

If we fast-track primary care, what do we lose?

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Speedier access, diagnosis, treatment and despatch may seem like undeniable progress for our healthcare. Yet such benefits may come with a large, though less obvious, sacrifice.

BBC Radio 4's *Today* programme recently (7.11.17) carried another brief discussion between two healthcare experts: Dr E, an entrepreneurial GP, and Dr RC, a senior GP speaking on behalf of her Royal College.

They were talking about the now widely reported problem of patients' difficulty in getting access to a GP. This is getting worse: what should be done? Dr E's idea is to rapidly increase the use of digital media technologies, so that most consultations could be done by email or Skype. This circumvents the usual requirement for face-to-face consultations with a known doctor in a familiar place. Our flexibility of service, and thus its efficiency, are thus considerably increased.

Dr E described how these e-doctors will operate. Because they are unhitched from local surgeries patients can be quickly streamed to wherever a duty doctor is connected and available. Waiting time can be cut to almost zero. Premises and staffing expenses are much reduced. This does require, however, that patients will deregister from their familiar local doctor for the convenience and rapidity of the e-doctor service.

Dr RC cautioned restraint. She saw such 'progressive' expedience as destabilising surrounding 'traditional' practices: GP practices are already dysfunctionally stressed from lack of doctors; if their already depleted staff are further reduced by doctors being lured to work in these virtual-consultation services, the established practices may be rendered unsafe and unviable. What will we be left with?

Today's time constraints courteously guillotined the discussion and this question.

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Dr RC's question can be interpreted as a large and seminal one, extending to the nature of medical consultations and their meanings. For Dr E's expediently clever, state-of-the-art technologised service seems to represent a certain kind of future medical practice. It vaunts a certain primacy: rapidity of access and delivery, and quality, to be assured by procedural uniformity and mass-management. To the more casual observer this can only be a good thing, surely? And if so then Dr RC's objections of destabilisation of the status quo can be politely dismissed: such is progress.

Yet the kind of consultations Dr E is wanting to propagate compromises much more than any short-term administrative stability. We also lose some essential human foundations of personal healthcare: context, meta-communication and personal continuity of care. These will be exemplified shortly.

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Dr E's working assumptions seem to be that medicine can be quickly and effectively reduced to algorithmic systems of diagnosis and treatment: presenting problems are seen as essentially *technical* and can thus be competently engaged, managed and despatched by any properly trained professional subject to correct governance. This underlying, narrowly biomechanical view of medical practice has become more prevalent in the last two decades and Dr E's system represents, for many planners, a desirable future. Why is this?

Well, procedural biomechanical medicine has been extraordinarily successful over the last century: our medical and surgical treatments now routinely cure many previously lethal or crippling infections, cancers, vascular and orthopaedic conditions. Likewise, our public health procedures have consigned many devastating or deadly contagions to history. In addition, such impersonal, systematised and procedural approaches can be more easily standardised, monitored, measured, managed and policed than approaches that are more guided by idiomatic context, metacommunication and personal continuity of care. No wonder, then, that such an approach is favoured by healthcare planners and economists, managers and politicians.

Yet such schematised healthcare has serious limits. We can see, for example, how the procedural biomechanical approach – exemplified by Dr E – can only deal with one person or illness at a time. It is most unlikely to perceive, and thus understand, other patterns or meanings. For example, how do we understand the person who has, sequentially, many apparently unrelated complaints? Or the family in which, similarly, apparently unrelated complaints seem to be rotated, or competing for attention? Or the person who, over most of their life, is never really well, yet never definably and substantially ill? Or (the statistically well-proven) fact that morbidity and mortality rates from myriad illnesses and accidents all substantially increase around periods of personal stress, loss and transition, *whose seriousness is defined by the patient?*

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Here are three illustrative authentic vignettes garnered from a more traditional – so personal – general practice. It can be seen that the denoted themes largely overlap and are interchangeable.

Situation 1. Context

Mustafa is clearly miserable with his spinal and sciatic pains. He is telling Dr A that in this last week the pain has been worse than ever. He knows that he is already on a high-dose cocktail of analgesic drugs but asks: 'isn't there something else you can give me, doctor?'

Dr A knows that Mustafa's pains are consequent to a tragic motor accident last year when Mustafa was driving. He sustained spinal injuries, but his wife, Abiba, died rapidly of head injuries. Mustafa's complex grief has many conflicting and tangled emotions: it is like a very tender wound – he does not want it directly touched, but he wants it understood and palliated.

In looking at his records Dr A sees that last week was the anniversary of the accident and Abiba's death.

Dr A gently leans forward. 'Mustafa, I can see how much the pain is upsetting you ... I'm aware, too, that it's this time last year that you lost Abiba. Do you think that's why your pain is worse?'

Mustafa is silent for several seconds, breathing deeply through his nose, then covers his face with his hands and sobs. Dr A is deeply affected, but waits patiently and quietly.

A minute later Mustafa settles to a different kind of tearfulness, now peaceful and receptive.

'I think you need a lot for your pain, but not more tablets ... Come and see me next week and we can talk some more', says Dr A softly.

Mustafa nods and smiles through his tears. He reaches out to Dr A, to grasp his hand.

Situation 2. Metacommunication

Abigail has known Dr B for many more years than she has known Marco, her husband. She had married Marco soon after the painful crumbling of her long-term affair with Sean, a married man with three children. Abigail's deep and committed love for Sean could not countervail or undo Sean's ambivalent love and sense of duty to his wife. The dying of the affair precipitated in Abigail many symptoms which were presented to Dr B: functional polysymptoms, he had recorded, thinking of her mostly privately borne turbulence, grief and protest.

When Abigail 'found' Marco and quickly announced their engagement, Dr B had silently hoped this was not part of a 'rebound syndrome': a way of attempting to rid herself of her pain, loneliness and sense of humiliation.

Abigail is now seeing Dr B for the third time regarding a general malaise and vague giddiness. Dr B says to her: 'Abigail, I can't find any problem examining you, and there's nothing in your story or all your tests to indicate any physical illness. Tell me, are there problems or stresses at work, or with your family...?'

'Oh no. They're all fine', she replies with level clarity.

'And at home, with Marco?'

Abigail now shifts sideways in her chair, with sudden discomfort. She crosses her left leg over her right and tucks her left foot behind her right, simultaneously crossing her arms: defensive closures. But then she uncrosses her arms to feel for her wedding ring, which she turns so that the precious stone is turned in to her palm, as if secreting it. She clears her throat and looks away from the doctor, up to the right-hand corner of the room. She bites softly on her inturned lips.

'Oh, it's ok', she says in a sagging, fading tone.

Dr B thinks he is, suddenly, on delicate territory. He does not now pursue this more directly, nor does he propose more tests or treatments. Instead he offers another imminent appointment to see what kind of conversation is possible or welcome.

Situation 3. Personal continuity of care

Since her excellent A level results and acceptance at her first-choice university, Sharon seems unhappy and deeply troubled. She complains to Dr C of tearfulness, poor sleep, painful periods and worsening acne.

Sharon's parents, Mr and Mrs Y, also seem disturbed and dis-eased. Mr Y's recurrent dyspepsia is worse. And he, too, is sleeping poorly – awakening sometimes with heartburn and a troublingly vivid awareness of his heartbeat. He thinks his recent increase in smoking and drinking might be relevant. So, too, his unsettled and fractious mood.

Mrs Y's symptoms have also intensified: migraines, hot flushes, emotional lability ... and then, at the end of a consultation, her description of vaginal dryness, 'but it doesn't really bother me doctor – though I know it should ... do you know what I mean?'. She looks at Dr C directly.

Dr C nods his quick and tacit understanding.

What is it that Dr C understands? And how has he arrived at this? Dr C would say it is from many apparently disconnected fragments over twenty years: his careful and clear records, too, can easily augment his memory. He still has clear memories of Mr and Mrs Y coming to him as a young couple, before they were married, with the accidental conception, of Sharon. Their joint religious conviction led them unwaveringly to a commitment to the birth, and to sanctifying marriage. But their good intentions were not matched by a natural or contented compatibility: Mr Y was reclusive and introspective, needing space; Mrs Y was extrovert and gregarious, seeking responsive contact.

Over the years their presented ailments to Dr C would come with discrete references to their honourably borne and discretely conveyed marital gulf and dyscompatibility. 'We've got Sharon and that's it', Mrs Y had said ten years ago: a short utterance pithily summarising history, predicament and prophesy. Another child was never conceived and Sharon rapidly developed into a precociously mature child conveying the gravitas of her family role – the lynchpin in this anxiously bonded triadic family: she was the life-purpose of both her parents, both individually and together; she kept them apart and kept them together. For everyone's 'happiness' she must be there, playing her role and paying attention.

So now, age eighteen, Sharon stands at the fragile family's Rubicon: dare she cross to leave for university, and independent life? How will her parents then deal with one another? With themselves? Can Sharon bear it?

Dr C knows he cannot solve or 'fix' any such problems. But his personal knowledge and understanding can help him to help them understand, contain, and creatively guide life's ineradicable predicaments. That, he has come to realise, is fundamental to palliation, healing and the whole of pastoral healthcare. These navigations of personal experience and meaning lie at the heart of what Dr C considers his life's work as a family doctor: something no algorithm, care plan or computer program can ever really engage.

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Yet on the radio our two expert doctors broadcast a view of medical practice devoid of such personal perceptions. Dr E cheerfully excluded them from relevance, while Dr RC had time to talk anxiously only of professional survival.

Meanwhile Dr A, Dr B and Dr C fear not just for the survival of general practice, but what kind of human activity will survive such a planned future.

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