Digital Healthcare: Clouded Horizons

Specious optimism from pundits and politicians

David Zigmond

The *New Statesman* recently published a supplement largely supportive of massively increasing digital consultations and clinical management within the NHS. But this would incur significant perils and losses. What are these?

More than a year after the breaking Covid pandemic storm, as our nervous confidence in survival grows with vaccine distribution, the *New Statesman* published an emblazoned supplement: *Spotlight: HEALTHCARE: TECH AND INNOVATION* (19/3/21). A short leader – 'Innovating in the public interest' – leads brightly to set an optimistic tone and direction to seven brief themed essays by politicians and healthcare pundits. These mostly identify and celebrate a fruit-fall from the Covid pandemic: the accelerated development of skills and applications of digital technology throughout our healthcare. These range from the inventiveness in rapidly creating and distributing new vaccines, to clinicians' almost seamless adoption of remote consultations: the writers draw attention not only to what a life-saver all this has been, but also how this expansion of IT should now determine the nature of our future health service.

Numerous examples are given to show how remotely delivered and IT-networked consultations, tests and instructions greatly increase access, agility, speed and thus cost-effectiveness of services. Together these sound like a paean to our expansion of digital health services. *Spotlight*'s acknowledged caveats are thus few and seemingly minor: for example, the dwindling minority of those not IT-savvy or equipped; the difficulty of rare diagnostic distinctions, for example between grade 3 and grade 4 of an Achilles tendon tear, when consulting by video. The prevailing message, though, is clear and confident: we should boldly digitalise whatever we can of our NHS healthcare, and without delay.

Such is the optimistic analysis and prescription given by *Spotlight*'s chosen luminaries: notably there is no space given for counter-arguments from experienced patients or clinicians: this is a missioned document.

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What would those counter-arguments be? Well, let us start with agreements: digitised media and data machinery is now unrivalled – often indispensable – for instant and accurate

transfer and storage of data, metrics and messages. When it comes to healthcare consultations, though, the benefits are far more conditional and thus partial – there are limits, and it is important to understand what these are. This is far more contentionable.

Most experienced clinicians and patients (eg those with chronic conditions) are very aware of the limitations of remote/digital consultations and what needs to be assured and protected of traditional, face-to-face consultations. Others may dismiss the reluctance or resistance of these experienced sceptics. Why do they not wholeheartedly embrace the coming inevitable radical change? Isn't such resistance just neophobia? Yet such dismissal of caveats, while expediently going-with-the-flow, risks seriously damaging oversights.

Agreement again: it is certainly and encouragingly true that certain problems and conditions can be dealt with well by remote and digital routes – yes, with these we can make considerable savings in time, immediacy, cost and convenience for all. This is particularly so with acute conditions which have relatively clear and unambiguous diagnoses, speedy and effective treatments or advice, or clearly understood reasons why this is not so. Examples of such conditions: appendicitis, heart attack, bacterial tonsillitis, evidently fractured hip, winter bronchitis. These conditions can be – mostly – quickly defined, treated or despatched. This industrial-type packaging can work equally well with large-scale screening and testing programmes. In all of these we can mostly dispense with other considerations of personal understanding, support and guidance – notions of personal history, meaning, context or subtext. Such personal factors then become relatively irrelevant and peripheral. It is the procedural delivery of technology that is important here, not any other meaning or relationship. We can call this digital-compatible practice Sort, Fix or Send (SFS) Medicine.

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Yet most NHS consultations (though certainly not most NHS funding) have been taken up by rather different non-SFS conditions: problems for which there is no simple formulaic

diagnosis or remedy that can be sorted, fixed or sent. This inconvenience is something that successive politicians, health planners and managers – for reasons both expedient and complexly cultural – have increasingly discounted or overlooked. What are these afflictions? Well, consider the following: those of doubtful or stymied maturation and development, stress-related/psychosomatic complaints, disturbances of mental health, chronic illness (by definition), ageing and degenerative conditions, palliative and terminal care… This vast galaxy of ailments accounts for the greater fraction of primary and mental healthcare: yet rarely can any of these humanly-complexed problems be rapidly and decisively fixed by the kind of algorithmic procedure or technology that is the mainstay of the now-vaunted digital and remote (SFS) healthcare. Clearly, in this less-organisable territory, many skills other than the biomedical are needed – those of a pastoral and personal nature.

Yet *Spotlight*'s authors seem heedless to this: they fail to acknowledge that what their suggested digitalisation may gain in immediate speed and economies it will lose in longer-term possibilities of pastoral healthcare (PHC) together with its underpinning of personal continuity of care (PCC). Surprising to some, most primary care needs far more than dispensing of technology and procedures; we often need – instead or as well – personal engagement, understanding, 'translation' of symptoms, encouragement, containment, accompaniment, comfort… All of these personal attunements can then contribute to that most benign and mysterious progeny of relationships: we can help one another heal and grow. Such is pastoral healthcare: it combines the science of biomedicine with the art of interweaving this science with a personal understanding, meaning and resonance. But – crucially – this can only be done where people can get to know one another, where relationships are – mostly – valued and safeguarded. That is why pastoral healthcare is so dependent on the skill and stewardship of its relationships – its personal continuity of care.

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Almost all older NHS doctors who have worked through recent decades of NHS reform will tell us that while the professional technology has dramatically improved, the personal relationships have become impoverished. Most experienced patients talk of a similar loss of personal identifications and relationships in their care, while acknowledging that certain technical treatments are much more effective. In this mixed picture both healthcarers and patients have increasingly found themselves lost in, and to, a no-one-knows-anyone-but-just-do-as-you're-told system and culture. This is particularly so with those problems least accessible to SFS-dominion. So this loss of personal engagement and investment is largely responsible for the plummeting of morale, and then staff retention, throughout NHS pastoral healthcare services. General Practice and Mental Health are evident examples of this hazardous misconception, and thus mismanagement.

This is the legacy of thirty years of 'modernising' NHS serial reforms, and unless we understand how this has happened any massive expansion of digitisation of our healthcare encounters will substantially add to this unviable malaise.

In particular, our currently much-vaunted plans for Integrated Care are doomed to become a Kafkaesque maze of insentient and insensitive bureaucracy unless we find some way of re-establishing our bonds of personal familiarity and knowledge.

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One seminal misconception has been this: that we can, almost entirely, model our healthcare on industrial manufacturing principles. This assumption is easy to understand – human evolution in the last century has been a 'triumph' first of scientific discovery, and thence to industrialisation: the manipulation and manufacture of almost all our habitat, activities and objects. Making, growing, maintaining or understanding any of these becomes less and less necessary for us, and then often occupies a merely recreational niche: what is important is

access, procedure and product. Specialists of all kinds provide us with what we require. We all become consumers.

The power and success of this idea – this human drive – is evident all around us: our enormous machine-dependent city populations, our consumer-dependent growth economies, our sedentary lives furnished with ever-increasing choice … Man on Mars? Amidst this our healthcare, too, has been massively empowered: the coronary artery stent and the rapidly developed Covid vaccines are just two examples of life-saving science application that did not exist for previous generations. Such technological power then becomes a bedrock of our group-assumptions, our cultural-mindset.

But there comes a point when more of something good becomes worse. That is what our very serious environmental problems – our collective folly of ecocide – is telling us: our powerful activities must be respectfully limited by other life-forms and eco-systems. Our current healthcare conundrum is a microcosm of this: managed biomedicine has brought humankind great benefits and some of these can be distilled to SFS procedures, sometimes remotely by digital media. But at what cost? And what are its limits?

Archimedes' Law of Displacement can help us understand this problem: the greater the pre-eminence of digitalised SFS consultations, the less the opportunity for personal continuity and pastoral healthcare. Transactions replace relationships. Procedure replaces dialogue. With the 'right' calls we can sometimes cure; but remote care, comfort or containment is much more difficult.

Erstwhile GPs and mental health workers knew the importance of personal knowledge, understanding and trust in having therapeutic influence. They knew, too, that these needed time, repeated contact and thus beneficent familiarity to develop. This was true not just with patients but with colleagues and support staff, too. These relationships, growing more naturally, could then be experienced as supportive, protective and trophic. Both patients

and practitioners would often conceive of the resulting humanly-nuanced consultations in ways well-served by nautical metaphors: anchorage, harbour, port in a storm, piloting the vessel-of-self in perilous seas away from the rocks, life rafts…

Enabling such 'therapeutic space' as an inherent part of personal medical practice was not just good for many patients, it was equally good for health-carers. This is why general practice, for all its stresses and difficulties, was so popular thirty years ago. And it is why, now that we have driven out those therapeutic spaces, general practice is stricken with such problems of morale and staffing.

Removing the likely personal familiarity and anchorage from consultations by increasing digitisation (by management strategy as opposed to individual patient choice) will surely further deplete those therapeutic spaces that have managed to survive the previous industrialisation and corporatizing reforms. These modernisations have all attempted to manage and manufacture healthcare as if it is an inorganic commodity, rather than caring for its nourishment, relationships and healthy environment – as we do in our care of living organisms … if we want them to thrive, or even survive.

The history of the last thirty years of NHS reforms shows the three main forces generating both our achievements and our losses. They are:

- **The 4 Cs**: competition, commerced commissioning and commodification.

  A *marketised* system.
- **REMIC**: remote management, inspection and compliance.

  A *policed* system.
- **Gigantism**: scaling-up and standardising wherever possible.

  A system of *industrial capacity*.

Together these have yielded us what we have now: services that are richer in data than human language; scanner-sighted but all too often humankind-blind; streamlining cures but struggling to care.

If our population's healthcare is unduly further corralled into digital traffic and compliance this expediently engineered welfare will become increasingly ill-fared.

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I have personal reason to pursue this analysis, and this leads to my anxious caveats.

For forty years I worked as a GP in the same small, inner-city practice. Increasingly I got to know people and much about their life-stories, their significant-others and what made them 'tick'. What they feared as night came, what they hoped a fresh day might bring; what brought them laughter, trust and joy – what weighed them with alienated despair and humiliation. The signalling and understanding of all this was quite as often implicit as explicit. I looked out for, as well as looked after, these people. It was often more relational than transactional. Such relationships certainly nourished and motivated my long career in this often difficult and demanding work. Patients overwhelmingly reciprocated my experiences.

Now, in my seventy-fifth year, I am fearfully aware of my growing wish, for myself, for such personally sentient and invested care. So far I am fortunate: I have, mostly, only well-controlled risk-factors. But that will change; unless I die very quickly I will accrue ongoing problems that will become less and less curable. This is our near-universal fate.

What then? What sort of care and doctors will be there, in this new era of Integrated Care Systems?

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