Sort, fix or send: what more can we expect from our medical practitioners?

David Zigmond

Healthcare systems management, particularly when thoroughly IT-dependent, attempts to rapidly sort, fix or send all presenting healthcare problems. What gets missed?

On a recent Rethink programme (BBC Radio 4, 23/6/20) a chief executive of Babylon – the entrepreneurial digital healthcare provider – reiterated his company's boldly radical view: traditional general practice is largely redundant and can now be swiftly replaced by new technologies. This, he said, has been demonstrated in our emergency adjustments to the Covid pandemic.

Such a claim will be excitingly liberating for some while being anxiously unsettling for others. What is the fuller and likely truth here?

Babylon claims that its AI systems now have non-distractible learning powers that make them, overall, more diagnostically reliable and accurate than even the most experienced and best doctors. They can, therefore, replace many frontline face-to-face consultations to define or eliminate well-defined physical disease or significant organ disturbance.

Yet even if Babylon's claims become largely proven, there will remain a vaster hinterland of primary care than eludes such processing. Why? What lies outside the slick remit – assumed by Babylon – that GPs' tasks are predominantly those of *Sort, Fix or Send* (SFS)? And – another Babylon assumption – if we identify these non-SFS activities, can we not simply and swiftly despatch these elsewhere?

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Nearly fifty years ago I began my lifelong interest, then career, in general practice. From the beginning I could see that while doctors were charged and privileged to sort, fix or send curatively treatable conditions, there were always many conditions that could not be so satisfactorily despatched or eliminated. So although curative treatments become ever-more effective and extensive they are nevertheless limited in scope: in primary care there are always presenting problems refractory to such rapid definition or resolution. So while SFS remains an essential responsibility and bedrock for general practice, it is all too often not

sufficient. It is the respectful recognition and skilful navigation of that insufficiency that constitutes the art and vocation of general practice: our pastoral healthcare.

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At the start of my medical career I realised the enormous and complex bulk of this non-SFS clinical territory. The most obvious examples of such problems are chronic physical illnesses, because they are all defined by their (albeit partial) resistance to SFS approaches: that is why they remain chronic. But in general practice we encounter much more. Consider: symptomatised problems of adjustment and maturation, stress-related and psychosomatic distress, mental health, inevitable ageing and terminal care … rarely can health professionals cure (eliminate) any of these. Here it is our medical bedrock of SFS that is rendered redundant.

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My early mentors helped me learn about the nature of this hiatus and what – with pastoral healthcare – we could achieve instead. The skills of this took off from our considerable instructed generic knowledge of human bodies and (rather less) minds to develop additional paths into particular individuals: to understand the endless variations of their susceptibilities, proclivities, matrices and meanings. *The more you see of someone, the more of someone you see*. This was a guiding principle for the help of all that we cannot simply fix: our empathic witnessing, guidance, support, encouragement, suggestions, amelioration, comfort and – often – that most cherished and mysterious of transformations and transcendences – healing. These – for several decades – were the frequent possibilities that flowed from the personal continuity of care that also provided so much of the vocational motivation and the (largely unmeasurable) human skills of being an erstwhile personal and family doctor.

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As a child I witnessed how our family doctor sensed, calmed and comforted some medically manifested family problems that were probably (rightly and skilfully) implicitly understood but never openly discussed. Later, as a young doctor, I learned more deliberately how much our delicate attention and influence to the inexplicit could often drastically change the experience of, sometimes the very course of, an illness. I saw, too, again and again, how all this can come best from skilled and longer-term personal contact; from knowing and looking out for one another.

This, the vast and irreducible bulk of pastoral healthcare, is what we must depend upon except when we suffer our most clearly and rapidly curable illnesses. Eventually, unless we die very quickly, we need these increasingly as we age – the skilled compassionate witness, guided support, comfort and encouragement of others. Often, too, the wisdom of masterful inactivity. Even if the outcome is the same (and in other areas it often is not), the experience of inevitability is very different.

As I grow frailer that is what I will want. What I will get instead from a Babylon-like, call-centred, screen-visioned practitioner is likely to be very different: a one-off remote contact with a stranger. Whatever their personal qualities how can they possibly compose those creative responses that can contain, comfort or even heal this kind of complexity?

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