To err is human –

If you really want to screw up

get a computer

David Zigmond

Our mounting trepidation about the darker possibilities of Artificial Intelligence is already foreshadowed in many of our 'smart' automations and innovations. Here is a prophetic tale from our current NHS healthcare.

July 1976. My first and only trip to the USA.

I am driving behind a large, languorously throbbing Oldsmobile, the kind of American car I'd only ever seen in movies. On its extravagant chrome bumper there is a bannered sticker. It says:

To err is human – if you really want to screw up get a computer

'What does *that* mean?' my wife, S, asks.

'Dunno … I haven't a clue. I don't really know what computers *are*, what they do…' 'Me neither', she snorts softly, commiserating our joint perplexity, 'but you hear about them lots now … they seem to be the coming thing. And California, here, is where they're developing them.'

'So I suppose that's a kind of local joke, is it? I don't get it', I say, my bewilderment shading into petulant frustration.

'Me neither', replies S, more cheerfully resigned.

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December 2022. E is very well-known to me socially, not professionally. He is eighty years old-young: trim, agile, active and alert – all buttressed by a disciplined lifetime's regime of healthy diet and exercise. For several decades he and his wife have been infrequent attenders at their GP surgery, and only for minor complaints

and routine checks. Yet, in recent years, both have remarked on how much the place has changed from what they remember of several years ago: everything has turned larger, more remote and more procedural. The newly-expanded, slicker, airport-like premises have none of the domestic-like familiarity, friendliness and informal accessibility they recall.

Their disquiet is not merely a *leitmotif* of ageing: even much younger staff and patients register unhappy estrangement from their factory-like pressure, cybernation and lack of human bonds and anchorage – these lacks have become hallmarks of our reformed, 'modernised' health centres.

Gone is the small number of friendly receptionists whose familiar faces and voices would greet patients in person or on the phone – electronic devices have largely replaced those receptionists and the current receptionists-who-do-not-receive are redeployed to mostly digital duties.

Gone, too, is easy access to a doctor who is likely to know you, or have the interest, or possibility, in doing so – consultations are most likely to be between two unfamiliar people, under time-pressure, and follow a management-designed, 'expert'-prescribed form and trajectory.

This changed ethos of general practice – *From Family to Factory* – long preceded any necessities or exigencies of the Covid pandemic: the trend toward such remotely managed anomie and depersonalisation had been steadily gathering long before, with the political tide of neoliberalism and the instrumental dictates of digitisation.

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Out of the blue E is stricken with intense and unprecedented abdominal-flank pain. After navigating the many obstructions and gateways of the health centre's telephone automated algorithms, E feels fortunate that, at last, a human voice is helpfully engaged and offering him an urgent appointment that same morning.

It is no surprise that the doctor, D, is unknown to E. E is reassured by the young doctor: a brisk yet kindly manner ushers a focus and then procedures of seemingly calm competence.

Dr D wraps these up: 'E, I think, almost certainly, you have a kidney stone – renal colic – so I'm referring you for urgent hospital investigations… Oh, and I notice you're rather overdue for other routine tests, so I'll also arrange those, too.

The prescribed procedures are implemented briskly, like a better airport experience. E is then contacted nine days later by the surgery: the unknown female telephoned voice has warmth, yet an edge of alacrity. She is Dr F, that afternoon's duty doctor, she says. Looking at E's electronic records she can see that a large renal stone has been confirmed and that remedial procedures have been urgently listed. She asks E about his analgesic medication.

But Dr F has an additional and less-anticipated agenda: she tells E, 'Your blood tests and X-rays seem to show a lot of abnormal activity coming from your prostate … we should do more urgent scans, which I'll arrange.'

E is surprised and alarmed: apart from his renal colic he has had no symptoms – only the residual mild bladder dysfunction so ubiquitous with older men.

'What does that mean?', E presses her.

'Let's talk about it after the scans. OK?', she says crisply, as a faux-bright farewell.

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Two weeks later E received four pages of scan reports, emailed from the hospital to the GP. These have been automatically forwarded to E by the practice, but without any accompanying comments, note or explanation. The reports are highly detailed and written in technical language. E is an intelligent man but has no medical training; in a haze of shock and confusion he estimates bad news.

Unable to make direct phone contact with the surgery, he asks two friends, both retired doctors, what the scans mean. The deciphered results are clearly grim: grossly metastasized and invasive prostate cancer throughout the pelvis, invading the rectum and distantly dispersed throughout the skeleton.

'But I feel perfectly well!', E protests with incomprehension.

Medically this story ends soon after, but let us stop it here, where the medical endeavours have lost/are lost to ready personal engagement with E.

Let us zoom out and look at the broader picture of what is happening.

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The shocked distress of any serious news can be compounded by its impersonal, quasi-accidental delivery: conversely, as disturbing as any such news may be, it can be made so much more assimilable and bearable when conveyed by a professional who can offer ongoing support, sensitive guidance and emotional resonance. Clearly that kind of bespoke encounter is best provided where we also find easy access, familiarity and personal continuity of care.

These ingredients of pastoral healthcare used to be the *sine qua non* of our better erstwhile general practice: there was a great personal satisfaction, as well as humanity, in helping and accompanying people face the incurable and, eventually, the fatal. But such subtly valuable pastoral healthcare has largely been displaced by an SFS (Sort, Fix or Send) service that functions much like a call centre, often staffed by carouselled, corporate-compliant health workers. That which cannot be processed by the SFS system has, increasingly, been fated for neglect or oblivion.

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Within a week of receiving the fire-and-forget radiological report. E and his wife, despite their dazed foreboding, ask the practice for an explanation as to how it can happen that they can be fired-at-then-forgotten in such complex and sensitive circumstances. The email they get back is replete with homilies and phrases aimed to exculpate, mollify and quieten, rather than encounter and explore. It seems typical of defensive responses from governmental or PR agencies skilled at defensive batmanship.

When shown to me, I wonder if this official response had been written by a Chatbot.

Remarkably, this practice was recently vaunted as a Flagship for a new NHS-commercial venture and rated 'Excellent' by the Care Quality Commission.

Exhausted and angrily dispirited, E and his wife apply to join another practice.

E dies rapidly, in the following week.

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This tale of E is one seminal to our age: this is what can happen when we employ complex systems of digital technology to prescribe our dealings with other humans – all too easily we become slickly blind-sided to individual experiences and vulnerabilities.

There are many such current tales that illustrate this *zeitgeist* predicament, yet E's story is one of the most shocking I have come across. It has also been personally close to me – that is why I have chosen to write about it.

Some may say: 'Well, there were certainly equivalently damaging failures and malpractices in our previous, predigital decades: they surely had their own oversights, blind spots and black holes of incompetence.'

All of that is true. But there are fundamental differences between the failures –

however egregious – of our previous regimes of human management and our emerging cyborg governance now. For our human errors were most often due to inadequate plans or errant practitioners, DSRs (Duffers, Slackers or Rotters). So the source of the problems was then more *individual* and less *institutional*.

The accelerating digitalised cybernation of our services has surely enabled our capacities for mass-production and mass-compliance: long-established black holes are quickly identified; DSRs summarily despatched. Yet the price paid for this kind of efficiency is much higher than many planners anticipated. For, in driving out errant individuals, we have mandated industrial and depersonalising processes that lead to serious personal exclusions and injuries for which no-one, it seems, can be clearly held to be responsible or accountable. Our serious human follies are not, then, attributable to human failures: they are by-products of the *system* that governs them.

There is now growing talk about the frighteningly destructive possibilities of Artificial Intelligence (AI): many academics, journalists, filmmakers and novelists have predicted possibilities of *Cybergeddon* – killer robots commanding craven humans, the irretrievable shutdown of essential utilities and services, the corralling of an increasingly deskilled and compliantly passive humanity … all such possibilities are emerging from the realms of science fiction to occupy imminent and increasingly possible realities.

E's abject predicament can be seen as harbinger for a much more widespread dystopia. Our immensely clever machines could plot his covert pathology with God-like precision, yet he was lost to sentient human care. With E the system was

powerfully scanner-sighted, yet haplessly humankind-blind.

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June 2023. I am thinking of E's end of life marooning, and then way back to 1976 when I tried to fathom the meaning on the Oldsmobile's bumper sticker. If it was a jolly jest then, it is now – for me, at least – the black humour of darkening prophesy.

What can we do?

> *There are no solutions. Only trade-offs*
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> – Thomas Sewell, Economist

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