GPs in Primary Healthcare:
What has Gone and What is Coming?

A dialogue from a restive and bewildered profession

Steve Taylor and David Zigmond

The two discussants here are veteran doctors who draw their thoughts from long experiences in NHS general practice. DZ's work started nearly two decades before ST's: together their survey encompasses more than fifty years.

GP to GP: Steve Taylor and David Zigmond in conversation

David Zigmond is on the Executive Committee of Doctors for the NHS. He lives in London, and was a Principal GP for forty years until 2016, working near Tower Bridge.

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Your GP Here for You *is a proposal recently published by DAUK.*

DZ: Looking at *Your GP Here for You*, this very much portrays how we operated in the past. It describes the bedrock of what we did…

ST: In a sense it's a kind of recipe, to reestablish better general practice: good continuity, good care, looking after your staff…

DZ: I'm interested in how these become extinguished. Almost anybody of my generation who liked their job would agree with us both. So how come it perished? I've spent a lot of time trying to understand that. It's partly neoliberalism but it's also dependent on this idea that we can model everything on corporate manufacturing industries. Of course we can model some things on manufacturing industries very well: screening programmes, pharmaceuticals … all of that mass-produced stuff. But the over-emphasis on that

overlooks the other side – the personal interchanges. That's as important as the objective science. I think that's what the decades of reforms have overlooked.

We need to understand what the experience is like for *this* particular person; and what kind of internal and external resources do they need to endure, or get through, their affliction? That's the *art* of general practice, that's the joy of it. Yes, I got satisfaction from picking up a new case of hyperthyroidism for example, but the greater satisfaction was seeing people through very difficult times – helping them endure and make use of the creative spaces they could still find in their lives. We can't do that with mere science, it's something else.

ST: In answer to the question, 'what happened?', it is a crucial factor that general practice became target driven. The resulting changes were aimed primarily at standardising across practices, in order to improve the bad practices; yet 90% of practices were already doing a good job.

DZ: That ties in with our excessive modelling on manufacturing industries: *they* are necessarily target-driven, and protocol and procedure-driven, regulation-driven, and so on. But there are better ways of weeding out the DSRs: duffers, slackers and rotters. Though it's true that there wasn't enough regulation 30 or 40 years ago to eliminate some bad general practice; such DSRs could then survive until retirement age. That wouldn't happen now. But instead we've now created this 'police state' in general practice: it aimed at preventing harm but its overregulation has hazardously devitalised general practice.

ST: That's what *Your GP Here for You* was aimed at countering: can we reclaim the essence of good general practice, but keep some of the benefits of the changes we've seen? Our ideas have received widespread agreement. The key will be, can we get the government to agree and support this? The Labour government came in pledging to 'bring back the family doctor', but doesn't seem to understand what that means.

DZ: Yes, for example, designating a particular doctor for particular patients hasn't happened because there now isn't the stable bedrock for general practice. Most general practice now seems staffed by short-term, often locum-based doctors on carouselled rotas servicing enormous practices. Vulnerable people tell me of having been designated a particular doctor, yet they say they've never seen them! To overcome this, we need commitment to working with colleagues in a dedicated area, usually for many years. That's how it used to be. That was the joy of it: 'a community within a community'. And the smaller the unit, the more possible that is. I look at some practices, and they are so big that nobody really knows anybody. The massive shift to remote and phone consultations is an exponential part of this: there's something very different in sitting face to face with somebody and sharing breathing-space with them.

ST: Within bigger practices, dividing the GPs into smaller 'firms' would be a way of achieving this: groups of 3 or 4 who look after 5,000 patients.

DZ: Oh yes … yet I would also suggest they have their own working space as well, rather than having to hot-desk. Of course, you can't insist that GPs always know their patients,

but you can encourage this wherever it's both possible and desirable. That's so often what patients want. Sometimes they don't care either way: healthy people who get occasional musculoskeletal strains, chest infections, etc, maybe they don't need it. But generally speaking, certainly as people get older, they do. Such personal continuity is very important to help people through more serious and chronic conditions; then most people want that. Holding the hand, metaphorically, and guiding people who are in territory they don't want to be in. That was a big part of general practice. To help others endure, and provide practical help. 'Having people in mind' was a large part of helping them endure … and helping the GP endure!

ST: The problem with the latest generation of doctors is they don't see the benefit of the interaction itself. They see it merely as transactional. Some younger doctors don't see the benefits of knowing the family or the individual. So my proposal is for them to see these benefits. So if – say – they are required to see the same patient once a year they may develop some kind of relationship as a default…

DZ: Yes, although many advisors and politicians will say 'we can't afford that', I would respond by saying that the current way – as well as being frequently unsatisfactory for the doctor or the patient – is also much more expensive! All this was easier for me because I often knew much about the patient, and I could see them very easily – they would come and see me both for 'trivial' and substantial problems. I greatly reduced unnecessary investigations and referrals. So if a patient came to see me with – say – dizzy spells but I knew they had been having fierce rows with their partner, I could avoid referring them by enquiring about and guiding their anxiety. If you know the patient and

have seen them for minor complaints over the years, the patient is much more likely to confide with you about their personal and domestic life. You'd see them through, you would 'hold their hand'. That's largely gone. No patient is likely to confide delicately important personal matters to a one-off doctor. It requires trust that's bult up over the years. That's how I was able to significantly lower my referral and prescription rates. Streamlining and triaging consultations cannot do this: paradoxically, it becomes *more* expensive!

ST: On my last day as a GP partner I did 50 consultations, a mixture of face-to-face and by phone – far too much. I think there are several reasons for this. On a practical basis, around one in nine patients is now waiting for hospital treatment (7 million for the NHS as a whole). They are not waiting peacefully and passively. They are coming to see us as GPs. Another aspect is that complexity has accumulated: people over the years have stayed in hospital for less and less time, they now come out of hospital less completely recovered. Thirty years ago the average length of stay in hospital was 8 and a half days. It's now 4. That's going to have an impact.

And we can do a lot more. When I started, 20% of the practice were on long-term medication, usually heart or blood pressure medication. It's now 50% because of all the preventative work we're doing. That's where so much comes from. Plus, as a partner, you keep on absorbing more work without realising it because you become very good at it. Bits of work keep being added on, and you get used to it. Before you know it, you are carrying too much – like the frog slowly dying as the water heats! – My practice, to save us that fate, has now introduced a limit of 30 patients per doctor per day.

DZ: In a way, I think that's new. When I was mentored, back in the early Seventies, it wasn't like that. People then would retire with a healthy ageing fatigue yet with gratitude and affection, and thoughtful satisfaction. Not the now common and current kind of sour exhaustion – turning people who were lovingly motivated to their work into people who become cynical and alienated, and burnt out. Burnout was then much less. Yes, people got tired as they got older, but usually they would want to carry on. What I see now is more like people who have run a marathon and are distressed and imperilled in the endeavour.

ST: It's generally the tick-boxes that are the problem!

DZ: Yes, we've now created this police state. General practice used to be like joining a family. Good families are characterised by growing trust and looking out for one another. Generally speaking, they can do this efficiently and willingly. They rarely have to be regulated from the outside unless there's something badly wrong. But in general practice, the State has taken good practices and subjected them to many external frameworks they must then be compliant with. We have got this balance wrong: most don't need that much regulation. I'm not saying everybody should always be able to do their own thing. But we need to leave most practices alone, generally speaking, just as we leave unproblematic families alone. We should, instead, intelligently focus attention on where we can see trouble; yes there are cases where, clearly, things need to be investigated. But, again, generally speaking, this is unnecessary – often harmful. The erstwhile Family Practitioner Committees respected this – they kept a watchful eye,

then offered non-managerial support. Hardly ever did they tell practices exactly how to operate: they were stewards more than micromanagers.

The old partnership model helped people commit themselves to a community. They could create something. They could take pride. Speaking for myself, and the colleagues I knew, we took great pride in having our patch, looking after it and growing it with people we trusted. Of course it went wrong sometimes, but overall it was much better in all kinds of ways than having the State organise and instruct everyone.

ST: Well, I'm fighting very much for the continued partnership model: the current funding system makes it harder and harder for partnerships to continue. Partnerships struggle to remain as the majority among practices (something like 70% are partnerships and 30% aren't). But the funding model challenges survival of many. Even in the last 10 years, the amount of money per patient a practice receives has dropped by 20% (£40), on average now to £169 per patient per year. If this had kept pace with inflation over the past 10 years this would be £209. Some practices get just £130. We also have a problem with politicians who don't believe in partnerships, and think the State running it might be better. This bias is often fuelled by a misunderstanding: that partnerships are effectively private enterprises. Partners are, in fact, jointly employed by the NHS. There is no other source of income…

DZ: It's a very interesting and unusual arrangement. The partnership model is partly like running a business … but you can't charge the patient, you don't really have competition. But neither are you just a state employee. That's a rare mixture of state

controlled and autonomous practice. For me, and the people I knew, it was very attractive. I don't believe I could have been as creative or as committed as I was if I had just been a State employee being told constantly what to do.

ST: I think that's the problem. Previously we had much more freedom to act and decide. Our proposal now is to regain that freedom. A lot of people see partners as comparatively very well-paid, but they're underestimating the job's complexity and nuance – the art of being a doctor versus the manufacturing of a doctor. So it's a tricky sell. It's a bit like running a shop, where you are on the checkout but you are also the senior manager. GPs are both on the front door and running the business.

DZ: Look back 30 or 40 years. Why is it that it worked as well as it did? There then wasn't the level of dissatisfaction that there is now. There was enormous staff stability and loyalty – not just the medics but also the associated nurses, receptionists, and so on. They were much happier. They are not happy places now. I think we have to look at the sources of what worked well, and see what we can replant and regrow.

ST: That's what our current document is about: hopefully to safeguard patient safety for the future. This is a pivot point for general practice. We either buy in to something like this model, or we'll end up with GPs increasingly like pharmacists are now – being taken over by multinationals and then working as a pharmacist in Tesco rather than running their own show. The people who may best benefit financially from your work will be shareholders in corporate healthcare providers.

Or the alternative option – which is probably less likely because it is harder to do – is that general practices will go private, and we will have a two-tier system like dentistry. In the Nineties it was different because the dentists invented their own private dentistry organisation, Denplan, and it was easier for everyone to buy into that. I think the days of that are long gone.

So I think GPs could easily end up being employed by BUPA, and Nuffield, and Tesco. I estimate we have a two to three year window – a pivotal period – where it can be rescued before it tips one way or the other.

That's my view from thirty years of general practice.

DZ: The tide certainly isn't going in the way we wanted it to go, and it has dragged a lot of good things with it. It is difficult but not impossible to re-establish these things. I agree that we have to replant the idea of partnerships. General practice should again favour motivation that is fuelled and sustained by vocation. That isn't just a salaried job. It's a way of life that has deep satisfactions. Of course certain things remain essential for doctors in terms of ethics, conduct and technical know-how. But beyond that it should be about having a certain interest in individual people and in developing communities. That is what has been lost. Our healthcare planners are turning general practice into relay-posts in a vast cybernated network where each person is impersonally responsible for one task, and after that it's pass-the-parcel. The erstwhile tradition of general practice was, rather, that the GP was the personal harbour, the anchor, the

navigational map, and provides buoyancy aid. And nobody else is now doing that. We can't simply proceduralise personal care.

ST: Yes, I think we're the last generalists. There used to be generalist physicians in hospital, but they've become extinct: GPs and fewer geriatricians are now the only general physicians in the NHS. Therefore, when you've had segmented care in hospital, you have to have somewhere where there is a generalist still, who looks at everything … can put the pieces back together.

DZ: Yes, we should bring back hospital general physicians; hospital care would become much cheaper if we restored them. An example: a patient of mine developed Lewy body dementia in his seventies and was looked after by his wife. He also had COPD, developed atrial fibrillation, and had Type 2 Diabetes. He went into hospital repeatedly because he would freeze, he would get urine infections, chest infections: he had to be looked after. But each time he went into hospital, his care was split up into different specialties and he saw about eight different teams. Each time, *all* the tests would be run through again. The most absurd example was referral to a trainee neurologist, who ordered yet another brain scan. Why? Probably because this trainee will never see the patient again; he will only be on that team for maybe two months, due to the rapid rotations. So each specialist thinks they had better do any and every investigation they can to avoid any future blame. There was no guiding senior doctor in overall charge. If the patient had been looked after by a general physician, they could have managed such a chronic and complex scenario with far greater intelligent sense, sensibility, and economy of finances and resources.

ST: I agree. We've lost the generalist in hospital, and we're in danger of losing the generalist in the community.

DZ: it's much easier to be a general physician, a GP, if you know people. You know how they've changed. You know what they'll tolerate, what they'll respond to... And you know your colleagues...

ST: ... and you know whether particular patients actually want further investigations or treatment, or what their life hopes are.

And what was the point of that extra scan? There was no point.

DZ: But current specialism-siloed doctors will do that as a default ... and this example costs another £1,000 ...

ST: So the NHS could be saved a lot of money just investing in more generalists.

DZ: Surely! Yet for GPs to be better generalists we need them to want to stay the course and provide continuity of care. With smaller teams, including the receptionist. Receptionists used to know patients...

ST: I'd agree with that as well. That's a particular challenge where you have these huge practices. By contrast, in my smaller practice, my receptionist would, for example, pick

up the early dementias. There's a lot of evidence that smaller practices are better in many ways. That evidence has been there for many years. Yet it keeps being disregarded.

DZ: I think the largest obstacle now comes from our cultural, industrial-manufacturing mindset. This doesn't understand relationships and so then urges us to think that the only important thing is to streamline the manufacturing process, and therefore scale up and centralise wherever possible. If it is expeditious to outsource something, we do that too. That's what manufacturing industry is about, and it works very well for motor cars or bottles of vinegar. But it doesn't work well when we're dealing with complex human needs. I am often opposed to giantism and centralisation there, except for very specialist, science-based activities. In other words, we can't do cardiac surgery in a little cottage hospital. We have to centralise that expertise, because these are very specific and elaborately scientific activities. For primary care, which is also the place of initial assessment, localism and small scale becomes much more important than centralisation and scaling up. Yet the current prevailing idea is to put everything in large centres and so have all services in concentrated management. This makes for enormous practices which are (wrongly) assumed to be much more efficient, by avoiding the duplication of premises and the infrastructure for running separate practices etc. I understand the logic, but it's false, because general practice is a different kind of activity from hospital specialisms.

ST: I worry that the memory of good practice will be lost if we are not careful. One of the huge losses in society is where we don't listen to those who have been around a long

time, and we assume they don't have any valuable experience-based knowledge. That's seriously short-sighted: a Western society problem.

Darzi recently talked again about introducing neighbourhood-merged centres, which we tried 20 years ago. There's talk, too, of amalgamating all the ICBs, which sounds like erstwhile Area Health Authorities. We'll be reinventing what we've had before, without learning why it was broken up in the first place … why it didn't work.

DZ: Revisiting a time before that … as a much younger doctor, I sat in on pioneering Balint groups. They were mentors for me, and enormously important to me in developing the skill of trying to assess and use what the patient was *not* saying. What was *not* explicit in the consultation, and how could that be used. So that's all the stuff that doesn't appear on spreadsheets, official diagnoses, tick-boxes, computer codes, and so on. It influenced my practice enormously, and many of my generation. But it's got swept away in the last 30 years. The 'Balint Society' now is very much like devotees of vintage cars: it's become increasingly unviable, because if you don't have continuity of care, how much can you use the inexplicit in the consultation?

The more you see of somebody, the more of somebody you see.

ST: It's helpful to be reminded of this, because GP training has increasingly become another tick-box exercise with all its perverse consequences. As I talk to people about the proposals in *Your GP Here for You*, I'm thinking that here are ways to help people understand the discarded, now overlooked, benefits both to patients and to their

doctors … and therefore to greater society. We have lost so much! We can make a start at reinstating relationships by, for example, encouraging GPs to offer annual discussion-review bespoke consultations.

'I'll give you half an hour, let's have a chat. Let's create a plan, you and me'.

DZ: Yes, but to create such spaces we need to consider how necessary rigid regular testing or treatment regimes should be. Yes, there are certain things where this is very important. Of course, we should support – say – measles vaccinations … because if you get epidemics of measles it's very serious for communities d. But elsewhere it's important to say 'we can possibly reduce the risk of this, and this, and this, are you interested?'. But I don't accept we should pressure people into having many things.

ST: I think that's the problem, particularly when the doctor delegates such work to somebody else. So if I'm doing this as a GP I will have a nuanced conversation with each person. If I give it to the nurse, she or he will be determined by protocol. And because it's protocol-driven, she must do it. It's the same with pharmacists, they will have to be protocol-driven. The traditional freedom we had as GPs was to use nuanced judgement and discrimination.

In this spirit NICE guidelines have become NICE rules. Our younger generation of doctors tend not to make that distinction.

DZ: I have a personal, brief example of that. I now sometimes get older person's aches and pains, fortunately nothing serious. I take diclofenac, infrequently, for a few days. So the GP says 'I'm going to have to give you lansoprazole. The guidelines say you should have lansoprazole'. I say 'please don't give it to me, I won't take it'. He says, 'I'm going to prescribe it for you anyway, otherwise I get into trouble with the authorities'.

That's a kind of madness!

ST: It sounds as if that particular doctor doesn't think he has the option of having a nuanced conversation with you about the extremely unlikely possibility here of a catastrophic GI bleed. Risk-management rarely achieves risk-elimination. Our current governance has often become clunky and clumsy in its over-reach of control. But I think such discrimination largely makes up the art of medicine – a broad view of personal well-being being its foundation. That's very different from manufactured medicine where, for example, we're trying to get everyone's cholesterol below 5 and their blood pressure below 135/80.

DZ: That's what I call 'civic engineering'. It's where we have complex human problems and we let them be defined and manipulated by designated experts who then mandate mass-compliance. The art of medicine is very different: it is to know how to engage people and their own internal resources. What is it that they want, and want to do? What is it they can bring to this? Civic engineering says: 'No, we're simply going to give you this, and we're going to do that'. Of course it's necessary sometimes.

But it shouldn’t increasingly be the determining principle: isn’t that now a large part of our many more subtle healthcare problems?

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