

Have rapid advances in IT, and the necessary coronavirus restrictions, rendered traditional face-to-face medical consultations largely redundant? Here are the views of three doctors: one younger, publicly on television; two older, more privately.

NEWSNIGHT'S VIEW OF THE FUTURE

In the third week of April 2020, already deep into our long COVID-19 maelstrom, a young female GP, Dr YW, was briefly interviewed for BBC2's *Newsnight*. She was fresh, direct, and warmly personable, and was introduced as, also, a newspaper journalist and thus (presumably) a part-time, 'portfolio' GP — a new and increasing breed of doctor better able to survive the otherwise unsustainable burdens of contemporary primary care. Portfolios may be rich in opportunities; they rarely commit, longer-term, to any community.

Dr YW was asked how, in her experience, was general practice coping with the current crisis? Her response was remarkably positive and optimistic: in her neck of the woods, she said, there was no crisis, in fact — paradoxically — the current challenges had improved many essential services in primary care.

How could this be so? Dr YW readily fired off her upbeat explanations: GPs had rapidly learned to increase their use of digital and IT devices to almost entirely replace the need for personal or physical contact with either patients or staff: *'In a couple of weeks we have learned, changed and thus advanced more than in the previous decade.'*

Almost all traditional face-to-face appointments could be replaced by emails, texts, and audio-visual phone calls. Consequently, at a stroke, much of the infrastructure and adjunctive services could be drastically reduced, if not eliminated: the large, costly premises with waiting areas, the numerous consulting rooms, and the reception staff. This unencumbered service has consequently become more manoeuvrable and (virtually) accessible. Teleworking professional staff can opt in to staggered work rotas providing vastly increased (virtual) consultation hours, often working from home: shared electronic records make personal continuity of care largely redundant and irrelevant. Likewise a shared working space. These bouncy, confident assertions could have been

mentored by a PR or advertising agency. *'Because of these rapid changes, we've never had more capacity [for core tasks].'* was one of her cheerful boasts.

At the end, if she had turned directly to the camera and beamed exultantly, *'The future's bright! The NHS is virtual!'* it might not have surprised the viewers. I imagine governing politicians and NHS executives watching felt relieved, if nervously, and only for a while.

A DIFFERENT VIEW OF THE FUTURE

A day later an older, a late-middle-aged GP, Dr MM, is talking on the phone rather differently of his working life. He had watched, and listened carefully to, Dr YW's youthful and bracing optimism. What he has to say is worth quoting at length:*

'Well in some ways she's correct, and persuasively so. Yes, it's true that we GPs and our staff have adapted remarkably quickly in adopting all the IT devices and procedures she mentioned to enable a new kind of lockdown service. So she's right to applaud the profession's efficiency and plasticity here. But I don't otherwise want to join her on her Bouncy Castle because I don't feel much bounce about what this job has now become: it may be charged with the adrenaline of a crisis, but it has assumed the lifeless loneliness of a call centre.'

'As that young Dr YW said, we now do exceptionally few face-to-face consultations and no home visits. Our 'real' encounters with other staff are much reduced: wary, brief, sparse and usually singular. So my workstation [should I still, hopefully, call it a consulting room?] has become — I imagine — like a command post in a submarine or nuclear fall-out bunker: I am planted there



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to receive and process signals and data from a world beyond that I must distance myself from ...'

'So there I sit, often for many hours, with screen or phone. There are endless emails. The increasing number from institutions — informing and instructing about innumerable things — are so many, long and bureaucratic as to defy my sustained consciousness. Those from anxious patients are often nervously chaotic beyond ready comprehension. I often feel like an exhausted traveller trudging for survival against a driving, blinding blizzard.'

'The phone calls with patients can actually be a bit of a relief: at least there's a human and individual voice there! That provides me with some personal exchange and vitality. But even that isn't what it was ... you see, in earlier times, when this practice was much smaller and GPs had their own patient-lists, we used to know our patients much more.'

'Why does that matter? Well previously

"Consider: problems of maturation and development; all chronic structural disease; functional and psychosomatic syndromes; stress-related illness; mental health; the degenerations of ageing; and terminal care [...] what is sacrificed in our acceleration into a health care that is rendered increasingly generic, cybernated, and remote?"

when I saw somebody's name or heard their voice there was already, frequently, a bond of knowledge and understanding — often trust and affection, too. That didn't just help me operationally, it replenished my morale and motivation ...'

'All this applies just as much to the enormous traffic of signals from hospitals and investigation reports, and then requests for prescriptions, and my own medical reports. In my younger days, when I looked at each of these, an anchoring and enlivening face, or voice, or memory would often, briefly, enter my mind — I would most often know the person referred to. That wasn't only more pleasant and interesting — it was also safer, too. Now I'm looking at these things and I usually don't have a clue who the person is — it's all become much more abstract and impersonal ... my attention is then bound to drift. Yes, I can go into the electronic records, but I find that that is no substitute for what I'm talking about: personal and historical knowledge — that's mostly gone.'

'In a way none of this is new, but it's certainly accelerated in these last few weeks: since I joined general practice twenty years ago all the reforms have made it less personally rewarding for me. All the automations and amalgamations have made strangers of our previous little communities. And the box-ticking way of controlling us has largely driven out my sense of judgement, skill and joy in my work.'

'Yes, I think most of my peers feel the same, but they keep going. Why do I continue? Well, I really believe in the NHS: in my youth I'd always wanted it to be my life's work ... I keep hoping that we'll somehow get back to some of the values that beckoned me to be a family doctor, all those years ago. I certainly never wanted to be a Senior Call-Handler or Submarine Commander!'

'Will I still be here in a couple of years? I'm increasingly doubtful.'

WHO IS RIGHT? WHAT IS LOST?

I am doubtful too, but also hopeful, that Dr MM might stay. He has, at least, a concerned sense of the human value of what is being lost: what is sacrificed in our acceleration into a health care that is rendered increasingly generic, cybernated, and remote? Dr YW seemed, to me, to have, instead, cheerfully jettisoned — or been oblivious to — these considerations.

History can explain some of this, and

my own perspective, too. I joined general practice in the early 1970s, when skilled personal encounters, often from a base of personal continuity of care, were regarded as a bedrock of our applied medical science. When Dr MM embarked 15 years later, this culture was well-rooted and respected, but already threatened by the early stirrings of neo-liberalism ... yet it remains for Dr MM as a clear, strong, early memory. Dr YW, in contrast, has had no such experience: she has known only a health care that, de facto, is increasingly cybernated, automated, marketised, and generic. Here corporations may (with difficulty) be publicly accountable, but individual vocation is driven to irrelevance. Dr MM and I reciprocally commiserate on this shared loss.

The general practice of this post-millennial era is modelled increasingly on a 'Sort, Fix or Send' (SFS) model. This limited (if demanding) brief is well-suited to contracts, measurement, procedural management, and thus commodification and commercialised industrialisation. So SFS is best suited to well-defined 'fixable' problems, usually of the surgical or acute medical kind. But such SFS practice falls far short of adequate when dealing with anything that cannot be so simply processed, and that (surprising to some) is the larger part of our erstwhile general practice. Consider: problems of maturation and development; all chronic structural disease; functional and psychosomatic syndromes; stress-related illness; mental health; the degenerations of ageing; and terminal care. Few of these can be fixed, but we are now pressured to be ingenious at circumventing or redefining them, to fit our SFS schedules.

So what may otherwise we do in this vast hinterland of SFS-incompatible problems? Well, the answer to this question tells us much about both the *raison d'être* and *esprit de corps* of the kind of general practice now lost to Dr MM and myself. In previous times on those occasions when we couldn't fix something we could find the headspace and heartspace to ameliorate, comfort, guide, support, palliate, encourage, and not uncommonly — that mystery that transcends any procedure — we could heal.

Yet all of these activities can anchor and thrive only alongside the growth and reliability of personal attachments, relationships, and bonds — these are not in the realm of the currently prevalent commercially-commissioned teams and procedures, but of vocational practitioners tending known individuals in the longer term. We can call all this non-SFS activity

'pastoral health care' and, importantly, it is mostly synonymous with personal continuity of care.

HUMAN GRIEF

Dr MM later talked of how moving and nourishing a particular encounter was for him when, just before COVID times, a freshly-widowed nonagenarian, Nellie, came to share her lonely, frail grief with him. He found himself far away from any clever package or fix:

'I know there's nothing you can do, doctor, but you've known us both for all those years ... I just want you to know what I'm going through. It makes the world of difference to me, my knowing that you know,' she had said.

In his more recent phone call Dr MM reflected:

'That brief tender conversation I had with Nellie made all the difference to me, that morning, too ... such deep and fragile sharing used to be much commoner in general practice, but we've made it very rare. Since COVID lockdown, I find it now impossible.'

A FINAL THOUGHT

As I approach my mid-seventies I count my blessings: I currently need only repeat prescriptions to contain my common risk factors. Eventually, unless I die quickly, I will want a vocational GP committed to pastoral health care. I may not live longer, or even be less ill, but such personal containment and care will make my experience much more bearable.

Instead, I fear I will be Zoomed by a pixelating face with a voice I do not know. The call will be compressed and monitored amid the many other remotely operated and cybernated clinical tasks for the doctor designated to that shift.

I wonder: would Dr YW feel vindicated or alarmed by this?

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*Dr MM wishes to be quoted, yet retain anonymity.

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