What do we want of doctors beside biomedical science?

David Zigmond

Our Covid-crisis has necessarily concentrated NHS general practice into a remotely delivered Sort, Fix and 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.

What is at stake?

No theory is good except on condition that one use it to go beyond.

– André Gide, *Journals. 1918*

It is only theory that makes men completely incautious.

– Bertrand Russell, *Unpopular Essays*. 1950

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 General Practitioner, it becomes ever-more crucial with every biomedical advance.

The expansion of biomedical science's influence and complexity also renders its cleverness often 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 distances 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 communal mindsets largely determined by the kind and prevalence of 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 benefits of such current cultural mindsets – at least short-term – 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.

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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.

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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 what they have considered an imperative: the institutional industrialisation and commodification (then commercialisation) of NHS healthcare. This necessarily then determines that all possibly managed activities become prescriptively standardised, systematised, and be 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 vaunted and propelled these changes despite the mounting reports of collateral damage: practitioners talked of the loss of professional autonomy, trusting colleagueiality, work satisfaction, personal continuity of care, and the comfort of beneficent communities; patients' experiences have very frequently mirrored these dissatisfactions of failure of personal engagement, understanding, 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 contexted as being the staple of being a family doctor.

The current GP is unlikely to be rooted in – or even find – much 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 be follies of remote bureaucracy!

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.

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So it is that 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. Within this design GPs are, increasingly, expected to perform as commissioned Sort, Fix or Send (SFS) practitioners with patients in communities they have usually no personal knowledge of and, most likely, will never develop. Such biomedically distilled SFS GPs have closer resemblance to a warehoused Kwikfit Fitter or itinerant British Gas Homeserve 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 all GP consultations to remain or become remote – conveyed either by phone or digital media – with only a small proportion of exceptions. Some advantages seem particularly clear to him – for example speed, access, corporate controls, staffing flexibility and less expenditure. But such confident enthusiasm demonstrates how limited is his view of our complex health problems and needs: he understands what technology and biomedicine can do, but does not seem to perceive the vast area of healthcare that lies beyond any technologies or biomedicine.

Admittedly, 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 – those relationships that can understand personal context and subtext; can contain, comfort and heal.

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It seems that Hancock is blinded by science he understands insufficiently. So dazzled by the rapid increases in the cleverness and power of digital technology and biomedicine that he cannot see where they cannot usefully 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. Many allege a similar blight 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 NHS 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 (by definition); 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 healthcarers can achieve with all those conditions we cannot quickly and decisively cure with biomedical procedures. With these myriad conditions – the majority of 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 that natural human heart that can extend itself, with an immured, mechanical one that can count but cannot value.

Sixty years ago Michael Balint began publishing his pioneering work investigating the vast hinterland that lay behind conventional biomedical categories and activities[1]. 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[2], is quoted at length in an Appendix[3] for more interested readers.

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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?

Ten lands are sooner known than one man.

– Yiddish proverb

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References, notes and Appendix

1. Balint, Michael. *The Doctor, his Patient and the Illness*. Pitman, London, 1956
   This book is probably the most seminal introduction to Balint's own work. Its style and milieu may be dated, but its important messages remain timeless.

2. Misselbrook, David. *Thinking about patients*. Petroc Press, London, 2001
   Written forty-five years after Balint's, this book certainly provides a bridge to our more recent past.

3. Note and Appendix

   Misselbrook's book *Thinking about patients* is a wide-ranging, very readable study of how much of medical practice lies outside the biomedical and how, in a way that is useful, we can best understand and address this.

   Misselbrook's professional basis for this analysis was as a long-serving inner city GP. He came to understand much of general practice as being more about the science-art hybrid of pastoral healthcare than its prevailing and increasing bias toward a less adulterated data-dominated biomedical science. He saw his own role as often being a kind of modern, scientifically informed Shaman.

   To illustrate his argument and evidence Misselbrook documented 11 consecutive weekend home visits he performed in 2000 while working an evening shift for an Out of Hours GP Coop that he shared with local, familiar colleagues. He arranged the case-vignettes in the sequence they occurred, and wrote them the following day. They were published in his book a year later.

   The Millennium occurred in the last days of the era where such person-centred pastoral healthcare was so much more possible. Misselbrook's vignettes are not concerned with continuity of care, but they do illustrate with candid, sharp clarity a human view of medical practice that is now so often lost to our procedure-defined reforms.

For this reason the cases merit our continuing attention. They are quoted, in full, in the following Appendix.

APPENDIX

Looking at a Co-op shift

So what difference does all this make? If we extend our gaze beyond the biomedical, if we use words and models from the broader perspectives we have examined, how does this affect our job? The doctor's shamanistic role within this broader gaze is illustrated by looking at an out-of-hours shift. In setting the scene I will mention the biomedical issues but not dwell on them. I am asking two questions:

- What's going on?
- What does the patient need from the consultation?

The practice to which I belong is covered out-of-hours by a large GP Co-op. I generally do a Sunday evening mobile shift, being driven round to calls that a colleague at base has passed on for a visit. Sunday evening is the time that things fray at the edges if you're sick. You might have been sick all weekend, hanging on for Monday when surgery re-opens, but as night draws in you can't make it. You need a doctor tonight.

This is an anonymised version of one Sunday evening shift in winter. I have changed details to protect patient identities, but even if the colours are different the patterns are true. As the shift went by it struck me just how little of what I was doing was "medical", so given that I was doing something, I noted the cases to try to work out what that something was.

Call 1

We started to drive to what eventually became call 2, but base diverted us, en route, to an urgent call to a man with difficulty breathing. The London Ambulance Service (LAS) were already on scene. Their message read "61-year old-man, possibly dying, ?LVF, but won't go to hospital". On our arrival LAS had nebulised him and he was "much better". He lived in sheltered accommodation. He had established COPD with asthma, and looked nearer 80. He was surrounded by empty lager cans and well used ashtrays.

On examination there was no LVF. He wouldn't go into hospital, as he would not be allowed alcohol or cigarettes. I started him on prednisolone - he already had some in hand. The warden came by and promised to keep an eye on him. I liked the warden - he looked like a wrestler and got on with the patient in an amiable and common sense sort of way.

- **What's going on?**
  The patient has a chronic illness, now irreversible, largely caused by smoking. He had a severe asthmatic exacerbation that was successfully treated by LAS. LAS are anxious that he is alone. He is anxious to maintain control over himself, and maintain his chosen lifestyle.
- **What do they need from the consultation?**
  LAS needed permission to leave him. They all needed me, as an authority figure, to adjudicate. He needed permission to start the treatment he already had. My role was as an adviser and social arbiter.

Call 2

An 87-year-old woman in sheltered accommodation. She has recurrent cellulitis of the leg, threatening to break down. The warden was concerned about the possibility of "a clot". On examination the problem appeared superficial with no evidence of a DVT. The patient gets confused and takes off the dressings. A pill check shows that she is not taking her antibiotics. The warden is not allowed to administer her medication. An equally unqualified carer should give her medication, but she gets a different carer on different days. I arranged that the warden would supervise the carer.

- **What's going on?**
  A mildly confused elderly lady has chronic leg problems, with a low level of uncertainty about the possibility of a DVT, which commonly has false negative examination findings. A bureaucratic system has disempowered the warden, the person most able to manage the problem. The warden feared a reprimand if she "missed something'.
- **What do they need from the consultation?**
  The warden needed me to be an authority figure, sanctioning a compromise to the bureaucratic impasse.

Call 3

Another urgent call, to a 66-year-old man with his anxious wife in their tiny old terraced house. He had just had his third ever TIA, which lasted about three minutes. There was much panic - might he be having a CVA or an MI? (He had a past history of both, and was on appropriate medication.) He calmed down with a cigarette, and was much better on our arrival. He complained of feeling shaky like "two days after action in Korea". There were no acute findings.

- **What's going on?**
  A TIA, provoking a fear of death or disability that they could not cope with.
- **What do they need from the consultation?**
  They need a shaman to tell them that "this is not the one", he will be all right.

Call 4

A teenager with his mother in a cramped attic conversion flat. He has earache after a URTI concurrent with a 14-hour plane flight. There was no 0M. I advised paracetamol.

- **What's going on?**
  Self-limiting Eustachian tube obstruction, with poor parental coping mechanisms due to the lack of an adequate social support network. Desire for a magic fix to a self-limiting problem.
- **What do they need from the consultation?**
  Self-help advice from an authority figure who restores a sense of control.

Call 5

A 2-year-old with a fever. He has been on Ciprofloxacin for 0M for 24 hours. The patient and his parents live in a hostile block of flats, with a Pit Bull type of dog for security in a basket

by the front door. The room is hot. They are giving sub-optimal doses of paracetamol. Examination confirms 0M only, and the child's general condition is satisfactory. I advise the worried parents.

- **What's going on?**
  Parental anxiety and lack of experience, exacerbated by the lack of a "granny' figure to coach and reassure. A parental desire for a magic fix to a problem that will soon resolve.
- **What do they need from the consultation?**
  Coaching and reassurance from an authority figure, as a granny is not prescribable.

Call 6

A middle-aged woman who six days previously had witnessed the failed resuscitation of her husband for haematemesis, during which he had received 10 units of blood. A neighbour had found her, confused and covered in red nail varnish. Her son was now with her, and was coping well. She has a past history of mental health problems, the son is not sure what, but it doesn't sound as if she has ever had a psychotic illness or admission. She is in a partially disassociated state, denying that her husband is dead, and is preoccupied with cleaning the house. She appears to be in no danger. I chat to the son about defence mechanisms. He will stay with her to ensure her safety, and will call us if there is further concern. I arrange for her own GP to review the situation tomorrow. This call takes some time.

- **What's going on?**
  The patient is in "hysterical" denial as an effective, albeit temporary, defence mechanism from a traumatic and horrendous loss.
- **What do they need from the consultation?**
  The patient needs to be able to face the early stage of her traumatic loss at her own pace, with family support, in a secure environment. The son needs to be reassured that he has the appropriate human resources to help his mother. The son also needs a sympathetic shaman to offload on in the absence of anyone else, as he is also processing his own loss. They both need the permission and support of an authority figure to get •through this with their own coping mechanisms, rather than medicalising the problem.

Call 7

A lady in her 70s with a productive cough two days after her cataract extraction. I prescribe amoxycillin.

- **What's going on?**
  A borderline bronchitis, possibly as a result of a general anaesthetic.
- **What do they need from the consultation?**
  A minor biomedical intervention and reassurance that all will be well.

Call 8

A young self-employed tradesman who has had intermittent left renal pain for five days. He is being investigated by his GP and has adequate analgesia, and is due an urgent Outpatient

appointment in the week. However his girlfriend wants it sorted out now. I check him over, but there is nothing that can be done at the weekend to further his management.

- **What's going on?**
  Tolerance of uncertainty can be hard. Loss of income can be harder. A magic fix would be better.
- **What do they need from the consultation?**
  I can give a reassuring second opinion and advise patience, but I feel I have little more to offer.

Call 9

A middle-aged woman receiving chemotherapy for cancer. She has been vomiting since the last cycle two days ago, and now has dysuria and frequency. Urinalysis is suggestive of a UTI. I give her some Cefadroxil and an antiemetic. The family is extremely anxious. We spend a few minutes talking about her treatment and I listen to her fears.

- **What's going on?**
  A minor medical problem is the last straw for coping mechanisms that have been over-stretched
- **What do they need from the consultation?**
  A minor medical fix. A shaman who can restore a sense of control and hope.

Call 10

A five-year-old girl with fever, abdominal pain and vomiting. She has a past history of UTI. On examination there is evidence of a viral throat infection only - urine was clear to dipstick. I advised paracetamol and arranged for a check MSU to go to the lab in the morning.

- **What's going on?**
  A self-limiting viral fever with an understandable parental concern because of her past history.
- **What do they need from the consultation?**
  Someone to check out their concerns and to offer support.

Call 11

An elderly man with dementia who lives with his extended family. He had been wandering the streets for an hour and a half, dressed only in a shirt and shoes, before being brought back by the police. It was the first time this had happened, and the family was very upset. He was unharmed — it had been warm for the time of year. He had cold peripheries but was otherwise well.

- **What's going on?**
  Family anxiety and guilt over their failure to be perfect carers.
- **What do they need from the consultation?**
  They needed a shaman who would say things were OK and restore the normal order.

That evening I practised very little biomedicine, but I feel that I did plenty that I would wish to be included in the job of being a doctor. Most of what I did would have been done as well or better in other societies by a neighbour, a granny, a shaman priest. My role was to stand in the breach for a society that either does not have - or does not use - neighbours, grannies, shaman or priests.

Interested? Many articles exploring similar themes are available on David Zigmond's Home Page (http://www.marco-learningsystems.com/pages/david-zigmond/david-zigmond.html).