

Five Executive Follies

How commodification imperils compassion in personal healthcare

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Summary: Commodification, competition and commercialisation have increasingly been introduced as agents of efficiency into State welfare services. In healthcare all of these may, unwittingly, lead to a loss of 'soft skills': personal understanding and then compassion. The human and economic cost is considerable. How this happens is not obvious. The following explains.

Postscript January 2025

A slightly shorter version of this essay was sent in 2011 to the, then, Health Secretary, Andrew Lansley MP. It was offered as a thoughtful warning.

Retrospectively it is dismally prescient.

Prologue

The threat to healthcare from inadequate resources or management has become a little-challenged truism: easy to understand and demonstrate. Healthcare is now – in a strategic drive for greater efficiency – submissive to our Management Culture: a world which then authoritatively delegates all human problems to specialists and their executive actions. All this can seem simple, sensible and correct.

The reality is more complex. Paradoxically, there is an additional and opposing, though less obvious, threat to our healthcare: an *excess* of such management, specialist activities and resources – but misplaced.

This more subtle and countercultural reality is – it is proposed here – responsible for much of our current system's incapacity to imaginatively address very substantial and inevitable individual variation. Such obliviousness to human diversity and complexity has undermining consequences.

The more stark examples of failures of physical care make headlines that are hard to understand or even quite believe. In contrast, failures of personal understanding, and thus therapeutic and compassionate engagement, are usually born invisibly, painfully and privately.

Such are the perils of abdicating our capacity to conceive or care more individually and holistically.

Our compassion becomes an inevitable casualty whenever personal engagement and attunement are compromised. The word 'compassion' derives its meaning from a Latin root 'to suffer together', thus offering a 'transpersonal' psychology: one drawing from the exchanges of resonance and imagination. This is often very different from the now prevalent distancing, 'objective' psychologies used unilaterally by healthcare professionals to pathologise, categorise and commodify in attempts to tightly manage healthcare. Yet there are many studies showing how an empathic bond conveying compassion is a

powerful source of comfort and healing for the sufferer, and – importantly – work-satisfaction (and healing) for the healer.

The informal yet skilled evocation of compassion often has powerful effects, but is a subtle activity. This was well recognised and explored by previous generations of practitioners. It now ails amidst clamorous and vacuous slogans of 'Increased Patient Choice' and 'Ensuring quality of care is always central'.

How could this come about?

The causal paradoxes and anomalies have been poorly recognised and understood. What follows dissects and explores.

Five Executive Follies: How commodification imperils compassion in personal healthcare

The fatal metaphor of progress, which means leaving things behind us, has utterly obscured the real idea of growth, which means leaving things inside us.

GK Chesterton

Fancies versus Fads, 1923

We are living longer, more complex lives. Our technological possibilities multiply. Inevitably healthcare expectations, then demands, burgeon. To manage all this, recent decades have unleashed a gathering Industrial Revolution in the NHS. This revolution is itself guided by a core phalanx of doctrines. These exist largely independently of other political considerations or affiliations, and are implicitly embraced by all.

Such assumptions have developed from cultural changes rooted in our advanced industrialised ways of life. These predicate often unconscious values and mind-sets. Consequently, our rubric for healthcare has become increasingly of *applied sciences*, leaving *humanities* peripheral and disregarded. The tasks then become reduced to engineering of tissues or behaviours, rather than extension to nurturing human understanding and healing contact.

The doctrines that flow from such assumed applied science and industrialisation may thus offer real help in discretion, but constitute destructive folly in excess. The Law of Unintended Consequences has become ever-more evident: industrialising healthcare, much to our perplexity, is responsible for very substantial 'collateral damage'. Despite allocating ever-increasing resources, in certain areas, our therapeutic and compassionate engagement is poorer. The progressive loss of quality and continuity of personal contact – essential conditions for personal understanding, healing and compassion – are crucial factors.

This brief survey samples what is lost and how these difficulties constellate.

This broad-scoped essay considers five seminal and interlocking notions. Particular attention is paid to their overuse. In the final section, authentic vignettes illustrate how these Five Executive Follies then converge; what happens to our care.

Failure to accurately conceive the essential nature and limitations of the objectifying medical model is a primal difficulty. Unbridled objectification all too easily turns to alienation. The underlying misconceptions unwittingly arise from 'category errors' – these are very powerful, yet rarely distinguished or discussed. Such discernment therefore requires us to think the unfamiliar about our working axioms. For this reason our first folly receives the lengthiest attention. The later appendix offers a tabulated summary and illustrative graphs.

1. **Medical diagnoses and treatment models are the most effective for dealing with human ailments. These methods are clear, authoritative and evidence-based. They should be precedent wherever possible.**

This is mostly and uncontentiously true when dealing with 'structural' diseases of the body, particularly where the condition is localised and acute. We can easily think of common examples: hip fracture, pneumonia, appendicitis. With any of these we are grateful and satisfied with competent and courteous biomechanical attention.

However, with other kinds of health problems this effectiveness becomes much less clear. The 'medical model' then loses its unrivalled command and precision; for example, when dealing with complaints that are not structural, but experiential, 'functional' and stress-related. What are these? They include an ocean of ill-defined but physically distressing complaints which present to GPs and various healers; they become loosely packaged with labels such as migraines, dyspepsia, dysmenorrhoea, tension headaches, IBS, PMS and ME. Then there is the vast range of human anguish – the psychiatrically classified Mental Disorders: disturbances of behaviour, appetite, mood or impulse (BAMI).

All together, these comprise the larger fraction of NHS consultations.

There is a useful general equation here that can guide our designation and understanding:

structural change = **disease**; *functional disorder* = **dis-ease**.

Although the words – disease and dis-ease – look and sound very similar, our optimal methods for approaching and apprehending them often need to be

very different. For example: structural disease can be tightly clustered into *generic* diagnoses where individual variation and meaning are relatively unimportant. 'One size fits all.' In contrast, functional dis-ease is more likely to be *idiomorphic*: the generic pattern now less decisive, but the individual meaning and variation crucial. 'Only the wearer knows where the shoe pinches.'

As we will see, erroneous conflation of the two leads to many other follies in practice, from individual consultations to national healthcare planning. Such conflation is easily done, and then often very hard to undo. Because of its importance, this subtle but powerful distinction is worth paying time and attention to understand.

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The dazzling success of biomedical science in tackling many structural diseases may blind our perception of its competent boundaries. Dazzled, we fail to see that overuse of medical diagnosis and treatment in areas of dis-ease so easily becomes counter-productive. This kind of misplacement is complexly inefficient: it frequently leads to eclipse or displacement of more personal and fruitful types of dialogue and understanding – the keys to healing, growth and resolution. Without these, compassion perishes ... and the costs mount.

There are problems, too, about the integrity, the 'realness', of our research and knowledge when we confuse or conflate these two territories, of disease and dis-ease.

Scientific conventions of quantification and 'evidence-basis' have now become a shibboleth to any 'service provision'. Despite this assigned pre-eminence, such esteemed quantitative research becomes much less valid when applied away from the shoreline of solid-state pathology: disease. Problems arise when investigating dis-ease because this is primarily a form of communicated *experience*, not a stable or simple physical *state*. Yet, no inner experience can be measured directly. We can only access and measure external, associated behaviours or verbal reports.

All this becomes hard for those healthcare workers in thrall to objective scientific method: they hope or believe that their measurements or observations reliably indicate private experience in the other. But such formulated indices are, alas, never equations. Research of internal experience here becomes

inescapably 'contaminated' by a myriad of personal, relational or institutional factors. For example, in mental healthcare, attempts to measure 'mood' or 'well-being' are fraught with subjective and interpersonal intrusions and distortions: they can never match the clarity or precision of, say, blood electrolytes.

To compound the problem, the contaminating factors (eg of conscious or unconscious suggestion, influence or wish) are themselves unmeasurable. In this welter of uncertainties, away from bodily structural disease, science can only operate with severely annotated compromises: a pseudo 'pscience'. Organisationally and economically, this introduces myriad tangles to the meaning and integrity of statistics. Projects such as 'Commissioning' and 'Payment by Results' then entice and accrue specious clarity, with all its inevitable difficulties and corruptions.

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All cultures are defined by a prevailing rhetoric. In our industrialised healthcare the categorised and the quantified are now the commanders, hegemonic. Flawed psience is now attempting to manage as largely unquantifiable vernacular. Such statiticised psience thus proceeds with a kind of abstracted, regal authority in areas of delicate interpersonal uncertainty. This is a growing problem, most clearly in psychiatry and primary care: here the insidious change has become cultural, and has, by definition, led to a diminution of certain kinds of professional awareness, analysis and debate.

The interpersonal skills deriving from these perish, too.

Such areas of healthcare – the 'people-work' of general practice and psychiatry – need to reclaim those receding and very different kinds of imaginative intelligence. For example, psience is likely now to assess a distressed person by administering a quantifiable mood questionnaire. A more holistic psychology instead asks: 'What is it like to be this other person; to have lived their life? What is the meaning and significance, for them, of this distress? What is the meaning and significance, for them, of me, now? What needs do I need to address that they might not (yet) be able to articulate'

Answers are hardly to be found in current academically studied or managerially administered psychologies. Only a *personally* imaginative and engaged sentience can lead us to such bespoke compassion.

Isn't all this just overcomplicated and academic? No.

Why, then, is it important? It is because our conventionally assumed or conferred language and knowledge largely determine our pattern of understanding and engagement with others. How we think, speak and document will then configure what we do. If our language eschews personal resonance and understanding, our actions will follow suit.

Any System, in excess, will offer specious clarity and certainty. So we must be vigilant in our applications of 'science'; an overreaching scientism will become a pyrrhic progress. Overusing the language, understanding and interventions of disease in the territory of dis-ease is such a seductive but debilitating error. Like a mislocated expedition, it leads to a massive misapplication of effort and resources.

Such misapplication is bound to damage our efficiency and economy. The loss of personal understanding is even more serious: unnecessary medicalisation of distressed experience and behaviour can be profoundly disempowering. Myopic and inapt labelling then generates its own disabilities. The loss of personal language, autonomy, agency and responsibility – these are all causes and casualties of an over-reaching medical model. In our current preoccupation to measure we often deskill and desensitise ourselves in the unmeasurable. A mind full of generic dicta, data and algorithms cannot heed the individual voice.

Such losses can largely account for the recurrently exposed, shocking and grotesque examples of basic failures of care in hospitals – institutions which are, by contrast, heavily invested with high-technology and managed care-pathways.

We are faced with a conundrum very particular to our technology-dependent age: in our muscular but blind resolve to treat, we may easily destroy the gentler and more delicate sentience to heal and humanely care. Compassion may be powerful in effect, but it is fragile in viability: it needs a mindful and respectful space and ambience to survive.

2. Healthcare is important and complicated. All practitioners should be tightly monitored and controlled. Increasing healthcare management is bound to be to the patient's benefit.

Yes, but only sometimes.

The caveats for this are broadly similar to the section above. For example, the rules and regulations addressing safety in a Cardiac Surgery Unit should be strictly enforced. Exceptions would be very rare, if ever. In contrast, such tight governance is much less helpful when attempting to relieve functional complaints.

For example, a perfectionistic lonely person with tension headaches, or another incapacitated by rage and grief at the discovery of a major infidelity, or another enervated by mysterious polysymptoms since his wife became pregnant. In these functional disorders, the therapeutic effect of the practitioner depends upon imaginative skills of personal contact and suggestion. Institutional or formulaic management are likely to run counter to these: rigid management so easily eviscerates compassionate imagination.

There are parallels here to family-life and how we bring up children. The balance we choose between rules *v* freedom and structure *v* spontaneity, etc, will vary with the child, its age, the situation, and so forth. Families where structure and discipline are rigid and excessive may, earlier on, yield children who may appear orderly and well behaved, but are then stunted in their capacities for creativity, initiative, expression, joy and intimacy. Necessary conflict, too, will be turned inwards or displaced ... with all the destructive effects within and without.

Organisations that are over-managed show equivalent afflictions. Such harassed groups suffer from defensive proceduralism, low-morale, high sickness rates, scapegoating, and a fascinatingly subtle range of subversion, both conscious and unconscious. Paradoxically, such depletions are retroflected casualties; the backfiring result of management compulsively 'driving' efficiency.

Over-controlling parents rarely get what they intend.

Compassion, too, requires our intelligent flexibility.

3. Mass-production and standardisation must be a good thing, if it makes things more available.

We don't question this with washing machines or ball-bearings. Entering the arena of healthcare, we can still extend this confidence to, say, pharmaceuticals, surgical materials and certain procedural treatments, eg cataract extraction. This remains true so long as individual variation, subjective complexity and personal understanding are relatively uninfluential.

In contrast, chronic and functional complaints confront us with the importance of individuals' variation of experience and meaning. These all-too-human factors are slippery to our medical model: they elude quantitative, formulaic and procedural approaches that are so essential elsewhere. Here we must develop more flexible, 'crafted' and individually addressed responses. Centrally-programmed factory workers are not equipped for this.

What are these elusive variables, and how are they important?

Much of this we know from everyday experience. For example, most of us, when distressed by deeper personal or relationship problems, find difficulty in describing, expressing or explaining these. We are likely to have all kinds of fears about sharing or disclosure. How a listener or helper might respond becomes decisive as to whether and how we do this. In this process we are exquisitely sensitive to the subtlest interpersonal signals and changes. Example: how we feel with apparently tiny variations of voice, timing or body language with a verbal greeting or a handshake. For all their power, such nuances of interpersonal influence are almost impossible to measure or manage directly. Paradoxically, though, over-management may stifle, even extinguish, an emotionally-literate environment, which creatively respects the fragile complexity and uniqueness of each interchange. That is what has happened with our industrialising NHS reforms.

Compassion needs space and oxygen to flourish – it cannot be regulated-in, but it can certainly be managed-out. Analogies with parenting are, again, clear and prophetic.

4. Competition, commissioning and commercial pressures will raise standards of care.

In industry, encouragement of these '3Cs' makes much sense: in providing technical services and physical commodities, and the manufacture and sale of objects. Yet with complex welfare activities it, again, leads to a similar pattern of the unintended. The '3Cs' solution often becomes more problematic than the problem it is attempting to address. For example, if we attempt to commodify, and then trade, in 'packages of care', how do we accurately pre-scribe the changing, often inexplicit, complexity of people's needs? And then any need for flexibility and sensitivity of response? How do we then standardise a package and a price? If we strictly mandate such specification, what is the human cost of doing so?

To illustrate such problems:

Mr C is 62 years and needs a total hip replacement due to premature osteoarthritis. He is otherwise very fit, healthy, happy and actively involved in his work and large family.

Mrs D is 83 years and also needs this operation. She is a childless widow: she had a stillbirth 60 years ago and never again conceived. Her beloved husband died of cancer a year ago. She now lives alone; lonely, with stoic and brave melancholy. She was an only child and was sexually abused: she is wary of any kind of physical care or examination. Her complex diabetes and emphysema add to her vulnerability, but she tends to deny this due to her aversion to any kind of dependency.

Clearly, Mrs D's anaesthesia, surgery, physical recovery and psychological resilience are all more likely to be problematic than Mr C's. All these processes will require intelligent and imaginative care. How can such delicate compassion be predictively and commercially contained, controlled or costed? How do we have 'diagnoses' for such kaleidoscopic but decisive human complexity? How

will each separate Specialty or Trust precisely delineate and invoice its responsibilities?

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What happens with a system of competitive commissioning? Practitioners become controlled by their thralldom to Trusts, and the Trusts are in thrall to optimising their profits and 'performance data'. Thus are they likely to fulfil to the letter (only) their contractual obligations. Official practice flourishes: managers, even lawyers, direct and tailor individual practice to suit institutional and commercially negotiated 'contracts', and thus policies. These replace more humanistic or holistic practice: encounters guided by broader and longer-term views and informed by a growing understanding of each particular individual.

Under such a system, over time, we lose vocational practitioners: those motivated primarily by the pursuit of humane enquiry and healing relationships. These become replaced by 'Teams' of management-directed, piece-work biomechanics. Chosen vocations become managed careers. Thinking and activity turn institutional, not interpersonal. Resources become increasingly commandeered for defensive and offensive organisational fights and feints: meetings about meetings – negotiation, litigation, imposing but slyly tendentious statistics, PR, 'spin'... Services that for several decades existed in a state of trusting and cooperative confederation, now become mistrustful competitors: Trusts (!).

The patient is now a commercial proposition: if he generates revenue (for the Trust), then find reasons to provide a service; if he does not generate revenue, then find reasons swiftly to discharge him somewhere (anywhere) else. 'It's not our responsibility.'

Amidst this Darwinian struggle for survival, can our compassion really be commissioned or commodified?

- 5. Specialisation is always a good thing. It provides greater expertise when and where it is needed.**

Yet again this is most impressively true with well-defined structural disease, but often counter-productive when dealing with more complex and less stable situations. Positive examples of the use of specialisation are clear and obvious. If we have a knee problem that requires surgery, then we want, not just a doctor, but a surgeon, an orthopaedic surgeon, and one who specialises in knees. The idea is that we can divide the body up into smaller and smaller parts and systems, and thus concentrate knowledge, effort and expertise with greater precision and efficiency. This is viable so long as we are dealing with disease that is stable and confined to a body-part or system. We can term this fragmenting specialisation 'Anatoatomisation'.

This kind of specialisation can become far from helpful when applied away from the stable, localised disease scenario. To illustrate:

Mr S is age 70 years. Two years ago he developed an aggressive form of Parkinson's Dementia, shortly after his retirement. He had been an extremely educated, fit, diligent and disciplined man, holding a senior post in international diplomacy. His multidimensional decline has been relentless and tragic. He has become an insentient and incontinent shell of his former self, recognising no one and requiring constant care.

Amidst this, his beleaguered, self-sacrificing wife discovers a breast-lump, a cancer. She then has chemoradiotherapy, which itself makes her ill, in the hope of a cure.

As Mrs S struggles to recover, Mr S's decline is unabated. He has unmanageable 'episodes': he freezes, falls, develops chest and urine infections, deepening deliria. Each of these needs his admission to hospital, and each time it is to a different Ward and a different 'Team', who do not recognise him. Each team then routinely refers him on to further specialist teams: to Gerontology (for his age!), to Neurology (for Parkinson's), to Elderly Psychiatry (for Dementia), to Urology (for recurrent urine infections), to Respiratory Medicine (for chest and urine infections). None of these teams is in a position to acknowledge the larger picture, and what is needed in terms of wise, humane contact; continuity, containment support and comfort. Mrs S is an intelligent woman, but now fatigued, despondent and confused by the constantly changing medical personnel, designations and venues.

'Why does he need yet another brain scan?', she wearily asks a bustling and brisk Neurology Registrar.

'Just to make sure we're not missing anything', comes his clipped reply, his tone of defensive authority primed by Trust Protocol.

Thirty years ago this unneeded and very expensive brain scan would not have been available. Nor would the panoply of specialist teams. Mr and Mrs S would, though, have had something else: continuity of care by a known general physician on a particular ward. This broadly-based clinician and dedicated nursing staff would have provided the personal investment, familiarity, acknowledgement and understanding that were needed to nurse and palliate all of these 'episodes'. They would have seamlessly apprehended the human needs, not just of the ravaged Mr S, but also his exhausted wife. They would probably not have used the word 'compassion', but it would have been more readily woven into their experiences, acts and utterances. Such traditional skills are now so easily displaced by the often specious imperative to 'specialisation'.

Last, but not least, this pre-polyspecialist system was much less expensive.

The whole is more than the sum of its parts: compassion is a tender and fragile fruit of holism.

Ms T is a 38-year-old single woman with a son of four years. Her persona of engaging warmth and polite cooperation belies her deeply troubled and troubling history. A product and victim of, and hostage to, a painfully unhappy parental marriage, she has spent most of her life trying impotently to break free, to establish an autonomous and wholesome self. But she has not the self-esteem, the internal model, or sense of entitlement to do any of these things. She is like a blinded, enraged, captive creature convulsively throwing itself against the bars of its cage, trying to find the outside.

The symptoms signalling this impacted struggle have been wide-ranging. They have been shepherded and clustered by a parade of specialists over many years: mood disturbance and instability, gastritis, eating disorders, intermittent alcoholism, impulsivity, irritable bowel syndrome, obsessive compulsive

disorder, migraines, menstrual dysfunction, eczema...

Each specialist attempted to subsume, quell, or at least contain, her disturbance with their own language and circumscribed focus of the medical model. Sometimes, paradoxically, such specialisation led to her being the object of exclusion instead: once she was lost between the GP Counsellor, the Psychiatric, and the Alcohol Services, who each said that one of the others should be responsible. Despite seeking helpful engagement, she was extruded by all three: 'she does not meet our intake criteria'; 'It's not our responsibility...'

Dr W, her General Practitioner, has learned over many years that such marathon, polymorphous disturbance is usually signalling some failure of personal evolution, some frustration of gratified belonging. It lies behind and beyond any specialisms, their language or measurements. He remembers an old mentor saying of his endeavours to help such people: 'You need patience with patients, and patients with patience'. But Dr W knows now that it requires also evocative but structured encouragement, to safely uncover and decipher what lies beneath. He arranges an hour's appointment with Ms T, to try to take them both from a world of fragmented and serial specialisms, to a holistic perspective deriving from, and imbued with, personal meaning. He has learned that often healing grows with the exploration and sharing of personal meaning.

The polyclinic Practice Manager is alerted, and now uneasy: 'We have pressure on clinic rooms, doctor, and this kind of work takes up a lot of time, and earns no additional "points" for the Practice ... in any case, all the other doctors have said this kind of work is not your responsibility ...'

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Is there a more crystalline coda for these Five Follies?

And the question arising? In a healthcare system increasingly determined by the quantifiable, the commercial and the industrial, how do we restore, and then assure, the primacy of holistic, human care – the quality and continuity of our personal contact with others? In our busy and difficult jobs, every day and in every consultation, how do we create afresh, then nurture, an ever-evanescent culture of compassion?

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'Is it progress if a cannibal eats with a knife and fork?'

Stanislaw Lec, *Unkempt Thoughts*, 1962

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APPENDIX

	Disease	Dis-ease
1. Knowledge	<ul style="list-style-type: none"> - Impersonal - Objective, generic, clustered, data 	<ul style="list-style-type: none"> - Personal - Subjective/intersubjective, Idiomorphic, bespoke
2. Ideology/paradigm	<ul style="list-style-type: none"> - Dualism, Determinism, Biomechanics 	<ul style="list-style-type: none"> - Monism, choice, consciousness
3. Resources/transmission	<ul style="list-style-type: none"> - External (eg drugs, instruments, radiation, manipulation, lasers) - By Conduction - 'Treatment' 	<ul style="list-style-type: none"> - Internal (eg immunity, growth, repair) - By Induction - 'Healing'
4. Power/responsibility	<ul style="list-style-type: none"> - Dr >>> Pt 	<ul style="list-style-type: none"> - Pt [⊗Dr]
5. Language	<ul style="list-style-type: none"> - Objective, Doctors', technical, designatory - Generic 	<ul style="list-style-type: none"> - (Inter)personal. Shared dialogue🗨️ co-creation - Idiolectic
6. Communication mode	<ul style="list-style-type: none"> - Didactic - Mostly logical/structured 	<ul style="list-style-type: none"> - Dialogue/Dialectic - Often openly imaginative/evocative
7. Psychology	<ul style="list-style-type: none"> - Designatory - 'Objective' - Quantitatively researched 	<ul style="list-style-type: none"> - Evocative - (Inter)subjective - Qualitatively researched
8. Role - metaphor of Doctor/healer	<ul style="list-style-type: none"> - Engineer, expert, teacher, manager 	<ul style="list-style-type: none"> - Gardener, guide, midwife, compassionate fellow-traveller
9. Art or Science?	<ul style="list-style-type: none"> - Science 	<ul style="list-style-type: none"> - Art
10. Accessibility to industrialisation: mass-management, , training, standardisation, mass production, commodification, measurement	<ul style="list-style-type: none"> - High 	<ul style="list-style-type: none"> - Low
11. Importance of personal contact, meaning and understanding	<ul style="list-style-type: none"> - Low 	<ul style="list-style-type: none"> - High

Figure 1: Disease v. Dis-ease; Art and Science, Treatment and Healing: comparative paradigms of effective response to human ailments

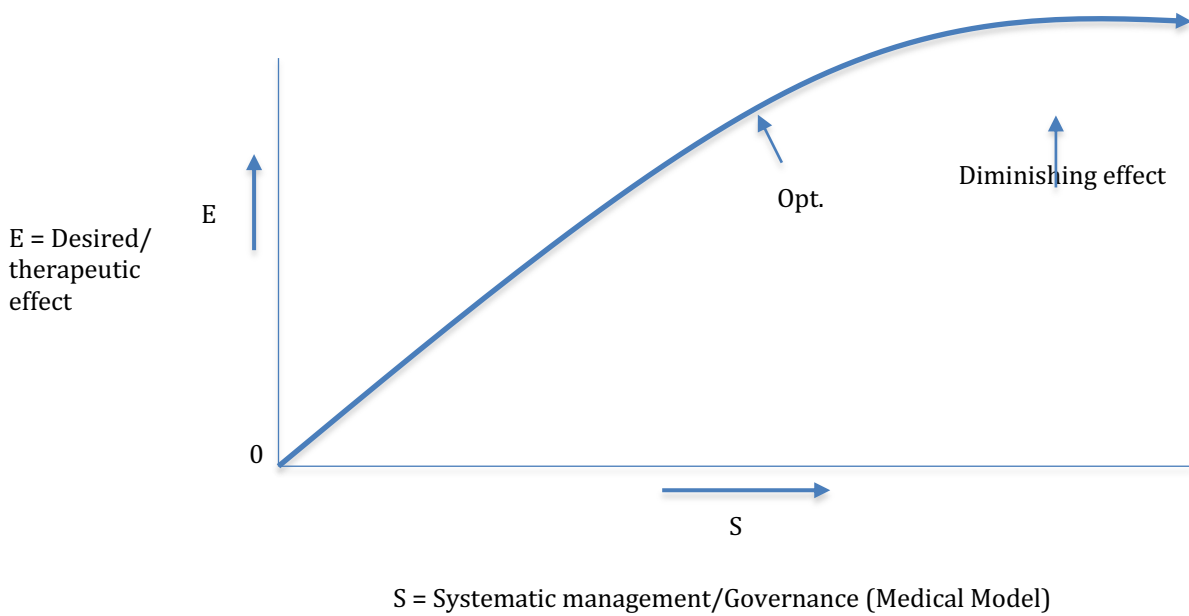


Figure 2: Systematic management and structural disease

Decaying exponential. Desired response proportional to systematic governance, until optimal point (Opt). Then diminishing returns. (Illustrated principle: structural disease responds relatively well to scientific strictures and structures.)

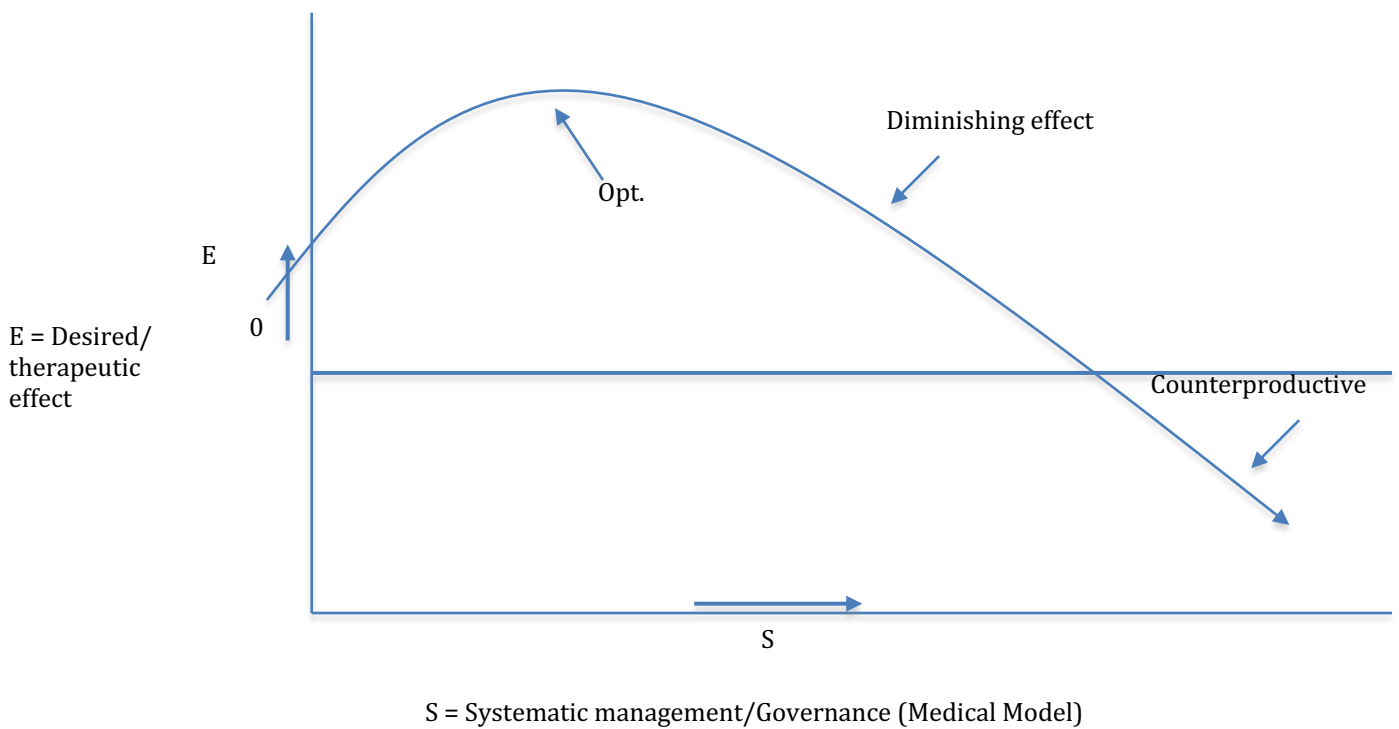


Figure 3: Systematic/generic management and functional dis-ease

Shallower Bell Curve with reversal. Desired response to systematic governance is less. Yields earlier to ineffectiveness, then becomes counterproductive. (Illustrated principle: functional dis-ease less positively responsive to impersonally prescribed approaches. Excess application has adverse effects.)

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