A Loss of Human Sense and Scale: a view from general practice

A dialogue between Doctors for the NHS and Dr David Zigmond

David Zigmond and Doctors for the NHS

What happens to our welfare services if our drive for ‘efficiency’ drives out the smaller scale that fertilises our better human sense? This dialogue examples and explores the current abject plight of NHS general practice.

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Alan Taman (AT) interviewed David Zigmond (DZ) about his specialty, general practice

AT: *What is wrong with the NHS, and general practice in particular?*

DZ: What most people say now is this: that the NHS is short-changed – more and more is expected from us without the necessary resources, so the system is buckling. Various levels of management and policy makers will attempt to obfuscate or justify that but anybody working at the system's frontline realises that more and more is unviably and unrealistically demanded from primary care. There has not been a commensurate increase in funding and hence it cannot cope. That is a very simple formulation and I certainly agree with this, yet wish to make an important addition.

AT: *What is that?*

DZ: Well there are three burgeoning forces that have made that conundrum worse:

1. The Four Cs – competitive commissioning, commodification and commercialisation
2. REMIC – remote management inspection and compliance
3. Gigantism – the wish to scale up whenever we can, particularly true in general practice.

These devices are supposedly there to make the system more fail-safe, more efficient, and yield better value for money. My view, instead, is that actually they have often been very damaging. The reforms that have been bought in to try to get better results for less money have, in reality, not just left us where we were – they haven't just been ineffective – they have damaged or destroyed many of the good services that we had.

AT: *Are you including general practice there?*

DZ: Yes, certainly. That's a prime example of what may happen when schematic management attempts to short-circuit human scale and personal relationships. So the

result here is that personal continuity of care has been relegated to a peripheral irrelevance, something that can be brushed off as unimportant. Yet it was that – personal continuity of care – which offered the greater satisfaction and motivation in general practice and also – very importantly – conferred significant therapeutic benefits. If we get to know people, we know how to talk to them better, we understand them better, we can make more rapid and more accurate formulations. *The more you see of someone, the more of someone you see*. That is what has been destroyed.

AT: *Why has this happened?*

DZ: Because we've attempted to industrialise almost all of healthcare. In general practice this is signified by how most people now cannot name their GP. They say they are registered with a large and designated practice, but they do not know who their GP – a *person* – is. A place is not a person. Now, from my own experience, I know that if I go to my GP I will probably, each time, see somebody different… So I'm experiencing the importance of that distinction first-hand.

AT: *OK, but generally what does that mean?*

DZ: What that means for the patient is that they are increasingly unlikely to develop a personal relationship where they feel understood and contained. That doesn't matter if you have a complaint that is likely to be fixed by one rapid intervention – but it can matter enormously with anything that is stress-related or chronic, so anything to do with mental healthcare, and anything to do with ageing… Those things can't just be fixed. Yet together they constitute, largely, the *raison d'être* of general practice! So the reforms have become inimical to all the fundamental tasks of primary care that depend on the subtleties, the multi-levelled ways, in which doctors and patients interact. These traditional considerations have become so peripheral as to become almost destroyed in current general practice…

AT: *So who is seriously affected by that?*

DZ: Well, again, the current trend is not good for those of us who don't have those relatively simple complaints that can be rapidly and completely fixed, because they don't see the same person again. For the doctors it's become very frustrating work. How can it be a satisfying job to be a GP if you don't personally follow up a patient's state of anguish and chaos – and then you find yourself saying to the next patient: 'one person, one complaint, ten minutes'? That's what it's like now.

The current way of operating assumes that everybody knows exactly why they are coming to the doctor and the doctor is going to readily and rapidly agree. But a lot of people go to their doctor with inchoate complaints: feeling dizzy, having headaches, not sleeping, or having 'no go in me', and they don't know why … or it's about 'that' but actually underneath 'it' lies a serious life problem for which they do not yet have clear thoughts or words. To just fire-and-forget those problems, deal with them in ten minutes, when you're not going to see the person again, is mostly going to be very unsatisfactory for patients, but it's unsatisfactory for the doctors too … and neither like it! That's why GPs don't want to do the job any more.

AT: *When you started as a GP in the 1970s how was it different?*

DZ: Well, in the past when practices were much smaller: doctors generally got to know many more of their patients, and over a much longer timespan… Yes, it's true that standards were then even more variable than now… But overall the satisfaction rate was very high – general practice was very popular until the end of the 1980s. Since that time, each successive effort to make it more like a competitive manufacturing industry, to marketise it and to police it, has made the job more and more unworkable and unappealing.

AT: *Could we reclaim the same degree of satisfaction in the current system if patients can mostly see the same one or two or three doctors over time?*

DZ: Yes, but that's much more easily done from a practice that is small-scale, so current Gigantism is a real problem here. I was a GP Principal for forty years. I worked very

closely from a small, stable practice with a few colleagues over a very long period. I always had an assistant, a counsellor, a nurse practitioner or an experienced nurse. There were at least four of us. Crucially, I got to know them all. We all knew one another personally, and the way each other worked – so we developed a kind of professional familiarity, professional intimacy even. The patients certainly knew us all by name. The receptionists, too, were very much part of this personal–professional network. Very often I'd listen to the receptionists answering the phone and hear how they would recognise patients' voices. Increasingly they would get to know patients as individuals. So right from when the receptionist picked up the phone it was personal and it was frequently subtly therapeutic. That's very different to what you usually get now. Hardly any surgeries have a receptionist who answers the phone. Each caller has to go through an automated series of algorithms to eventually (perhaps) speak to somebody. There is very little comment or debate about this change, yet I see it as a deceptively profound loss. Again, this is justified as being apparently 'cost-effective'.

AT: *What's the result of this?*

DZ: Well, the receptionists aren't receptionists now. They hardly greet or get to know patients. They rarely calm or guide patients. Mostly what they do, instead, is back-office work with computers … about patients who are unknown to them. This is now part of a massive cultural problem: we believe that anything made quicker and cheaper by automation must be better. So often we ignore our losses until it is too late.

AT: *In this vein, how do you see smartphone apps affecting general practice?*

DZ: Initiatives such as *GP at Hand* and remote consultations can seem good, again, for people who have a single problem that is fairly easily and rapidly identified and fixed. So in other words, if you are a young, fit person and you get, say, a throat infection, you can probably be fixed with a single intervention. So it doesn't much matter who is diagnosing because it may not be particularly complex, stress- or life-related. Then it's OK. So young, mobile, fit, relatively untroubled people do like this kind of service because it's a bit like getting a pizza delivered to you at 11 o'clock at night: you just get

what you want very quickly. But it is certainly not so good if you have a complex condition, or if whatever condition or vulnerability you have is related to all kinds of other life stresses and wounds – and all that is very common in general practice. So we can see that these 'quickies', such as *GP at Hand*, can engage only superficially with the vagaries of mental health. Generally, if we have any kind of deeper anxiety, preoccupation, struggle or stress, it is far more effective and comforting to talk to somebody who we know rather than somebody you don't know and whose face and voice we don't recognise. The problem with remote consultation apps is, it's a little bit like internet communication…

AT: *So what's the problem with that?*

DZ: Well, all the meta-communication gets short-circuited…

AT: *What does that mean?*

DZ: It means that there's no body language, mien, physical demeanour. So we lose all the things we radiate and emanate with one another that we're often not really aware of. All of that becomes peripheral to our screen-signalling and is therefore discarded. Human presence is often so different from cybernated signalling. Indeed, I think that often the most valuable part of consultations are these human-to-human connections, vagaries and unmeasurables.

AT: *Is that all that's lost?*

DZ: No. The other thing that concerns me is the effect on our healthcare economy. You see, apps like this can easily cream off all the stuff that is rapidly and easily fixed. This leaves those people who can't or won't use them to be cared for by the increasingly depleted and overburdened remaining general practices, who are then inordinately responsible for all those most difficult and refractory problems… The consequent conundrum then is, how do we arrange the funding to reflect that, because things that are *not* easily

fixed are bound to take up much more time and resources than things that *are* easily fixed.

I think a crucial misconception here is misdirecting us. So much of our healthcare is now modelled around the notion that *anything* can be straightforwardly and definitely diagnosed and fixed. I would say that this assumption is very often untrue: sometimes we can't make such a single, definite diagnosis.

AT: *Why not?*

DZ: Well, just say we are dealing with somebody who was married for a very long time and she or he loses their spouse and then, after the spouse's death, they find out that the spouse had been both financially and sexually devious with them over many years. This person comes to the GP complaining of all kinds of multi-systemed and protean symptoms – what is the diagnosis? And how do we guide them through that? So with such raw and real problems we need all kinds of skills, and we need often several consultations to guide people through such painful and confusing mazes. This kind of complexity requires a lot of delicate trust developing on both sides. And that example is not an uncommon kind of scenario in general practice … if we have time to see the gestalt!

AT: *Don't the powers-that-be recognise this?*

DZ: Mostly not. If we're not receptive to things, we don't see them. The health policy people – managers and planners – have tended to view everything as if it can be diagnosed, dispatched or treated in a factory-packaged consultation. Yet the reality is often so different: it might take four or five very sensitive prior consultations to get someone to even begin to share what is personally, and then diagnostically, meaningful. So often people come with all the symptoms first and the doctor thinks, 'what on earth is going on? All investigations are normal.' Only if the GP can talk to such people in the right way may they eventually tell the GP the story. And that requires the kind of time, headspace and heartspace to develop the required trust, bond and relationship…

AT: *Is trust being ignored in the way general practice is being changed?*

DZ: Yes, not only ignored but destroyed. Most practitioners now are not trusted. Why else do we have to get them *all* to do so many appraisals, audits, 360-degree feedback – all these compliance submissions – and *then* to police the service as heavily as we do? The kind of scenario outlined above, where it requires a lot of receptivity and trust for somebody to open up, depends upon a certain kind of ambience and space in a GP surgery which you can't do if people – doctors and patients alike – feel they are being pushed through a micro-managed sausage factory. You can only achieve this kind of delicate interaction if the person really feels that the doctor is personally interested in them as an individual. In doctors' current working conditions, patients are far more likely to get a stressed, tired, bleary-eyed doctor who's looking at the computer and in no state to take that kind of particular interest them – the kind of interest that leads to the possibilities of healing encounters that I am talking about, and that the better GPs used to be very good at. We called it 'person-centred' medicine: it was what got me into general practice forty-five years ago.

AT: *Is everything to be justified in terms of monetary cost?*

DZ: That's a seminal danger. Of course money is a factor: we don't have unlimited money for anything, or certainly everything. So we want money to be spent in the best way. It wouldn't be satisfactory for one GP to see five patients in the day if other GPs are seeing thirty-six. Five people a day is then not good value for money!

The problem is complex. So we have to make sure that our answers to this problem are sophisticated and flexible because, as we can see, so many things we deal with and do cannot be accurately measured. Value for money can only be defined with any degree of clarity and precision with things that we can readily measure, like how many patients are being seen each day, how many people have had their blood pressure taken and so on. It's easy to measure such things. But what about the kind of scenario that I described above? That's much more difficult: yet such unmeasurable aspects of

healthcare are probably greater than the measurable ones (but how can we ever measure *that*?!). So then it's very illusory to come up with simple formulae that are going to give us value for money. Our over-assurance here is where we've gone so very wrong.

AT: *Can you give examples?*

DZ: Yes. I'll probably repeat myself, but this is important. If you are, say, a cataract surgeon it's quite easy to measure how many cataracts you're doing and how many of them go wrong, and how much money was spent on running your service. So the inputs – resources, finances, staff required, etc – can be clearly established. This is also true of the output: the number of extractions and the number having a post-operative problem. All those things are easy to measure. But how do we do this with general practice? How do we do it with the patient in intense domestic turmoil, the one who struggles with secret addictions or complex grief? How do we metricise family problems causing symptoms in the children? How do we measure that a GP contains and guides the parents in such a way as to secure a better long-term outcome for a child? It's all very difficult to measure. I think I can tell a good consultation when I see one but it's very difficult to assess via mere statistics. Yes, as I've said, we can readily measure some simpler parameters, such as hours worked, number and ages of patients seen. But the quality of the guidance through difficult illnesses or life transitions and so forth, and the nature of the experience for the patient – all this is very difficult to measure, if only because very often these are delicate matters, and people don't want to fill in questionnaires about them.

AT: *What effect have computers had on all this?*

DZ: Vast, but my answer here necessarily has to be brief! I think since we've been able to use computers, which are unprecedently brilliant at crunching numbers, we have become obsessed with metrics. We think that we have to measure everything. We certainly didn't do this nearly so much in the era before computers because we would have had to employ a million people to collect data and then do the calculations!

Because computers can so easily do all this, we have become more and more computer-oriented.

AT: *What does that mean? What has it led to?*

DZ: Well, we have increasingly over-valued – often fetishized – what we can measure, and then we have increasingly under-valued what we can't measure … and then, most egregiously, we kill it off.

AT: *Are GPs are especially affected by this?*

DZ: Yes. The reason why GPs are so frustrated by this, and eye surgeons are probably not, is because we can more readily proceduralise eye surgery and monitor it, and so make it much more algorithm-based than we can with psychiatry and general practice. Interestingly, those are the two professions that, in particular, have become massively unpopular and demoralised. Practitioners there feel they have lost the art, the heart, the soul and the spirit of practice – what makes the job creative, meaningful and worthwhile.

AT: *We haven't yet talked of privatisation…*

DZ: Ugh, privatisation! The *bête noire* of the DFNHS! Well I certainly think that privatisation makes all this worse. Where we privatise care we find that practitioners pursue short-term tasks and not the long-term effects of intervention, for example on the individual's life course or on the wider family. Privatised services tend, rather to be more interested, say, in how briefly can this person stay in hospital: is this good value for money, and eventually even good value for the Board and the shareholders? The Four Cs, REMIC and Gigantism – which we talked about earlier – are boosted very much by privatisation because governing authorities then want to run things like a factory, which makes a profit – often in a short-term way that is unsustainable. That's a very different set of guiding principles from socialised Welfare, or pastoral healthcare, which is about a more holistic and inductive kind of influence, where one often does not see immediate

benefit – akin to hopefully and carefully planting seeds that will take root and flourish later on.

AT: *Did you, then, see that as a large part of your work?*

DZ: Yes, certainly. What I found in general practice, over many years, was the value of having certain kinds of conversations: with struggling parents, turmoiled youth or lonely elderly, say, where I could help them in their difficult predicament of being isolated and alienated when they had become adrift from Kith or Kin. Personal continuity of care is mostly essential for such effective comfort and healing.

AT: *And now?*

DZ: Well, our increasingly industrialised and commercialised healthcare is not going to be interested, or even register, such common human predicaments or their relief is it? Where is the contractually extracted profit in that?

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