

Fictional *Bodies*, Factual Reports:

Public inquiries, tv drama, and the interrogation of the NHS.

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Abstract.

This essay addresses the question ‘what can popular culture know?’ via an examination of the critique of one British public sector institution (the NHS) articulated through a medical drama aired on another British public sector institution (the BBC). I situate Jed Mercurio’s *Bodies* (2004-6) in the context of political intervention in the NHS over the last thirty years, and explore the relation it bears to two public NHS scandals. I argue that *Bodies* is highly self-aware in its representation of the changes to professional life occasioned by successive waves of NHS reform, and directly indebted to the events of, and conditions surrounding, the 1990s Bristol Heart scandal. I further claim, however, that the series situates the kinds of incompetence and mismanagement that underlay real-life events in Bristol within a fictionalised managerial workspace culture in which many of the recommendations for future practice articulated in the Kennedy Report are already in place. In so doing *Bodies* offers a proleptic perspective on what can go wrong in the NHS, anticipating in fiction the conclusions of the Francis Reports on the Mid-Staffs scandal, several years before the events unfolding in Mid-Staffs were exposed to public view. In that process, I conclude, the series lodges a more generalised critique of neoliberal public sector reform implicitly extensible to other public sector institutions.

Keywords: Jed Mercurio, *Bodies*, NHS, medical drama, public sector, BBC, managerialism, audit, target culture, medical malpractice.

I: introduction: the politics of mainstream medical drama

Jed Mercurio’s short-lived medical drama, *Bodies*, ran for two seasons on the BBC in 2004-2006, concluding with a ninety-minute finale which wrapped up the story and put it to bed in, it has to be

said, fairly perfunctory and unsatisfactory ways. Beginning life in 2002 as a novel (also by Mercurio,) *Bodies* was adapted into a television series screened first on BBC3, and then on BBC2. It remains little known, even in the UK, although Mercurio's work has become familiar to recent UK audiences through his earlier precinct drama,ⁱ *Line of Duty* (2012 -) some of whose preoccupations, notably its interest in professional selves, professional identities, and professional ethics, *Bodies* shares. That interest in professionalism forms part of my focus here insofar as it underscores *Bodies*' relation both to the NHS it represents and to the successive public enquiries into serial scandals in NHS hospitals that punctuated the decades of the late twentieth and early twenty-first centuries, in particular the Bristol Heart Scandal of the 1990s and the Mid-Staffordshire NHS Foundation Trust scandal which was to come fully to light almost two decades later. The former issued eventually in the 2001 Kennedy Report, *Learning from Bristol*, which predates the series. The latter, emerging through the media to public consciousness in 2008-9ⁱⁱ, issued first in Robert Francis' February 2010 independent enquiry report, and subsequently in the 2013 public enquiry Report, whose findings resulted in the dissolution of the former Mid-Staffs NHS Foundation Trust, and also, in the fallout from that debacle, of the University Hospital of North Staffordshire NHS Trust. Health service provision in the Staffordshire area was reconstituted in October 2014 under a new Trust, the 'University Hospitals of North Midlands NHS Trust': the extent of the repercussions of the Mid-Staffs scandal can be ascertained from the fact that this rebranding eradicates any vestige of association with 'Staffordshire', whose post-scandal connotations had become so toxic as to deter health professionals from coming to work in the area, or from staying in it once they had concluded their medical degrees. Most medical dramas, it is my contention here, largely eschew attention to this wider political context; *Bodies*, by contrast, self-consciously interrogates it. In presenting a Bristol-like picture of incompetence and mismanagement in the context of a fictional workplace wherein the recommendations which issued from the Kennedy Report on that scandal are already largely in place, *Bodies* formulates a prescient critique of successive, ideologically-driven, interventions in the NHS which is just as trenchant (although somewhat differently inflected,) as those articulated in the documents issuing from major public enquiries and which, by extension can be applied to other public sector institutions, including the BBC.

Jed Mercurio has some claim to insider knowledge about the NHS, his early career having begun in it: after qualifying as a doctor he worked in a Wolverhampton hospital, and *Bodies* bears the signs of this first-hand experience of working life in the NHS. In this respect, as in others, *Bodies* is very different from most televisual medical dramas, many of which, be they UK or US series, bear only a tenuous relation to the actual world of hospital medicine in their respective countries. Late twentieth and early twenty-first century medical drama may not idealise medicine, doctors and nurses quite as transparently as a *Dr Kildare* (1961-66) or *Marcus Welby MD* (1969-76) might have done, but it remains highly sympathetic to the medical professionals it depicts, who operate to all intents and purposes in an environment hermetically sealed from the exigencies and inconvenient politics of the real world.ⁱⁱⁱ Marc R Cohen and Audrey Shafer have remarked that the physical beauty and healing capacities of doctors and nurses of most television medical drama are matched only by the ‘degree of [their] compassion’ for their patients; and that in the environments most such series depict, the labour of paperwork and bureaucracy is almost always eclipsed either by the drama of surgery, or by the development of intense personal interactions between medical professional and patient to which the professionals are invariably (in British shows at least,) able to devote an enormous amount of time (2004: 211-12). Into their dramatic spaces economic realities seldom intrude: equipment and medicines are up-to-date and departments well-resourced (Turow 2010: 2-3). Both *Chicago Hope* (1994-2000) and *ER* (1994-2009) do indirectly acknowledge tensions about American healthcare in their graphic depiction of injuries and the pace of their episodes, as well as by the relatively short durations of the doctor-patient engagements they depict (Turow 2010: 339). But *ER*’s Chicago County General, Cohen and Shafer (2004: 212) remark, ‘is the one hospital in America that hardly ever asks about [a patient’s] insurance status’ (an observation also true of *House MD* (2004-2012)). Vanderkeift suggests that in the past, disregard of external economic drivers was not accidental: plots that appeared to be sympathetic to socialised healthcare, he notes, frequently attracted hostility from AMA advisors (2004: 230).^{iv} In similar manner, most UK shows, if occasionally partial to the odd snipe about a financial cut or NHS initiative, have rarely allowed such allusions to interfere with their depictions of protracted personal relationships between staff and staff, or staff and patients, or to constrain the ever more incredible storylines in

which they indulge. In *Casualty* (1986-) and *Holby City* (1991-), time spent with patients is often an infinitely elastic commodity, and medical staff lead unusually exciting lives: doctors, nurses and paramedics are stabbed, raped, or blown up with alarming frequency, and forever end up treating their own relatives in the absence of any sense either of medical ethics or the governance of professional behaviour by inconvenient regulations such as GMC codes of practice. Although not entirely denuded of the temptation to political critique (in recent seasons *Casualty* and *Holby City* storylines have explored the health consequences of benefit sanctions, poverty and immigration) mainstream British medical drama consistently subordinates the professional, as well as the political, to the personal.

II: Realist revisionism: *Bodies*' NHS

Bodies was very different. In it, Mercurio set out to produce a series overtly 'revisionist' of mainstream British medical drama (Mercurio 2014) and although it is not the only series which has cast a less than adulatory gaze on its subject matter (the US *Nurse Jackie* (2009-2015) and the UK *Getting On* (2009-2012) also have an edgier relation to the 'real' world of medicine than mainstream hospital dramas do,) *Bodies* comes from a different stable altogether. It is a peculiarly British drama, not merely in its focus on the NHS, but also in that its critique of the management of that public sector institution is equally applicable to any number of other public sector institutions – universities, for example, or the BBC itself – all of which have been subject over the same period to the same kind of neoliberal reform.^v Commissioned by the then BBC3 controller, Stuart Murphy as an attempt both to introduce to that channel longer dramatic formats and as a deliberate 'challenge' to the 'perceived opinion about medical drama' generated by primetime shows such as *Casualty* and *Holby City* (Timms 2004) *Bodies* aimed to be 'the ultimate antidote to mainstream medical drama' (http://www.bbc.co.uk/pressoffice/pressreleases/stories/2004/02_february/17/bodies.shtml). It had its genesis in Mercurio's earlier BBC1 series, *Cardiac Arrest* (1994 – 1996) whose overarching narrative charted a gradual breakdown of faith in the NHS in hugely overworked junior doctors whose

disillusionment was echoed in breakdowns of faith in Christianity, marriage, and the psychiatric self. *Cardiac Arrest* often tipped into parody, in content and in form (for instance, in the highly mannered musical scores that in early episodes accompanied the entrance of certain characters), but *Bodies* aspires to a tighter kind of realism: Mercurio is a devotee of ‘realism in drama’, in particular, as we will shortly see, realistic representation of ‘the world of work’ (Hughes 2015). But many of the preoccupations of *Cardiac Arrest* (in particular the divisions between junior doctors and consultants, and doctors and hospital managers) get distilled in *Bodies*, which eradicates the manneristic elements of the earlier show. And like *Cardiac Arrest*, *Bodies* interrogates the issues with which it is concerned through the point of view of a relatively inexperienced protagonist; in this case, Rob Lake, who arrives at ‘South Central Infirmary’, a regional teaching hospital, as the new Specialist Registrar in the ‘firm’ of one of the hospital’s two Obstetrics and Gynaecology consultants, Roger Hurley (the other consultant being one Tony Whitman). The series’ premise is that while Whitman is a highly competent consultant but an arrogant, sexually predatory human being, Hurley is personable but incompetent. He is, in the words of two characters at different points in the series, ‘a good man, but just not a good doctor’; he is someone who has reached consultant status through a research route rather than through extensive clinical practice, and someone who repeatedly makes life-threatening mistakes. Maria Orton, a consultant anaesthetist present from the opening sequence, attempts in vain early on to whistle-blow on Hurley’s incompetence; the rest of the series revolves around Lake wrestling between the moral duty to whistle-blow and the practical consideration that if he does so his career will go down the tubes.

We never know precisely where *Bodies* is set, but in keeping with its realist ethos, it was shot on location, rather than in a studio, at High Royds Hospital, an abandoned former psychiatric hospital near Leeds. This location situates the drama firmly in the antiquated Victorian architecture of numerous regional NHS hospitals in the UK at the time (figs i, ii, and iii): slightly dreary and forbidding, not really fit-for-purpose, the fabric of its buildings creaking at the seams.^{vi}



Figs i and ii *An exterior wing of High Royds and an interior corridor.* (credit: Mark Davis, High Royds Hospital digital archive site.)



Figs iii and iv *The location as it appears in the series*

The semiotics of this space thus immediately embeds the drama in an NHS-with-a-history, distinguishing it both from the more modern and more anonymous, spaces and sets of mainstream hospital drama, and from the ‘futuristic’ studio-based sets of a *House MD*^{vii} or more pertinently, from Mercurio’s most recent Sky-commissioned foray into the genre, *Critical* (2015) whose flashy, hi-tech set is studio-based (for the resuscitation unit) and whose exterior scenes were shot at Brent Civic Centre.^{viii} And while other medical dramas often gesture to a space outside work, *Bodies* does so only rarely. *Casualty* for instance, often begins and ends in open, airy, spaces outside the hospital, as staff arrive for work in the morning or leave for a drink at night, as if they worked 9-5, and were a happy community of colleagues in which everyone joined one another in the pub most nights and senior medical staff rubbed along happily with porters (quite literally sometimes, given the cross-hierarchical affairs which punctuate the action of these shows). The action in *Bodies* is largely confined to the hospital’s interior: this is precinct drama taken to extreme, a world of work sealed off almost entirely from anything

outside that world. Characters sometimes emerge from that space to smoke a cigarette or indulge in a private conversation away from the management ears, but such excursions are rare, and almost always confined to the single location of the hospital back entrance (*fig iii*), or the miserable hospital bedroom in which Rob Lake and Sister Donna Rix conduct an illicit, erotically-charged, but increasingly soulless affair in the interstices between exhausting, stressful, relentless shifts. Unlike the tidy, orderly, calm wards of a *Holby City*, where most things, apart from an occasionally unruly patient, are neatly in their places, the wards of the South Central Infirmery are littered with scrappy pieces of paper and antiquated filing systems, some of which deftly signify not just the lack of material resource to put a proper sign up, but also the likelihood that you will not be attended to in good time (*fig v*).

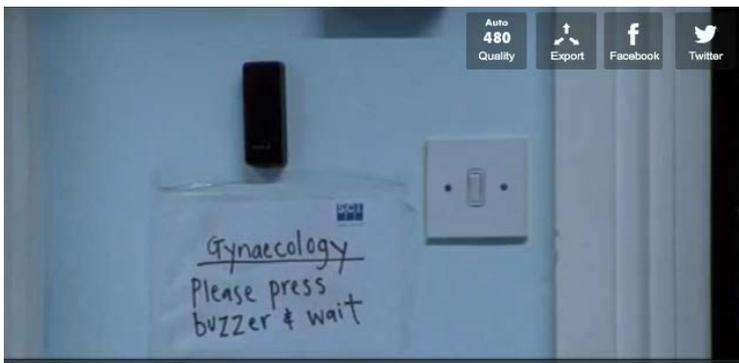
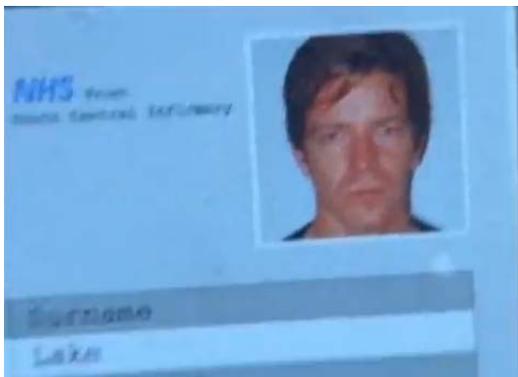


fig. v

The spaces of *Bodies* are claustrophobic, pressured, hostile. In keeping with the show's realism, the fake *vérité* shooting - handheld and shifting cameras – echo the visual tropes of investigative reporting shows, docudrama or mockumentary. The framing of shots is frequently tight, the camera close up against the backs of individuals to result in a sense of overcrowding, people – bodies – populating the background as well the middle-ground and foreground. From the series' opening sequences (see <https://www.youtube.com/watch?v=LWKpc8O9Dyk>) everything communicates a sense of obstruction, surveillance and lack of communication. The ubiquitous cameras, the medical security personnel, the mugshots on i.d. cards (*figs vi, vii and viii*); the doors which are successive barriers, often policed (*figs ix and x*); the multiplicity of incomprehensible snatches of conversation spoken in different languages by nurses and doctors recruited from abroad: all are at once studiously realist – this is *our*

NHS, right now, today – and proleptic of a workforce riven with tribalism, division and competing interests and allegiances. This workplace is all-encompassing and alienating; this NHS is an intensely policed, managed, and divided space.



figs vi, vii, viii and ix



fig x

III: Bodies, Bristol and NHS reform

All this is fundamentally important, for it is not Rob Lake, but the NHS itself as public sector institution which is *Bodies'* central focus. The show's preoccupation with issues of medical

incompetence and the impediments to whistle-blowing did not come out of nowhere. Two NHS scandals, the Alder Hey organ scandal of 1988 to 1995 and the Bristol Heart Scandal of the 1990s, had exercised the British media in the decade preceding the series. The latter scandal had first come to light on April 5th 1995 when Bristol Royal Infirmary (BRI) admitted it had ‘halted a pioneering technique for open heart surgery for infants after 9 [out] of 13 babies ... had died over an 18-month period’ (Prasad and Butler 2002); a series of investigations in the ensuing years, some confidential, many precipitated in the first instance by *Private Eye*, culminated finally in the 2001 Kennedy Report. This was a period characterised by much larger-scale, and ongoing, reform of the public sector, variously termed the ‘New Public Management’ (Power 1997, Newman 2000) or New Wave Managerialism (Poole 2000), which began in the Thatcher years, was intensified in the Blair governments, and has continued unabated ever since. Colin Leys has argued that the NHS was a particularly crucial nexus for the success of this neo-liberal project of public sector transformation, not least because it ‘occupied a major sphere of potential capital accumulation from which capital was excluded’ given first, its ability as monopoly supplier to negotiate ‘hard bargains with pharmaceutical companies over the provision of drugs’ and second, its status as the largest single employer of a strongly unionised workforce: the NHS was, Leys argues, the ‘strongest pillar of the social-democratic temple’ that Thatcher sought to destroy (2001: 167-8). A veritable barrage of policy directives dogged the NHS in this period, as it did other public sector institutions: new financial arrangements, including the institution of internal markets and the creation of mixed economies of provision (Ling 2000); new relations between centre and periphery, state and citizen; increasing competition between providers of services; increasing attention to outputs and key performance indicators (Clarke, Gewirtz and McLaughlin 2000). The early 80s saw the first concerted effort to introduce into the NHS a new (sometimes neo-Taylorist, especially with regard to Nursing^{ix}) managerialism (Poole 2000); techniques of New Wave managerialism grew throughout that decade with the creation of self-financing ‘Trusts’ in 1987 (Leys 2001: 170), and the Department of Health’s White Paper *Working for Patients* in 1989, one of whose objectives was to encourage clinicians into hospital management in order to defuse resistance of doctors to the program of reform (Poole 2000: 104). The Community Care Act 1990 epitomised the new predominance of the language of ‘competition,

efficiency, providers, purchasers, consumers, effectiveness and markets' (Poole 2000: 103) and instituted a plank of privatisation, transferring responsibilities for long-term care of the chronically ill to local authorities, who could charge for the cost of that care (Leys 2001: 172).

It is from that general context that *Bodies* emerges; that it is specifically related also to the Bristol Heart Scandal is signalled by direct allusion in episode 5, series 2, where South Central Infirmary has just successfully bid for a 'High Risk Pregnancy Unit' (HRPU). This fictional bid mirrors Bristol's historical success some years earlier in its bid to get its Pediatric Cardiac Surgery Unit designated as a 'Supra Regional Centre' (SRC). As Kennedy notes, the plan of the Department of Health, the Regional Health Authorities and the Joint Consultants Committee was to develop a 'Supra Regional Service' (SRS) system which would 'protect, nurture and support the development nationally of highly specialized and financially vulnerable services' (vulnerable because of their relatively low volume of patients and high cost) (Kennedy 2001: 98). Designation as an SRC conferred a guaranteed funding source, and thus was widely perceived as conferring recognition of 'excellence': 'in the minds of clinicians' Kennedy notes, '[SRC designation] was a feather in their cap to be sought and won' (2001: 99). This is replicated in *Bodies*' representation of South Central Infirmary's winning of the HRPU wherein is emphasised both management triumphalism about securing a new funding source in a very competitive economy and clinician confidence (at least among those promoted to management positions) that securing the unit bestows recognition of clinical excellence. But it also suggests that within this changing NHS, resources are distributed to those who best manage the bidding process, not to those that best guarantee quality provision. In a team meeting celebrating the HRPU victory, a middle manager explains to collected medical staff that securing that unit will offer them experience in dealing with conditions they have hitherto only rarely encountered, allowing them to 'consolidate their knowledge base'. 'That's what they said in Bristol,' Whitman replies, in an aside aimed at non-managerial clinical staff.

This direct reference is one of several ways in which the series echoes Bristol history. In life as in art the whistle-blowers are consultant anaesthetists: Maria Orton in *Bodies*, Stephen Bolsin in Bristol. Bolsin's 2011 own account of the events surrounding the Bristol Heart Scandal, archived on *Medical*

Harm.org, a website co-created by Phil Hammond and Andrew Bousfield of *Private Eye*^x furnishes other similarities. Despite Bolsin's having raised Bristol's high mortality rates with senior staff, the surgeon most at fault (whose name, in a cruel irony, was James Wisheart,) assumed increasingly 'powerful and influential positions within the 'Trust' becoming Chair of the Hospital Medical Committee and then Medical Director of the Trust (Bolsin 2011), a trajectory mirrored in *Bodies*, where Hurley rises to influential quasi-managerial positions despite Orton's attempts to expose his incompetence. Bolsin was threatened with constructive dismissal, had cardiac sessions removed from his roster, was shunned by colleagues and pronounced 'unappointable' by successive interview panels for jobs in other hospitals; in *Bodies*, similar outcomes dog the careers of Orton and Lake: management suspends Orton on the spurious grounds of psychiatric problems; Lake's applications to other posts are sabotaged by Hurley's off-the-record conversations with Lake's prospective new employers.

The Kennedy report exposed a litany of failures of communication, leadership, teamwork and resources. It described a hospital with 'a "club culture"; [and an] imbalance of power, with too much control in the hands of a few'; one in which consultants were supremely powerful (2001:193) and staff 'not encouraged ... to speak openly' (2001: 202). *Bodies* rehearses these findings from its opening scenes, where Orton's instruction to 'put the diabetic first on the list' introduces a chain of events in which all these failures can be observed in a sequence which sets the scene for the drama's analysis of failure as sure-footedly as its location centres its action in a particular history of the NHS. The viewer first meets several patients on a rapid ward round, one of whom – Mrs Campbell, the diabetic – is in for a laparoscopy and dye to investigate her infertility; another of whom – Mrs Collier – is in for a lap and sterilisation; first Hurley muddles the names of the two patients; second, the nurse charged with drawing up the theatre list transposes the names, but not the operations, on that list; third, a more junior doctor, Maya, whose responsibility it is to check the list, fails properly to do so. Orton realises, just as surgery is about to begin, that they are about to sterilise a woman who is in there to discover why she cannot get pregnant, but when she asks Hurley if she should report the incident as a 'near miss', Hurley replies sharply 'I've just said 'I'll deal with this later'. No-one does deal with it later; Rob Lake destroys the faulty theatre list and with it the evidence of how nearly catastrophe was averted.

This opening sequence thus exhibits the failures of communication, leadership, and teamwork, the club culture, the imbalance of power, the discouragement of speaking openly which Kennedy identifies, and all are explored at length as the series continues, as is the implication that failures emerge from causes both over-determined and systematic, and not from individual incompetence alone. Orton's suggestion that she report the incident as 'a near miss', however, echoes not so much the findings of the Kennedy Report but, importantly, some of its recommendations. The series, in other words, not only reflects the enabling conditions of the Bristol scandal, but also implicitly critiques the recommendations lodged both in the Kennedy Report, and in the numerous policy documents published in the aftermath of that scandal. Orton's locution ('near miss') derives from the aviation industry, which was invoked both by Kennedy and by the 2000 Department of Health report on learning from adverse events in the NHS, *An Organisation with a Memory (OWAM)* as a model for the new regime of quality control and safety assurance whose introduction they recommended.^{xi} Both Kennedy and *OWAM* advocated the institution of a 'mandatory reporting scheme for adverse events and specified near misses' (*OWAM* 2000: 5.12) ; both laid heavy emphasis on the improvement of clinical governance as the way to prevent such scandals happening again. Both stressed the need to publish 'standards of clinical care for healthcare professionals to follow' and to set 'standards for hospitals as a whole' debarring hospitals falling short of such standards from NHS practice. Both detailed the need to develop risk management systems adopted from key industries (amongst which the aviation industry was most salient,) and both stress the importance of collecting accurate, complete data and of publishing information about the relative performance of different hospitals, services and consultant units. Clinical audit 'should be at the core of a system of local monitoring of performance' advises Kennedy; 'independent external surveillance [must] review patterns of performance over time'. Kennedy advocates the institution of a new 'NHS Leadership Centre' (2001: 445), and it is at this time that the notion of hospital league tables is seriously mooted and then put into practice by the then health secretary Alan Milburn, who described them as 'a significant step towards developing a new public sector enterprise culture in the NHS to ratchet up performance' (Batty 2001).

The locution ‘near miss’, along with these other recommendations, denotes in factual and fictional texts the introduction into public sector management of a notion of Total Quality Management adopted from industry (Power 1997): the documents’ emphases on risk management, audit and data publication betray the influence of a substantial national shift in the approach to public sector management. The 1997 New Labour government’s ‘third way’ had seen a new focus on globalisation, efficiency, and the cost of welfare, centred on the notion of partnership within which NHS Trusts had a new statutory duty to work with service commissioners (Poole 2000: 108-112), and within which all management teams were supposed to have clinical input; this also was the point at which the NHS had become ‘primary care led’ (Leys 2001: 175). Further policy documents, of which *OWAM* was one, and *The NHS Plan* (an intensely ambitious policy document presented by Alan Milburn) another, appeared in 2000. The latter, though full of a heady sense of promise, hope and optimism that would be hard to discern in parallel documents today, characterised the NHS as a ‘1940s system operating in a 21st century world’; what was ‘1940s’ about it were its lack of national standards and ‘old fashioned demarcations between staff’ (27) as well as its failure to offer the incentives private sector organisations utilised to ‘improve performance’. ‘The current system,’ it observed,

penalises success and rewards failure. A hospital which ... treats all its patients within 9 ... months ... may be told that ‘over performance’ means it has been getting too much money ... By contrast, hospitals with long waiting lists ... may be rewarded with extra money ... – even though the ... problem may be poor ways of working rather than lack of funding. The NHS has to move from a culture where it bails out failure to one where it rewards success

(Department of Health 2000 b: 28)

To eradicate the vestiges of the 1940s, *The NHS Plan* promised to audit hospitals on a rotational basis (62); to introduce a traffic-light system (a ‘Performance Assessment Framework’) which would flag organisations which failed to meet core national targets (63); to establish a ‘new Leadership Centre for Health’ (87) in order ‘to develop a new generation of managerial and clinical leaders’ (12); and to increase ‘patient choice’ over the GPs and hospitals which they would grace with their presence (89). It introduced changes in the relationship between the NHS and the private sector (Chapter 11),

particularly pharmaceutical and bio-pharmaceutical industries, to allow ‘faster and more effective recruitment of patients into clinical trials (98). The document was intensely target-driven (chap 16 and annex 3) in the investment in resources it promised (chaps 4, 5), the efficiency targets it set (chap 6) and the waiting times it promised (chap 12) (and see Leys 2001: 203-207).

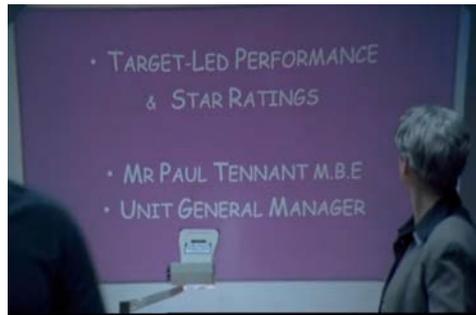
IV: Bodies and the critique of the new public management.

Bodies is generated by events surrounding the Bristol Heart Scandal, but it is crucial to our understanding of the prescience and depth of its political critique to recognise that it assumes that many of the recommendations articulated by Kennedy subsequent to the exposure of that scandal are already well-established in the NHS it represents. Orton’s ‘near miss’ locution, for example, suggests that a system for reporting such events is already operative in South Central Infirmary. Equally established in the series are phenomena such as the target-driven culture, and inappropriately cosy relations with the pharmaceutical industries. The latter are played out through storylines such as Specialist Registrar Polly Gray’s dubious pharmaceutically-funded research on a drug intended to eradicate ‘female sexual dysfunction’ (read: not enough orgasms) and Consultant Whitman’s pharmaceutically-funded jollies to conferences in exotic locations; the former are signalled through the ubiquitous presence in the South Central Infirmary of systems of monitoring, data reporting, and league tables. Certainly, some of the managerial techniques *Bodies* represents embody the ethos of an earlier, pre-audit age. Power 1997 notes crucial differences between audit and surveillance cultures which emerge, he maintains, ‘from different programmatic ideals’: surveillance he claims, is a first-order system of control whereas audit’s underlying objective of the inculcation of self-regulation denotes a second-order mechanism of discipline. *Bodies* shows us both. On the one hand, its surveillance culture functions as a technique of first-order control. The mugshots on id cards, the signage, security notices and cameras are all contextualised in wider discourses of management and control and increasingly revealed as a way of managing staff rather than protecting patients, demarking hospital hierarchies (hospital managers do not have to ring to get entry, clinical staff do), or deployed against troublesome staff members (security

personnel accompany Orton on and off the hospital premises after her suspension – another instance, incidentally, of *Bodies*' revisionism of mainstream medical drama, where security personnel almost always control unruly patients, not the staff).^{xii} But the initial emphasis on first-order mechanisms of control are increasingly displaced by the ethos of the new public management, wherein discipline is internalised, effected by structures of accountability and quality management rather than force. So, for instance, *Bodies* includes numerous sequences wherein consultants report to peers and management the statistics of recent cases (*fig xi*); management delivers to assembled staff powerpoint presentations of the targets to which they wish them to aspire (*fig xii*); or staff are shown participating in externally-driven quality audits of target-driven performance (for instance, in a dry-run of an audit of meeting time targets for throughput of patients from entry to hospital to treatment and discharge – the management functionary in that sequence times the proceedings with a stopwatch).



(*fig xi, data-reporting session*)



(*fig xii, Target-led performance – managerial presentation*)

Bodies' representation of the manager reflects a post-Bristol, new public management transformation in the nature of that figure, wherein managers have metamorphosed into 'team leaders' with 'visions' who 'drive colleagues forward' in the pursuit of an 'excellence' defined by relative positioning with respect to other institutions in a new, competitive, economy of provision (Clarke and Newman 1994: 15). And as it (slightly sardonically) represents this new managerialism, it charts two other characteristic but somewhat self-contradictory qualities of this reformed public sector workplace. One is the erosion of the distinction between management and some professional staff (as first Hurley and then later Whitman are promoted to the position of clinical director); the other is the resistance of

professionals as a body to the ethos and practices of the new public management, embodied in the series in the figure of Paul Tennant, the aptly-named flag-bearer both for the hospital and for the new managerialism which the series dissects. Managers and professionals in *Bodies* are tribal identities, defined by oppositional allegiances to, respectively, the hospital-as-corporate-entity and successful-treatment-as-professional-*raison d'être*. 'I cannot over-estimate the importance of achieving the targets set by the Department of Health from which this unit will be star-rated' the Unit General Manager, Paul Tennant informs the team at a meeting intended to secure staff engagement in audit procedure; 'Audit day is the most important day of the year ... we have to reduce waiting times in order to become a 3* hospital ... that is what we are here for'; in response to which Whitman mutters a *sotto voce* riposte to Polly Gray, 'Not to treat patients' (series one, episode 5, available online at <https://vimeo.com/channels/186279/22359959>). That tribalism is explicitly noted in the Kennedy report, but *Bodies* represents it as being exacerbated, not curtailed, by the new target-focussed, managerial institutional culture whose introduction post-Bristol policy documents recommended as the panacea for the ills of the NHS. In *Bodies*, management's presentations on 'Target-Led Performance' produce not compliance, but resistance, signalled in a professional antipathy clearly legible in the body language of the hostile professional audience watching those managerial presentations. Indeed, that tribalism is a material factor in the failure to expose the problems at the heart of the show: this is a world where 'doctors stick with doctors' and whistle-blowing entails an implicit challenge to a deep and ingrained conception of professional identity and affiliation.

V: *Bodies, the Mid-Staffs scandal, and proleptic critique.*

In the sequence from which *fig xiii* was captured, the targets are set with the objective of enabling the success of South Central Infirmary's bid for 3* status. Star ratings for hospitals were introduced in 2001, league tables having first been trialled in 1994;^{xiii} 3* status was a prerequisite for application to Foundation Trust status. This was a competitive tender in which the Mid-Staffs NHS Foundation Trust was involved in the period in which *Bodies* was screened (the Francis Report covers the years 2005

to 2009), and also, of course, the period during which took place the events which were subsequently to lead to Mid Staffs' own unenviable status as the most infamous NHS scandal of all. While the Kennedy Report predates Mercurio's *Bodies*, press attention to the events at mid-Staffs post-dated the series by some two to three years, and the final Francis Report itself appeared almost seven years after the series was screened (the first appeared four years after the series). And yet, Robert Francis's description of the Mid-Staffs NHS Foundation Trust over the years in which the scandalous conditions operational there played themselves out might just as accurately describe the culture of the fictional hospital that had appeared on British television screens several years earlier. Francis notes a preference for figures over people – a 'common response to concerns' he writes, had been 'to refer to data, often of a very generic type such as star ratings' and 'a focus on systems not outcomes' (2010: 398). He observes that staff were 'disengaged from the process of management,' both in that staff expressing concerns were ignored by those to whom they brought their concerns, and in that this was a culture in which staff 'separated themselves from management' (2010: 399) and finds that the culture at the Trust was not conducive to providing good care for patients or a supportive working environment for staff for numerous reasons. Of all of these phenomena, *Bodies* offers its audience a proleptic account. Francis notes an atmosphere of fear of adverse repercussions (2010: 15 and 159); *Bodies* dramatises those adverse repercussions. Francis notes the high priority placed on the achievement of targets set by the Department of Health, the Strategic Health Authorities, and the Primary Care Trusts, in particular with respect to A and E waiting times (2010: 16, 162); *Bodies* shows sequences in which exactly those waiting times are audited and found wanting against management-set targets. Francis describes a consultant body which had largely dissociated itself from management (2010: 166-8); *Bodies* repeatedly illustrates this antipathy. Francis observes low staff morale (2010: 169-70) and a sense that raising concerns implied 'breaking ranks' (2010: 166); *Bodies* repeatedly reiterates the dictum that 'doctors stick with doctors'. The 'domination' of management thinking 'by financial pressures' (2010: 18, 447); their obsession with achieving FT status to the detriment of quality of care (2010: 22); the lack of internal and external transparency regarding the problems that existed at the Trust – all of these findings are foreshadowed in *Bodies*, not just the 'atmosphere of fear of adverse repercussions' or the 'low morale

amongst staff, which are not historically so specific, but, and in particular, the preference for statistics and reports over patient experience data; the target culture; the centrality to management thinking of the deeply competitive imperative of achieving certain forms of nationally-driven status signifiers.

‘That primary experience of working in the NHS informs me,’ Mercurio has observed of his later (police) precinct drama *Line of Duty* in an interview in which he notes the ‘losing battle’ entailed with ‘wrestling with the idea of realism, particularly in the workplace’ (Curtis 2012). A losing battle it may be, but Mercurio does successfully communicate something of the experience of those who work in contemporary public sector institutions, many of whose conditions are not particular to one or other discrete profession. ‘We looked at the real world of the police,’ Mercurio notes of *Line of Duty*, ‘and asked which parts of what they do nowadays weren’t represented in cop shows. That was easy: the target culture and the bureaucracy. They’ve been documented in the press but haven’t made it into mainstream drama’. Targets, he maintains in that interview, ‘were introduced for laudable reasons, because it was very easy to hide medical failure or misconduct within the police. But these institutions have complicated and evolving cultures, and the imposition of targets and forms of oversight hasn’t necessarily had the results their designers expected.’ (Curtis 2012). A similar point is lodged in rather different terminology by Power 1997, who claims that the appeal of Total Quality Management lies in the way it mystifies the notion of quality, which denotes in this context ‘not high standards, but those which are uniform, predictable, and verifiable’; [BS 5750] he goes on, ‘is not ...an evaluation of the quality of the product or services, but of the practices and procedures of manufacture or provision’. The audit explosion, Power notes, is a ‘distinctive response to the need to process risk. Auditing threatens to become a cosmetic practice which hides real risk and replaces it with the financial risk faced by auditors themselves. Audit society is a society that endangers itself because it invests too heavily in shallow rituals of verification at the expense of other forms of organizational intelligence’ (1997: 123).^{xiv}

Bodies is not nostalgic: it does not hark back to a mythical ‘professionalist’ social democratic ideal in which professionals were pure of heart, motivated only by a sense of public service (Clarke, Gewirtz, Hughes and Humphrey 2000: 252). Its doctors and nurses and midwives are flawed at best,

and cynical, self-deceptive and self-serving at worst. It suggests that the underlying causes of the drama it represents is not just one individual's incompetence, however crucial that incompetence is, but systematic and overdetermined in nature, the product of the conjunction of an externally-driven, macro-political, neoliberal agenda focussed on targets, data, audit and marketised competition (Leys 2001) with an alternative notion of professionalism inherited from an earlier age. The professional loyalties it represents may stem from an era in which professional authority was less circumscribed by management *dictat*, but that age was also one which bequeathed to the present an intensely hierarchical structure, rife with sexism, petty antagonisms and the exploitation of junior staff by senior 'colleagues', all of which become only more polarised and factional in the context of this changing managerial regime. In dissecting South Central Infirmary in this way, *Bodies* offers a post-Francis representation of the NHS years prior to the publication of that inquiry, but whereas Kennedy focuses on Bristol, and Francis on Mid-Staffordshire, South Central Infirmary is a kind of medical Everyman, a representation not only of a particular hospital in a particular place but of the state-of-the-nation, its diagnoses of public sector management instantly recognisable to those who work outside the health service as well as to those who labour within it.^{xv} This is what popular culture can know. It is the NHS itself which is *Bodies'* protagonist and ailing hero; the NHS itself whose agonistic struggle, against apparently insuperable market forces, is what is at stake.

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i On the term 'precinct drama' see Ellis, 2007: 99-105.

ii The public and the local press played a large role in bringing the scandal to light after Julie Bailey's mother died at Stafford Hospital in 2007. For details see the website of Cure the NHS at <http://www.curethenhs.co.uk/about-cure-the-nhs/>

iii On the close relationship between, for instance, the AMA and television dramas such as *Medic* and *Dr Kildare* see Vanderkieft; the AMA, he remarks, offered official endorsement of *Medic* in return for script approval, ostensibly in the interests of ensuring 'technical accuracy' and the American Academy of Family Physicians endorsed *Marcus Welby MD* (2004: 218, 221). Turow notes to the contrary that Barbara Crane, president of the National Federation of Nurses, complained about *Nurse Jackie* to the *New York Daily News*, and that the New

York State Nurses Association asked Showtime to add a disclaimer to episodes to the effect that Edie Falco's Nurse Jackie was an aberration; Showtime, to its credit, refused to do so (2010: 307).

iv See Strauman and Goodier (2010) for an argument that the ideal of doctor-hero is ultimately upheld even in *HouseMD*, which only superficially appears to violate that generic norm.

v On 'Britishness' see John Ellis 2004. See also Julian Petley 2004 for a discussion of the need for television criticism to address the erosion of public service broadcasting. On the analogous marketisation of British television regulation in the period see Jonathan Hardy 2012. Mercurio's critique of the new public managerialism is lodged in *Line of Duty* as well as in *Bodies*; it is unclear whether BBC management were aware of the parallels to be drawn between the new managerialism in the NHS and the new managerialism in the BBC.

vi See <http://www.highroydshospital.com/galleries/bodies-filmset/> The building began life as the West Riding Pauper Lunatic Asylum in 1888; it closed as a psychiatric hospital in 2003.

vii *House MD* is in many respects a generic outlier in the realm of hospital drama, its narrative form following the deductive process of Conan Doyle-inspired detective fiction, as signaled inter alia in the name of its protagonist, which puns on the name of Holmes.

viii Mercurio has claimed that the set of *Critical* is based on the Queen Elizabeth hospital in Birmingham which he describes as a 'purpose-built hospital built in the twenty-first century' (Mercurio 2014). On place and the ethics of studio-bound drama see Chibnall and Petley 2007.

ix Newman and Clarke (1994: 15-17) synopsise Pollitt's 1990 distinction between a Neo-Taylorist management ethos (mainly aimed at 'a rational analysis of organizational inputs and outputs and committed to efficiency and increased productivity') and the 'new managerialism' which dislikes bureaucratic systems and attempts instead to loosen formal systems of control, to replace the concept of the manager as controller with that of the manager as leader, and to stress the value of motivating employees to strive for a collectively-embraced notion of 'excellence'. Pollitt, they argue, claims that neo-Taylorism was predominant in shaping the practice of 1980s public sector management; Newman and Clarke see the new managerialism as more significant in that reforming project, although they see public sector organization in the period as characterized by coexistence of these models rather than chronologically successive.

x Hammond and Bousfield co-authored the *Private Eye* special 'Shoot the Messenger' (2011) and Hammond was for years *Private Eye*'s medical correspondent, helping to break the Bristol Royal Infirmary story.

xi As in Chapter 26 of the Kennedy Report on ‘The Safety of Care’ where the phrase ‘near miss’ is discussed and the epigraph to the chapter is a comment by James Bagian, ‘engineer and former astronaut, head, US National Centre for Patient Safety, Veteran’s Administration’. Kennedy groups both ‘adverse events’ and ‘near misses’ under the umbrella term ‘sentinel events’. In OWAM, see especially pp 44-45. Like the Kennedy Report, this document seeks to avoid blame of individuals in favour of the reform of systems; it characterizes NHS culture as erring too much towards ‘blame culture’ rather than ‘safety culture’ (ix) and see pp 20-21.

xii Security mechanisms in the series are also used to suggest misallocation of resources. Figure viii for instance, shows Hurley entering the ward, viewed via the security camera screen Donna Rix monitors; simultaneously, Rix is on the phone (the phone cable visible in the foreground) fruitlessly attempting to get someone to sort out a broken X-Ray viewing box seen earlier; when Hurley enters, the day’s surgery list has been cancelled due to financial cutbacks; shortly thereafter, Rob puts all the material that has been meticulously prepared for the cancelled surgery in the bin.

xiii On the way in which the arrival of trust status is signaled to denote a particular narrative of change see Clarke and Newman 1997. For a timeline of key changes in NHS organization see the Nuffield Trust’s timeline of NHS reform at <http://nhstimeline.nuffieldtrust.org.uk/?gclid=CIDVs8j8jsUCFYnLtAodhhsAhw>

xiv See also Clarke, Gewirtz, Hughes and Humphrey 2000.

xv For a collection of short articles which examine the effect of similar neoliberal assaults on the BBC see the special issue of *Discover Society* issue 24, Sep 1, 2015, especially Murdoch and Freedman.