Manufacturing doctors is one thing; sustaining working communities is quite another

In an age of mass-production and commodification it is not surprising that the governmental response to our increasing losses of doctors is to recurrently and rhetorically press for greater production and wider recruitment.

But in doing so are we avoiding deeper human problems of community and ecology?

September 2022. Another new prime minister. An economic and political maelstrom is about to break. Meanwhile there are new faces on the parliamentary front bench, but their rhetoric is already familiar. On *Sky News* (22 October 2022) the then new Health Secretary, Thérèse Coffey, sounded sincere in her emphasis: she said she would 'bring a laser-like focus' to solving our growing NHS problems, especially waiting lists for procedures and GP accessibility for patients.

A senior GP spokesperson, Dr S, wearied but diplomatically patient, dismissed all this as mere wishful thinking: his colleagues' crumbling workforce could not possibly deal with the extra demand entailed. The interviewer asked why our GP service had become so dysfunctional and depopulated.

Dr S quickly cited the longstanding and relentless time-squeezed work pressures, now yoked in an ineptly disincentivising pensions arrangement. The contended issues became, yet again, about the adequacy and distribution of money and resources.

Surely adequate money and resources are essential for any competent and compassionate health service: we have seen how they must, again and again, be defined and fought for. So this is an ongoing battle. Being unavoidable, it will necessarily return to our analysis and debates. Yet, however essential this theme is, it often obscures another, one that is equally essential but more nuanced and less quantifiable, so much less discussed – our loss of community.

Dr S made no reference to this. His otherwise very pertinent observations about money, workload, and resources omitted an equally important and longstanding fact: that GPs generally no longer get the erstwhile deeper, personal work satisfactions that can – and often did – infuse, nourish, and sustain a vocational working lifetime.

Few GPs now enjoy their work, unlike most of their predecessors. So that is a crucial reason why we do not have, and (at present) cannot have, an adequate and sustainable workforce. If people do not like the work, either they will not come or they will not stay.

Nevertheless, successive government ministers and spokespeople either do not see or will not speak of this. Instead, they recurrently talk of 'fixing' the problem by training more doctors here or recruiting them from abroad. But such planned staff replenishment is most unlikely to succeed. Apart from the inescapable delay of many years, such measures do nothing to restore what has been lost in the nature and quality of the work – what fuelled and spirited those previous generations of GPs to (usually) very willingly devote a working lifetime to full-time practice, often working longer hours than their much more miserable counterparts now.

What has been lost – or jettisoned – in our decades of 'modernising' or 'streamlining' healthcare reforms are personal experiences of connection, relationships, community, and the rich values and meanings that can grow from these.

Rather than theorising abstractly about such losses it is probably clearer to describe my own (and I believe the majority of my peers')[1] experience.

MY EXPERIENCE

I first became a GP principal in the mid-1970s, in a small inner-city practice. The practice had been established with the birth of the NHS, and three decades later I listened to older patients recalling, mostly with affectionate respect, their first NHS GPs. Reciprocally, my senior partner and our receptionists and practice nurse often drew on historical and current knowledge of many of our patients, their families, neighbourhoods, and networks. All inhabited a kind of sentient community.

My partner's preceding dozen years in practice had stocked his canny and engaged observations: he perceived the personal context and subtext of the lives and illnesses of the many patients he got to know well. With those individuals he shared much beyond their current sufferings and reliefs – the substratum of their dreads and hopes; what brought them aspiration, inspiration, love, or hatred; what triggered grief or laughter; their hauntings and dreams; what they (wanted to?) get up for with daylight; and what they feared when darkness came.

I soon realised that I was enfolded into a mindful and concerned network that had anchorage in personal familiarity. The patients, professional, and support staff together functioned largely through shared experiences and individual understandings. From these grew bonds of trust, support, and affection. Such relationships were the threads weaving a nexus of care: how we could both look after, and look out for, one another. Yes, occasionally such benign webs broke – there would be shards of error, misunderstanding, and grievance, even more rarely, bad faith. But mostly the webs held.

GPs were then often referred to as family doctors. This was apposite as we very often engaged with, and therefore got to know, patients as members of families. Yet it was also true in another sense: our practices usually functioned much like happier families – with high levels of personal knowledge, understanding, trust, loyalty, and intelligent flexibility. I felt that this family doctor surgery where I now worked provided me with a secondary family, a home from home. This became my professional home for 40 years.

These, then, were small communities serving larger surrounding communities. By accruing personal bonds and knowledge with others we could better care for, and look out for, them.

Such 'families' extended beyond the nuclear; GPs then got to know kindred professionals – hospital specialists and their secretaries; locality district, health visitor, and psychiatric nurses; probation and social workers; housing officers and charity conveners; local pharmacists – these were all people whose faces, voices, and work we got to know. They were local, our jobs were stable, and, before digital technology, our exchanges were mostly personal, conversational, and direct. In such 'extended families' we often felt we were

"… GPs generally no longer get the erstwhile deeper, personal work satisfactions that can – and often did – infuse, nourish, and sustain a vocational working lifetime."

helping one another shoulder the burdens of what can be very difficult work.

Most GPs of my generation found our deeper satisfactions in such longer-term stability. General practice was never glamorous or charismatic. It is rarely as dramatically heroic or scientifically clever as some specialisms but through its then-quotidian personal continuity of care it could generate those kinds of bonds and understandings that provided a potent mix of composite skills; we could weave together the science of medicine with the art of care.

With this we could often help the person through experiences that made them ill; we could help them through experiences from being ill. We could help endurance, and then the most creative responses within that endurance. *Medicine is a humanity guided by science; that humanity is an art and an ethos*, would be a guiding maxim.

This maxim has greatest value where problems cannot be rapidly and decisively fixed by medical technology; it is important to recognise that that is a very large part of primary and mental health care. The satisfactions that come from practising such pastoral health care are much akin to those that come from art, craft, and our best parenting and stewardship.

Within the framework of biomedical knowledge we did not just treat. We could care – by the resonance that comes from familiarity we could best contain, guide, support, encourage, or comfort whoever came to us suffering with whatever ailed them. This is an important distinction; while generic science can treat, it is only the idiomorphic that can heal and care. In those days of smaller practices and far greater personal familiarity we could fruitfully ask: how do we best engage with *this* person at *this* time?[2] Answering this question remains the essence of pastoral health care. It was inseparable from the *raison d'être* and the *élan vital* of traditional general practice.[3]

And both have been largely swept away by the buffeting and storm-surges of three decades of serial reforms. These successive reforms have a common theme and result. 'Efficiencies' were mandated widely but very often understood narrowly. The governing assumptions have been these: whenever and wherever possible, health care should be automated, standardised, coded, measured, centralised, proceduralised, and scaled-up.

These reforming imperatives together constituted a kind of industrialisation; later all have been accelerated and amplified by the superimposition of a market ideology – both actual commercial tendering and tariffs, and the cultural emulation of competitive commercial corporations. All of these reforms have been inimical to pastoral health care. Personal relationships and understandings – if they are now considered at all – are likely to be seen as (at best) peripheral and irrelevant, or (more likely) a distraction from the 'real work'. The 'real work' becomes the commodified (and so depersonalised) procedure.

This reformed healthcare terrain is thus barren to almost all forms of personal continuity of care that require a *modus operandi* that intelligently prioritises personal contact and familiarity.

ALAS

Let us return to the presenting problem. It is the destruction-through-reforms of the relational/pastoral side of health care that is most responsible for the alienated demoralisation of GPs and their retreat. Our imperatives to industrialise and marketise our previously village-like communities-within-communities has rendered us now, instead, a bleak, dystopian cityscape of lonely but crowded, tower-blocked, wearied, shift-working, gig-economy workers.

GPs now are most unlikely to know or even see their patients – their stories, their homes, their families, their hinterland. They are probably hot-desking, screen-gazing, part-time, on short contracts in large practices where their contact with other professional and support staff is largely business-like, remote, and perfunctory – there is little time for more. The previous hostess function of receptionists (yes, they were mostly women) has been almost entirely automated-out; they, too, are mostly now screen-bound and cyber-bubbled with digital duties.

Increasingly, this is a no-one-knows-anyone-but-just-do-as-you're-told-and-follow-the-algorithm world. In this the contemporary GP must function as a largely SFS (sort, fix, or send) practitioner, with patients who are personally unknown and will probably remain so. Contact with specialist services is most likely automated, remote, and algorithmicised. Known faces, voices, and stories; shared jests, joys, and sorrows; nuanced consolations and affections, all become rare as the people we know and the communities we organically grew, and which nourished us, disappear. In the future our technology may conjure cyborgs – Robodocs – for us to do such work reliably at the planners' behest. Meanwhile, our only-human doctors will not – cannot – commit themselves to such work.

Now a retired onlooker, I reflect on my working life. If I could live my life again would I be a GP from the 1970s? Definitely and joyfully. Would I be a GP in the 2020s? Never. Most of my peers have the same view.[1] No amount of money, training, or foreign recruitment will solve this predicament.

We need, instead, much restoration.[4]

Further reading

A more recent analysis, and elaborated remedial suggestions, can be found here: Shah R, Clarke R, Ahluwalia S, Launer J. Finding meaning, locating hope. *Br J Gen Pract* 2022; DOI: https://doi.org/10.3399/bjgp22X720845.

Footnotes

1. This statement is based on journalist-like qualitative research: for over 20 years conversational enquiries and written correspondence were conducted with hundreds of doctors and other primary care staff. The vast majority of those qualifying and working before the mid-1980s expressed the kinds of experiences and understandings conveyed in this article. Similar concurrence was found in kindred specialist and hospital practitioners, especially those working in mental health.

2. The centrality of such questions in the practice of two decades of GPs was crystallised and amplified by a pioneering psychoanalyst, Michael Balint, who, for many years, explored with GPs the human hinterland lying behind the technicalities of their work. His book, *The Doctor, His Patient and the Illness*, was often inspiringly influential to many GPs until the first neoliberal NHS reforms at the end of the 1980s. Balint's studies drew from the work of GPs whose personal continuity of care was a *sine qua non*.

3. Most older GPs agree that general practice was most satisfying, stable, and popular (with both professionals and patients) in the 1970s and 1980s. In this 'Golden Age', indices of staff stability, recruitment, motivation, and morale were all comparatively excellent. (This prevailing view did, however, recognise the greater irregularity of standards and the inferior technology of that time). Notably this period lay between the peak of Balint's influence and its extinction by industrial and neoliberal reforms that eventually made most personal continuity of care all but impossible.

4. The kind of restorative measures necessary for any successful salvage of better NHS pastoral health care – and thus the viability of its workforce – is outlined at the end of a think-tank article, *The Perils of Industrialised Healthcare, Exploring the Limitations of the King's Fund report: 'Reforming the NHS from Within'*, August 2019: https://citizen-network.org/uploads/attachment/657/the-perils-of-industrialised-healthcare.pdf.

David Zigmond,
Retired GP and psychiatrist, London. David has written and campaigned on problems within the NHS for several years: http://www.davidzigmond.org.uk/david-zigmond-archive-homepage/
Email: Zigmond@jackireason.co.uk

This article was first posted on *BJGP Life* on 17 November 2022; https://bjgplife.com/manufacturing

DOI: https://doi.org/10.3399/bjgp23X732177