What do we want of doctors beside biomedical science?

'It is only theory that makes men completely incautious.'
Bertrand Russell, *Unpopular Essays,* 1950.

WHERE ARE WE NOW?

Our COVID-19 crisis has necessarily concentrated NHS general practice into a remotely delivered Sort, Fix or Send (SFS) service and — latterly — a mass-vaccination contributor. The current Health Secretary says that further remote digitised-cybernation of general practice is now the way ahead for our post-Covid NHS.[1]

WHAT IS AT STAKE?

As medical science becomes ever-more elaborate, extensive and exact, it necessarily divides into specialisms which need to be fed by some kind of sorting or referral agencies. While this was always a routine task for the GP, it becomes ever-more crucial with every biomedical advance.

The expansion of biomedical science's influence and complexity often renders its cleverness remote to lay understanding, seeming like magic conjured by inscrutable experts. This is so even if — perhaps particularly if — these incanted effects are both speedily and readily accessible: Abracadabra! So it is that biomedicine has come to be perceived much like the wondrously seamless yet now quotidian utilities and mass-produced objects our consumerist lives depend upon. The energy we use, the processed food that fuels us, our essential and safe water, the digital signals that connect us or cybernate the world around us — all of these things we know well how to work, often with little thought or even consciousness; yet we remain largely ignorant, oblivious or even indifferent as to how they themselves work. As consumers any advances in technology further distance us from any deliberation or concern of causation or context: if I press the button in a lift for the 12th floor I simply expect it to take me there.

All ages have probably had mindsets largely determined by the technology then available, and thus the instrumentalism they can bring to bear. Ours is one largely modelled and characterised by such achievements: precision engineering, remote control and commodified consumerism. The short-term benefits of current cultural mindsets in the last century have been immense. But so, too, are the accruing yet insidious liabilities — our almost unfathomable, unravelling environmental apocalypse is a now our most ominous example. If that threatened great unravelling is the signatured macrocosm of 21st-century evolution there are, inevitably, numerous heralding microcosms — examples from our daily lives — to configure this larger picture of unviabilities. The fate of NHS general practice is the one we are considering here.

WHAT WENT WRONG?

So why and how has NHS general practice become so blighted and unviable? Have we, increasingly, invested in spurious and mistaken reforms?

Well, for many years governing authorities have acted on their imperative: the institutional industrialisation and commodification (then commercialisation) of NHS healthcare. This necessarily then determines that all managed activities become prescriptively standardised, systematised, and delivered from increasingly large units that can provide a workers' pool of greater capacity and flexibility. This, in turn, can only be implemented by increasing surveillance and micromanagement of the workforce; it must become one that prioritises compliance to these larger plans, and eliminates non-compliance.

The subsequent serial 'modernising' reforms of the last three decades have all driven these changes, despite the mounting reports of collateral damage: practitioners talked of the loss of professional autonomy, trusting collegiality, work satisfaction, personal continuity of care, and the comfort of beneficent communities; patients' experiences have frequently mirrored these dissatisfactions of failure of personal engagement, understanding, and

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containment or care. Contrast this to erstwhile, pre-reformed GPs: they (mostly) could look after, and look out for, people usually known to them — both patients and colleagues. They felt themselves to be part of a professional community that itself looked after a wider community of those in need: a community within a community.

Those earlier practitioners, I think, knew that such relationships were essential for the kind of familiarity that could generate trust, and that these were cornerstones to the more powerful — sometimes decisive — nuances of diagnosis and healing. They saw the personally known, the idiosyncratically expressed, and the community context as being the staple of being a family doctor.

The current GP is unlikely to be rooted in — or even find — such human comfort or leverage: that which so effectively and personally anchors or amplifies the mere biomedical. Instead, the current Primary Care Commissioned Service Provider — who probably is personally unfamiliar with any particular patient — will be directed by algorithms to 'consider all aspects of the biopsychosocial'. How easily such intended motivational carrots become doomed to become follies of remote bureaucracy!

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The accumulation of such follies is not just an absurdity: it is a major reason why this profession is losing, first, its mojo and then, inevitably, its staff.

WHERE ARE WE GOING?

Leashing doctors' work ever-more tightly to the skeleton of the biomedical has become a directing and motivating principle of our thirty years of serial NHS reforms. GPs are, increasingly, expected to perform as commissioned Sort, Fix or Send (SFS) practitioners with patients in communities of which they may have little personal knowledge. Such biomedically distilled SFS GPs have closer resemblance to a warehoused Kwik Fit fitter or itinerant British Gas HomeCare engineer than any family doctor forebear.

Recent developments since Covid have amplified and accelerated these processes. This has become — for now — akin to wartime restrictions: the dangers of the pandemic and the priorities of survival have made most remote consultations imperative, and thus personal continuity of care a near impossibility. GPs have rapidly adapted to a default concentrate of SFS medical practice, delivered by telephone or digital media.

Few question that in this perilous and unprecedented pandemic such widespread cybernation of practice is surely a necessary and responsible compromise. But our current Health Secretary, Matt Hancock, sees many other opportunities besides: he sees such remotely delivered SFS-briefed practice not only as an essential — albeit temporary — life-raft, but thereafter as a favoured line of development throughout our health services. He reiterated this idea several times soon after it became clear how quickly and adeptly most primary care had adopted phone and digital technology to provide, at least, a skeleton service that was remote and thus Covid-shielded.

The Health Secretary's vision is for almost all general practice consultations to remain or become remote — conveyed either by phone or digital media — with only a small proportion of exceptions. The advantages seem clear to him — for example speed, access, corporate controls, staffing flexibility and reduced expenditure.

But such confident enthusiasm demonstrates how limited is his view of complex health problems and needs: he understands what technology and biomedicine can do but does not seem to perceive the vast area of health care that lies beyond any technologies or biomedicine. His scheme may work well for more straightforward acute conditions that can be rapidly streamed by an unknown SFS practitioner. But what about the many that are unstraightforward: the chronic, the compound-complex, the atypical, the proxied, the encoded and perilous cri de coeur? Where, in a system of remote and usually unfamiliar SFS practitioners, can we find the powers of personal continuity of care — relationships that can understand personal context and subtext; can contain, comfort and heal?

WHAT IS BEING LOST?

It seems that Hancock is blinded by science he insufficiently understands. So dazzled by the rapid increases in the cleverness and power of digital technology and biomedicine that he cannot see where they cannot reach. He is not alone in this bedazzlement: a similar blindness can be seen to be accruing with each of our many previous serial reforms. A similar blight is spreading throughout other welfare services, too.

So what is this vast healthcare hinterland that cannot be adequately and decisively 'fixed' by biomedicine? Soberingly, it is most of mental health and primary care. That is most of our consultation time, though certainly not the recipient of most of our healthcare funding. Consider: problems of development and maturation; stress-related and psychosomatic syndromes; chronic illnesses; most mental health; degenerative and ageing conditions; palliative and terminal care.

In this vast galaxy of afflictions biomedical science can rarely fix much decisively and thus often plays a secondary role. It must be choreographed and contextualised within professional capacities of personal experience, imagination and resonance. Such empathic skills and disciplines are, in many ways, artforms, though the doctor must always subject them to empirical trial and observational scrutiny — the foundations of all science.

This complex hybrid activity is what makes for any success that health carers can achieve with all those conditions we cannot quickly and decisively cure with biomedical procedures. With these myriad conditions — most consultations — we do many other things: we understand personal meaning; we witness, support, comfort, harbour, encourage, contain. Sometimes these meld into what is that most mysterious and blessed of influences — we heal. That is the art and science of pastoral healthcare — the human heart of our erstwhile general practice and mental health services.

But our reforms have by now made a thorough job of replacing the natural human heart that can extend itself, with an immured, mechanical one that can count but cannot value.

HINTERLAND

Sixty years ago Michael Balint began publishing his pioneering work investigating the vast hinterland that lay behind conventional biomedical categories and activities.[2] He explored how a different, more personal, kind of thinking and discourse could greatly enlarge our diagnostic understanding and therapeutic influence. Many writers have since explored and mapped this hinterland.

One, a frontline GP, David Misselbrook, describing an evening general practice Out-of-Hours visiting shift, stated *'That evening I practiced very little biomedicine, but I feel that I did plenty that I would wish to be included in the job of being a doctor.'*[3]

Will our post-Covid era doctors be, as our current Health Secretary recommends, ever-more cybernated and remotely accessed? And when they can neither arrange or enact a rapid cure, how will they then care?

David Zigmond,
Retired GP and Psychiatrist, London. David has written and campaigned on problems within the NHS for several years: http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html

Email: Zigmond@jackireason.co.uk

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