11th July 2016. Because I was travelling abroad, I did not receive the message until a few hours before the hearing.

The Care Quality Commission had applied to "urgently cancel the provider's registration under section 30 of The Health and Social Care Act 2008 on the basis that there were several breaches of the 2014 Regulations which presented serious risks to people's life, health or well-being." All of the accusations against my surgery concerned processes and procedures. My popularity and respect amongst patients and staff were not disputed, nor was my actual record.

My request for an adjournment to seek legal representation was declined and, after an eight-hour hearing, the surgery was ordered to be closed immediately. Patients arriving for their appointments on Tuesday morning were confronted with a 'Surgery Closed' notice on the door.

Consequences of management adrift from humanistic anchorage

Clearly there was an anomaly here that continues to deserve our fuller understanding. Among the many factors contributing to this anomalous judgement and execution are five that are widely observed to be now problematic throughout our Welfare services, yet epitomised in this single outlying practice (note 5):

1. The UK's public health and Welfare sector has witnessed increasing standardisation and regulation regimes that, by definition, then cannot intelligently encourage or respond to a variety of contexts and to more subtle aspects of patients' needs.
2. A tick-box culture results. Put starkly, this reduces all problems and remedies to systems of executive-commands mandating employee-obedience.
3. This has led to a vast command-and-control regime that inevitably requires considerable resources and management. This, in turn, necessitates the development of what I call REMIC (remote management, inspection and compliance) – the increasingly algorithmic and automated ways of monitoring, assessing and controlling the workforce.
4. In particular, this has led to the gathering official disfavour of small practices, partly because of their greater difficulty interacting with burgeoningly complex bureaucracy and compliance requirements. Yet the high popularity of small practices with many members of the public has remained, both because of – and despite – this fact.
5. REMIC, like so many systems of automation and mass production, tends increasingly to become a hermetic system, accessible to, and modifiable by, only a small cadre of designated and privileged 'experts'. Intelligent and open dialogue becomes ever harder outside of this elite; compliance to managed procedure becomes pre-eminent, if not coercive, in the assurance of professional survival.

All this has become clearer with my experience at the hands of the CQC. It has long proved almost impossible for any practitioner to meaningfully engage the relevant authorities (in particular here, NHS England and the Care Quality Commission) in candid discussion. I had hoped that my sudden and enforced retirement might reduce my spectred threat or perceived impertinence-rating: not so. Courteous and thoughtful letters from me (see Section G of my Home Page) inviting from them responses in kind have been answered (if at all) by formulaic and defensive types of wariness that are more informed and limited by didactic regulations and computer templates than any openly thoughtful minds.

Despite my most thoughtful and diplomatic efforts, I received only procedural obstruction to my invitation to a more open dialogue. There are many others – a 'silent majority' – who also wish for such a dialogue but are now too professionally wearied or afraid to pursue this, or in any way directly challenge governing authorities.

So, what, from here, is the best course?

The following, a fictive essay, is one response: I have here constructed an imaginary dialogue between the REMIC authorities and myself (DZ). While the dialogue is clearly fictitious, the problems discussed are very real. In this 'conversation' I have tried to imagine how REMIC would respond were they to take part in such an exchange, now, in a spirit of what might be understood as humanistic management.

A fictional dialogue

How may we replant our human sense? First steps

REMIC: Why are you still contacting us, after all this time?

DZ: Well, I've long wanted a broader conversation … Not just about my own case, but what it represents throughout Welfare services … Many people continue to contact me about it.

REMIC: Look, we're not here for such 'broader conversations'. We're getting on with an important job to help the public. We do that using established and transparent procedures. If you think we haven't followed those procedures correctly, then you have every right to an appeal: that, again is a correct procedure. We note you haven't followed it.

DZ: Well, the reasons are pretty substantial…

REMIC: Meaning?

DZ: I was seventy years old at the time of my decommissioning. My practice income from real work was falling, while my regulatory and compliance expenses kept rising (note 6). Like many small practices I was doomed to extinction.

Most important, though, was that the way I was closed down made it almost impossible for me to ever reopen…

REMIC: Why is that?

DZ: Well, I was immediately stopped from working. So my patients had to be cared for elsewhere, and a final 'closure payment' was made to my practice. But my reception staff etc would need security of future payments and jobs and I couldn't vouchsafe these during a lengthy appeal process … I couldn't continue to pay them for an indeterminate period for an unsure future. Being realistic, they would have to find other jobs. And, being equally realistic, I would never be able to replace them with people of equal calibre. Who would give up a good job to join a battling septuagenarian? I knew I was finished by this strike: I couldn't get back onto my feet again.

REMIC: No, those are not our considerations. But, again, you could have appealed.

DZ: Well I could, but without hope of success, yet incurring much expense and stress. REMIC is a large corporation which simultaneously is the executive, the judiciary and the jury and has funds and lawyers aplenty. I am an outlying septuagenarian with no ready funds or lawyers, who has been very selectively non-compliant with – and therefore in breach of – REMIC-managed contractual regulations. How could an appeal possibly succeed? … So I decided to continue to argue my cause, but to cut my losses before martyrdom.

REMIC: Beyond your own hurt and losses why do you think your cause is so important?

DZ: Well, I see the incremental effect that the machinery of REMIC has had on our healthcare culture. Look at us! We are a sickened and demoralised profession. If you want statistics there are many to show the extent of our dispirited trouble: poor recruitment, career abandonment, earliest possible retirement, retreat into 'portfolio careers', widely varied physical and mental illness, intra-institutional litigation, drug and alcohol abuse, marriage and family breakdown … and …

REMIC: OK, OK. And your point is?

DZ: That if we're not very careful REMIC increasingly generates more problems than it can solve. In my working lifetime I've seen the collapse of my profession's heart, art, spirit, soul, intellect and wit. And other Welfare services, with their own kinds of REMIC, report much the same (note 7) …

REMIC: That's quite a list! We can't be held responsible for all that, surely?

DZ: Well not personally, and not completely. But it's like any partially-sighted yet overdeveloped public system. It becomes dysfunctional because it becomes both hermetic and then difficult to change or steer. And then all participants are forced into one of three roles: perpetrator, victim or bystander. There is, however, a fourth position: opponent, but that has its own problems, as you can see. So direct opposition from employed practitioners is frightened into retreat and hiding.

REMIC: We've heard this from you before and think it's unfair. It's certainly not our intent…

DZ: OK, probably not to begin with. But all sorts of social and political campaigns have a horrible tendency to turn into something quite different. And then avowed intention becomes very different from consequences. Shall I give you some historical examples?

REMIC: No! We don't need all that from you. What we're trying to do is quite straightforward. We're assuring for the public the quality of their health service: its compassion, competence, comfort, efficiency and safety. What can be wrong with that?

DZ: Only that you're conflating your mission with your method.

REMIC: What does that mean?

DZ: Well, few people are going to dispute your mission. Who would? But almost all experienced practitioners who are not defending a governing position have much more doubt about REMIC's methods. How can we possibly fulfil a mission if our method can't even get people to do, or stay in, the job? What kind of care can we offer others if we, ourselves, are dispirited, insecure, harried and harassed (note 8)?

REMIC: One of our concerns about you is that you seem to be against all organisational rules, regulations, checks and disciplines. You don't seem to see the necessity for any of it … In our view that makes you look very risky.

DZ: Hm! I'm in the same boat as you, then: that's not my intent, but those are the consequences. I apologise for you misunderstanding me. Look, I'm not that kind of nihilistic anarchist. I believe all structures, strictures and penalties have their place and value, but that such placement and value are complex matters needing endless thought, editing and navigation. We have to understand how something good in one context can be very harmful in another. Our structures must often be tempered by flexibility. We have to understand how some grand schemes spawn even larger, however unintended, problems …

REMIC: So how much institutional direction do you believe in? Will you submit to?

DZ: Well, I'm certainly not going to give you a figure! Let me answer with a metaphor. The health service used to mostly resemble a well-functioning family, which depended on appropriate trust, commonality, personal understanding, overlapping and interchangeable responsibilities and flexible judgements about these. But our reforms have attempted to disband the 'family' and replace it with a network of factories, where all these 'family' qualities are replaced by rigid command-and-control procedures, protocols and instructions.

Sometimes parents will attempt to bring up their children in this way – they are over-structured, overly strict, intrusive and controlling. They say: 'we are only doing what is best for them, for the family.' The long-term results, though, are usually very different to what they say they intend …

REMIC: But all our procedures and disciplines are there for good reason. Overall they are there for everyone's safety and protection. Abandoning those responsibilities would lead to much greater problems, dangers and harm. Do you not see that?

DZ: OK. I agree that REMIC is not the same as, say, a military dictatorship! What I am saying is that, if we are not careful, there are similarities in process and outcome.

REMIC: But what about our public responsibilities?

DZ: Look, let me repeat an important point: I agree with your concern and your mission, though clearly and often, not your method.

Perhaps it will help my mission to make these distinctions:

- Creative dissent is different from destructive anarchy.
- Outliers to systems are not necessarily bad; they may even be outstandingly good.
- In history, Galileo, Gandhi, and Martin Luther King were outstanding conscientious objectors. In contrast, the millions who automatically obeyed governing authorities brought us … what?

  I'm sure you can fill in the gap.

REMIC: Yes, yes. History, the herd, the compromised individual, the corrupted mission. But what about our question about public responsibility?

DZ: Of course, but I think we've become paralysed with anxious confusion and lost sight of this: in the Welfare sectors most workers want to do good work with good care. Generally, this is what they will do as long as they get good human contact, encouragement and satisfaction from their work milieu. But the inverse is also true: If welfare workers are frustrated in their human and vocational satisfactions, no amount of regulations, rules, trainings and inspections will remedy a failing service. That is what we have now: a tendency to draconian and forensic management attempting to control – yet actually further damaging – an ailing service. Flogging a dying horse.

… and this brings me back, REMIC, to your first question: 'why am I still trying to discuss all this with REMIC authorities?'

Different kinds of grief

In a way I am trying to heal my own grief, of both private and public kinds. Let me differentiate.

There is my private grief for the ending of my much-loved role, my practice, familiar and dear people and daily time-structures, my reciprocated significance for others … If we live long enough, we all have to face such losses, so they are universal and inevitable as well as private. You may be sympathetic, but you cannot otherwise help me with this.

My other kind of grief may be publicly generated but must be privately borne. It is about the cultural loss of certain kinds of relationships and shared values. For the first half of my long career I was blessed by welfare work that – for the most part – could grow healthily in a wholesome and trusting (yet inevitably flawed) 'family'. The second half of this working life has seemed like an accelerating and enforced march to work in a series of mistrustful and depersonalised, REMIC-controlled 'factories'.

What I learned, how I practised, and how I taught were all anchored in this earlier vocational, fraternal ethos. My grief is about the systematic deracination and destruction of all this: it exceeds what I personally have lost; it is more about what I am leaving behind, in the public sphere, for others. So it is a transcendent and transpersonal grief.

This you can, certainly, help me with.

REMIC: So we're not just the bad dictators, then?

DZ: Not so long as you invite discussion and debate. There's more hope for all of us then.

Some conclusions

Regulators' approaches follow cycles, as they try various assessment philosophies, while assuming or pretending they have found the right answer. And then these new 'solutions' become the diktats of whoever is then the current responsible government minister. Eventually the cycle becomes tired, the benefits are outweighed by the burdens, public and professional support wanes, the minister is replaced, and new regulators and inspectors are appointed who call for the adoption of a new model. Where there has previously been a single-minded focus on outcomes, this is replaced by a focus on inputs and throughputs which means a plethora of rules and protocols that are assumed to better deliver political ends … until that formula too, in its turn, tires. Such approaches often play into politicians' need to demonstrate decisive commitment via expedient 'one size fits all' regulations (note 9).

Ofsted's new approach to schools' regulation makes an interesting comparison with this example I have here considered from the health sector. Amanda Spielman, the new chief inspector of schools, outlined details of the new Ofsted inspection regime ('Ofsted inspectors to stop using exam results as key mark of success – watchdog chief outlines new inspection regime judging schools on quality of education', Guardian 11 October 2018.).

Spielman considers that "For a long time our inspections have looked hardest at outcomes, placing too much weight on test and exam results … Instead, schools would be judged on quality of education". She interprets this as focusing on "the curriculum taught within a school, rewarding those schools that offer a broad range of subjects". Spielman's appeal to greater human sense and wisdom was congratulated by the profession for her flexibility as a 'breath of fresh air'.

Perhaps the CQC might take a leaf from Spielman's book and, instead, focus on the real-life quality of each GP's provision of good healthcare – as opposed to mere procedural compliance. In doing so, it needs to look again at its forensic – even draconian – approach (see reference 3 below), one that employed a legal team to close down, with peremptory zeal, an outlier GP practice such as mine of otherwise excellent record and repute. This rigidly procedural style of management then swiftly deracinated a practice for positive variations it no longer had the capacity to observe, to tolerate or to thoughtfully understand.

Indeed, as the CQC effectively claimed in court with regard to my case:

> *"We have rules and regulations designed to ensure good safety and probity. We expect evidence of compliance with these. Failure to demonstrate this to our satisfaction thus becomes a definition of errant and outlawed practice. This GP practice failed to comply, is therefore unsafe, and must be closed forthwith."*
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> [CQC – 11 July 2016]

Crossing the Rubicon: the author swimming in the Thames after work

Acknowledgements

I gratefully acknowledge the generous assistance of Dr William Tate of the Institute for Systemic Leadership in preparing this article for publication.

References, further reading and notes

Zigmond, D. (2015), *If you want good personal care, see a vet.* New Gnosis Publications

Zigmond, D. (2015), pp 197-205, *From Family to Factory*. New Gnosis Publications

All other referenced articles are available via my Home Page, www.marco-learningsystems.com, Sections D, G and L.

1. In this article *Welfare*, when used with a capital 'W', refers to government-delivered services. This differentiates it from welfare – our unmanaged and 'natural' empathy and beneficence with one another.
2. Using an industrial analogy, the CQC judges and regulates the methods of production, but not the product itself. Thus, in the following example, my practice was closed, but my competence and license to practise elsewhere remained unchallenged.
3. *Death by Documentation. The penalty for corporate non-compliance and Introduction.* Articles 73 & 74, Sections G and L. Written the week after the coerced closure, this provides a freshly graphic description of events.

4. *Obituary: St James Church Surgery 1987-2016: the demise of small General Practices. A personal celebration and lament.* Section D. This portrays the kind of general practice that are subject to plans of elimination, and gives reasons why.
5. *Collectivising the Personal. Seminal lessons from Bolshevism.* Article 100, Section L. This takes a long and broad view of such problematic management. Equivalents are found throughout Welfare services and large events in 20th Century history.
6. The current regulations and financial arrangements have become starkly inimical for small practices. For example, at the time of my decommissioning my practice list size was only slightly below average, yet my hourly working pay could allow a rate only 10% above my receptionists. This has become a common predicament for the few small practices that manage to survive: such practices are now running more on vocation than viable funding.
7. The Centre for Welfare Reform has documented many such problems across our Welfare services.
8. *General Practice used to be the art of the possible, but we have turned it into a tyranny of the unworkable. Reflections on our inspections regime.* Article 75, Sections G and L. This essay was written originally for NHS England, the year before the practice's closure. It forewarned our services' wider, now burgeoning, tribulations.
9. The psychological and social damage within our Welfare services wrought by our current regulation and management regimes is outlined in a report for the King's Fund: *Industrialised healthcare: how do we replant our human sense?* Article 109, Section L.

About the author

Dr David Zigmond is a veteran NHS doctor. He has worked as a psychiatrist, psychotherapist and small-practice GP. For more than forty years he has taught and written about the nature and importance of holistic and humanistic healthcare. In recent years he has drawn attention, particularly, to the serious consequences of neglect of these principles.

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About the Humanistic Management Network and AMED

The Humanistic Management Network (HMN) is an international group of practitioners and academics who share a concern that organisations exist to benefit society. Humanistic management is based on three principles; 1) respect for the dignity of each person, 2) ethical organizational decisions and processes and 3) on-going dialogue with multiple stakeholders. Humanistic management (HM) can be a driver for sustained business success and can reduce the cost of conflict, high levels ofContents stress-related absence, and the costs of raising capital. But HM principles are not shared by everyone and are increasingly under threat. As the newly-established Humanistic Management Network UK Chapter, we are very open to your suggestions and ideas about how we can develop and grow.

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