Redundant subjectivity?

"My partner knows the difference between depression and physical depletion. This counts for little before the statistics and external guidance that have captured the GP's judgement and prescription pad."

I actively avoid going to my GP. One who 'should know better', over the years I have developed an increasing aversion to visiting the hard-working souls charged with my primary care. At the heart of this, I think, is the feeling that my subjectivity is now redundant and disregarded.

I go to the GP with a small number of problems, important to me, but apparently insignificant to them. Instead of attending to my concerns, the GP, gazing first at a computer screen, and then, driven perhaps by prompts and advice from government and other health bodies, takes my blood pressure and interrogates me on my lifestyle before giving me unsought advice about living a healthier life (as if I didn't know that I could do that, and were not ashamed of the fact that I don't). I leave the surgery officially edified, but feeling unheard, guilty, and demoralised.

My psychotherapist partner has become hypothyroid, a condition she was warned years ago that she might develop. She contemplated relinquishing her flourishing practice as she could not think. The GP's response: the blood tests show that you are within normal range, so we are not going to do anything about it. But you seem depressed, so why don't we give you a mental health plan and refer you to psychiatric services?

My partner knows the difference between depression and physical depletion. This counts for little before the statistics and external guidance that have captured the GP's judgement and prescription pad.

Strangely, if you go to the doctor saying you feel low, you can be administered heavy-duty psychoactive drugs without recourse to any physical tests whatsoever. So sometimes the patient's subjective experience 'trumps' all other information. Sometimes it is irrelevant, however lousy the patient feels, however close to some statistical borderline they are, and however cheap the putative treatment.

I write in a spirit of perplexed solidarity with GPs. My perplexity revolves around the fluctuating currency of subjectivity in illness and clinical encounters, the value of different kinds of evidence, and the nature of doctors' role in a context of ever more, and better, information and testing.

Regarding the changing value of subjectivity in illness and clinical encounters, until patients and doctors model themselves on machines, behaving consistently and predictably, subjectivity is unavoidable. If ignored, it will obtrude; patients will become uncollaborative, angry, or any number of other unhelpful, distressing things. This will be painful within doctors' own subjectivities. And surely doctors' own varied, needful persons are not just an unhelpful contaminant, perverting the course of clinical investigation?

The patient–doctor relationship, complex and contextual, requires many different kinds of evidence to achieve mutually satisfactory outcomes. What is statistically true for the population generally may not be so for individuals. Scientifically derived information is, at best, only half of the needed information. Other narratives and data are important; especially to patients themselves.

So to the role of GPs. Perhaps in someone's mind the aim is to make humans redundant in medical encounters so we can self-diagnose and treat with computers and sampling kits. But is it not GPs' job, skill, and satisfaction to mediate between varied data and facts and the subjectivity of patients, to attain a satisfactory outcome by which patients engage more fully with their lives?

I have heard senior doctors in the RCGP argue for this skilful, mutually rewarding approach. It would be much appreciated by patients, and it is not a reality in all local practices. Trust depends on attending to people and their concerns. GPs, please take our subjectivities seriously: we are stuck with them. If you don't, your capacity to deliver on 'evidence-driven' targets may be threatened by our avoidance and non-cooperation. The sources of guidance, protocols, and targets need to recognise that doctors and patients have awkward, delightful subjectivities so that we might enjoy happier, healthier professional relationships. Who knows, maybe the outcomes of encounters that take subjectivity seriously may be cheaper and more effective in the long run?

Stephen Pattison,
Professor of Religion, Ethics and Practice, University of Birmingham, Birmingham.

DOI: https://doi.org/10.3399/bjgp17X690257

ADDRESS FOR CORRESPONDENCE

Stephen Pattison
University of Birmingham, Theology and Religion, ERI Building, Edgbaston, Birmingham B15 2TT, UK.
E-mail: sbpattison@hotmail.com