Our neglected impoverishment: the destruction of our healthcare communities

David Zigmond

Can we arrest the haemorrhage of morale and staffing of our NHS general practice by fragmenting and devolving more of its traditional work?

Probably not

Here is why.

Early in May 2023 comes yet another government initiative to stem the ever-growing overwhelmed disintegration of our general practice. Apart from the perennial mantra-like promises of expanded funding and training, the beleaguered frontline doctors will now be relieved even sooner by new regulations: pharmacists will now be licensed to treat common infections and pain conditions; patients will be able to self-refer directly to physiotherapists.

Such plans may seem to make quick and easy sense and would add to our already established GP-deflector roles: healthcare assistants, nurse practitioners, care navigators, associate physicians… All of these have been introduced in recent years to devolve and reduce doctors' work as quickly, cheaply and safely as possible. 'Just-as-good', we are promised, but cheaper, more efficient and so more sustainable.

A worthy quest, surely?

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Well, it would be if it turned out as planned, but the evidence is that, generally, it does not.

Why and how such increasing managed division of labour so often backfires can largely be understood by considering a mistaken founding assumption: that medical practice – particularly general practice – is essentially a system of scientifically formulated separate diagnostic and therapeutic interventions. Our healthcare can then be executively designed and delivered, like any industrialised utility, commodity or manufactured object.

Yet this working assumption is only effectively true in certain situations; in other healthcare situations it works badly, even hazardously. For example, it works well with vaccinations or anaesthetics; it fares poorly with all conditions that cannot be swiftly and decisively eliminated by prescribed procedures. And that terrain is vast. Paradoxically (for some) it comprises the greater bulk of primary and mental healthcare – that is disturbances/disorders of maturation and ageing; stress-related/psychosomatic reactions; distressed patterns of BAMI (behaviour, appetite, mood and impulse); chronic physical illnesses; palliative/terminal care… Rarely are any of these easily eliminated by impersonal procedures of medical science alone. They need also the skilled, bespoke engagement of a professional whose knowledge of science is threaded through a growing fabric of personal knowledge of each individual patient.

Clearly this *modus operandi* is not a perfectible or completable task. It is an aspiration, and adopted as such it *was* responsible for the previous comparatively excellent professional morale, recruitment, stable retention and work satisfaction of erstwhile GPs and their staff … and in reciprocated trusting and affectionate satisfaction among patients.

Of course there were exceptions to, and failures of, this ethos of better practices – but it was sufficiently true to make British general practice for about three decades an internationally reputed and studied exemplar of equitable, sustainable, safe and economical primary care. Time and again its personal continuity of care was identified as an essential anchoring and motivating principle. By getting to know their patients – their stories, their predicaments, their families, their neighbourhoods

– they could better comfort, contain, guide, advise, witness, encourage … all those human aspects of relationship that help us endure and heal. It also enabled quicker and more accurate diagnoses and treatments of those conditions that are readily treatable.

It was this facility, to weave the art of the personal with the science of the procedural that made general practice such a stable and popular profession … until the serial reforms intruded to destroy this subtle balance, a little over thirty years ago.

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The cumulative error of our 'modernising' reforms has been the destruction of relationships in pursuit of standardised, measurable, manageable procedures. Practitioners are now less motivated by vocation, yet more driven by corporation. Increasingly, consultations have become remote, tick-boxed and compliant to a no-one-knows-anyone-but-just-do-as-you're-told-and-follow-the-algorithm culture.

In our government's quest to model our healthcare, first, on competitive manufacturing industries – and then to adopt some expedients from the gig economy – we have sacrificed the deeper satisfactions of the job for practitioners, together with its consequent beneficence for patients.

To remedy this reform-inflicted damage GPs do not need to have their work further fragmented and subcontracted by management design and decree. That merely adds to our system's malady: a bit-part relay-culture where more and more professionals must know prescribed procedures and protocols, but not patients.

Our more sanguine, happy and stable general practice traditionally had four cornerstones: relationships, personal continuity of care, generalism and holism.

If we wish to invest in our own health – as well as those of our communities – we must carefully replace and secure these sunken foundations.

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