Icarus Plummeting:

The depersonalisation and depopulation of General Practice.

A cultural analysis

David Zigmond

The demise of the personally and community anchored physician – the erstwhile family doctor – parallels the perishing of many other, much larger, eco-systems. This essayed letter, to the Royal College of General Practitioners, is a personal reflection of fifty years of professional practice in a world of seismic change.

Icarus plummeting. The depersonalisation and depopulation of General Practice. A cultural analysis.

We are here to add what we can to life, not to get what we can from life

– William Osler, 1894-1919

Among older practitioners I hear much agreement about the nature and significance of current healthcare problems. This long predates our Covid crisis which has – simultaneously and paradoxically – obscured our debate while also worsening our underlying problems. Our post-Covid world of General Practice looks set for a long, dispirited and turbulent illness. This extended essay considers the broader and *cultural* causes of this particular avoidable tragedy: the dispirited decimation of a previously much-loved and stable profession. In this largely social analysis I avoid blaming any political or professional groups, or how money is distributed – I take the view that all these, too, are manifestations of culture, of *Zeitgeist*.

The broad project of understanding the complex terrain and matrix of our human stewardship was expressed earlier in the subtitle of my anthology *Industrialised Humanity: Why and how should we care for one another?*

That question has been central to motivating decades of my healthcare writing and now guides this essayed letter.

*

I am writing now as a time-expired practitioner with dwindling influence, so it will encourage me to know that some of the next generation will still pursue the bigger picture: that which lies *behind* our current and gathering professional problems – hopefully we are then in a better position to educate and influence policy. Collectively, and with resolve and media publicity, the Royal College of GPs can probably exert good vantage and leverage. In any case, current GPs will be better placed than my cohorts: the many wearied and dispirited practitioners of my generation who, after earlier careers of gratified devotion, mostly leave the profession feeling intolerably powerless and alienated.

Amidst any hope I have often feared that the next generation of practitioners will lose sight of any broader and historical picture, and then lack both a sense of direction and motivation as to what we need to do. I think there are two reasons for this:

i. Younger practitioners are less and less likely to experience a system of better pastoral healthcare and therefore will struggle to perceive or understand its deficit. How can they then understand – through experience – that personal continuity of care is often a cornerstone ethos more than a commodity; that caring relationships are best rooted in shared experiences that can develop as a form of natural growth?

ii. Current practitioners are often so stressed, tired and saturated that they have neither the headspace nor the heartspace to consider those subtle but bigger picture issues that veteran practitioners are now so concerned about. It is significant that there is currently much talk now about 'resilience' – how do we best *survive*; there is, worryingly, little discussion about how to *thrive* –

what best sustains and then further motivates and nourishes doctors over a lifetime of often demanding and difficult work.

In the meantime, we have governments flaunting inflated figures as to how many 'new' GPs they will train to replenish the alarming depletions, while most doctors talk of survival tactics to immure against ratcheted work pressures and contractual mandates. But neither of these responses address a crucial truth: *the working culture itself has become so unsatisfying and alienating that it will not retain its staff*.

*

My experiences were very different when I started as a young GP Principal in the 1970s – the profession certainly had its unevenness and inadequacies, but it was largely fuelled by high morale and robust work satisfaction. Indeed, my joining this profession was largely inspired by many elders who emanated a kind of vocational love, guided and fuelled by their personal knowledge of individuals and their networks.

This kind of personal doctor was also known as a 'Family Doctor' and has become all-but extinct. My view is that we must understand the nature and seriousness of this loss and how it has come about. Unless and until we do so, any boost to funding or recruitment campaigns will be doomed to another haemorrhage of labour or – at best – an atrophy of engaged motivation.

Seeking understandings about the cause of this tragically derogated and devitalised profession has been a central mission of my recent years' writing.

*

There are several current GPs who emphasise the importance of 'relationship-based care' and, of course, I support this. But I have some important caveats. For we must first acknowledge that relationships – the essential ingredient of how we responsively engage with others – are natural, and thus holistic, processes. This means we cannot readily produce them to order. So any of our attempts to synthesize, manufacture, regulate or proceduralise relationships will usually render us, instead, mere administrative artefacts of compliance that are bewilderingly devitalised and unviable.

Here is a current danger to our well-intentioned talk of 'relationship-based care': it will be swiftly and expediently subordinated to the current and dictating modus operandi – 'relationships' will be viewed and processed as yet another form of management project or manufactured commodity. Natural relationships can all too easily be relegated to bureaucratic transactions.

To prevent this requires a different kind of thinking.

*

We need, instead, to see that our best relationships are akin to fertile crop growth: both need good seeds *and* good soil. If the soil is barren or toxic the seed cannot germinate and mature. Similarly, our good talk of 'relationships' will swiftly turn to chaff if the working ethos and milieu is, as now, inimical.

Let us be more specific here about General Practice. It used to be a *sine qua non* of the erstwhile Family Doctor that personal knowledge and understanding was necessary for contextually sensitive care – that kind of personal knowledge did not just involve patients, but included kith and kin, and then the doctor's support staff and colleagues. It was this personal and fraternal infusion to medical practice that enabled doctors' more nuanced judgements, healing encounters and – very relevant here – their deeper work satisfactions: generally the degree of satisfaction that both doctor and patient may derive from care is proportional to the depth and length of bond between them. These aspects of medical work often generate its deeper meaning, yet are elusive to quick charisma or even measurement. It is easy to see, therefore, how and why successive healthcare reforms have each added to their marginalisation: this is a key to understanding many other difficulties.

In a recent discussion paper for the Centre for Welfare Reform, *The Perils of Industrialised Healthcare*, I identified three major, synergistic components of our successive reforms that have led to the etiolation of pastoral healthcare in general, and the near-extinction of Family Doctors in particular. They are:

1. **The 4Cs**: Commercialisation, competition, commissioning and computerised commodification. *Markets*.
2. **REMIC**: Remote management, inspection and compliance. *Policed Industrialisation*.
3. **Gigantism**: The expedient tendency to merge to ever-larger units. *Behemoths*.

These managing principles fit well with a neoliberal agenda and have been unleashed across the whole of our Welfare services, not just the NHS. How these

three allied governances operate, and the price we pay for them, is clearly illustrated by the corporatisation of General Practice. We can example four strands:

a) **The abolition of GP personal lists,** registering each patient with a *place* or *institution* (a practice), rather than a *person* (a named practitioner).

b) **The systematised closure of small practices in favour of corporate mergers.** [Many enduringly popular and otherwise excellent small practices have been forced to close by regulatory requirements that only large practices can readily manage and which, in any case, are usually much more relevant for large depersonalised organisations.]

c) **The employment of salaried, part-time and locum staff on short-term contracts**, rather than long-term partnerships of fuller-time doctors.

d) **The mandated requirement for compliance** to increasingly formulaic and computerised micromanagement and inspection regimes, often increasingly adrift from nuanced judgements of engagement and care.

Each of these contributes to an often craven noone-knows-anyone-but-just-do-as-you're-told culture which destroys both the spirit and the caring basis of personal continuity, and thence to the entire span of pastoral healthcare. And then, as already indicated, comes the inevitable destruction of deeper meaning and satisfactions in practitioners' work.

In 2012 I published *From Family to Factory: The dying ethos of personal healthcare* (Article 31 on my Archived Writings and Home Page). I there described the experiences of many in the changing culture, interpreted the warning signs, and prophesied the inevitable consequences of such serious depersonalisations. Events of

these last few years have brought me far more sorrow than satisfaction in seeing those predictions' accuracy.

*

I still remember our Family Doctor, Dr B, from the 1950s. My mother, an emotionally complex and hidden woman with protean illnesses to match, was never cured, but was somehow protected, anchored and comforted by him. Often, without asking or saying much, he would then guide, contain and quell the secondary disturbance that rippled elsewhere in the family.

That childhood experience influenced my choice of career, and how I would perform it. For my first two decades in General Practice I functioned much as Dr B had, but with more modern technology. The skills involved in weaving together the personal and the generic, art and science, the contextual and the formulaic – I found all this endlessly interesting and deeply rewarding on many different levels. In that earlier NHS I was granted long-term stewardship of these responsibilities and felt privileged to be trusted and acknowledged to do it well.

The next twenty years would be very different due to the serial reforms that successively made such vocational personal and family doctoring more and more difficult. By the time my practice closed, the 4Cs, REMIC and Gigantism together had squeezed out the fraternalism, the headspace and the heartspace from practice in a way that only the exceptionally heroic, stoic or readily submissive could tolerate. The vocational spirit and values of Dr B, that I then took up in a kind of

relay, could no longer be carried. Everywhere I looked, morale and staffing was crumbling.

*

What of the future? I am now seventy-five years old and personally have, so far, only the common age-related physical risk factors to manage. But unless I decline and die very rapidly, I shall suffer gathering and more incurable compromises and failures. To help me traverse these with empathic comfort and humanity I will want a doctor who knows not only about biomechanisms but is also interested in the nature of the sufferer and how best to tend them. What kind of life have I had? What gets me up with the morning light? What do I fear with night's darkness? What do I hope for? What makes me laugh? What is most angering? Humiliating? What do I want understood, yet not made explicit?

Dr B, I believe, considered these questions quite as important, often, as the usual medical interrogations. Maybe he had heeded William Osler's famous dictum: '*It is as important for a physician to know what kind of a person has a disease as what kind of disease a person has'*.

These were, certainly, the kind of influences that moulded the kind of doctor I wanted to be in my Bermondsey practice for forty years. But that kind of accessible, bespoke understanding, containment and kindness is now hardly possible. Will I, in the coming years, receive the kind of care I witnessed from Dr B, and which I strove later to protect and deliver to others?

I fearfully doubt it.

*

In recent correspondence one of our profession's eminents wrote to me: 'I am an optimist'. I replied that I think of myself, rather, as an 'idealistic fatalist': I will do what I can, in Gandhi's counsel, 'to be the change in the world I wish to see' – despite much greater forces that seem to be pulling in the opposite direction. What is that opposite direction? And why do I think that it is?

Let us imagine viewing our problems with a zoom lens. We have here been zoomed-in on the fraternal dispiriting and dis-integration of personal and family doctoring. If we zoom-out a little we can see that this is merely a part of similar experiences throughout our Welfare services – from primary school teachers to university professors, from District Nurses to Probation Officers, from Social Workers to Circuit Judges. All talk of similar stressed depersonalisation, deskilling and demoralisation that has roots far wider and deeper than enduring and important funding issues. The roots extend out to working (yet ultimately unworkable) assumptions about how humans may best attend to, and then care for, one another. And then how we should design and organise groups to do these things.

If we zoom-out much further we can see global and inter-related variations on this theme, extending far beyond our national Welfare services: the pursuit of, and dependence on, consumerist growth-economies and sophisticated technologies whose conditions, requirements and disposabilities we cannot sustain, and whose social and environmental consequences have disruptive or destructive consequences

far beyond our powers of prediction, planning or control. Just as our global climate has become hazardously disturbed by our accelerating expedient technologies, so too are our internal and social worlds: new and burgeoning cognitive and mental disorders; IT viruses of hate, specious untruth and hazardous populism; unprecedented obesity, addictions and gender dys-identifications… We can view all such modern ailments as being due, in part at least, to our increasingly potent capacity, then compulsion, to do and have more and more but – crucially – in a way that we cannot then meaningfully assimilate, direct, contain or sustain. All too often our cleverness in invention is not matched by wisdom of discrimination or restraint: we create ever greater speed, comfort, ease and entertainment amidst rising ecological harm and self-harm.

So there is a telling and important equivalence between our particular microcosmic concern here – the sickened impoverishment of General Practice – and the macrocosmic problems of environmental and social unviability. Both are due to our intemperate 'cleverness' in our command of resources and devices … and both lead us to their own kinds of toxic or unbalanced unsustainability.

After many years of writing about how this was happening, both to me and nationally, I decided in 2016 to send an essayed letter to NHS England, titled *General Practice used to be the art of the possible, but we have turned it into a tyranny of the unworkable* (Article 75 on my Archived Writings and Home Page). They never replied.

All of this, I think, indicates leaching cultural problems – refractory and often unconsidered massed assumptions, then resistant to challenge. And how does one

confront or undo such *Zeitgeist*? My difficulty in answering this is why my optimism is so cautious and conditional.

*

How may we understand this bigger picture, of which the distressed malfunctioning of contemporary General Practice is but a small example (though clearly important for us)?

I have recently been considering how Iain McGilchrist's research, depicted in *The Master and His Emissary*, can help explain what happens. McGilchrist convincingly describes the different activity of our two cerebral hemispheres, and how these may become unbalanced. The left hemisphere is *instrumental* and *manipulative*, and processes the world by fragmenting analysis, sharp focus, and objectification. The right hemisphere is more globally vigilant, receptive and *identificatory* and perceives larger patterns and meaning that are not immediately actionable. So the left brain is convergent and atomistic and needed to fix your car: *what is*; the right brain is more speculative and holistic and required to understand and love others: *what might be*.

McGilchrist writes of how the spectacular human advances of the last two centuries in science and technology – and thus in society – are largely due to our left-brain activity. This success has then generated, then anchored us in, a reinforcing cycle: by inventing technology that amplifies our left-brained powers of analysis and manipulation, our post-industrial world then requires humans to act and think in ways that will expedite those machines' functions. So the machines we create and use (eg computers) eventually mould our minds to conform to the machines' way of

operating. But we pay a price for this increasing pre-eminence of left-brain activity: a kind of disuse-atrophy of our disfavoured *right* brain – we get better at seeing parts and thinking in algorithms, but lose our capacity to see wholes or patterns that have no immediate function or meaning for us. Our insistent definitions of the explicit often lose the imagination of the implicit. This shift to left-brainedness offers a good account and explanation of the developing strengths and weakness of much current medical practice.

An extension of this idea is that humankind generally, as we depend increasingly on technology and computers, has developed a kind of Left Brain Hyperactivity Disorder (LBHD) which combines our increasingly skewed brain function together with the all-too-human flaw of not knowing when and how to stop doing things at an optimum time. A pathological-anatomical analogy is Hypertrophic Obstructive Cardiomyopathy where the heart's ventricular musculative becomes so thick that its chambers cannot fill adequately, leading to the heart becoming, paradoxically, too propulsive to pump effectively.

So our contemporary and epidemic LBHD (my term) can be seen throughout our lives wherever our instrumental use of the world or one another leads to excesses that cause significant collateral damage to the very relationships or eco-systems that sustain us. This kind of power is uniquely human. The egregious excesses leading to global eco-destruction is now (very belatedly) much discussed. If we zoom-in to consider the role of our left-brain excesses in managing our NHS healthcare – our 'clever' instrumental devices of the 4Cs, REMIC and Gigantism – we can see how we are, equivalently, destroying our sustaining human ecosystems. Of course, the scale

is much smaller, but the process is the same. And for the casualties the life-effects are often massive.

Bad systems, like bad relationships, are far harder to get out of than get into. And, sadly, in any large-scale contemporary human enterprise, it seems that our left brain will almost always be dominant.

*

The corresponding grandee finished with a brief question to me: 'Do you think your writings are having an impact?'.

My answer was another rueful paradox. Yes: my readership has been wide and substantial, garnering much supportive and appreciative feedback, over many years. But no: over that period the problems I have been writing and talking about have got much *worse*. So while my writing may have ready and resonant impact on individuals, it has no effective impact (yet) on institutions.

That bracketed 'yet' might be activated by somehow starting a bi-hemisphered dialogue with those who have some current leverage with governance. If I can help with that I would be very pleased to do so.