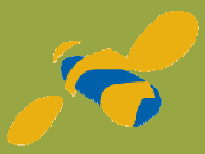
Love's Labours Lost

Why society is straitjacketing its professionals and how we might release them

Michael Shea Memorial Lecture
Edinburgh, September 2012



Dr Iona Heath

International Futures Forum

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Why society is straitjacketing its professionals and how we might release them

Dr Iona Heath CBE FRCP FRCGP

Michael Shea Memorial Lecture, Edinburgh, 10 September 2012

I am a doctor. So when talking about professionals I all too easily slip into talking about doctors. Forgive me – my intention and hope is that everything I have to say about doctors applies to a greater or lesser extent to teachers, social workers – indeed to any group who have been previously described as public servants.

My title is 'Love's Labours Lost'. In order to explore it we need first to understand better what exactly constitutes 'a labour of love'.

Labour of Love

The phrase is derived from the Bible and it seems to have two possible characteristics. First, work undertaken from fondness for the work itself and/or secondly, work that benefits persons whom one loves. Both of these characteristics are relevant to the work of public service professionals.

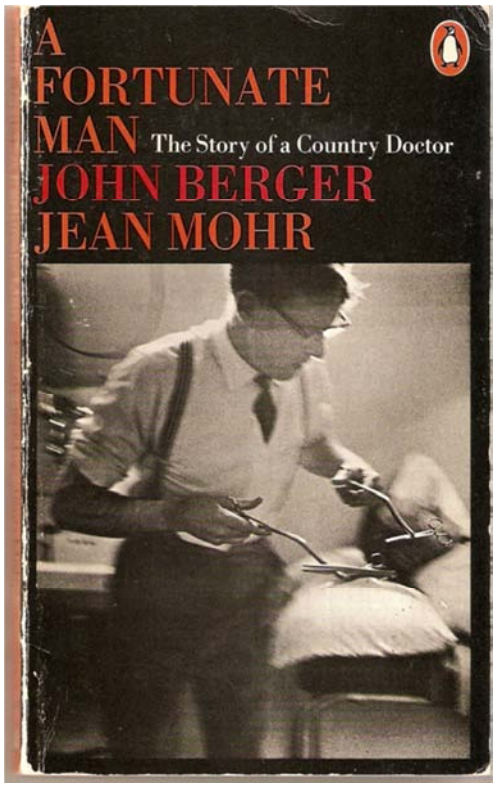
Love in the sense I am describing is derived from the Greek word 'agápe'. This is usually translated as love, but in the King James version becomes charity which I find intensely unsatisfactory - it is perhaps closer to beneficence or altruism. It is the sort of disinterested but unconditional commitment needed by professionals.

Agape is one of the four Greek words for love, the others being eros for sexual love, philia for the love of friends and storge for family love. It is surprising that a language as rich as English has to cover all four with just one word.

I am reminded of Sabin's wonderfully titled paper in the British Medical Journal *Fairness as a problem of love and the heart* in which he says: "We clinicians can love our patients and the population they are a part of only when we can comprehend the needs of both in emotional as well as clinical and epidemiological terms."[1]

He continues: "Being able to do this depends partly on whether our clinical education and professional ethics include public health as well as individual care values. But it depends at least as much on a political process that addresses priorities and rationing in the same caretaking spirit that the best clinicians apply in the care of their patients. This requires a political leadership that has been comparatively rare to date." In terms of political leadership, that would perhaps seem to understate the case.

So let's go back to 1967 and what is in my view the greatest book ever written about general practice, about what I tried to do every working day for more than 30 years. In *A Fortunate Man*, John Berger describes his friend John Sassall:



"His satisfaction comes from the cases where he faces forces which no previous explanation will exactly fit, because they depend upon the history of a patient's particular personality. He tries to keep that personality company in its loneliness.

This is most certainly a description of a labour of love.

Yet by 1996, in his book of essays *Photocopies,* John Berger is writing this: "I have come to mistrust most doctors because they no longer really love people."[2]

From the author of *A Fortunate Man*, this is a devastating indictment.

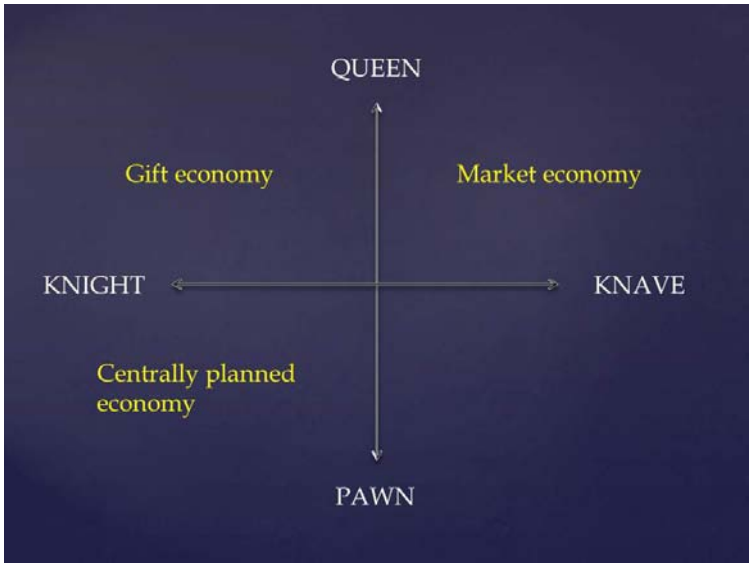
Knights and Knaves and Altruism

What had happened in the intervening years? For one thing - the government of Margaret Thatcher: a nadir for the politics of hope, inclusiveness and social solidarity.

Then there is the thinking espoused by the economist Julian Le Grand who himself became part of the problem as the health adviser to the No 10 Policy Unit under Tony Blair. He has written extensively about what he refers to as "knights, knaves and pawns" in social policy.[3]

He puts Queens and Pawns on the vertical axis and knights and knaves on the horizontal (see over) in order to identify a number of different domains.

He claims that in a centrally planned economy professionals are seen as knights acting entirely altruistically while the recipients of services are seen as pawns, passively grateful for what they get.



With the shift to a market economy, pawns become queens because 'the customer is always right' and professionals are recast as knaves who can be assumed to be acting in their own interests unless constrained by regulation.

When I embarked on my career in 1974, to be a public servant was to be doing something good. But by the end of the 1980s, the same role had become, through a painful and demoralising process, somehow despicable. Economists argued that the only effective incentives were financial.

What disappeared was any trace of a gift economy within which professionals remain knights but recipients can be queens – in a context of reciprocation and solidarity. Teachers stopped teaching sport after school. Doctors looked to give up out of hours care. Once altruism was no longer acknowledged and valued, it began to wither.

In his essay 'The Moment of Cubism', John Berger quotes from Apolllinaire's last long poem *La Jolie Rousse:*

> Pity us who fight continually on the frontiers
> Of the infinite and the future
> Pity for our mistakes pity for our sins

And this too was what was lost in the Thatcher years – any sense that public service professionals work every day along these frontiers of the infinite and the future, that mistakes are inevitable however hard one strives. Any attempt to understand the nature of the professional task all but evaporated from the consciousness of politicians.

As Ballatt and Campling say in their book *Intelligent Kindness*, "It is easy to forget the appalling nature of some of the jobs carried out by NHS staff day in, day out – the damage, the pain, the mess they encounter, the sheer stench of diseased human flesh and its waste products."[4]

False Certainty

All these trends represent an ever greater assertion of a crude reductionism - in both science and economics. These have been the driving forces of each successive attempt at 'reform', be it in the health service or in education. Both deal only with objects and make no concession to the subjectivity of either the recipients of services or of professionals.

Both deal in false certainty. Both treat the body as a machine and medicine as the pursuit of technical solutions. Both are disconnected from any notion of human suffering. Yet contrary to much we are told, medicine is not engineering, the body is not a machine and there are no easy answers.

The trends have been towards certainty and control. Certainty pretends that there are always right answers and this illusion becomes the basis for control and coercion.

The Nobel physicist Weiner Heisenberg argues against this grasping at certainty: "One may say that the human ability to understand may be in a certain sense unlimited. But the existing scientific concepts cover always only a very limited part of reality, and the other part that has not yet been understood is infinite."[5]

And lines from Love's Labours Lost seem to say much the same thing:

> If study's gain be thus, and this be so,
> Study knows that which yet it does not know.

There is always more to learn, more to understand.

False and premature certainty – the delusory idea, for example, that we fully understand the causes of illness and disease and how to intervene; or how children learn and the best way to teach – all this closes down our curiosity and constrains the reach of our minds.

Yet, as the American anthropologist Clifford Geertz has it, "the reach of our minds, the range of signs we can manage somehow to interpret, is what defines the intellectual, emotional and moral space within which we live."[6]

False certainty constrains the intellectual, emotional and moral space within which we live – and sabotages that sense of wonder described by Shakespeare – again in Love's Labours Lost:

> These earthly godfathers of heaven's lights,
> That give a name to every fixed star,
> Have no more profit of their shining nights
> Than those that walk and wot not what they are.

Power... and Resistance

The waning of professional power is portrayed as being in the interests of patient autonomy but its replacement by corporate power within a market economy may compromise patient autonomy even more destructively.

It is the interests of corporate profit which underpin the diminishing of both patients and doctors to replaceable units - one of health need and the other of healthcare provision. These trends are generating huge and increasing commercial profits and are shifting attention and investment within health care from the sick to the well, from the old to the young and displacing care mediated by touch with a system driven by paper and computers.

These trends operate in the interests of politicians because a system in which the agents are interchangeable is much easier to organise and to control and it also minimises the possibilities of physicians and patients forming political alliances with the potential to draw public attention to the deficiencies and failure of government. The trends operate in the interests of global capital because markets are maximised wherever consumers and employees can be standardised.

Yet, the exercise of power always breeds resistance. As Eliot Friedson puts it, "substituting [bureaucratic] arrangements for trust results actually in a Hobbesian situation, in which any rational individual would be motivated to develop clever ways to evade them.... An enormous variety of empirical studies carried out over the past half-century has shown that, when they feel no loyalty to it, people do not passively obey, but instead actively seek ways of 'getting around the system' wherever they can. Heavy-handed emphasis on individual material incentives or on conformity with bureaucratized standards can be expected to lead to manipulation of the system to the detriment of policy intentions."[7] I think we see these processes in action across the public services.

Risk and Contingency

On top of all this, also as part of the culture of control, we have powerful new strands of rhetoric about risk and safety – the one to be minimised, the other maximised – aims which are now assumed to trump other equally valid aspirations such as allowing children to explore, to play freely and to learn from their own experience.

As one commentator rightly points out, "risk discourse is redolent with the ideologies of mortality, danger, and divine retribution. Risk, as it is used in modern society, therefore cannot be considered a neutral term."[8]

The rhetoric of risk trades on a politics of responsibility which transmutes into an increasingly oppressive social obligation. We are encouraged to be afraid or ashamed of what we eat and drink and breathe and to avoid a whole panoply of different risks and to lead ever more regulated lives devoid of fun and thrills.

The Royal College of Psychiatrists tried to stem the tide in a 2002 report: "Strict adherence to guidelines, for fear of risk, should not be allowed to stifle responsible, innovative practice or the patient's choice of alternative therapeutic solutions to the same problem."[9]

There are clear dangers in the rigid application of protocols based on population data to individuals and the increasingly heavy hand of bureaucratic surveillance seems likely to impede sensitivity, flexibility and innovation in the delivery of care. The standardisation of professionals is welcomed as a way of eliminating the worst of practice, but it may also eliminate the best. Is this a beneficial exchange?

Let us listen to two wise women – first the British philosopher Mary Midgley. She says, in *Science and Poetry*: *"O*ut of this fascination with new power there arises our current huge expansion of technology, much of it useful, much not, and the sheer size of it dangerously wasteful of resources. It is hard for us to break out of this circle of increasing needs because our age is remarkably preoccupied with the vision of continually improving means rather than saving ourselves trouble by reflecting on ends."[10]

We have become the age of unthinking doing – keep doing, don't stop to think – there's no time! And there's no time because we are too busy doing.

The second wise woman – the American philosopher Martha Nussbaum - recognises the monstrous ambition now in play: "The human being, who appears to be thrilling and wonderful, may turn out at the same time to be monstrous in its ambition to simplify and control the world. Contingency, an object of terror and loathing, may turn out to be at the same time wonderful, constitutive of what makes a human life beautiful and thrilling. "[11]

Only because we do not understand everything and because we cannot control the future is it possible to live and to be human.

Trust and Regulation

In May 2006, in the aftermath of the Harold Shipman murders, I was asked to speak at a conference at the Royal Society of Medicine. I was given the title *After Shipman: redefining trust between patients and doctors - a medical view*. The thesis seemed to be, as so often, that something dreadful had happened and so *everything* must change.

I argued that this was neither appropriate nor possible. It is not possible to redefine trust, any more than love can be redefined when it turns sour or justice when, yet again, it falls short. The hope of all three – the aspiration - remains intact despite all the ravages of history and Harold Shipman seemed unlikely to change that.

In his poem *Flora*, John Burnside writes:

> Because it can only be shared
> like a waltz
> or trust

Trust occurs between particular individuals . I may have been insensitive and complacent, but I had been unable to detect any effect of Harold Shipman on the trust between my patients and myself. And it is a two-way trust: "Basic trust permits a type of letting go that may be at once the most difficult and the most necessary: relinquishment of the need for certainty itself, in recognition that lingering, ineradicable doubt - intellectual, scientific *and* moral - is given with every demand for action and decision by finite human beings."[12]

Without trust, constructive social interaction and all forms of society are impossible. When I stop to ask a stranger for directions, we must both trust each other's intentions or we turn from each other in fear. Patients went to see doctors the day after the Shipman verdict because when you are sick and vulnerable, you must find someone to trust – trust that your story will be heard and believed, trust that you will be seen and valued as a unique human individual, trust that you will be given advice informed by both medical science and an appreciation of your own values and aspirations.

Here is a Norwegian philosopher using a wonderful old English word for well-being: "Their weal has to do with the degree to which they are treated with a sense of justice and with trust and the degree to which their dignity and autonomy as persons is respected."[13] This applies to everyone – to doctors just as much as to patients. Doctors, teachers, social workers, have needs too.

We know that two wrongs do not make a right. The first unprecedented wrong was the murderous criminal activities of Harold Shipman. But the second wrong is this: the increasing surveillance and coercion of doctors.

The idea that trust can be secured by regulation is at best questionable. It is well to remember that the worst abuses of medicine have occurred at times when doctors have been completely subservient to politicians – in Germany, in Russia, in South Africa and in the US.

As Thurstan Brewin said in discussing the concept of 'primum non nocere'(first do no harm) in *The Lancet*, "in medicine it is hard to be sure of anything. We can only weigh the evidence; bear in mind individual lifestyle, hopes, fears, and wishes; and rely on the varying proportions of trust and informed consent that each patient seems to want or need."[14]

Julian LeGrand wrote to me when he was Tony Blair's health policy adviser. I had obviously written or said something that did not make any sense in his world. "How does the idea of greater agency for doctors sit with the idea of greater agency for patients?" he asked.

It seems to me that only an economist could imagine that agency is part of a zero sum equation. In reality, the intention of most human interactions is to increase the agency of both parties and interactions between doctor and patient are no exception. The task of doctor and patient is to work together to achieve greater power and control over illness and disease and the agency of both parties is increased in its successful execution.

The real power struggle today is not between doctors and patients – in the real power struggle, most doctors and most patients are on the same side.

Numbers and Coercion

Computers are driving an obsession with measurement and it is being used in a normative and coercive way – to define, demonise and coerce "deviant" behaviour whether among doctors or patients.

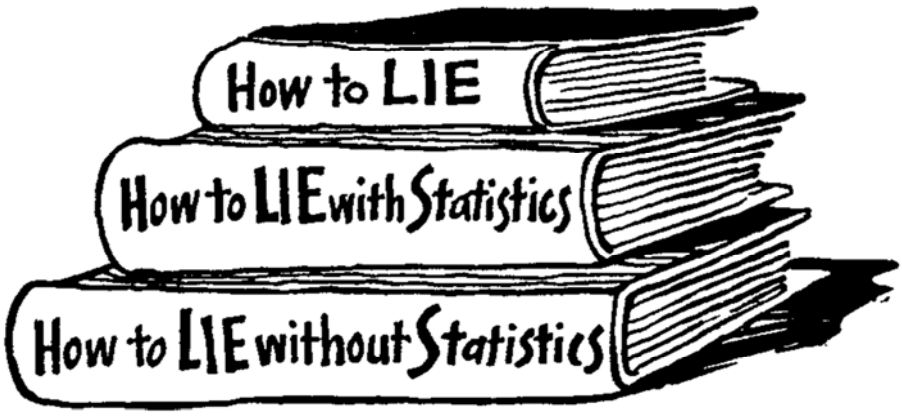
Depression provides perhaps the most obvious example of how this operates in the interests of those in power. Over the last two decades we have seen a pandemic of depression.

Richard Layard, emeritus professor at the London School of Economics, claims that around 15% of the population suffers from depression or anxiety. He notes that the economic cost in terms of lost productivity is huge - around £17bn, or 1.5% of UK gross domestic product. Any practising clinician knows that depression is not a random and discrete sickness but a complex human reaction to frustration and disappointment - to inadequate housing, to relative poverty and to lack of educational and employment opportunity. Focus on the problem of depression allows those on the losing side of society to be portrayed as mentally ill and the injustices of society can remain unexamined.

Each individual human being is in some fundamental sense unknowable and we struggle with that all the time. And within contemporary society, we obscure our view yet further by our obsession with numbers.

Alvan Feinstein, Professor of Epidemiology at Yale, suggests that clinicians who know a lot allow themselves to be intimidated by numbers: "The incomplete clinical reasoning is encouraged by the silence of clinicians who know better, but whose innumeracy makes them insecure or intimidated when confronted by statistics."[15] Again, I suspect that this holds true across the public service professionals.

In 2010, I had the good fortune to attend the Bradford Hill Memorial Lecture at the London School of Hygiene and Tropical Medicine, given by Sander Greenland, Professor of Epidemiology and of Statistics at UCLA. He described contemporary statistical practice as perpetuating hopelessly oversimplified biological and mathematical models and promoting excessive certainty through the promulgation of a two-valued logic which allows only complete certainty of truth or falsehood.



As one of Feinstein's intimidated clinicians who has spent a professional lifetime trying, with only limited success, to align the assertions and dictates of medical science with my patients' experience of illness and suffering, I found these revelations both alarming and comforting. It becomes so much easier to understand the regular appearance of apparently contradictory studies and the way in which very promising treatments can be rapidly discredited as the harms begin to outweigh the benefits. And when all of this is compounded by systematic exaggeration of claims to support the sale of pharmaceuticals or to cajole patients to participate in screening interventions, the whole enterprise becomes yet more murky.

The Need For Judgment

I am arguing that the vaunted claims of certainty are illusory and coercive – the only real certainty is the moral challenge of The Other. Zygmunt Bauman puts it like this in his *Ethics After Uncertainty:* "As the greatest ethical philosopher of our century, Emmanuel Levinas, puts it morality means *being-for* (not merely being-aside or even being-with) the Other. To take a moral stance means to take responsibility for the Other; to act on the assumption that the well-being of the Other is a precious thing calling for my effort to preserve and enhance it."[16]

How do we undertake this "being for" for each of our patients or other group of those we are expected to serve - and particularly for those who are most vulnerable and most damaged?

We can never do it by allowing ourselves to become standardised and interchangeable : "Human variability is such that for a seriously ill person, the physician cannot be a replaceable part. If we insist on treating ourselves as such, we should not be surprised if society treats us as laborers rather than as professionals. We should also not be surprised if it does something to us as people. As we withdraw from our patients, we will be the poorer for it. Our professional lives will be less satisfying, and we will lose much of the depth of experience that medicine can give us."[17]

Medical and most other professionalism is essentially to do with the attempt to match general truths to individual needs.

Medical science has achieved enormous success through this process – yet every individual is unique. Given this uniqueness, there will always be a mismatch between the general and the particular which leads to the possibility of different courses of action, different views of what is right and wrong and hence a situation that is always difficult and which requires judgment and commitment.

This is what Donald Schön described so adeptly in *The Reflective Practitioner*. "In the varied topography of professional practice", he wrote, "there is a high, hard ground where practitioners can make effective use of research-based theory and technique, and there is a swampy lowland where situations are confusing 'messes' incapable of technical solution. The difficulty is that the problems of the high ground, however great their technical interest, are often relatively unimportant to clients or to the larger society, while in the swamp are the problems of greatest human concern."

"There are those who choose the swampy lowlands. They deliberately involve themselves in messy but crucially important problems and, when asked to describe their methods of inquiry, they speak of experience, trial and error, intuition, and muddling through."[18]

Medicine is an endeavour that must constantly balance the technical and the moral – in which uncertainty is inevitable and the capacity to exercise judgment essential – "the flexible discretionary judgment that is necessary to adapt services to individual needs."19

Professionals, alongside Italo Calvino's evocation of the god Mercury, find themselves: "between universal laws and individual destinies, between the forces of nature and the forms of culture, between the objects of the world and all thinking subjects."[20] And professional judgment is in constant danger of being crushed between government regulation on one side and the market forces of competition on the other.

The novelist George Eliot also wrote about pawns and queens, but in a rather more interesting way than Julian Le Grand. "Fancy what a game of chess would be if all the chessmen had passions and intellects" she writes in *Felix Holt*.

"You might be the longest-headed of deductive reasoners, and yet you might be beaten by your own Pawns. You would be especially likely to be beaten, if you depended arrogantly on your mathematical imagination, and regarded your passionate pieces with contempt."[21]

Medicine is conducted in dialogue between doctor and patient and both parties have passions and intellects - and the actions and responses of neither party will ever be entirely predictable, and will always frustrate those exercising only their mathematical imagination.

Vulnerability

This is Charlotte Williamson, first chair of the RCGPs patient liaison group: "Patient autonomy requires that the patient be free from coercion, whether overt or covert. The doctor, too, must be free from coercion, free to explore values, perspectives, anxieties and clinical evidence, free to discuss all possible courses of action with the patient."[22]

We hear the truth of what such an encounter really involves from Miguel Torga, pseudonym of Adolfo Correia da Rocha, one of the greatest Portuguese writers of the 20th century. He wrote poetry, short stories, plays and a 16 volume diary. And he was also a rural general practitioner - this is from his diary:

"I'm not equipped to get used to the routine, to sleepwalk under the professional mantle; each consultation, even though I'm already an old hand at this job, is still a initiation rite, a smiling martyrdom. Yes, I smile, and inside I eat my heart out. Unable to stick the standard treatment stamp on the envelope of symptoms, I stop, indecisive, at harm's cross-roads; puzzled by its fatality which, in the best of cases, is only deferred."[23]

This is what it is really like to be a professional. To a very great extent it depends on remaining vulnerable – not least to doubt and uncertainty.

Politicians must always put the needs of the population above those of the individual; clinicians, if they are to retain the trust of patients, must necessarily do the reverse. There is an irreconcilable conflict between societal fairness and sensitivity to individual need. Increasingly, in the laudable pursuit of equity, a utilitarian public health agenda is being actively imposed on the fragile good of the clinical encounter.

And on, as Camus put it, "the job of keeping alive, through the apocalyptic historical vista that stretches before us, a modest thoughtfulness which, without pretending to solve everything, will constantly be prepared to give some human meaning to everyday life."[24]

Population-based public health objectives with centralised control and a strong emphasis on cost-effectiveness and equity damage and detract from the individual focus of patient-centred care. Patients' needs extend far beyond the biomedical and are easily marginalised if the agenda of the consultation is dictated by forces outside it.

When political imperatives predominate, the political becomes concrete and people become abstract, diminished to units of political significance. Politicians and policy-makers tend to regard the health care system as instrumental to the end of a healthier and longer-living population and ignore the intrinsic value of health care as expressing society's commitment to the welfare of its citizens and constituting in itself a societal good.

The former objectifies patients as the recipients of units of heath care, whereas the latter responds explicitly to the subjectivity of patients. Much of the political history of the last century demonstrates how easily utilitarianism at a policy level can degenerate into the coercion of individuals.

This is the great Polish poet Zbigniev Herbert – in many of his poems Mr Cogito appears to be is alter ego:

> Mr Cogito's imagination
> has the motion of a pendulum
>
> it crosses with precision
> from suffering to suffering
>
> there is no place in it
> for the artificial fires of poetry
>
> he would like to remain faithful
> to uncertain clarity[25]

The great comfort is that none of us knows exactly what will happen to us tomorrow. We know a lot about probability but probability is a long way from certainty. People do not

always get the result predicted by their lifestyle. Not everyone who smokes or is obese dies prematurely. Conversely, a good diet and regular exercise does not provide complete protection from random disaster. Nonetheless, when death or disease occurs prematurely and unpredictably, the rhetoric of preventive medicine suggests that someone somewhere must somehow be at fault. The situation is immensely more complex.

Uncertainty is the basis of both intellectual freedom and political resistance.

Moral Literacy

Professionalism demands and is defined by different modalities of literacy. For doctors:

Medical literacy ensures that where the patient has a disease for which medicine offers effective treatment then the pattern of the patient's symptoms will be recognised and appropriate action taken. This relies on a solid grounding in biomedical science and an ability to work things out from biological principles.

Physical literacy makes use of the doctor's subjective awareness of his or her own body, combined with his or her objective knowledge of the body as a biological specimen. This combination underpins the empathic interpretation of the patient's symptoms which lies at the root of diagnosis.

Emotional literacy allows the doctor to acknowledge and witness the patient's suffering and pain, and to help in the struggle to find a way forward.

Cultural literacy enriches the search for meaning with examples of the way others have made healing sense of the same sorts of hurt and pain.

And finally we also need *moral literacy*. Because making professional judgements in the face of uncertainty requires and will always require moral courage.

In the words of the great francophone poet from Martinique, Aimé Césaire:

"Beware, my body and my soul, beware above all of crossing your arms and assuming the sterile attitude of the spectator, because life is not a spectacle, because a sea of sorrows is not a proscenium, because a man who cries out is not a dancing bear."[26]

And that is why we must do everything possible not to lose the commitment, the courage, the openness, the willingness to keep thinking, that makes up the love in our professional labours.

--ooOoo--

Author

Dr Iona Heath CBE FRCP FRCGP was a GP at the Caversham Group Practice in Kentish Town in London from 1975 until 2010. She was elected President of the Royal College of General Practitioners in 2009.

Michael Shea

The lecture is held in memory of Michael Shea, former diplomat and press secretary to the Queen and a prominent figure in Edinburgh's public life who passed away in October 2009. Michael was a great friend to the International Futures Forum. He loved nothing better than the stimulus of good conversation and partnered first Scottish Council Foundation and then International Futures Forum in hosting Enlightenment salons in his rooms at Ramsay Garden with a host of visiting speakers whose only instruction was to 'make the audience think'. The sessions continue – and this lecture is held very much in the same spirit.

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