It is so difficult to see your GP because family doctors are now extinct

Now long into the dangerous mire of Covid, many are anxiously confused about the continuing difficulty in accessing NHS consultations. Responding to this, a news presenter recently asked: 'Why is it so difficult to get an appointment to see your family doctor?' (BBC Radio 4, *Today*, 19/11/21).

This seemed a straightforward and important question. Yet it was, in its wording, more askance and pregnant in meaning than the presenter had, I think, consciously intended. Family doctors, in fact, are now extinct or all-but. So talking of 'family doctors' is now like talking about 'box offices' or 'telephone lines': they have, in reality, been superseded, though the language-habit may persist. Almost certainly the presenter meant, more accurately, a current GP or even, more precisely, a Primary Care Service Provider.

Here is the hidden lesson in this slippage: we have such a shortage of doctors in general practice *because* they cannot now be family doctors. This is no word-playing pedantry but an important distinction that has been overlooked or ignored – hence the questioner's telling inaccuracy.

'Family doctor' was once an accurate synonym for 'general practitioner' – until about thirty years ago. That was because those erstwhile doctors were *both:* they were generalist primary physicians who – importantly – worked in communities in such a way that they got to know individuals within the patients' own milieux, their families.

Such family doctors typically and importantly worked in smaller (than now) units that were like a home to stable and identifiable professional communities: all this resembled a kind of community family. So those doctors had two professional forms of identification and belonging: amongst their colleagues and amongst their patients.

This previous stability, locality and familiarity generated many subtle benefits: senses of security, anchorage, containment and comfort that can only come from bonds and more delicate personal understandings – all these themselves must grow, organically, from shared experiences. Such social and personal realms were respected and refined as the 'art' of the family doctor – the base of care from which the 'science' of facts and procedures – treatments – could be more meaningfully and sensitively given.

So it was that family doctors could be 'personal generalists': this is how they could best – with humble pride – look-out for, and look-after, others whom they got to know increasingly well.

The guiding maxim then could be summarised: *Medicine is a humanity guided by science: that humanity is an art and an ethos.* That culture of humanity-through-familiarity was largely responsible for the high morale, popularity and stability of the profession for many decades … until serial reforms eliminated family doctoring from general practice.

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How did this happen, and what have been the consequences?

Well, in brief, successive government-led reforms have removed the personal art of medicine so that all attention and resources can be deployed to its science. So milieux of care have been swept aside by imperatives of treatment. Personally scaled vocational motivation has been replaced by the gigantism of corporate compliance. Headspace and heartspace for individuals are crowded out by the demands of industrialised algorithms and protocols applied to people the doctor very often does not know and, very probably, never will.

This is the operational framework of the current, post-serially-reformed GP who must work as a generalist without the human suffusion and nourishment of a colleagueial or patient 'family'. Most often they are working part-time in very large health complexes, with other healthcarers and support staff whom they hardly know and who all, rarely, get to know any of their many patients. This is a siloed fraction of a no-one-knows-anyone-but-just-follow-the-protocol culture, where any problems that linger are usually relayed and shuttled between different practitioners, rotas and teams. Doctors cannot here glean the depth of knowledge or satisfaction that comes with personal continuity of care. For patients there is little comforting harbour, refuge or resonance of familiarity: 'it's always someone different'. The steadfast buttressing and witnessing of others' lives vanishes.

So that is what it is like being a contemporary GP now that they cannot be true family doctors: the work has become, more and more, a proceduralised, checklisting series of tasks performed according to the schedules of remote authorities, with patients whose lives, stories, families and predicaments are deemed and disregarded

as irrelevant. Where can any practitioner find long-term satisfaction in such work? And who would want to do it?

Fewer and fewer is the answer. The workforce is now decimated by depersonalising dissatisfaction.

That is the most important, and the most enduring, reason why it is now so difficult to see your GP. No amount of money, training and recruitment can solve these predicaments that come, inevitably, from our misdirection. What about the mooted further initiatives of gigantism – Primary Care Networks and Integrated Care Services? Surely they will make such problems worse.

If GPs were still, also family doctors, the situation would be very different.

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