Yesterday's man?

INTRODUCTION

I'm yesterday's man. It's now 15 years since I last saw a patient, and over 30 since my book *The Inner Consultation*[1] first appeared. I've never consulted by smartphone, or Skype, or even by email. Granted, lots of trainees, trainers, MRCGP candidates, and coalface GPs continue to invite me to ride my hobby-horses in retirement and talk to them about consulting and the doctor–patient relationship. Indeed, in Sweden, where things are a little more leisurely, I'm still today's man. And in Japan, where family medicine is in its infancy, I might even be tomorrow's. But in the UK, where GPs are desperate for time and overwhelmed by demand, and the QOF has them by the throat, I suppose I'm a dinosaur. *Passé*. Yesterday's man.

THE TRADITIONAL CONSULTATION UNDER PRESSURE

Just for old times' sake, though, indulge me; let's think about the consultation. At its simplest, in process terms, only two things need to happen when a doctor sees a patient. You work out what the problem is, and then you agree what's to be done about it. The important thing is to do them in that order, problem before solution. Most of the time, given today's superabundance of advice, guidelines, and protocols, deciding what to do isn't the hard part. The hard part is first making sure you've identified the *right* problem, the problem that *really* needs addressing, which is not necessarily the one that's obvious, or easy, or convenient, or state approved.

The pressures on traditional ways of consulting are only too familiar: rising workload and expectations; lack of time and resources; information overload; technological hyperinflation. And there is no shortage of suggestions for how to deal with them.

Too many patients with lists? Stick up a notice in the waiting room saying 'One appointment, one problem'. Always running late? Don't waste time on ideas, concerns, and expectations, and ignore hidden agendas. Not enough appointments? Forget continuity of care, and delegate the boring stuff to a nurse or physician assistant. Fed up dealing with the psychosocial? Swap the Kleenex for a rack of leaflets. Too many unreasonable demands? Just say 'no'. Too many reminders on the computer? Deal with your own agenda before the patient's. Middle-class patients complain they're too busy to come to the surgery? See them online. Tired of being too big a fish in too small a pond? Work 'at scale'. Belief in the egalitarian ideals of the NHS starting to wobble? Babylon beckons.

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It would be nice — wouldn't it? — if the challenges patients presented were either straightforward or somebody else's problem. It would be nice if more of them would yield to a quick fix: a management slogan, a politician's rhetoric, an IT upgrade, or a firm smack of what Stott and Davis[2] creepily called *'modifying help-seeking behaviour'*. But they don't, and never will. And if history teaches us anything, it is that simplistic solutions to complicated problems have unintended consequences, often catastrophic. Think Iraq, think Trump, think Brexit.

WRONG SOLUTIONS AND UNINTENDED CONSEQUENCES

A small but vociferous posse of innovation-besotted band-wagoners like to assert that the old assumptions about good consulting have had their day. *'Patient-centredness is an over-rated luxury'*, they cry. *'It's the flexible reed survives the gale, not the unbending pine.'* But I, yesterday's man, can't help thinking of babies thrown out with bathwater, or frenzied Gadarene swine rushing to oblivion. As HL Mencken said, for every complex problem there is an answer that is simple, plausible — and wrong.

New technologies, advances in artificial intelligence, revamped consulting tactics, alternative ways of working: all have their place — but only if they are genuine means to our only legitimate end, namely, to bring the best of personalised care to individual patients. To use them primarily as sticking plasters on a wounded NHS, or to keep a lid on demand, is, in the words of TS Eliot, *'… the greatest treason, To do the right deed for the wrong reason.'*[3]

In general practice today there is only one real problem, compared with which all others are as pustules to a pelvic abscess, and that is the lack of capacity in the system. There are not enough doctors, time, and resources to do the job as well as we know we should, could, and want to. That's the nub of it. Any so-called solution to any other so-called problem is a distraction, a betrayal, a mirage of symptomatic relief, but not a cure.

And then there are those pesky unintended consequences. The creeping erosion of long-established standards of consulting, whether in the name of necessity or techno-worship, has some important and far-reaching implications. According to the latest British Social Attitudes survey,[4] satisfaction with GP services fell in 2017 to 65%, by far the lowest level for 35 years, and for the first time ever general practice was not the highest-rated public service. If we are proud of the work we do, and want to remain so, and want to inspire the rising generation of young doctors to join us, then we should respond to this fall from grace with more than just a shrug. It is crucial, not

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paranoid, to ask ourselves why people don't love us like they used to.

PRESERVING KINDNESS IN AN ERA OF COMPROMISE

The core principles of general practice are so profound that they can be easily stated. The RCGP motto gets it right: *Cum scientia caritas* — science in the service of compassion, heart and intellect in harmony. Compromise on either one of them, and both are diminished. It is not 'progressive' to assume every new idea is a good one. It is not 'efficient' to try to lighten our workload by throwing patient-centredness to the wolves. It's one thing to compromise on what we know in our hearts is proper person-centred care as a temporary expedient during hard times. It's quite another to do so claiming, as Orwell's Big Brother might have done, that *'mediocrity is the new excellence'*.

Consulting skills are not a set of circus tricks, like spinning plates or lion taming. They are the expression, in words and behaviour, of our professional values. The consultation is a shop window where we display what we think is important about doctoring. To the patient, it is the litmus test of whether or not we in fact care as much as we say we do.

The playwright Alan Bennett, musing on the fact that his politics had not drifted rightwards with the passing years, recently gave as his opinion that *'little has happened to England since the 1980s that I have been happy about or felt able to endorse'*, and concluded, *'One has only to stand still to become a radical.'*[5] There are times, it seems, when true improvement consists of no more than sticking to one's principles while the rest of the world chases after novelty like potheads on a stag night in Amsterdam. General practice is, I suspect, living through such a time.

Let us hope that our profession does eventually get the injection of funds and the boost in staffing grudgingly promised by government. It will nonetheless be a Pyrrhic victory if in the meantime we have allowed our consulting skills, our ability to fashion life-pivoting conversations with our patients, to atrophy, discredited by the cynical and the smart-arsed. The understandable temptation, faced with rising demand and insufficient capacity, is to settle for more perfunctory, superficial doctor-centred consultations. But what starts as compromise can quickly turn to defeatism, and after defeat — extinction? We are spunkier than that. Let's at least tackle the right problem.

The novelist Sarah Moss puts this timely thought into the mind of a Victorian woman doctor: *'We make our choices and then we live with them, but nothing that we can choose exonerates us from the need for kindness.'*[6] I'll hazard a guess that if, 10 years hence, general practice still flourishes in any recognisable form, it won't be because ruthless pragmatism has won out over personalised care in all its fluffiness. It won't be because consulting a GP has become as impersonally convenient as shopping on Amazon. And if *anybody* comes to be seen as yesterday's man, I'd like to think it won't be me.

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