Commodity or Community?

The predicament behind the terminal illness of general practice

David Zigmond

Recent increases in violence toward NHS primary care staff probably signal cumulative senses of alienation and impotence that remain elusive to direct address. How and why is this happening?

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In early June, from the long-shadowed downlands of NHS general practice, a new nadir is briefly publicised. Both broadcast and print media reported[1] a massive increase in threats and acts of violence by the public against general practice staff. Official responses were so predictable as to seem automated: government sources talked of taking all such problems 'very seriously'; health ministers assured us that long-term solutions were coming 'at pace' to train and recruit many thousand more GPs; the Chair of the professional Royal College objectively judged the situation 'totally unacceptable'.

Many long-term critics were equally predictable, yet again pointing to 'chronic underfunding'. This has become a near battle-cry for the more analytical commentators of our long-troubled system, but this seemingly unanswerable argument is itself very conditional. A recent researcher showed that NHS funding is, in fact, very similar to healthcare funding in comparable OECD countries.[2]

However, we can almost all agree on this: our health service – especially primary and mental healthcare – has developed increasingly hazardous systemic problems. Beyond that there remains significantly less agreement. For even if we accept the (now doubtful) simple equation of inadequate funding/resources = fractious underperformance we are still left with the larger, and antecedent, part of our problems: *GPs, increasingly, no longer like the nature of their job; they have lost deep or long-lasting satisfaction from their work.*

This assertion may not be universally true, but is sufficiently so to account for clear patterns: the unprecedently low morale which then results in plummeting

recruitment, and then high levels of sickness, burn-out, drop-out and career abandonment. Those that remain working, tellingly, rarely want to commit long-term, full-time, as partners. They prefer very part-time, locum and portfolio careers: 'It's all I can bear … No, I don't want to commit…', is a common refrain. Some government apologists will attempt to shrink and temporise these problems by emphasising the recent debilitating and depleting effect of Covid, but any such truth is very partial – we are dealing with a long-term sickness-of-heart that has been gathering for three decades – well prior to the pandemic.

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What is this sickness-of-heart? And how did it evolve?

An account of my own experiences and understandings may significantly illustrate an answer.

1970s

From the mid-1970s I started as a GP Principal, staying in the same practice for forty years. As a young doctor I was attracted to the work by my observations: (generally) the high morale of vocationally energised older doctors, and the humanly engaging nature of their working milieux. My first dozen years amply satisfied my expectation: though I found the challenges were often difficult and demanding, and the working days were long, I was buoyed and fuelled by (mostly) a culture of friendliness, trust, appreciation, good judgement and good faith – all anchored to a fraternal, yet watchful colleagueiality. This was a *vocational* workforce – one that generated the most apposite (ie professionally contextualised and boundaried) kinds

of respect, vigilance and affection. Yes, certainly there were some exceptions to this benign picture, but most practices I encountered resembled well-functioning families: they developed, endogenously and naturally, the personal knowledge and understanding to look after, and look out for, their own staff and colleagues and then, of course, the patients who became, often, increasingly familiar and attached. So these local practices (often then called 'family doctors') formed small professional communities to serve the healthcare needs of a larger, surrounding community of patients – general practice was then experienced as a community-within-a-community.

The word 'community' here is important and certainly different from, say, 'population cluster': the word is used here to connote not mere physical proximity but, rather, personal and shared understandings, bonds, and concerns. People in such 'communities' will – more likely – resonate and care better for others. These attitudes and activities are naturally-grown phenomena (although they can have appealing synthetic facsimiles in, say, the hospitality industry). Such 'natural growths' are essential conditions and ingredients for much that we used to value and depend on: for care and healing (as opposed to treatments and procedures), for guidance, comfort and containment (as opposed to 'chargeable and contractual items of service'). These comprise 'pastoral healthcare' and all require a bedrock of personal relationships and identifications to be most effective: they are much more difficult – often impossible – one-off with strangers.

This kind of personally bespoke practice – pastoral healthcare – is based largely on familiarity. It used to be called the 'art' of medicine, to distinguish it from the generic, always reproducible and transposable 'science'. Such 'art' is rarely referred

to now: it has been eliminated by successive reforms that have predicated and privileged – almost entirely – only the impersonally generic, the scientific, 'treatments'. The personal – the art in medicine – has been left to perish.

This is seminal to our growing problems because although most GPs experienced a certain intellectual satisfaction from delivering correct major diagnoses and treatments, the deeper and more nutritious satisfactions came from the broader, personally contexted understandings of care – the therapeutic effect of growing rafts of shared experience and meaning. Each diagnosis could then become a personally affecting vignette; each consultation an exchange of our common humanity and transience. This may not have been spoken of much explicitly, but we felt it often – both doctors and patients.

And now – so often – we feel its absence as a kind of lonely pain.

This is a central reason why doctors were then much happier: that is why they often delayed their retirement.

And that is why patients were happier with their doctors.

Yes, I could see that our pre-serially-reformed NHS (pre-1990s) did have greater 'unacceptable' variation and technically inferior treatments, but humanly – in terms of pastoral healthcare – I observed it to be generally both far better, and certainly more sustainable, than what we have now.

So what has gone wrong?

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> *'… Who is society? There is no such thing! There are individual men and women and there are families and no government can do anything except through people and people look to themselves first.'*
>
> – Prime Minister Margaret Thatcher. Interview for *Woman's Own*, 1987

The meaning of these words, like many biblical texts, is debatable. What is more certain is what followed with that government, and all since.

Thatcher's background and knowledge was in commerce and science, not the human vagaries and complexities of art or welfare. So her default position was to view welfare through her familiar prisms: of commerce and science. Such viewpoints of the NHS projected pictures of seeming imprecision: unfocused and untargeted waste, laxity, unsystematised variation, and inefficiency. The solution? Welfare services could and should, therefore, be targeted and tightened in line with competitive manufacturing industries. To do this would require (several) waves of reforms: to standardise, marketise, competitively commission, scale up (and close smaller 'uneconomic' units), and incrementally increase regulation, inspection, monitoring and policing. All these would ensure factory-like compliance.

The premise behind Thatcher's thinking – and her long enduring neoliberal legacy – is that complex human activity and welfare can be advantageously (*for all*) manufactured and managed like *commodities*. So healthcare can be extracted/(re)produced/purified/tested/piped/distributed/traded/sold as if it is a

utility or consumer object. It is not, then, to be thought of as akin to a living organism that needs a protected environment made viable by nutrition, relationships and 'oxygen'. Conditions of ecology can, therefore, be surrendered to – displaced by – principles of engineering.

So it is that three decades of neoliberal reformers have left us this belief-legacy: that all important healthcare can be reduced to such reliable and predictable – and so commodifiable – assessments, tests, management protocols and treatments. Such commodification can then open up the greater opportunities that come from industrial mass-manufacture and then its competitive tendering and commerce. Surely, the reformers say, we have all benefited from such progress elsewhere in our lives…

Certainly there are areas of healthcare where scaling up, standardised mass-production and strict (sometimes policed) quality controls are preferable, even essential – for example pharmaceutical and vaccine manufacture and distribution, many surgical procedures, the effective treatment of incontrovertible and serious acute physical conditions … in other words those problems that are clearly fixable, directly controllable or preventable.

The problem with the serial reforms' premise is not that it is utterly mistaken, rather that it is massively over-represented and overdeveloped – the reforms have been rolled out (often rolled over) on the assumption that healthcare consists essentially of only of procedurally fixable, directly controllable or preventable problems. While this is often true now in many surgical or acute medical conditions, it remains far less true in mental and primary healthcare – the greater part of our NHS

consultations.

This may surprise many (often younger) people who have been dazzled by a techno-glamourised view of medicine and its clever recent hi-tech marvels. All this has an important reality. But even well into our technically brilliant 21st Century our problems of primary and mental healthcare continue to require, as much as anything else, nuanced skills of personal engagement and understanding.

Sceptical? Well consider the following categories of problems the traditional GP would encounter:

- glitches in maturation and life-phase adjustment
- stress-related and 'psychosomatic' conditions
- all chronic disorders (by definition not fixable)
- the larger part of mental health: BAMI (behaviour, appetite, mood and impulse disorders)
- degenerative and ageing conditions (that cannot be prostheticised)
- terminal care.

Such conditions account for most of the work of the erstwhile GP, yet very few are rapidly fixable or directly controllable: any manoeuvre to rapidly dispose or 'cure' are likely to rebound with additional, secondary problems. This has now become frequent and highly problematic.

So what earlier traditional GPs could offer, instead, were their best improvisations of pastoral healthcare: skilled guidance, comfort, encouragement, support. Or – to use a nautical metaphor – harbour, anchorage, buoyancy, mapping, navigation…

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Early 2000s

'Surely a counsellor or health psychologist can do all that stuff: it doesn't need a GP!', enjoined an impatient NHS manager, M, nearly twenty years ago. I had been attempting to explain the subtle yet deep – and now imperilled – benefits of personal continuity of care, both therapeutically and diagnostically.

I resume: 'Look, "*the more you see of someone, the more of someone you see"*: most older doctors like me know just how important that can be in best helping people who are ailing through difficult times and illnesses… If the next generation of doctors don't have the opportunities to get to know their patients – if personal continuity of care disappears – they will never know what they are missing…'

My voice trails as I see M's eyes blear at me, then dart away towards the door, her imminent exit.

'Sorry. I really don't have time for all this now: I really must get back … there's now so much to do with the new NHS GP contract…'

Indeed. M knows she is merely a small part of a vast and growing network of managers tasked with streamlining, modernising, marketising and commissioning. To do this, the encumbrances of personal lists, small practices with their semi-autonomous owner-partnerships would be discouraged or destroyed. Corporation would replace vocation. Informatics would burgeon, rendering personal

relationships, knowledge and understanding obsolete. Human error, incompetence or corruption would be eliminated by computerised systems of regulation, algorithms and manufacturing. Opaque ecosystems would surrender to a clearly managed machine…

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Let us now return to the recent threats against GPs and their staff. Surely they are but a small, if alarming and dramatic, part of the fractured and fractious service that is the legacy of three decades of rolling neoliberalising and industrialising reforms. Within the vast requirements of pastoral healthcare I saw, again and again, how both patients and doctors must now increasingly endure a no-one-knows-anyone-but-just-do-as-you're-told culture that has become progressively detached from personal engagement, understanding, resonance and support.

While (some) patients currently express their distress in naked rage, the distress of medical staff is most often displaced and retroflected: commonly by withdrawal – into depression, sickness, chemicals and even – most tragically – by withdrawing entirely their skilled services, and even their valuable lives…

That is the price I have seen that we have paid for substituting, so thoroughly, commodity for community.

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Notes and references

1. Various newspaper and BBC reports themselves drew on at least three contemporaneous

reports and studies, eg:

- *British Medical Journal* 1.5.22. 'GPs demand tougher action against patients who abuse them.'
- *Keep our NHS Public* 2.6.22. 'Violence against GPs has doubled.'
- *British Medical Journal*. 14.5.22. 'Abuse from patients is harming GPs' mental health, leaders warn'.

2. *Financial Times* 3.6.22. 'How to fix Britain's chronically ill health system.', John Burn-Murdoch. This thorough meta-analysis is compiled by the FT's data journalist.

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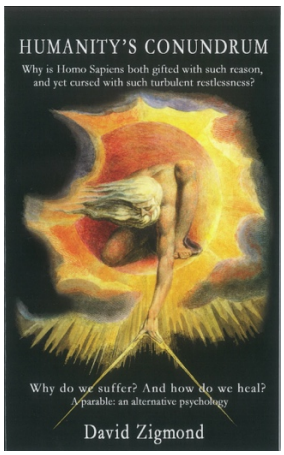
David Zigmond is the author of *Humanity's Conundrum: Why do we suffer? And how do we heal?* (Filament Publications, London)



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